A PRAGMATIC EXCHANGE:
A SHORT HISTORY OF THE HEALTH INFORMATION EXCHANGE AND THE RECONCILIATION OF CHRISTIAN FAITH AND HARM REDUCTION

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INTRODUCTION
In 1991, some 21 years ago, The Salvation Army Australia Southern Territory took the courageous decision on behalf of some of the most marginalised members of the community to establish a Needle and Syringe Program (NSP) at its Crisis Contact Centre in St Kilda. The NSP, which opened on 3 March 1991, represented the Army’s first involvement with the then controversial service which would, only some years later, become universally acknowledged as a primary tool in containing the potentially catastrophic public health threat of Acquired Immune Deficiency Syndrome (or AIDS) that emerged in the mid- to late-1980s. The incorporation of harm reduction policies in Salvation Army practice was in direct contrast to the Christian organisation’s previous commitment to abstinence in its delivery of drug and alcohol treatment and reflected the acknowledgement that the punitive nature of a strictly prohibitive approach to illegal drugs caused as much – if not greater– harm than the use of the drugs themselves. As this report details, the decision to open a NSP was not easily made. However, it became the means by which The Salvation Army extended its hand of support to those of its service users who were also intravenous drug users – from infrequent, ‘recreational’ users to isolated and problematically drug dependent individuals – accepting them wholly and without reservation so as to build the relationships that would assist many to reclaim a rightful place as valued and equal members of a genuinely inclusive and empowering community. Further, it reveals how the maturity of The Salvation Army’s Australia Southern Territory directly contributed to the prevention of an AIDS outbreak of the likes that occurred across other centres of drug using activity across the globe.

Initially, AIDS was believed to be an illness originating in the homosexual community – a consequence of the majority of the first victims of the virus in Australia and the United States identifying or being identified as members of local gay communities. However, the disease and the then inevitable death that followed diagnosis of the illness was made all the more frightening because of the lack of accurate knowledge as to its true causes and means of transmission. Through the late 1980s, media film crews were on hand to document how once healthy and fit young men were increasingly filling hospital beds, their blazing lesions, emaciated frames and empty eyes staring through the camera and into those of an increasingly panicked Australia. Compounding this panic was the fact that this was a disease about which the medical establishment knew little if anything. Fear escalated when altruistic and unknowingly infected blood donors led to the inadvertent transmission of AIDS to haemophiliacs, including infants, who given their fragile and still developing immune systems, succumbed quickly to the disease. Sensationalist tabloid coverage of these tragic deaths only escalated the alarm and moral opprobrium of a society all too willing to seek to isolate the threat to a community whose sexuality was stigmatised and seen as deviate. The shallow understanding of sexuality in Australia at the time and the immaturity that characterised homosexuality as a lifestyle ‘choice’ as opposed to one’s sexual orientation encouraged and inflamed existing and widespread homophobia. Fundamentalist Christians who drew on the Bible to argue that AIDS was a ‘gay plague’ sent by
God to punish perversion (Chapman 2007) only added a veneer of legitimacy to claims that the sexual activities of gay community were placing the wider community at risk. The perfect storm of ignorance and fear led to vicious assaults against members of the gay community and attempts to drive them ever further beyond the margins of the ‘mainstream’.

Despite this initial focus, the potential for the disease to spread to the broader public was increased by the identification of intravenous drug users as another population considered as being at sufficiently high risk of contracting and transmitting the virus that emerging experts spoke of a ‘second wave’ of AIDS. As Sendziuk observed of the ‘new’ vulnerability:

> The threat that AIDS posed to injecting drug users, their sexual partners and their children was first articulated at the Second International Conference on AIDS in Paris during June 1986 … Injecting drug users had, of course, been reported among the first casualties of AIDS, and there is no evidence to prove they were infected by gay men who shared needles and syringes, or that AIDS had spread from the gay community. Nevertheless, this was the epidemiological narrative that emerged as the threat to heterosexual drug users and their sexual partners was articulated. Within months of the Paris conference, the news media in Australia were warning of a ‘second wave’ of HIV infection that would ‘break’ among the heterosexual population unless urgent action was taken to stop the transmission of HIV between people who injected drugs (2003,160).

The discovery of medical science that AIDS was caused by HIV, (the Human Immunodeficiency Virus) which was, in turn, located in bodily fluids including semen and vaginal fluids and blood, made clear the potential for the virus to be transmitted just as easily via heterosexual sexual contact as via homosexual contact. In fact, HIV positive blood simply needed contact with another’s blood for transmission of the virus to occur. In the right conditions, the virus was found to thrive and the constant exposure to others blood, as found in the injecting drug user community, reflected such conditions. The ease of transmission widened the perceived threat and focused attention upon sex workers and intravenous drug users. The supply and possession of needles and syringes for illegal drug use was a crime punishable by imprisonment. Needles were difficult to access and were reused and shared until no longer usable. Given that blood was being drawn through the needle and into the syringe during the process of each injection – and that blood remained in the needle and syringe when passed on to the next injector – IV drug users had the potential to rapidly increase the pool of infected persons. One needle used by an infected individual could potentially infect any number of people who used it thereafter. It was injecting drug users who posed the threat of a potentially uncontrollable epidemic in Australia. Injecting drug users are a reflection of the broader community in which they live – existing across social and economic
classes, in various levels of employment and unemployment and of various sexual orientations, although predominantly heterosexual. In comparison to the relatively insular homosexual communities, the sexual relationships of intravenous drug users – a minority of whom also worked as sex workers – threatened to spread HIV and consequently AIDS to the wider community. One re-used syringe could mean the unwitting infection of a drug user, who infects a casual sexual partner before both go on to potentially infect numerous unsuspecting individuals.

The reaction to the perception of an increasingly indiscriminate killer was the continued spread of hysteria throughout the public consciousness. Myths pervaded the public sphere – kissing, or even bodily contact with an infected individual could transmit AIDS; the use of public facilities such as swimming pools and toilets by infected individuals could expose others to potential infection and so on. Hospital workers would leave meals at the open doors of HIV wards, afraid to approach the dying patients (see Chapman 2007 for a compelling portrait of the fear and ignorance that characterised initial responses to AIDS). Neither the attempts of medical science to counter these myths, nor the absence of any evidence to support them succeeded in addressing the irrational fears that led for demands for action to address perceived threats to the ‘mainstream’ population. This made for a difficult environment for those in positions of political and social leadership to address an unprecedented public health threat. The first part of the following report sets the scene in which The Salvation Army hierarchy in the Australia Southern Territory sought to respond to an increase in both injecting drug use in the direct vicinity of its Crisis Services network and the susceptibility of many of its service users to the AIDS virus. Particular attention is paid to the political culture. AIDS emerged as a genuine public health issue in the early years of a newly elected Labor Government led by Prime Minister Bob Hawke.

The work of the federal Health Department, under the ministerial leadership of Dr Neal Blewett, is shown to have been instrumental in Australia’s departure from an illegal drug policy that had, for many decades, existed solely within a strictly prohibitive framework enforced by the criminal law. However, ‘war’ on drugs is effectively a war on visible drug users – meaning the homeless, the streets sex worker and/or the mentally ill user, the most problematic drug users and most vulnerable individuals to potential HIV infection. Under the changes introduced at the instigation of the Health Department, harm minimisation became the foundation upon which Australian drug policy would rest. This incorporates the acknowledgement that a drug-free society is an unachievable ideal. Drug use has been an aspect of human existence since human experience was first documented and has long been most problematic when drugs are used to numb trauma and/or mental ill-health. Under such circumstances, and given the failure of strictly prohibitive policies, the Hawke government, in recognition of the entrenched nature of illegal drug use in Australia, introduced the concept of harm reduction –within the harm minimisation framework – to existing policies that sought to exercise control over the illegal market via means of

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Surveys at the time of AIDS emergence indicated that in excess of 90 per cent of intravenous drug users reported sharing needles at one time or another due to the difficulties associated with acquiring sterile injecting equipment (Crofts et al. 1996; Sandiuk 2003).
supply reduction (e.g. enforcement on laws prohibiting the production, sale and / or use of proscribed drugs and prosecution of those in breach of these laws) and demand reduction (e.g. education programs to warn of potential negative outcomes of drug use and to discourage / dissuade experimentation). Harm reduction does not seek to reduce (or even control) illegal drug use but to reduce the harms associated with that use – regardless of whether they are incurred by the user, their family or circle or friends of the broader community. Of most salience to this report is the adoption of such services as Needle and Syringe Programs (NSP). This was a measure that sought to restrict the re-use of syringes for intravenous drug use and prevent the transmission of HIV/AIDS among the injecting drug using community. Another particularly noteworthy initiative is the opioid substitution program. This involves dispensing oral doses of the synthetic opioids methadone or buprenorphine to opioid dependent individuals (overwhelmingly intravenous users of heroin). As opposed to demanding abstinence from opioids from individuals who may not be mentally or physically capable of addressing their dependence, those in substitution programs are ‘maintained’ on medically and legally prescribed opioids in an attempt to remove them, not only from the illegal and expensive subculture of the criminal black market in drugs, but also from the practice of injecting drug use. The potential harm of injecting drugs-and exposure to such viruses as HIV, is consequently reduced.

Acceptance of the concept of harm reduction implied acceptance of the ineradicable nature of drug use and also the belief that it should be addressed as a public health issue and not as a legal issue to be resolved by application of the criminal justice apparatus. This is not to confuse such a principle with support for the legalisation of currently illegal drugs. Supply reduction and demand reduction remain part of a three pronged strategy – with the former hopefully more productively focused on pursuing manufacturers and wholesale drug dealers. Further, harm reduction recognises a responsibility to reduce the harm that strict and indiscriminate enforcement of prohibitive laws can cause – particularly when the most visible users of drugs are the most vulnerable and pushing them further underground means they are beyond the reach of services that provide information, advice and, most importantly, medical, material and moral support.

