International Journal of Drug Policy 71 (2019) 56–61

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

Care, agency and criminality: Making sense of authorised extended distribution in the accounts of key stakeholders

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ARTICLE INFO

Keywords:
Extended distribution
Secondary exchange
Satellite exchange
Needle and syringe program
Peer-led intervention

ABSTRACT

Introduction: One of the current harm reduction debates in Australia concerns the legalisation of the extended distribution of sterile needles and syringes, a practice that is currently unlawful in most Australian settings.
Methods: We used data from a unique pilot program of authorised extended distribution to document the opinions held by 22 key stakeholders -service staff, drug users and police - about the risks and benefits of authorisation, and to analyse the ways in which drug users were understood within these.
Results: Opinions were strongly in favour of authorising extended distribution, based on the belief that this would reduce the transmission of hepatitis C. However, stakeholders also identified that distributors risked attention from police and some noted that the consequences of this would be borne by distributors themselves and not the services that support them. These opinions rested on specific assumptions about people who inject, some of which reflect negative constructions of drug users as a source of danger to the public or as helpless 'addicts' with little control over their risk reduction. But there were other representations that positioned drug users more positively as responsible agents with a strong duty of care to themselves and others whose choices are often limited by inadequate service structures. Staff participants drew on these understandings in careful and strategic ways, arguing for the rationality and expertise of drug users, while also problematizing the individualised approach that any form of authorised extended distribution might take.
Conclusion: We argue that localised and incremental changes such as those that took place to support this pilot project, and the extensive support for extended distribution among stakeholders in this study including police, creates meaningful opportunities to think about extended distribution differently, which can in turn support conditions for future discussions about legislative change.

Introduction

Extended distribution of sterile needles and syringes has received modest ongoing attention in the research literature over the past 15 years. It refers to the 'informal' supply of sterile needles or the practice whereby people who inject drugs give new sterile needles that they originally obtained from needle and syringe programs (NSP) to their peers (Bryant & Hopwood, 2009; Lenton, Bevan, & Lamond, 2006). In New South Wales (NSW), Australia's most populous state and the setting of the current study, this practice is unlawful. People who pass on sterile needles without the legal authority to do so are subject to prosecution, a situation that has attracted some recent debate and attention.

The peer-led informal supply of sterile needles is, of course, not a new phenomenon – there is a long and important history of peer-led harm reduction. Underground needle exchanges were developed by drug users in multiple locations in the 1970s and 80 s, including Rotterdam and New York for example (Freidman, de Jong, & Rossi, 2007), as a way for users to protect themselves from blood-borne viruses. These early initiatives have developed into the range of modern, formal, state-sanctioned NSP that exist in many international settings today. Australia supports a wide network of NSP through public and private sector initiatives: primary stand-alone outlets run by peer groups or government health departments; secondary distribution sites such as hospitals, community health centres, mobile programs and vending machines; and private distribution via community-based pharmacies. While sterile needle distribution is supported through these formal mechanisms, any form of extended distribution is unlawful unless a person has a special legal exemption. Current exemptions apply only to NSP workers and pharmacists and they leave all others who

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https://doi.org/10.1016/j.drugpo.2019.06.008

distribute, most notably people who inject drugs, exposed to criminal conviction (Lancaster, Seear, & Treloar, 2015). In practice, this legislation has been associated with one known criminal conviction (Schimmel, 2002) and is thought to significantly limit the kind of intervention work that NSPs can undertake (NUAA, 2009).

Research from other parts of the world shows the potential of extended distribution to innovate existing harm reduction programs. In the United States and United Kingdom, where there are well-established NSP, informal extended distribution is seen as the next platform by which to reach large numbers of people who inject (Craine, Hickam, & Parry, 2010; Des Jarlais, McKnight, & Goldblatt, 2008). In other settings, such as Russia, where NSP receive much less support, a formal model of extended distribution has been trialed, involving the training and supervision of volunteer drug users who distribute to their peers. This showed that extended distribution could reach more drug users and distribute a higher volume of needles than fixed-site exchanges in the same setting (Irwin, Karchevsky, Heimer, & Badrieva, 2006). The current environment in NSW means that neither formal nor informal extended distribution can be supported, a situation that is thought to shut down opportunities to build on the existing successes of harm reduction.