As is discussed in the report that follows, both the Crossroads Project and The Salvation Army Crisis Services network have a long history of responding to the direct needs with which their clients present. This proved to be the genesis of the initial proposal that emanated from within these services of The Salvation Army’s Australia Southern Territory. In a process described in detail, this proposal led to considerable discussion and contemplation of the Army’s broader social mission. The proposal that was being considered constituted the Army’s first involvement with an NSP in any capacity anywhere in the world. Given the unbridled hysteria that had accompanied the emergence of HIV / AIDS that continued to derail any attempt to construct a rationale social response, the dialogue initiated by The Salvation Army Australia Southern Territory was an unprecedented step by this long-established organisation to, first, engage notions of the still controversial principle of harm reduction as incorporated into official
Australian drug policy in the mid-1980s before making an explicit commitment to the principle. This was reflected in the courageous decision to engage with the best means to address the potential harms associated with injecting drug use and the related if inadvertent spread of HIV / AIDS and establish a Needle and Syringe Program on the premises of the Crisis Contact Centre in Grey St, St Kilda. This was not an easy decision by any means. It was the outcome of a process that involved deliberation on the balance of evidence, the seeking of international counsel and much consideration of the consequences of both going forward with this decision – or, alternately, maintaining a previous and strict focus on abstinence as the basis of The Salvation Army’s drug and alcohol treatment programs. This report offers readers the story of how the latter focus was replaced by a determination to meet the needs of the most vulnerable and marginalised members of the community in which The Salvation Army sought to pursue its mission.
THE CONTEXT – THE EMERGENCE OF AIDS
Rarely has society policy been made with so thin and contested an information base and with societal mechanisms so inadequately prepared and reluctant to take on the task as in the early years of AIDS policy making (Neal Blewett, Health Minister of Australia (1983-1990) in Blewett 2003)

Just three decades ago, the spectre of AIDS and the moral panic and controversy that would characterise its emergence were unknown to the public – let alone those ‘high-risk groups who would become the focus of irrational fears and prejudice. In the United States in 1981, the Centres for Disease Control (CDC) diagnosed the suppression of the human immune system (or its outright failure) which had left a small cluster of homosexual men in Los Angeles vulnerable to opportunistic infections which were attacking their organs. Most frightening in the modern age of medical science was that the cause of this loss of natural immunity was completely unknown to those professionals who first documented its devastating and fatal impact (CDC 1982). In October 1982, a young homosexual man from New York, on a working holiday in Australia, was admitted to St Vincent’s hospital in Sydney where he was diagnosed with the ‘syndrome’ that had begun to increase in prevalence in the US. Little would be learned by the physicians – including immunologist Prof Ron Penny – treating him. In fact, given the lack of a diagnostic test, a number of phone calls were made to experts at the CDC for Penny and colleagues ‘to be convinced’ that their young patient was afflicted by the same illness as reported in the US (Penny (1993 cited in Sendziuk 2002, 1). Although the first such diagnosis in Australia, the physicians responsible for his care deemed his condition improved sufficiently for him to be discharged … only for the young man to return home and die in March of 1983.

In that same month, the Hawke Labor Government was elected in Australia. The first Hawke Ministry – the 55th Commonwealth Ministry – quickly set about enacting a large scale program of reform that included major health initiatives such as the restoration of Medicare, the national health insurance first introduced by the Whitlam government (1972-75) before being ended by the conservatives upon the resumption of their otherwise exclusive hold of Commonwealth power since 1949. Consequently, when the newly appointed Minister for Health, Neal Blewett, accompanied by his personal staff, arrived for a briefing from the Health Department at parliament on 12 March, just the second day of the Hawke Government, he was met by a bureaucratic representation of 25 officials, led by the Secretary for Health, and bearing two volumes of papers containing all of the then known health issues that would demand a policy response from the incoming government. During the afternoon of the all-day briefing, as Blewett recalls, his attention was drawn
to something in the second volume of papers called GRID – or Gay Related Immune Deficiency (Blewett 2011).

Upon enquiry, it was explained to Minister Blewett that GRID was the term then in use to refer to a mystery disease manifesting as an unusual form of skin cancer or distinctive pneumonia (both related to deficiencies in the immune system) that had affected clusters of gay men in the US. The aetiology of the disease remained unknown with medical professionals struggling to ascertain whether the cause was to be found in viral or bacterial origins, if it were a product of its environment or whether it could be attributed to ‘a distinctly homosexual lifestyle’. Initially, the Departmental officials briefing the new Health Minister played down the potential threat to Australia (Blewett 2003). However, no party at the briefing sessions was under any illusion as to the possible ramifications were an unknown and infectious disease to take hold in Australia for the first time. Further, the symptoms of the disease that had been diagnosed in St Vincent’s Hospital had taken some time to manifest, the lapse between apparent infection and manifestation rendering border and customs officials helpless to stop newly infected tourists, immigrants and expatriates returning home from unknowingly bringing the disease into the country. By the time the immunologist responsible for the Sydney diagnosis, Prof Ron Penny had reported the case in the Medical Journal of Australia, the first Australian had been diagnosed with the disease (Sendziuk 2006). Never before had a disease about which so little was known posed so great a potential public health risk.

Although its origins remained unknown, the epidemiology of this deadly illness was such that it found a nurturing host in its surrounding environs. What had been a small ‘blip’ on the radar of the United States CDC in 1981 was being referred to as a killer epidemic by mid-1982 (Khmer 2003). This lent a level of urgency to efforts within the Health Ministry to address the disease before similar rates of infection were recorded in Australia. One of the factors that would shape the initial response was, as noted by the Minister, the fact that usual ‘owners’ of disease – the medical profession – whose specialised knowledge had allowed them significant influence over policy responses in regard to chronic illness and disease had as little knowledge as the layperson when it came to this new disease. Minister Blewett would note that his Ministry and Government were afforded a blank policy slate that enabled them to coordinate a federal response. As Blewett would note in reflection:

> The advantage of [having a blank slate] is that diseases [usually] tend to be in the political possession of the medical profession. Cancer, you certainly can’t move without being in line with the cancer specialists on the whole. The same would be true of diabetes and issues like that. Whereas, because there was no medical professionalization of AIDS, you had a degree of freedom that certainly later Ministers would not have had because there was [then] a body of medical expertise.
It had been those most visibly affected by the disease that led the mainstream US press to coin the term GRID when reaching to name a frightening disease that ravaged the affected, spreading frightful lesions over bodies that were simultaneously wasting and attacked the victims’ internal organs before death (Altman 1982). This identifier briefly entered the ‘mainstream’ consciousness via the media, informed and excited as it was by a combination of a heretofore unknown, visibly terrible illness and sex (widely perceived to be deviant sex) that reached the public in the form of the lurid sensationalism colouring the stories and headlines that reported and charted the diseases progress through a specific marginalised community. In May 1983, Sydney’s Daily Mail headlined one such warning ‘AIDS: The killer disease that's expected to sweep Australia’ (Downie 1983, 8). The media focus provided an identity for this alarming and incurable virus that threatened ‘mainstream’ society despite infection and transmission being attributed to the hedonism of an irresponsible homosexual community, driven by their deviant sexual urges. Such reportage validated the physical, visceral response of a distorted masculinity that allowed for the violent urges of certain men to be cast in a self-appointed role of protecting the community. The hysteria of the tabloid commercial media accelerated after contaminated supplies of blood, donated by gay men unaware of their positive status, led to the transmission of HIV to haemophiliacs and others needing blood supplies – including new-born infants (Blewett 2003). Hospital staff in Sydney recalled with distress the consequences of the prevailing stigma of the time - young men dying alone, disowned by their own families whilst sons, brothers and fathers were left nursing the consequences of the physical outrage meted out by self-appointed vigilantes and / or homophobes all too willing to flex the muscles of ignorance (Chapman 2007). While bloodshed reflected the rampant discrimination against the gay community, analysis of the means of transmission also confirmed the viral nature of the disease and its transmission via an individual coming into contact with ‘contaminated’ blood.

The tone of the times encapsulated the entrenched tradition whereby ignorance and fear need an identifiable outlet in the form of scapegoats. The further marginalisation of the gay community was actively encouraged by the commentary of those who continue to influence social discourse as self-appointed moral arbiters – including claims that the disease was divine retribution. Christian fundamentalists, such as prominent Sydney preacher, Fred Nile, proposed ‘solutions’ including banning the entry or exit of gay men into Australia as well as the closure of gay-friendly venues (Wotherspoon 2008). Despite this self-serving ‘targeting’ of an already marginalised population (Nile would be elected to the Legislative Council of NSW as one of the most prominent

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2 In the most publicised of cases, four babies died in November 1984 in Queensland which, along with Tasmania, was one of two conservative states where the influence of a conservative, faith-based morality led to resistance towards community based initiatives involving the active participation of AIDS affected populations. The deaths of babies provided further grist for the tabloid media that had already brought AIDS to the forefront of national concerns leading to the long-time donor responsible for the babies infection in the Queensland case, a man motivated only by altruistic concerns, branded a murderer, who was advised to ‘commit suicide’. The Queensland government, for its part, investigated potential manslaughter charges (Blewett, undated). Amidst the upset, the Red Cross requested that ‘sexually active’ gay men with ‘multiple partners’ to refrain from further blood donations (although these two disqualifying terms required far greater definition, a clarification that was not forthcoming).
spokespersons for the anti-homosexual lobby that prospered from the hysteria surrounding AIDS), it was soon apparent that the disease was not a product of, or isolated to, the gay community alone.\(^3\) The emergence of the disease amongst communities of injecting drug users and haemophiliacs provided further evidence of a viral, blood borne virus. It was in the US, at a July 1982 meeting between CDC investigators tasked with tracking the virus, and federal bureaucrats, along with leaders of the gay community, that the less ‘exclusive’ name Acquired Immune Deficiency Syndrome or AIDS was introduced. By September 1982 the name AIDS had been officially adopted by the CDC which was taking significant steps to define the illness – and subsequently demonstrated that AIDS could potentially affect any person regardless of sexuality, rendering any attempt to locate its causes in a homosexual ‘lifestyle’ a prejudicial untruth.

Despite the recognition and naming of AIDS, the Australian Federal government was struggling with what was, in reality, the distinct disadvantage that the medical profession lacked the usual expertise required to assume a degree of policy ownership and oversight of AIDS. While it did allow the government a greater role in developing a response, without advice or expertise, it was a response that the government struggled to develop. As Minister Blewett noted in a paper reflecting on the ‘primitive years’ of the disease in Australia:

> Rarely has policy been made with so thin and contested an information base and with societal mechanisms so inadequately prepared and reluctant to take on the task as in the early years of AIDS policy making (Blewett 203, 4).

This reluctance would prove the case amongst State governments, who, despite having jurisdictional responsibility for disease control, were found by the Health Minister to be ‘uncharacteristically unpossessive’ about a disease around which religious and secular views ‘seethed.’ The controversial nature of the illness added a complex – and potentially vote damaging – ideological basis to policy-making in respect of AIDS (Blewett 2003, 7-8). Further, the imagined cost of addressing a disease with the potential to spread from a very small pool of infection to a public health crisis of epidemic proportions furnished an expectation that the Commonwealth would coordinate a national response and take ‘ownership’ of the issue. This would ultimately prove a blessing. By the end of 1984, 47 cases of AIDS had been diagnosed in Australia and 18 fatalities

\(^3\) The CDC soon noted infections occurring outside the homosexual community and prior to AIDS becoming the established name for the disease, it was briefly known as ‘the 4H disease’, given its relative prevalence amongst Haitians, homosexuals, haemophiliacs, and heroin users. Still, the continued association with mostly marginalised populations did little to ease the discrimination already encountered by such individuals on an everyday basis or relieve the moral condemnation from the likes of evangelical Christians who claimed the disease was a divine punishment by God for homosexuality (see for example Sider 1989).
had been recorded. In the following year, the Health Minister departed for an educational visit to see the means that were being put into place to deal with the flashpoint of the epidemic, the United States. Public awareness of AIDS in Australia in the form of a viral infection did not occur until some 18 months after surfacing in the United States. This effectively provided the government with ‘a window of opportunity’ to observe the successes and mistakes made by political authorities in that country (Sendziuk 2002, 7).

Neal Blewett has since stated his US trip was the formative influence on his response to how best to address AIDS. This was characterised not only by his guidance of the federal government’s response to the potential, spread of AIDS via unsafe sex but it would also characterise the government’s response to the threat posed by injecting drug use. This response marked the return of public health to a position of national importance after decades of atrophying that had limited public health expertise to sexual health clinics (Blewett 2003). A public health approach would soon be adopted in response to the potential spread of AIDS amongst the broader public including informing certain drug using practices that have continued to characterise the Australian approach in this respect.

In the United States, Blewett witnessed the Regan administration’s conservative reluctance to undertake public education programs to promote safe sex (especially targeted to the gay population) and an even greater reluctance to provide funding for initiatives informed and guided by these communities for their consumption (Sendziuk 2002). The moral overtones influencing the US response greatly frustrated doctors and community-based outreach and service workers who found practical responses constrained because of the administration’s preconceived moral judgements (Sendziuk 2002). While observing widespread anger directed towards policy makers for their failure to develop a proactive response, Minister Blewett also noted that the absence of a coordinated national approach had given rise to an ad hoc approach had led to vastly different regimes across the United States. While disastrous for affected communities in the US, the vacuum of national leadership and, subsequently, the wildly divergent strategies adopted across the continent allowed Minister Blewett the benefit of being able to compare the different outcomes attributed to the differing principles that underpinned programs in individual states. In New York, a traditional public health model was established with medical authorities imposing a top-down ‘contain and control’ model, identifying and isolating individuals affected by AIDS. In contrast, the Minister observed a cooperative approach in California whereby medical authorities actively engaged the affected communities in cooperative partnerships so as to benefit from their intimate knowledge of a disease that they had seen affect lovers, friends and acquaintances. By virtue of their proximity and vulnerability and, consequently, their undistorted understanding of the disease and its routes of transmission, gay communities across the US were able to demonstrate
their commitment to the wellbeing of not only their peers, but the broader community in a considered and composed manner. The preventative campaigns they informed would place as great an emphasis on education of at-risk individuals as on medical treatment (Blewett 2003). The deliberate involvement of affected communities into public health campaigns and service delivery in California, in contrast to siege mentality exhibited by New York’s public health officials had a profound influence upon the Minister Blewett. In particular, the fact that the latter pushed affected communities further towards the margins of society from where they could neither access the assistance of medical authorities nor advise potential prevention responses as experts on the transmission and containment of AIDS. Blewett would later state that his trip to the United States was, ‘the single most significant influence on my own views about AIDS’ (Blewett 2003, 9).

I returned from the United States convinced that if there was to be a single imperative driving government policy, it must be the determination to resolve the dilemma between community and individual by winning the confidence and cooperation of the affected individuals for policies that would ensure community monitoring and assessment of the disease [and of policies implemented to contain it]. This ruled out most forms of compulsion, impracticable in most cases anyhow. All AIDS policies were subjected to this over-riding consideration (Blewett undated)

The Minister’s educational mission to the US ultimately shaped Australia’s national response to AIDS. As Blewett recalled years later, Prime Minister Bob Hawke, largely allowed his Ministers, ‘a fairly free hand’ in respect of decisions within their respective portfolios ‘as long as they didn’t run into too much trouble or spend too much money’ (Blewett 2012). Consequently, the Minister’s explicitly stated intention to undertake a cooperative community-based approach guided the subsequent campaign that characterised Australia’s response – a response that at the most recent (19th) International AIDS Conference was, at the time of writing, seen to be clearly responsible for having prevented an HIV epidemic in this country (Gallop 2012). The cooperative approach would become a world leading ‘model’ in terms of its pragmatic and progressive response to AIDS and was commended in this capacity by the director of the World Health Organisation’s Global Program on AIDS (McIntosh 1987). Of course, the politics of what remained a demonstrably sensitive issue

4 The success and efficacy of this approach would also inform efforts to contain transmission of HIV / AIDS via the sharing of needles by intravenous drug users once this mode of transmission became widely known.
for the public was depressingly evident in continued ‘gay-bashings’ and calls for compulsory testing regimes and surveillance of ‘at-risk’ populations. The following observation alludes to the reality of any policy that seeks to address the broader public’s wellbeing:

[The comfortable truism ... that epidemiology is the science of public health – is not actually true. It may be closer to the reality to say that politics is the basic science of public health (Moss 2000, 1385).]

What the public will accept in the interests of public health – particularly if traditionally stigmatised populations are seen as beneficiaries of health reform – is not necessarily the most effective policy response as the continued enforcement of highly counterproductive prohibitive drug policies have demonstrated over past decades. Nonetheless, it was the delicate politics of public health that allowed Minister Blewett to introduce a national coordinated response in an area in which the Australian States had effectively abdicated jurisdictional responsibility. The religious and moral stereotypes long employed by both opportunistic politicians and the commercial mainstream media in respect of homosexuals, sex workers and the intravenous drug users who comprised those seen to be most at risk of – and thus associated with – the emergent AIDS ‘epidemic’ only entrenched a broader reluctance to engage with a pressing social issue.

Politics doubtless played a significant role in shaping the response to AIDS in Australia. However, in retrospect, Blewett has been careful to ensure credit for Australia’s strategy has been shared where justified. He is adamant, for example, that he did not personally impose a cooperative approach upon the medical profession, but that an authoritarian alternative to containing and controlling those affected with AIDS was never seriously considered by Australia’s leading medical professionals despite their limited knowledge. Further, he noted, ‘the single imperative driving policy was to resolve this dilemma by winning the confidence (and cooperation) of the affected’ (Blewett 2003). Policies were passed in the knowledge that health policy is rarely if ever made with perfect knowledge of an issue and that the outcomes of interventions can never be predicted with complete confidence (Blewett 2003). The absence of any opposition based on medical expertise smoothed the path of these initiatives.

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5 In October 1985, a poll in the Melbourne Sun, found that 91% of survey respondents wanted ‘at risk’ populations subjected to compulsory blood testing for AIDS. In 1987, the year as Australia’s approach received such esteemed praise, the findings of a survey of 2000 people conducted by the Commonwealth Communicable Diseases Branch included that 42% of respondents wanted all people aged 16+ years to be tested while 63% and 68% supported compulsory testing of intravenous drug users and sex workers respectively (Sendzik 2002, 3)
In view of the political sensitivities surrounding the issue, Blewett’s response to the ‘ownership gap’ left by a lack of corroborated medical expertise was to invest in both expert- and community-led initiatives. Two national bodies were established to investigate, provide advice and develop public health responses to draw upon both community knowledge and professional medical expertise. The latter was incorporated in the National AIDS Taskforce, chaired by Professor David Penington, a haematologist and Chair of the National Blood Transfusion Committee. The deliberate appointment of a medical specialist outside of the then nascent body of AIDS specialists was an attempt to lift the Taskforce above the rivalries already emerging between these new specialists (Blewett 2003). The Taskforce was established as a scientific body to report to the Health Ministers of the States and Territories. In practice, therefore, it was responsible to no individual in particular and was able to pursue the latest medical and scientific advice (Blewett 2003).