This disjuncture in NSW between the unlawful position of extended distribution and its potential to reduce BBV transmission has been the subject of recent scholarly work by Lancaster et al. (2015). They used legal and policy documents related to extended distribution to document how people who inject are commonly cast as irresponsible and untrustworthy and argue that this fundamentally constrains how needle provision can be thought about: people who are seen to be untrustworthy cannot also be given the task of dispensing sterile equipment to others. We seek to extend this analysis in the current paper by examining how people who inject are constructed in the discourse of some of the key stakeholders involved in the extended distribution debate in NSW. We draw on data from the evaluation of a unique pilot program of authorised extended distribution that took place in Sydney. We document the perceptions held by key stakeholders about the risks and benefits of authorised extended distribution and explore what these opinions reveal about how people who inject are understood and what implications this holds for changing the current regulatory environment.

Methods

In 2009, the NSW peer-based drug user organisation, the NSW Users and AIDS Association (NUAA), together with other advocates including researchers, government policy analysts, and harm reduction clinicians and service providers, began collaborating to develop strategies to change the legislative arrangements of extended distribution. In 2013, a pilot project was established at two of NUAA's NSP after the government granted a temporary exemption to the laws that criminalise extended distribution, allowing clients of NUAA's services to legally distribute sterile needles to their peers. The legal exemption was applied to a fixed site primary NSP situated in inner city Sydney and a mobile van outreach service located in a suburban part of the city.

The pilot program

The pilot project ran for a period of 22 months from October 2013 to June 2015. It was designed by NUAA to involve minimal intervention. This reflected their wish to avoid creating confusion and fear among clients who already distributed sterile needles about the unlawful status of this practice. As such, the pilot maintained the standard distribution practices of the NSP, with the addition of some targeted and coordinated messaging to clients which were developed by staff during a one-day workshop. Twelve messages were conveyed by staff to clients in brief conversations and were used on signage at the NSP. (Example messages included 'Are you just picking up for yourself today?' 'You can pass these on to your mates'.) Also, clients were provided with a wallet card to show police in the event that they were questioned about distributing sterile needles. (Data evaluating these aspects of the pilot are reported elsewhere (Brener, Cama, & Bryant, 2018). Thus, a formal model of extended distribution, of the kind implemented in Russia for example (Irwin et al., 2006), was not used. Clients did not undertake any training to purposely distribute sterile needles, nor was their distribution closely monitored.

The evaluation

The research design used a mixed-methods approach which included a quantitative survey and a series of in-depth interviews. Interview data are the focus of this paper. We targeted three groups of stakeholders: clients of the authorised NSP services, staff at the services, and police officers from the local areas in which the services operated. These groups were selected in consultation with NUAA and the evaluation funders as they were thought to have the highest investment in the authorisation of extended distribution, and were most feasibly recruited with the resources available for the evaluation.

We used purposive sampling strategies to recruit a total of 22 interviewees: 10 clients and 6 staff of the authorised NSP services, and 6 police officers. Service clients had to be aged 18 years or older and had to have used the services in the last month. They were recruited via a leaflet with the research team's contact details that were distributed by staff. Police officers were recruited from the police stations in which the two authorised services were located. Police officers were purposively selected from each site based on their professional role in policing, assuming that those in management roles and in street duties might have different perspectives and experiences of extended distribution. We sought views from general duties officers (responsible for street policing), crime managers (responsible for day-to-day administration and decision-making at the local stations) and commanders (responsible for overall leadership of local area stations). Interviewees were selected with the assistance of the crime managers who were asked to shortlist potential participants based their professional role and their willingness to be interviewed. These shortlisted participants were then provided with an invitation letter from the research team.

Staff were also purposively selected based on their professional role within NUAA. We sought views from those who worked at the NSP front desk and had direct, daily interaction with clients, and those in management roles. Being a peer-based organisation, most staff had current or past personal experience of illicit or injecting drug use. Possible interviewees were shortlisted by the NUAA executive team in consultation with the research team and in relation to our purposive sampling criteria. Staff interviewees were invited to participate using an invitation letter from researchers.

Interviewees were asked about the impact that the temporary authorisation had on their day-to-day practices, and for their opinions about the risks and benefits of authorising extended distribution on a broader scale across NSW, including what implications there may be for others in their professions. Interviews took approximately 30 min and took place in person at the police stations (for police) and the NSP service (for staff and clients). Interviews were audio-recorded and transcribed. Clients were given $20 for taking part in an interview. Other participants were not reimbursed.

An iterative thematic analysis approach was applied to the data. The research team read a subset of transcripts and met several times to discuss and develop a coding frame, until an agreed set of codes was established. Data were then coded by a research assistant according to the agreed coding frame.

The research received ethics approval from the Human Ethics Research Committee at the University of New South Wales.

Results and discussion

The ten client interviewees included nine men and one woman, ranging in age from 21 to 63 years. All reported that they distributed sterile needles to their peers. Of the six staff interviewees, four were female and two were male. All had worked for NUAA for at least one and a half years, with the longest reported to be 6 years. All of the six police officers were male. Two held senior managerial positions (25 and 28 years of policing experience) one held a middle management position and three were general duty officers (with five or fewer years of experience).

All participants felt that there was overwhelming benefit to authorising extended distribution and that there were few risks. They identified that there was the potentially enormous benefit of reducing the transmission of BBV, and that extended distribution could reach people who might not otherwise have access to a NSP, a group they called 'hidden users'. But they also identified that authorised distributors would attract attention from police and that the consequences of this would be borne by drug users themselves and not the services that support them. Some of these opinions about risks and benefits rested on specific and negative assumptions about people who inject – as 'victims' of their addiction, or as untrustworthy and a source of danger to others– but others reveal strong counter-representations of drug users as active and capable, and as people with altruistic intentions and a strong duty of care to others.

All benefit: reducing BBV transmission

The overwhelming view among participants was that the benefits of authorising extended distribution in NSW were many and the risks were few. All groups of participants – clients, staff and police – expressed this view. It was based on a belief that the authorisation would reduce BBV transmissions, a logic that assumed that if the practice was legitimised then more sterile needles would be distributed and more people would use them.

Clients were most fervent in expressing this belief. When asked for their opinion about the potential benefits of authorised distribution many responded with disbelief, feeling that the answer was obvious: 'I can seriously only see beneficial outcomes from it' (Client 4) and 'there are 100 reasons why' (Client 2). Police also shared the view that authorisation could reduce BBV transmission and that they couldn't 'see any downside to it' (Police Officer 2); and some officers were surprised it was a criminal act, believing instead that the restrictions around informal distribution came from government health policies (Police Officer 3). However, some police participants, while seeing the potential benefits for BBV reduction, expressed reluctance about authorisation and, as described later in the paper, could not easily separate the carrying of injecting equipment from the criminality of drug use.

Staff also fervently expressed their belief that authorised extended distribution could reduce BBV transmission risk. They identified a series of related benefits, including the opportunity to develop new ways of doing harm reduction work, the important symbolic meanings of care attached to authorisation, and a decreased risk of BBV transmission to the wider community:

> Not only does that have a beneficial effect for the people that inject drugs but it also has a benefit for the wider community and the police and the ambulance service because for the simple fact that the less sharing there is the less chance of transmission. (Staff 3)

Staff identified how authorised extended distribution enabled new ways of working within the NSP, including changing the way they packaged equipment for distribution and what they could say to clients:

> It's a way in which we can target peer education messages and actually look at and have discussions with people about how they distribute and what do they do at the point of distribution and …. I think it does allow more frank and open conversations around initiation and a whole range of things around injecting process. (Staff 4)

The authorisation gave staff permission to engage clients in conversations about their distribution practices and package needles specifically for them and their varied relationships and connections. For example, clients who picked up needles for themselves and their sexual partners could be provided one package with two separate containers of needles; thus, permitting a mode of sterile needle distribution that treats partnerships, rather than individuals, as the primary unit to be resourced, and forefronts shared responsibility in risk reduction (Fraser, 2013).

Finally, while staff fully supported the view that extended distribution could reduce BBV transmission, they cautioned against this being seen as the only benefit. They argued that the authorisation had important symbolic meaning by legitimising the care that drug users show for themselves and their peers, demonstrating that 'we are not selfish addicts, self-centred and unkind people and that we do give a fuck about each other and are willing to make sure that we are all looked after within our group.' (Staff 5). For some staff, this was viewed as the main benefit – that the authorisation would be an explicit acknowledgment of the self and community care that drug users take part in.