In contrast, the National Advisory Council on AIDS (NACAIDS) was to advise on educational initiatives and was directly answerable to the Commonwealth Minister. NACAIDS embodied the cooperative approach that Blewett was determined to establish to avoid the mistakes and moralism of the Regan administration. The membership included gay men and haemophiliacs under Ita Buttrose as Chair, a decision criticised by many given the latter’s career to date as a former editor of glossy ‘women’s magazines’ before becoming editor-in-chief of News Limited’s tabloid Daily Telegraph. Blewett suggested Buttrose was subject to sniping due to ‘a media besotted by medical expertise’ (2003, 14). It proved an inspired choice. What a community panicked by tabloid media reports needed given that medical professionals lacked the evidence required to provide reassurance and surety was a clear and objective communicator, a role Buttrose was ably equipped to fulfil. On one occasion, she appeared in a nationwide TV campaign to explain that donating blood at a blood bank did not pose a risk of catching AIDS (the fear of which had caused a significant drop in donations) (Sendziuk 2002). The public information campaigns launched by NACAIDS were instrumental in the evolution of the public’s misperception of AIDS as ‘a gay disease’ to an understanding of the potential threat the virus posed to mainstream health. This did not spare the highly visible, prolific nature and controversial subject matter from constant debate as to its value and appropriateness. This is best exemplified by the notorious April 1987 advertisements that depicted AIDS in the form of the Grim Reaper, the skeletal figure in rags leaning on a scythe while sending bowling balls racing down a bowling alley to violently and indiscriminately knock aside men, women and children alike before the camera pans back to show a row of such nightmarish figures each repetitively sending down missile after missile towards hundreds of fearful victims undistinguishable by any specific traits. This was the most visible (and controversial) aspect of a $2.9 million national campaign, the first to directly target AIDS transmission outside of ‘high-risk groups’. Although the controversy saw the advertisement discontinued after a short few months, its impact is readily recalled by those exposed to it at the
time. Its influence was later acknowledged by Prof Ron Penny who would become a pioneering AIDS specialist in Australia.

I think there’s never been anything on television or any media that has ever matched it in terms of impact, but no advertising can be without some downside, and that was never intended. But it at least made people aware and probably did change sexual practices of heterosexuals (Penny cited in Centres for Disease Control 2002)

Even before the launch of this national campaign, the need to address the potential spread of HIV / AIDS transmission within the heterosexual community had already been identified. The Second International AIDS Conference, held in Paris in 1986, was the first global meeting to draw a specific and unprecedented level of attention to the potential role injecting drug users may inadvertently play in spreading AIDS throughout the heterosexual community by the re-use and sharing of injecting equipment. However, this revelation on the global stage was not necessarily news to policy makers in Australia. Blewett recalled that concerns about sharing needles as a potential transmission path of AIDS were: ‘No doubt … accelerated by the Paris Conference, but [this route of transmission] had been brought up [in Australian policy circles] earlier.’ In fact, the Commonwealth Government had, a year prior to the Paris Conference, paid specific attention to the dangers posed by IV drug use – as is addressed further below.

While the National Taskforce and NACAIDS were entrusted with national leadership on the issue of AIDS, it was ultimately those people who were engaging in the very activities with the greatest potential to spread the virus who would ultimately be responsible for ensuring the success of the messages that these bodies were pushing in the public realm. While the proliferation of safe sex and drug using messages could be informed and guided by those on the two appointed advisory bodies – and safer behaviour facilitated by the availability of, and access to, condoms and sterile injecting equipment provided by government – it was ultimately the responsibility of individuals to make use of resources to reduce high risk activities. As Minister Blewett’s key advisor Bill Bowtell noted of potentially risky sexual and drug using ‘transactions’ in the documentary Rampant:

6 Following a successful ‘strike’ with the first ball, the Reaper knocks down all but one standing figure with his second. The ‘Reaper’ scores a ‘spare’ by skittling the young woman left standing, clutching her crying baby to her chest in a hopeless attempt at protection.
Unless you’re in that transaction, you can’t prevent [HIV transmission] … you have to rely on the common sense, responsibility and goodwill of the parties in that transaction. You have to persuade them to act responsibly (Chapman 2007).

This reiterated the Minister’s belief in the need for government to engage potentially affected individuals in cooperative efforts to acknowledge that (perceived) ‘high-risk’ activities were not lifestyle choices that could – let alone that would – be stopped because of a potential threat. This reflected Australian policy makers’ pragmatic acceptance of human nature, an approach that saved thousands of lives when compared to the United States where morality outweighed an objective approach to implementing evidence-based policy – an issue that continues to plague demonstrably counter-productive drug and sex work laws in place elsewhere to this day (Rolles et al. 2012). Any comparison with the US and its attempts to deter certain activities via a control and contain agenda, let alone prohibitive laws, are put into stark relief by the observation of former High Court Justice Michael Kirby that, ‘law and the risk of punishment are usually the last things on the minds of people in the critical moment of pleasure’.8

The motivation and gathering impetus of the Commonwealth Government’s attempts to counter the public health threat posed by AIDS meant that by June 1986, when the Second Annual International Conference on AIDS focused international attention on a potential ‘second wave’ of AIDS infection spread by intravenous (IV) drug users, the federal government had already taken steps to adopt the first truly national illicit drug strategy in Australia to negate this possibility. The National Campaign against Drug Abuse (NCADA) was underpinned by the principles of harm minimisation – a radical departure from the exclusive focus on the criminal law imposed upon signatories to past United Nations Conventions that, beginning with the 1961 UN Single Convention on Narcotics, a binding international agreement that compelled member nations to implement rigorous enforcement of criminal penalties against certain proscribed drugs. Reinforced by subsequent conventions to incorporate both new drug discoveries and the increased recreational use of certain drugs, including synthetic hallucinogens, MDMA (ecstasy) and amphetamines, the blanket approach ignored circumstances particular to member nations. As the then Health Minister Neal Blewett later recalled, while the Hawke Government was committed to introducing a comprehensive national drug policy in Australia for the first time, he also believes that as a policy priority, ‘It might have been a bit later if not for AIDS’ (Blewett 2011). However, as

7 It should be remembered that the use of psychoactive drugs has been a common characteristic of humanity since the experiences of those using them could be communicated via primitive art (as in the ritualistic use of hallucinogenic mushrooms in South American cultures dating from 1000-500 BC) or written pharmacopeia (e.g., the use of cannabis in Chinese pharmacopoeias from 2727 BC) (see Campbell 2001). Similarly, homosexuality is also documented from the earliest civilisations when depictions of sexual activity were again depicted in art and writing of the time (examples of both can be seen at Van Dolen 2012).
8 Kirby cited in Sendziuk 2002, 8.
early as mid-1983, AIDS has been confirmed as a viral disease, carried in the blood and able to be transmitted if the blood of an infected person (or bodily fluids containing blood) came into contact with the blood of an uninfected individual (Blewett 2003). At this time, needle sharing was common practice amongst the greater majority of IV drug users. It was difficult, in a country devoted to a punitive and prohibitive policy against proscribed drugs –that marginalises the users of these drugs as ‘deviant’ and looks upon those who inject drugs with particular distaste to bring such persons aboard as partners in health prevention efforts. Prior to the potential public health threat posed by AIDS, neither chemists nor medical suppliers provided needles to those without a need that was perceived as ‘legitimate’ in the eyes of the law (e.g. for use by diabetics dependent on the frequent injection of insulin). Consequently, needles and syringes were a very scarce but much needed aspect of the injecting drug use experience. The limitations – alongside the sense of community that develops to both protect and provide a sense of belonging for members of marginalised communities (see Bessant et al. 2003) – led those in possession of needles to share them with other IV drug users. As Jude Byrne, former President of the Australian Intravenous Drug Users League (AIVL), Australia’s peak drug user peer organisation noted, diseases, including hepatitis C and potentially AIDS, were rapidly spreading amongst the IV drug using community (prior even to the former’s identification by medical professionals (Crofts 1999):

> You certainly couldn’t get needles ... There’d be one fit\(^9\) between 20 people ...
> You just didn’t worry about [AIDS], you just assumed you were going to get it.
> We didn’t talk to anybody outside our circle, we certainly never told our doctors.
> If you got a dirty shot, you assumed it was because the dope was dirty, not the syringe (Bates & Warhaft 2010)

\(^9\) This has recently led to efforts to have the circumstances unique to individual signatory countries recognised. In 2008, then Chair of the Australian National Council on Drugs, the primary advisory body to the federal government wrote an article calling for recognition of the validity of the diverse approaches of signatory nations implementing policy responses in deference to the cultural characteristics of unique member nations which had suffered due to the legal compulsion to impose blanket prohibitive policies regardless of their suitability. The most basic understanding of comparative policy recognises that uniform policy imposed without regard for the unique character of the nations is destined to fail. As Heron wrote:

To put it simply, we have to update the conventions to reflect our most modern and effective approaches of tackling the world's drug problem. Both Australia and New Zealand have balanced and pragmatic drug policies compared with many other regions in the world. Why? Because it works: our national drug strategies are also among the few that are subjected to comprehensive evaluations, and as a result we have long had an evidence-based approach to formulating our drug strategies (Heron 2008).

The inappropriateness of a blanket approach was been reflected by the demands of the Bolivian and Peruvian Governments. The former’s efforts to have the centuries’ old tradition of chewing of coca leaves by Bolivians in the Andas region excluded from the criminal prohibition imposed by the 1961 Convention were rejected by the International Narcotics Control Board (INCB). A subsequent letter to the INCB sent by the Peruvian Ministry of Foreign Affairs stated its clear disappointment with the refusal of its request to have the traditional use of coca leaves exempted from the provisions of the 1961 Single Convention (Ministry of Foreign Affairs (Bolivia) 2012). In June 2011, Bolivia formally denounced this inflexibility. Bolivia and Peru since reverted to traditional practices in light of the heavy handed responses to requests for an amendment that would recognise and enforce all aspects of the Convention but for those that impinged upon national customs. Following the Bolivian government's decision to withdraw as a signatory to the Convention, the UN agreed to recognise the traditional use of coca leaves and Bolivian's right to chew the leaf in their territory. This limited but overdue recognition of the need for laws to reflect the unique nature of the societies they seek to govern Dhywood 2013).
In 1996, a review of all Australian studies on injecting drug use by Crofts et al. concluded that almost 100 per cent of injecting drug users were sharing injecting equipment in 1986. This posed a huge threat to the broader public outside of outside of the homosexual community. As was observed:

It was known that the injection of HIV-contaminated blood directly into a vein was an extremely efficient way of transmitting the virus that causes AIDS, and that heterosexual injecting drug users (IDU) already constituted approximately 2 per cent of HIV cases in Australia (Sendziuk 2003, 161).