Participants belief that authorising extended distribution would reduce BBV transmissions rested on a specific logic that if drug users were provided with more sterile needles then they would use them. Here, drug users are seen to be capable of acting responsibly in relation to their own risk reduction, acting as 'public health agents' (Bennett, Bel, Tomedi, Hulsey, & Kral, 2011) working to protect themselves, their peers, and the wider community. This view was particularly evident in the narratives of staff who believed that the authorisation has political potential to destigmatise. This destigmatizing has important material effects since, as Hassin (1994) describes, negative representations can be internalised, and affect how people see themselves and present to service providers and to each other. Other research shows how drug users who actively take part in harm reduction activities experience increased confidence and sense of control, and an appreciation of their own expertise (Wagner, Davidson, Iverson, & Washburn, 2014). Positive representations of care and responsibility make space for drug users to understand themselves as essential players in the needle distribution effort.

Yet, as we describe in the last section of the paper, staff had reservations about the extent of responsibility placed on drug users in relation to extended distribution. They worried that there would be insufficient attention to the structural constraints involved in people's efforts to pass on sterile needles – structural constraints such as socio-economic inequalities and stigma, the limits to which services can support extended distribution activities, and most importantly the environment of drug prohibition in which any harm reduction practices, including extended distribution, must operate.

Benefit: meeting the unmet need of "hidden" populations

Authorised extended distribution was seen as a particularly useful method for getting sterile needles to 'hidden' drug users or people who are 'hard-to-reach' (Staff 3) who do not have easy access to NSP services. Some staff believed that this was a key benefit:

> Sterile injecting equipment will be getting into the community for people who are in need and close up that gap of unmet need. (Staff 1)

Clients also noted this as a benefit, identifying it as a way to help people who could not get to an NSP due to being sick, or who had no transport. One client explained how the authorisation did not benefit him personally, but that he believed it had helped others who he perceived to be more prone to risky behaviour:

> Well, it hasn't helped me but it's helped them, because otherwise they would re-use somebody else's. (Client 6)

Another client described something similar, that extended distribution could help people who were 'hanging out' (in heroin withdrawal) and in immediate need of a sterile needle and syringe. He

explained that while he was able to say no to reusing a syringe, others were not as 'fortunate':

There are many people who, especially if you have got a habit and you are hanging out, if somebody came along and offered you something like that there are people who wouldn't think twice, they would choose the drug. (Client 2)

In these accounts, 'hidden users' are seen to have greater needs and to engage in riskier behaviour. Staff interpreted these risky behaviors to be a product of inadequate service delivery structures and not to any shortcomings of people using the services. They talked about 'closing up a gap' in service delivery, and in doing so placed the responsibility for improving risky behaviour with harm reduction services and not with people who inject. Underpinning this were staff views that drug users could be and were responsible agents in the management of their equipment and BBV risk, but that they were constrained by the arrangements of the service provision system and the policies that structure it.

Clients' accounts rested on a more individualised view of 'hidden users'. They described 'hidden users' as a group whose drug dependency overrides their capacity to source equipment for themselves: without help, they 'wouldn't think twice'. The interpretation provided by staff – that there were inadequate service supports for 'hidden users' - was much less prevalent in clients' narratives who instead relied on representations of 'the addict' prevalent in disease models of addiction interventions such as Alcoholic or Narcotics Anonymous (Gowan, Whetstone, & Andic, 2012; Karasaki, Fraser, Moore, & Dietze, 2013). In these, drug users are seen to be slaves to the addictive pharmaceutical properties of the drug. They are thought to be powerless in controlling their use and, as identified by participants here, seen to be almost helpless in their decisions around risk reduction.

Representations of drug users as lacking agency have highly problematic material consequences. Views of people who use drugs as unmotivated and indifferent to the consequences of their drug use are widespread and these can be internalised by drug users themselves as 'spoiled identities' (Cama, Brener, Wilson, & von Hippel, 2016; Hassin, 1994; Scambler & Hopkins, 1989) and also impact on how they understand the actions and choices of their peers. These deficit representations have particular salience in western cultural settings where self-management is seen to be a marker of a person's worth and value (Beck-Gernsheim, 1996), and their power lies in the fact that those very people who are most subject to their stigmatizing capacity can also be the ones who recount and reproduce it. Indeed, as Client 6's account describes, this sort of representation has a divisive 'othering' effect, whereby 'hidden' and ostensibly more needy drug users are cast as suspect and drawn on as a way to establish one's own position as capable and self-managing. The deficit meanings attached to the 'disease model' of drug use also make it much less likely that drug users will see authorised extended distribution as something they can contribute to or participate in.

Staff also draw on the 'disease model' but do so as a way to problematise the inadequacies of state-structured harm reduction services. They use this representation to 'deindividualise' harm reduction discourse, which often places extensive responsibilities on drug users, and direct attention to the material constraints in which extended distribution is practiced. Staff narratives demonstrate the careful epistemic work they undertake in drawing on harm reduction discourse and arguing for the rationality and expertise of drug users, while also problematizing the individualised approach of harm reduction policy which hides the difficult day-to-day contexts of some drug users' lives.

Notably, none of the police participants talked about 'hidden' drug users and the potential benefit for them of extended distribution. Instead, as will be outlined next, police participants tended to view drug users in much more negative terms as prone to criminality and potentially dangerous.

Risk: increased police attention

The most commonly identified risk associated with authorising extended distribution was that distributors would attract police attention. It was widely reported by all participants that carrying injecting equipment triggered police searches. Police explained their reasoning for this:

It's an indication of them using an illicit drug. And, of course, the response to that is that they're gonna be more thoroughly searched' cause there's always the suspicion that they're actually still using or still have the drug on them. And, further to that, of course, that that group or types of persons, that they're the type of people we're looking for for committing break and enters and stealing from motor vehicles. (Police Officer 3)

Far from signifying responsibility and self-care, for some police participants, the possession of sterile needles was seen as a marker of criminal behaviour. Indeed, sterile needles were seen to signify not only personal drug use, but a range of other much more serious crimes. Clients' told concurring stories:

I have been carrying them back [from the NSP] and they have seen them in the yellow canister and they've said have you got anything in there and I have told them straight up - and they like don't want to go putting their hands in there obviously without putting on their rubber gloves and I just pull the canister out and go look "I'm just walking down there to exchange or give back blah blah…" but they did still give me the third degree sort of because they had the sniffer dog go around me and the sniffer dog found nothing but they still dragged me off around the corner and searched me and stuff. (Client 3)

Carrying injecting equipment, even in large quantities, is not an offence in NSW. However, the meanings police attach to needles and syringes played a significant role in the way that authorised extended distribution happened in the setting of the trial. Police narratives describe drug users as inherently suspect – the 'type of people they look for' – and necessarily criminal because of their drug use and the activities this is assumed to include such as break and enter and car theft. Their reasoning reflects the logic of the prohibitionist drug law environment where drug use is understood as deviant and drug users are seen to require strict regulation. This reasoning remains even when drug users are engaging in harm reduction activities – such as by carrying sterile needles to distribute to others or, as Client 3 describes, when they return used equipment to an NSP.

Representations of drug users as anti-social and prone to criminality have important consequences for how authorised extended distribution might happen day-to-day. As clients' accounts suggest, the threat of prosecution is significant and restricts their opportunities to collect, distribute and return needles to and from the NSP. In such a setting, it will be unlikely that the full potential of extended distribution can be achieved, especially when distribution activities are forced to be concealed, restricted to private settings or done quickly to avoid notice. Other analyses of harm reduction interventions also identify this (Holloway, Hills, & May, 2018; Lancaster et al., 2015) and question how innovations in harm reduction can ever be impactful without changes to the prohibitionist legal framework in which illicit drugs are understood. Indeed, the accounts of participants here support this: even if the distribution of sterile needles is authorised for peers, this does not change the meanings attached to needles. Injecting equipment is a signifier of criminality and any person carrying it is suspect.