Further, like any other member of the community, IV drug users enjoy sexual relationships – whether they are ‘straight’, gay or bisexual in sexual preference. The potential existed for one user, unknowingly carrying the AIDS virus, to share a needle with many others, infecting numerous individuals in one sitting. The subsequent spread of a growing pool of infection within the IV drug using community could then act as a vector through which the heterosexual community might be infected via sexual contact – whether their partners were long term or overnight. If HIV was established amongst IV drug users, Australia faced a public health nightmare. The reality of this threat had already emerged in the United States, only strengthening Minister Blewett’s resolve to avoid the punitive top-down approach in that country:

In an article in Time in January this year [1989], it was estimated that the first contaminated equipment-related [i.e. shared needle and / or syringe] AIDS case found a total of 12 other people who were HIV antibody positive once contact tracing was done [i.e. the initial infected person had shared contaminated equipment with the result that 12 others had tested positive for HIV]. The implications are frightening ... by 1988, 53 per cent of all diagnosed AIDS cases in New York were infected by sharing contaminated equipment ... 75 per cent of people infected with AIDS through unprotected heterosexual encounters in New York are attributable to sexual partners who shared contaminated equipment (Caesar 1989, 26).

‘Fit’ – an abbreviation of the street term to describe the ‘outfit’ of needle, syringe, tourniquet, spoon and any other items needed to prepare drugs for injection and to subsequently administer them.
Sendziuk provides a compelling portrait of the circumstances in Australia at the time:

The threat that AIDS posed to injecting drug users, their sexual partners and their children was first articulated at the Second International Conference on AIDS in Paris during June 1986 ... Injecting drug users had, of course, been reported among the first casualties of AIDS, and there is no evidence to prove they were infected by gay men who shared needles and syringes, or that AIDS had spread from the gay community. Nevertheless, this was the epidemiological narrative that emerged as the threat to heterosexual drug users and their sexual partners was articulated. Within months of the Paris conference, the news media in Australia were warning of a ‘second wave ‘of HIV infection that would ‘break’ among the heterosexual population unless urgent action was taken to stop the transmission of HIV between people who injected drugs (1993,160).

Australia – by virtue of a curious mix of the personal and political that began with the first family in Australian politics – was already taking action to address this second potential source of an HIV / AIDS epidemic in the years prior to the Paris Conference. Following Opposition accusations that he was ‘soft on drugs’ after his daughter successfully appealed against a conviction for the cultivation and possession of cannabis in 1984, then Prime Minister Bob Hawke appeared in a tearful televised address to the nation to explain the personal difficulties his family were experiencing as a consequence of the heroin dependencies of his daughter and son-in-law (The Age 1984a; The Age 1984b). The issue of drugs and the use of so-called ‘hard’ drugs, such as heroin, gripped a public consciousness already attuned to threats to broader health. Accompanying media coverage only exacerbated these concerns. The combination of his family's personal trials and the public anxiety led to a pre-election commitment, were the Hawke-led Labor Government to be re-elected, to educate Australian youth about drugs and their dangers (Blewett 1987, 3). Following the government's re-election, this commitment took the form of a special Premier's Conference, named the Drug Summit, held on 2 April 1985. The Health Department – as opposed to the Justice Department – was formally handed responsibility for the establishment, agenda and outcomes of the Drug Summit. Dr Blewett noted it was beneficial that the Health Department was given responsibility for the Drug Summit (as opposed to the Justice Department) this facilitating the space for ‘a powerful lobby of doctors and public health figures [who] had through the course of the 1980s been advocating both a nationalisation and a reform of drug policies.’ Further, although there was division on several key issues, others received near unanimous agreement. These included:
Prior to the National Drug Summit, the responsibility for drug strategy was a matter of state jurisdiction. The Commonwealth’s role was limited to interdiction of illegal drug imports via federal control of Customs (Blewett Undated). While Blewett acknowledged the benefits of the Health Department being given responsibility for the Drug Summit, the period of preparation for the April meeting revealed how ill-equipped the Department was to handle questions of public health. Health had been a non-cabinet Department for some time and lacked the associated prestige and resources to provide sufficient research and recommendations to counter the perceived threat (Blewett Undated). Public health had, in the Minister’s words, long been atrophying. Consequently, the mobilisation of the Summit became the responsibility of a small and over-burdened Department. To address its relative under-resourcing, the Health Department brought in experts from the medical sciences as well as service providers and members of the affected communities to advise on policy and set about reviving public health as a policy priority of Australian health policy. This included the Alcohol and other Drugs Council of Australia (ADCA), then known as the Alcohol and Drug Foundation Australia (ADFA) who brought together key stakeholders to develop consensus-based proposals for a strategy at a prior meeting in February 1985, the Drugs in Australia: National Action Workshop. This was used to set the agenda for the upcoming Summit at the Drugs in Australia (Blewett 2011).

This agenda had, at its centre, the conscious move away from the continued criminalisation and relentless enforcement of prohibitive drug laws in favour of addressing the harms associated with drug use – to the individual concerned and to the broader community within which they were using drugs. By late 1985, there was official recognition that parenteral transmission via injecting with contaminated needles was the primary means of AIDS transmission after anal sex. This was the greatest potential harm that injecting drug use presented to the community and underscored the approach adopted under the aforementioned National Campaign Against Drug Abuse (NCADA). One advantage of having been granted primary responsibility over the Drug Summit was that the Health Minister and his Department were able to write the strategy document that emerged from negotiations at the Summit (Blewett Undated). The principal goal as explicitly stated by the communiqué that emerged from the Health Department was to place the philosophy of

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11 The NCADA was later given the less prescriptive (and restrictive) name of the National Drug Campaign. It continues to be evaluated and assessed by successive governments.
harm minimisation, or more specifically, harm reduction, at its core. The Minister was explicit in demonstrating the philosophical distance between harm minimisation and a ‘war on drugs’. In 1987, he articulated the still emerging definition of the philosophy in the following terms:

No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely to minimise the effects of the abuse of drugs on a society permeated by drugs (Blewett 1987, 2).

It is important to differentiate between harm minimisation and harm reduction, the latter of which brought change to drug policy in Australia from 1985 onwards. The NCADA incorporated a three-pronged strategy that placed equal emphasis on treatment and education as upon the once dominant area of law enforcement. The continuation of prohibitive laws as enforced by police and customs officers illustrates that harm minimisation did not represent a departure from drug prohibition. Rather, it is a philosophy located along a continuum of potential policy responses to illicit drug issues. These range from ‘drug war’ at one extreme through to the legalisation or regulation of drugs. What harm minimisation represented was a shift in drug strategy away from any affiliation of notions of a ‘drug war’ towards an approach located towards the centre of the aforementioned continuum.

While definitions of harm minimisation have continued to evolve since 1985, the principle is taken to refer to policies and programs that are designed to prevent and / or minimise drug related harm by balancing three approaches: Supply-reduction, which seek to disrupt the illicit drug supply through the use of law enforcement; demand-reduction, which attempt to prevent the initiation of drug use, primarily through education; and, most importantly, harm-reduction initiatives designed to reduce all manner of harm related to drug use, whether suffered by drug users or the broader community Rowe & Mendes 2004). The incorporation of harm reduction marked NCADA’s departure from past policies and was a direct consequence of the emergence of AIDS. The unprecedented nature of this threat emphasised the need to prioritise the prevention of the collateral health and social damage associated with drug use over the goal of abstinence as the sole objective of drug policy. As an evaluation of NCADA would later note:

The emergence of AIDS as a major public health issue ... and the role of unsafe drug injecting practice in the spread of the AIDS virus, is perhaps the most important change in recent years in the context of drug policy (National Campaign Against Drug Abuse Task-Force on Evaluation 1988:7).
The Health Minister would later by personally identified with the adoption of, and emphasis given to harm minimisation. However, as Blewett later observed with some bemusement:

A myth grew up in the media at the time and frequently occurs in later analyses that Australia’s liberal, non-judgemental, inclusive community-based approach to AIDS containment was imposed by the minister and a dubious coterie around him (Blewett Undated)

Dr Blewett later revealed that the priority accorded to harm minimisation was more a consequence of those within the Health Department understanding the need for this principle to inform policy if the government was to be effective in addressing the potential spread of HIV / AIDS via IV drug use. In fact, Dr Blewett has stated that a particularly proactive public servant was responsible for articulating the prioritisation of harm minimisation. When the Summit was concluded, the initial communiqué issued by the Health Department had not even mentioned harm minimisation. However, the policy document released to summarise the outcome of the Summit read on the very first page: ‘The aim [of the campaign] is to minimise the harmful effects of drugs on Australian society’. He would later acknowledge of those responsible that ‘they were a bit bold’ on harm minimisation given that a number of State representatives, particularly from the then conservative States of Tasmania and Queensland, had reviled at the suggestion of actually using the phrase ‘harm reduction’ let alone ‘harm minimisation’. As he later related: ‘If we had have said [harm minimisation] to the Queenslanders straight out, they would have all walked off.’ He ultimately credited the health bureaucracy for raising harm reduction to the prominence that it had been given in the Ministerial communiqué he was responsible for:

The first assault on [the adherents of a continued prohibitive response to drug use] came within a week and from an unexpected source—the Commonwealth health bureaucracy and its allies. Given responsibility for the Strategy Paper, which would underwrite the campaign, they used the opportunity subtly but undeniably to shift the emphases of the ministerial communiqué to reflect more clearly the concerns of the public health community. The opening statement of the Campaign document reads: ‘The aim [of the Campaign] is to minimise the harmful effects of drugs on Australian society’. Yet ‘minimising harm’ or ‘harm minimisation’ or ‘harm reduction’ occur nowhere in the 6-page ministerial communiqué. What has been described as ‘the cornerstone of the Australian approach to drugs’ was an inspired but bureaucratic intervention (Blewett 2009, 98).
Despite the then Minister’s attempts to play down his role at the Summit, he did ensure the health lobby – with a public health agenda – as opposed to a traditional criminal justice approach had dominated the Summit proceedings:

For the first time, there was a commitment to a cooperative national campaign against drugs with the Commonwealth providing significant additional funding much of which had to be matched by the States. ... The triumph of the health lobby was signalled in the pre-eminence given to demand reduction in the second paragraph of the communiqué. The law enforcers had to wait to paragraph five where it was noted that supply reduction efforts needed to be ‘intensified’ although ultimately these initiatives secured more money than the health initiatives (Blewett 2009, 97).

Still, the immediate challenge to the advocates of harm reduction was to prevent users contracting – at the time – a fatal, and still incurable, disease through re-using needles. The need for clean needles was placed on the political agenda. The fact that such was openly canvassed was an apt reflection of the social change that AIDS had wrought. Penington and Buttrose – for once in uniform agreement, demanded ‘sterile needles and syringes be made available’. While there was political will at the national level and on the ground – including within the two primary advisory bodies earlier established by Blewett, providing easy access to injecting equipment would take some time given that possession of such equipment was illegal under existing state laws and then conservative states, such as Tasmania and Queensland, opposed any moves to lift restrictions (Albion Street Centre 2012). In a bid to drive the agenda forward, the federal government believed community pharmacies to be the best placed services to offer sterile injecting equipment to users. This had the support of those such as Professor Penington of the National AIDS Taskforce. In October 1986, for example, Penington presented an open letter to the Victorian branch of the Pharmaceutical Society of Australia, urging pharmacists to stock and sell syringes to IV drug users to reduce the spread of HIV via shared injecting equipment. It was, at the time, a controversial idea that met with much opposition. The call for pharmacies to provide syringes was labelled ‘ridiculous’ by the Victorian Police Association, whose spokesperson reflected the general ignorance of the time:

The likelihood of it decreasing the multiple use of syringes is questionable and it could exacerbate the use of intravenous drugs [by] the uninitiated (Cave 1986, 1)
Nonetheless, the Pharmaceutical Society of Australia began to advocate for a policy of making cheap syringes available at community pharmacies and by the end of 1986, schemes at pharmacies were established in Victoria, NSW and, through 1987, in all remaining states excepting Tasmania and Queensland (Wodak 1995). The government foresaw potential criticisms and initiated a program by which diabetics (and others reliant on syringes for the administration of legally prescribed medications) could also access inexpensive injecting equipment. As Blewett expands:

We were able to [establish subsidised pharmacy needle and syringe provision] without too much kerfuffle because the previous year, we’d done the same thing for diabetics – provided a subsidised needle program through pharmacists, so we were really building on that existing program which then didn’t allow people to say you’re giving cheap needles to ‘druggies’ but not to poor diabetics … in 1985, we had introduced a subsidised program for people who required injections [for medical reasons] (Blewett 2011).

Despite this advance, front line service providers doubted the efficacy of providing relatively affordable needles and syringes via community pharmacies alone. This was particularly so given the realities of a drug culture characterised by illegality and stigmatisation – one aspect of which was the fact that many drug users continued to encounter discriminatory attitudes from pharmacists when requesting injecting equipment. What was needed was a free and confidential service that would, most importantly, engage with IV drug users in a judgement-free manner. A commitment to this goal was responsible for the campaign of civil disobedience that effectively led to the reform of NSW drugs laws and was instrumental in establishing an NSP network throughout Australia in the following years. Writing about his involvement in these events, Dr Alex Wodak, Director of Drug Services of Sydney’s St Vincent’s Hospital for the 30 years from 1982 until 2012, recalls a vigorous and, at times, acrimonious debate, during the years of 1985-86 as regards the efficacy of providing access to cost-free and sterile injecting equipment as an HIV / AIDS prevention strategy. However, Wodak, had gathered evidence from jurisdictions such as Amsterdam, the first to establish an NSP, as well as having seen the potential deterioration of public health in areas that took a contrasting stance, placing their faith in maintaining a firmly prohibitive response to what was still illegal drug use.

Dr Wodak, like Health Minister Blewett, identified an educational visit to the United States as pivotal to his becoming a staunch, indefatigable proponent of harm reduction measures. During his visit, Dr Wodak was exposed, firsthand, to the consequences of a continued reliance on the strict
enforcement of prohibitive policies against affected communities (Wodak 2009a). His observation of a stereotypical ‘shooting gallery’ – a deserted and derelict inner-urban tenement where needles were rented, sexual favours swapped for drugs and where hygiene, let alone running water were non-existent, quickly convinced him of the necessity to embrace an approach that would reduce the greater harm being inflicted by counterproductive drug policies. Dr Wodak later wrote of the four hours he spent in Brooklyn, NYC, in October 1987 as part of his trip to learn about the nexus between HIV and injecting drug use:

I watched for hours as four Hispanic men and women injected ‘speedballs’ of heroin mixed with cocaine. It was a life-changing experience. We were in the basement of a dilapidated, abandoned tenement building. There was no electricity. Cars parked in the street were propped up on bricks with smashed windscreens. This was urban squalor unimaginable in Australia …

… Renting a ‘shooting gallery’ for a few hours reduced the risk of being bothered by police. Needles and syringes were supplied, but the catch was that they had already been used by many other people.

I watched as these four injected with little regard for hygiene … I wondered why these American injectors had such little concern for their future. Then I realised that a decent education, proper housing or a reasonable job would have been impossible dreams. Hope for a better life for their children and grandchildren? Forget it.

I made 13 submissions to the NSW Department of Health begging to start a needle and syringe program, but they were all declined or ignored. I realised I was never going to get permission, and so we had to resort to civil disobedience. That was not an easy step to take but I’m absolutely convinced it was necessary… (Wodak 2009b)

As revealed above, Dr Wodak experienced great frustration in his attempts to establish Australia’s first NSP through formal channels. In his own words, after being told ‘my submission was too long or too short, it asked for too much money or not enough money or it was too academic or not academic enough … I decided I was being played around with’ (Chapman 2007). The refusal of the health department to respond favourably – no doubt due to political pressures led Wodak into action, albeit with ‘covert support’ from senior political and Health Department figures (Wodak 1995, 49). By subsequently advertising and providing access to free injecting equipment for the purpose of injecting illegal drugs, these actions were explicitly criminal. However, Dr Wodak was not dissuaded. Indeed, the lack of a response to his formal requests was an abrogation of
government responsibility. No less a body than the United Nation’s International Drug Control Program (that body entrusted with maintaining a focus on prohibitive policies) has: ‘Public policy is policy for which government is accountable, i.e., they are expected to demonstrate that the overall costs of a policy are outweighed by its benefits’ (UNIDCP 2007, 159). It was the discrepancy between the need for policy action and the absence of such on the ground that led Wodak and colleagues to establish Australia’s first –illegal – NSP in Darlinghurst, Sydney in November 1996. As Wodak later noted:

> We put a note on the door [of the St Vincent’s hospital drug and alcohol centre] that day: ‘free needles and syringes. Press buzzer. [He was promptly called into the Health Department and told to stop] Nothing was going to stop me because I knew I was right (Chapman 2007).

Blewett recalls:

> We were fairly clear about the policy during the course of 1986. The first preference was to go through the pharmacists and then people like Alex Wodak and others said that’s not going to be sufficient, people aren’t going to go into pharmacies’, we’ve got to go out onto the street and have needle exchange programs.

Dr Wodak determined not only to risk his reputation but his freedom by opening a free needle and syringe service, an illegal activity that carried a penalty of up to two years’ jail. Interestingly, Dr Wodak would later note the empathetic response of police following his being taken to Darlinghurst police station as a consequence of his ‘illicit activities’:

> … It was very controversial. I was interviewed at great length by senior detectives, but at the end of the interview they indicated they would not press charges. It’s also important to emphasise that a lot of people helped set this up. It’s not something anybody could have done on their own (McNamara 2012).
Under questioning by local police, Dr Wodak explained the basis for the NSP, laying out the evidence and the objectives of the move (and the threat of a potential infectious epidemic if there was a failure to act). As he related in an interview with ANEX in 2012:

I had prepared myself for this eventuality by gathering a wealth of information about HIV among drug injectors from other places, such as New York. In the event it was a very civil conversation and the police indicated that they would not be pushing charges even though technically we were in breach of the law … … The matter was discussed in NSW cabinet, and when it became apparent that police would not be laying charges, it was clear we were able to continue with the pilot (ANEX 2012).

As the local police subsequently turned ‘a blind eye’ to their activities (Blewett Undated), Dr Wodak witnessed the federal Health Minister’s support for NSPs in what he referred to as a wonderful answer (Chapman 2007). Questioned as to his position of needle and syringe programs, Dr Blewett replied that while it was it was not something anybody in government or the broader community ever wanted to see, ‘… it is a lesser evil to see that there were clean needles rather than AIDS’ in that same community (Chapman 2007). NSW authorities, faced with the growing patronage of the facility, acquiesced and granted it approval on a trial basis. In 1987, the Sydney Needle and Syringe Program trial was evaluated and found to be a success and it became the policy of the NSW government to provide free injecting equipment to people who inject drugs (Albion Street Clinic 2012). In July 1987, the Global Program on AIDS released a report titled Australia’s Response to the AIDS Epidemic: A Model for Others. It highlighted Australia’s successful prevention of the spread of HIV, via partnerships between governments and affected communities, as innovative and praised the response as world’s best practice and an excellent example for others to emulate (Albion Street Centre 2012).