Risk: the burden of responsibility placed on drug users

The responsibilities placed on drug users were identified as a concern for many staff and some clients. Staff in particular noted that much of the risk associated with extended distribution would be carried by the people distributing and not the programs or institutions supporting them. As above, the prohibitionist environment and the risk of police attention was central:

We have to take care about how we utilise people to be walking the streets with backpacks full of syringes when, because my question always is, it may be legal for them to do that, they are supported by their own NSP to do that, but if they get pulled over by the police and they have got that amount of syringes on them they are going to get searched. So while we still operate within the prohibitions framework - I think we need to be careful about what we expect the individual drug user to do. (Staff 4)

Clients' accounts provided further detail about how police attention could result in significant losses. Client 2 described how he worried about losing his home. He and his partner had invested considerable time and resources to secure their home, and this was put at risk through his distribution activities:

But the reason we told them [needle recipients] to go as far [away] as they can is because if they do get busted, and they do get asked where did you get your stuff from, and they can point out our place, you know, we are homeless instantly. (Client 2)

Staff worried that it was these associated risks that would not be given sufficient attention in any formalised extended distribution setting: even if the distribution of sterile needles is authorised, this does not remove police surveillance and its associated consequences, including that drug users might become 'instantly homeless'. Here, staff critiqued the individualising tendency common to harm reduction interventions where insufficient attention is paid to the structural conditions in which drug users live. Prohibition is one obvious structural constraint that was identified by staff, but there were also others: the material contexts that shape some people's dependency on drugs in the first place (Moore & Fraser, 2006) such as volatile family histories, poverty, and early disconnection from education and employment; the environmental conditions by which people who use drugs make decisions about their risk reduction (Rhodes, 2002); and the difficulties faced by disadvantaged and stigmatised people in navigating complex social and health services (Treloar & Holt, 2008).

Evident again in staff narratives is the way they engage in 'epistemic work', drawing strategically on representations of people who inject as rational, responsible and capable of self-management, but equally as vulnerable to the material conditions of their day-to-day lives and the failures of service systems to adequately support them. They mobilise different representations of drug users, at different times and for particular purposes. In doing so, we argue that they create space to think about the authorisation of extended distribution as an opportunity to do harm reduction differently – to 'deindividualise' it and consider how structural support can be better provided through policy and practice.

Conclusion

The temporary authorisation of extended distribution in two of NUAA's NSP services provided a unique opportunity to document the perceptions held by key stakeholders about its risks and benefits. Most of our participants were overwhelmingly supportive of the authorisation, believing that the benefits were substantial and the risks few. The main benefit was seen to be the potential for it to reduce the transmission of BBV, and the main risk was seen to be increased police attention on distributors. As our analysis reveals, these opinions rested on specific assumptions about people who inject: as responsible and capable, and as people with altruistic intentions and a strong duty of care to self and others; but also as powerless victims of their 'addiction', and as potentially dangerous criminals. As we outlined, these understandings of drug users have consequences for how extended distribution can be understood by practitioners, policy-makers and drug users.

One clear conclusion is that the concepts underpinning harm reduction – care, agency, and especially 'responsibility' - remain key tools in advocating for innovative and progressive policy-making. The salience of the individualising and 'responsibilising' approaches of harm reduction have wide appeal, especially among those stakeholders such as police whose views of drug use and drug users are understood through the framework of prohibition and criminality. Further, as staff accounts demonstrate, the agency permitted through harm reduction discourse can be mobilised as a way of destigmatising drug users (Gowan et al., 2012), generating different and more positive subject positions for people who use drugs to be seen as active players in managing their health. In this way, the authorisation of harm reduction initiatives like extended distribution can have important political consequences – they can transform popularly-held understandings of drug users from passive objects of intervention into rational and capable 'public health agents' (Bennett et al., 2011).

Yet, when looking at authorised extended distribution as an example of efforts to progress harm reduction policy, it becomes clear just how highly contested harm reduction remains in the Australian setting. Analyses of peer-administered naloxone in international settings provide a useful comparison to illustrate this. In her analysis of peer-administered naloxone, Faulkner-Gurstein (2017) notes that a key challenge in its implementation has been concerns about the level of responsibility placed on drug users and whether they can manage the training and technical knowledge required to administer it (p. 23). Yet, these concerns have been discounted in multiple locations around the world where emergency peer-administered naloxone programs have been implemented (apart from Australia where naloxone distribution remains largely in the hands of health care professionals). In comparison, extended distribution of sterile needles is a practice that most people who use drugs already engage in (Brener et al., 2018). It requires no training (at least in informal models) and, even in a context of a formal extended distribution program (of the kind implemented in Russia for example), would involve a much lower level of responsibility for drug users compared to peer-administered naloxone. This suggests that concerns around the authorisation of extended distribution lie almost entirely with the perceived inadequacies of drug users and demonstrates how difficult it is to detach harm reduction programs from the political trajectory of the criminalised 'addict' (Gowan et al., 2012).