In November, 1987 a Needle and Syringe program was officially begun in Victoria. At first, this was a pilot scheme restricted to just four outlets, including the Prostitutes Collection of Victoria (PCV) located in the heart of the St Kilda’s entwined street sex and drug trades. At the end of the following year, Australia had documented a cumulative diagnosis of 7,116 people having tested positive for HIV, 797 diagnosed with AIDS and 429 related deaths. In contrast, 50,787 cases of AIDS had been reported in the US (Albion Street Centre 2012). The sense of urgency that characterised attempts to establish NSP networks reflected Health Minister Blewett’s willingness to employ novel collaborative approaches to addressing a public health threat, of which no prior evidence base
existed, served Australia well in the initial years of the virus emergence. The Minister would later emphasise this collaborative role, noting:

> It is doubtful if governments and bureaucracies left to their own devices would have moved with such speed. It is a measurement of the empowerment resulting from the diffusion of authority in both the fields of AIDS and drugs and the changed climate of opinion resulting that we astonished both ourselves and the world (Blewett Undated).

Still, Victoria faced problems; as would other States. Given the constraints of space, however, the focus of this paper is henceforth on the former. Despite its establishment, the NSP program in Victoria was limited to just four sites and Alan Murnane, who would assume responsibility for the coordination of NSP in Victoria in the late 1980s noted a lack of the momentum needed at that time to expand the program to the degree necessary. The Labor government of the time accepted the need for such measures. However, the ‘politics’ of NSP hampered their development given that elected representatives who remained dependent upon popular support for their continued governance were all too aware of the controversy NSPs generated in the broader community. It was a reticence that key people within the then DHS bureaucracy worked hard to combat and, with time, successfully did so. As Murnane explained:

> Once the government adopted the concept, I found them to be very committed. There was a nervousness about issues such as whole boxes [of needles] going out to one person but I could never say there was a negative attitude towards it. There was a caution towards it which was different to being negative about it ... When I first went [to the DHS] I was the needle and syringe exchange coordinator. My immediate superior was Lisa Moore, overseeing HIV Prevention and needle exchange ... Three years LisaMoore left and I was appointed into her position ... My experience working with Lisa ... and Rob Moodie, the Chief Medical Officer ... was that there was a like-minded group of people running [the program] and, while they were careful about it, it was a very politically sensitive issue, they were very supportive of it. When I commenced in 1989, the program had been passed by the Minister-in-Council ... The Departmental staff had already dealt with some of the community and government concern, they had seen the program could work, that there was kudos for the Government and Department in the innovative response. In summary, there was a very positive momentum by the time I commenced in 1989.
I was really impressed with the Department commitment … I remember thinking, ‘look what can be achieved when Departmental staff are committed to the needs of their client group, then governments can do things. The funding kept increasing. When I commenced in 1989 there were no funded needle exchange apart from the Department supplying the required equipment for distribution but the program grew exponentially. It started off as this concept of the PCV and a few community health centres providing injecting equipment without funding, but very quickly the need was identified for a more proactive response and we were funding $100,000 outreach programs. There was a strong community push, and there was evidence of the need, but it needed people in the department who would argue for the increased resources to fund the proactive response, especially the outreach and home delivery. I saw how effective strong advocacy from Departmental staff makes government work. They were staff who believed they could create change and did (Murnane 2011).

Still, just the four pilot programs remained in Victoria in 1989 and at least one, the PCV, was unable to meet demand while also meeting the needs of those sex workers who comprised their core clientele (as discussed below).

Alan Murnane confirms that the philosophical momentum was somewhat constrained by the practical nervousness of those services on the ground which had nominated themselves as sites for NSPs and the potential consequences of entering such unchartered territory:

I think we had between 4-10 outlets by late 1989 … When Lisa and I would go in and provide training, many of the staff and committee members were unconvinced and quite nervous. The management and CEO had approved the operation – but there was always staff who were unsure of the strategy given the previous reliance on abstinence (Murnane 2011).

The political ‘nerves’ associated with NSPs were apparent and understandable (if not entirely justifiable) even to the architects of Australia’s inclusive and cooperative response to AIDS. In retrospect, Dr Blewett would reflect on the obstacles that confronted politicians whose careers depended on the ability to continue to win a majority of public support in their respective constituencies. He later related the ‘advice’ of a State colleague, proffered in ‘half-jest’ to then Health Minister that, ‘… there are no votes in buggers, druggies and prozzies’ (Blewett 2003). This is an apt a reflection of the opportunistic political mindset that avoids serious engagement
with seemingly intransigent social issues while taking a high-profile (or popular) approach if there are obvious electoral benefits. Taking a ‘tough’, prohibitionist stance on drug policy, no matter how counterproductive, is one example at distinct odds with the pragmatic and common sense approach adopted under Blewett’s watch. As the former Health Minister observed of similar political responses to AIDS:

> I suspect that hard-line policies on AIDS that accorded with the popular sense of the victims as the marginal, as the other, would have won votes as they have on drug policies and refugees... Compassionate policies that challenged popular conceptions were never going to be easy (Blewett undated, 4).

However, for medical professionals in the field, as well as the likes of committed advisers and experts acknowledged by Alan Murnane above, the need to implement a comprehensive and statewide NSP network could not be understated. This was made clear by the devastating consequences amongst vulnerable populations in those countries and states that had subordinated a pragmatic health response to political expedience. As just one example, a January 1989 article in Time magazine reported that the first contaminated injecting-related AIDS had traced a total of 12 additional people who had tested HIV antibody positive after sharing injecting equipment. By 1988, 53 per cent of all diagnosed AIDS cases in New York, that same state that had insisted upon a top-down punitive control efforts were infected by sharing contaminated equipment, and the figure ‘is as high as 63 per cent in Italy [not to mention SE Asia] ... 75 per cent of people infected with AIDS through unprotected heterosexual encounters in New York were attributable to sexual partners who shared contaminated equipment’ (Caesar 1989, 26).

Despite the devastation – and a sense of growing helplessness in nations facing infection of epidemic proportions – the leadership demonstrated by Australia in its acceptance of harm reduction initiatives as part of a drug policy underpinned by harm minimisation remained contentious, particularly in the broader community. This was especially the case for faith-based organisations that had long engaged with marginalised and vulnerable members of the community, including inveterate alcoholics and problematic drug users as part of their mission. They did so in a manner that upheld their Christian principles. Such principles were espoused by church leaders, including Pope John Paul II, who informed a 1991 international drug conference that the use of drugs should always be considered illicit given the consequences include the unjustified and irrational refusal to act and think as free persons and limit access for the Holy Spirit’s influence. Being ‘free’ does not imply a personal freedom to take drugs as humans – as God’s creation – do
not have a right to harm themselves or abdicate the personal dignity allowed them by God (John Paul 1995). The teachings of the Vatican reflect Christian principles that draw on biblical passages to emphasise the importance of the body as ‘the temple of the Holy Spirit’ (1 Corinthians 3:16-17), the need to remain fit and healthy to fulfil our responsibility to care for God’s word (Genesis 1:26; Romans 12:1) and the importance of being clear-minded and able to exercise self-control (1 Peter 4:7). Such teachings entrenched long-established abstinence-based treatment models in faith-based organisations such as The Salvation Army.

Since 1971, the declaration of war on drugs by then US President Richard Nixon, and the anti-drug propaganda used to support the claims that drugs threatened the wellbeing of western civilisation has only accelerated fears in the public consciousness. The fact that the greater majority knew little of the alleged ‘killer’ drugs and those who used them outside of the sensationalist exposes of the tabloid media made it even harder to accept the advice and actions now recommended by representatives of the Australian Commonwealth Government and such initiatives as the implementation of NSPs. The rationale for prohibitive policies was the need to minimise supplies of not only drugs, but precursor chemicals and drug using equipment through the strict application of punitive law enforcement that reflected the supposedly dangerous and deviant nature of those prepared to contravene social mores and legally accepted standards of behaviour. It is difficult to fathom, in this context, a government program whereby not only was the use of needles and syringes being legalised for the purpose of injecting illicit drugs, but the State government, in the Victorian context, was prepared to provide this equipment. While the acknowledgement of intractable and entrenched drug use might resemble an admission of failure on the part of the past defenders of prohibitive drug laws, NSPs touched on a new fear. Given the now common knowledge that HIV could be transmitted via contact with HIV positive blood, the alarmist depiction of widely distributed needles being discarded in public spaces (and thus carrying the threat of HIV into the relevant neighbourhoods) invited such responses as that of the Victorian Police Association who decried Prof Penington’s call for needle and syringe distribution to be integrated into pharmacy programs as ‘ridiculous’ in light of police attempts ‘to stem the use of drugs’ (Cave 1986, 1). The Police Association articulated the fear that such a move might exacerbate IV drug use among (presumably impressionable) individuals who might see state-sanctioned needle distribution as ‘a message’ of approval of the activity to which such needles would be put. Such fears were countered by Prof Penington who, while eager to acknowledge the spread of HIV, drew attention to the potential but as of yet absent role that current prohibitive policies could play in making injecting drug use the portal for HIV to spread from IV drug users to the mainstream community via sexual contact:
Recent studies indicated more than 90 per cent of IV drug users shared needles and syringes at some time. [Penington] said most IV drug users surveyed in Melbourne last year claimed they had shared syringes because of the difficulty they had in obtaining clean equipment. Only one of Australia’s [then] 146 AIDS deaths had been an IV drug user with no other infection risk factor, but overseas the AIDS virus had spread rapidly once it appeared among IV drug groups (Cave 1986, 1)