Efforts to progress harm reduction policy are further complicated in the Australian setting by the current emphasis on treatment as prevention (TasP) for hepatitis C through direct anti-viral (DAA) treatments, which have been available free of charge through the country's universal Medicare system since 2016. In relation to HIV, the TasP strategy has attracted sustained criticism for its over-emphasis on biomedical responses the detriment of social and behavioural responses, and for its focus on HIV-positive over HIV-negative individuals (Adams, 2011; Kippax, 2012). Harris, Alber, and Swan (2015) draw convincing comparisons to hepatitis C and argue that the promise of DAA is a biomedical and population-health response that is more appealing to policy makers than human-rights responses, and that this biomedical emphasis and the costs associated with it threatens resources for primary prevention and harm reduction, including the introduction of NSP innovations such as extended distribution. Indeed, in a setting where biomedical solutions are seen to be achievable, there is much less enthusiasm for seeking the authorisation of extended distribution which would require difficult legislative changes.

Other contestations of harm reduction policies are also evident in our analysis, outlined most clearly by staff who warn against the over-individualisation of authorised extended distribution. The valorisation of rationality and responsibility in harm reduction approaches sets up expectations of behaviour and self-management that are unachievable for some people who inject, given the difficult conditions of their day-to-day lives (Moore & Fraser, 2006). Like many other public health approaches, harm reduction policies and programs have governmental effects (Peterson & Lupton, 1996): they operate to regulate the actions, choices and behaviours of the individuals they target (Miller, 2001). As staff in our study argue, the expectations and obligations placed on drug users in relation to authorised extended distribution pays insufficient attention to the structural conditions in which drug users must undertake their distribution activities: the conditions of material socio-economic disadvantage (Moore & Fraser, 2006); the stigmatising

discourses that they are subjected to and can internalise (Cama et al., 2016; Hassin, 1994); and, critically, the prohibitionist legal setting associated with illicit drug use. This critique is important and, as we've argued, through their epistemic work advocates like NUAA staff establish space to think differently about harm reduction policies and programs.

The analysis we have presented here accords with the current analyses of extended distribution in the research literature – that removal of the prohibitionist environment associated with illicit drug use is a clear way to address the perceived risks of authorised extended distribution (Lancaster et al., 2015). How this might be achieved is, of course, the focus of enormous attention both internationally and in Australia. Our experience during the formative stages of this pilot project demonstrate that legal change (at least that change associated with extended distribution) is possible in localised and temporary forms when key advocates such as government, researchers and clinicians work together under the leadership of drug user advocacy groups. And our evaluation findings show that important stakeholders such as police support the purposes and 'responsibilising' philosophy of harm reduction. Our experiences with this pilot demonstrate how the norms of harm reduction can be shifted through 'user developed responses' (Higgs et al., 2016), through the counter-discourses developed by advocates or social movement actors (Campbell & Shaw, 2008; Gowan et al., 2012), and through dialogue between policy makers, drug users, researchers and practitioners (Marshall, Dechman, Miniciello, & Alcock L Harris, 2015). Thus, even in an environment where harm reduction is highly contested, incremental and localised changes are possible. These localised changes create important and meaningful opportunities to think about how the provision of sterile needles can be done differently, which can in turn support conditions for further discussions about legislative change.

Declarations of interest

None.

Acknowledgement

The authors acknowledge the excellent advice of the project's Advisory Committee, including Nicky Bath, Lam Huynh, Collette McGrath, Andrew Miles, Kate Reakes, Craig Parkinson, Darren Newman, Angela Matheson, and Ingrid Van Beek. A range of other people provided valuable assistance including Rebecca Gray, Sione Crawford, Penny Cheverell, Megan Brooks, Kelly Kortlepel, Norman Booker, and Annie Malcolm. The authors extend a special thanks to the participants of the evaluation study for their time and careful responses to our questions, and to the IJDP reviewers and editor who provided thoughtful and constructive feedback to earlier versions of the paper. This evaluation study was funded by the NSW Ministry of Health.

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