In this environment, the challenge presented to those seeking to counter this potential threat could not be underestimated. As the NSP pilot experiences in Australia made clear, government figures remained reticent to embrace such ‘controversial’ harm reduction initiatives while partisan politics and exploitation of populist fears could translate into a significant electoral deficit. It had taken a wilful act of criminal disobedience by respected members of Sydney’s medical profession to replace the brave, if ad hoc, activities of drug user activists seeking to distribute contraband needles through dealer networks, to force the hand of government to implement a legal NSP network in late 1986. Victoria’s policy makers were even more reluctant, initially, to take the steps exhorted by the likes of public health experts – as related by coordinator Alan Murnane – Victoria’s pilot program had, to a certain extent, been characterised by ‘a nervousness about’ the extent of the needles being passed out into the public. However, the success – in terms of IV drug users’ patronage of existing NSPs, to the extent allowed by pilot programmes inadequate staffing and resourcing to meet demand saw the Department of Human Services adopt a comprehensive strategy in 1989. It was only thereafter the NSP network would expand significantly.
ESTABLISHING THE NEEDLE & SYRINGE PROGRAM
In September 1986, a new manager, Will Crinall, arrived at The Salvation Army Crisis Contact Centre (CCC). Crinall came to the Contact Centre and the broader Crossroads program from Youth Accommodation Services North East Region (YASNER) and brought with him years of experience in the field of youth homelessness. This experience was reflected by his involvement in numerous initiatives including the establishment of youth accommodation services across regional and sub-regional Victoria in disadvantaged areas that included sections of the La Trobe Valley and Dandenong which, along with women’s refuge services and general accommodation services, represented a specific strand of the Victorian Government’s Supported Accommodation and Assistance Program (SAAP). The focus of this strand was a belated but welcome recognition of the need to target and counter the growing problem in youth homelessness in Australia – from the initial point of crisis and accompanying need for refuge through to supported, secure and stable housing. It also represented a different approach from a myriad and ad hoc ‘pile’ of Youth Accommodation Services programs that lacked not only focus but, perhaps more importantly, a determined philosophy of commitment to address the burgeoning issue of youth homelessness. Will Crinall recalls this new focus emerging from a youth rights perspective in many ways – something that had defined The Salvation Army’s Crossroads Youth Project in St Kilda under the management of (Major) David Eldridge.

Well before the enhanced response of the State Government, the Crossroads Youth Project had maintained a primary focus on accommodating young people who were in urgent need of the security and support of stable accommodation provided by a trusted service. Not only was Crossroads a service that targeted the young, it deliberately sought out those seen as ‘difficult’ and deemed unacceptable to other programs. Consequently, from its very inception, Crossroads was ‘biased towards’ working with the most disadvantaged and isolated young people (Salvation Army 1985, 10). An early profile of Crossroads stated:
Chronic homelessness is the result of a long process whereby each level of a person’s support gradually deteriorates. A young person is either ejected from or leaves their family. They may move in with friends who eventually reject them and this process repeats itself until local community support is eroded and community services run out of answers. Again, they are forced to move on until transience becomes a way of life and the skills of developing and maintaining relationships are lost. What then occurs is a shift from short-term homelessness to a state of non-belonging.

The majority of young people involved with Crossroads are part of this group. They have very little sense of belonging to, or being part of, a community … a significant proportion of these young people come from disrupted families … it may be disruption caused by family histories of violence, alcohol or drug abuse; families which are severely restrictive or disciplinarian; or the young people may have long histories of institutional care (Salvation Army 1985, 1).

Crossroads’ had only recently established a presence in St Kilda at the time of Will Crinall’s arrival at the CCC. Highlighting the focus of the program on the most marginalised of young and homeless, Will recalled not just strict rules that governed the movements of clients at most accommodation services in the early 1980s, but also their use of ‘exclusionary categories’ that effectively excluded the mentally ill and / or drug dependent. Despite the demands inherent in the service’s focus on those most in need of intervention, the Crossroads program initially operated from modest facilities in Tranmere Street, North Fitzroy, a six-bedroom house purchased by The Salvation Army in 1978 (Will Crinall recalls ‘a bit of a wreck’). Despite limited infrastructure – a further two flats were obtained in Fitzroy in 1980 – the (long-term) guidance of David Eldridge ensured there was a strength of commitment to the program’s philosophical foundation on a belief in pragmatic and sustainable approaches to youth homelessness. At its core, this entailed looking at the whole person within the Crossroads program and establishing what services would be required, not just to meet a client’s material needs in the present, but also to help them meet their aspirations. This meant allowing Crossroads’ staff to draw on resources beyond the provision of accommodation to address other aspects of clients’ experiences that may have predated homelessness, including employment needs and educational barriers (Crinall 2011). This holistic approach went far beyond attending to clients’ immediate needs. As an early paper on the Crossroads Program specified:

Involvement in work and recreation was seen to be very important and residents [in Crossroads accommodation] … were offered several options in these areas. The refuges organised camps and social excursions aimed at expanding the young people’s social experience. Residents became involved in sporting teams organised by the program (Salvation Army, 1985, 6).
As a result, the Crossroads program served as something of a ‘lightning rod’ to long frustrated workers in the welfare sector attracted by Crossroads’ commitment to ensuring a response that was relevant and lasting for young people who were without alternative service options. David Eldridge recalled working with a strong team, ‘right across Crossroads [that] was unified about the issues’ (Eldridge 2011). Resolving the issues meant placing client’s best interests first. Eldridge elaborated at length on Crossroads’ client-centred approach and the unity that held the Crossroads’ team together in applying it:

When we had a managers’ meeting to talk about an issue, you knew that the most effective position from a client’s perspective would be the one that would get a run from management at Crossroads … I was so fortunate to have a good team, it was always a team at Crossroads. A team of good managers, good support staff and good staff down the line. The culture managed itself – the culture forced out people who didn’t fit … if [an employee] was someone who didn’t have the ethos [of the program], it was the staff who would pull them into line – ‘No we don’t treat people like that, or we don’t kick kids out for that’. It was a very developed culture because of the team that was there … I think we had minimal trouble because the workers were so focused on outcomes for clients that the Army people would say, ‘It’s sort of like the real old Army, isn’t it, it’s really gutsy and gets down to the issues that need addressing. I think we had a pretty easy run because of all that. There were bureaucratic things about the Army that drove us all mad but the passion of the staff kept them engaged (David Eldridge 2011).

The dedication of these uniformed officers returned The Salvation Army to its original mission as embodied in the work of the organisation’s founder William Booth. Booth initially engaged with persons seen to be irredeemable or ‘hopeless cases’ by other charitable and / or religious organisations in the late nineteenth-century. The Salvation Army’s founder had no such qualms, former State Social Secretary Col. (ret.) Edwin ‘Eddie’ Hayes recalling Booth’s acknowledgement of the limitations of ‘salvation’ via religious means and expressing a pride that alcoholism and, by extension, drug dependency was recognised by the Booths – and consequently the Army – as a ‘disease’ as early as 1890 (i.e. not a consequence of moral failings) (Hayes 2012; Davies-Kildea 2007).
The Booths’ work with the poorest members of the East London community in the mid-19th Century was, as documented by Jason Davies-Kildea, initially motivated by the evangelical zeal that drove attempts to convert the poor to Christianity for the benefit of their spiritual life (Davies-Kildea 2007). However, as he writes:

… for The Salvation Army to be authentically and deeply involved in mission with the poor meant that they would be unable to ignore the social and material plights which shaped the life of the poor and in turn would shape the life of the Army. Much of this work arose from an intuitive response to the needs of people in desperate poverty. Early social work in The Salvation Army was not characterised by highly structured social or theological analyses of these situations, but rather an immediate, practical response to human need (Davies-Kildea 2007, 70).

The immersion of Booth in the poverty stricken lives of his potential converts led, over time, to his increasing concern with issues of social justice and the need for structural change to remedy the inequality he witnessed. In his own words: ‘as time wore on, the earthly miseries connected with the condition of the people, began to force themselves more particularly on my notice’ (cited in Davies-Kildea 2007, 70). In 1890, Booth published the thesis In Darkest England and the Way Out, a work that led to his denunciations as a socialist for the clear political implications apparent in such passages as the following:

The commiseration then awakened by the misery of this class has been an impelling force which has never ceased to make itself felt during forty years of active service in the salvation of men. During this time I am thankful that I have been able, by the good hand of God upon me, to do something in mitigation of the miseries of this class, and to bring not only heavenly hopes and earthly gladness to the hearts of multitudes of these wretched crowds, but also many material blessings, including such commonplace things as food, raiment [clothing], home, and work, the parent of so many other temporal benefits (Booth, 1890, 5)

At the time of interview in late 2011, Captain Jason Davies-Kildea was engaged as the Divisional Social Program Secretary of The Salvation Army’s Melbourne Central Division. Davies-Kildea has a long history of working as both a social worker and officer in The Salvation Army, working on the front line of the Army’s social services, spending a year at the Tranmere Street Youth Refuge, two years at the Crisis Contact Centre, four years in employment and training programs for homeless youth and another five years at The Salvation Army Brunswick, a relatively small church with a large suite of social services attached, including a regular afternoon ‘service’ (albeit with less conventional church services known as Connections that provided a safe place for those whose lives had been characterised by violence and desperation to rebuild resilience with the support of workers present).
Motivated by such beliefs, Booth’s mission moved beyond the conversion and the eternal salvation of the souls of those whose daily lives were characterised by a struggle for survival. Of equal importance – as reflected in his writings – was the mission to deliver a measure of salvation from the misery and deprivation that characterised the physical lives of those at the margins of society. Under the guidance of William Booth, these two missions – spiritual and material – would come to hold equal importance. The provision of material assistance in the present was no longer simply a means gaining the attention, interest and conversion of the poor and ‘downtrodden’ but was of equal importance as a means of relieving poverty in the present. Indeed, Booth’s understanding of how ‘such commonplace things’ as adequate clothing and accommodation would prove the means of further progressive benefits reflects philosophy at the basis of current service provision understandings based on a hierarchy of need. Without stable housing or presentable clothing, the chances of acquiring the kind of employment necessary to permanently remove oneself from poverty are unrealistic. In this way, services that provide material assistance that is not in any way sustainable are often, inadvertently, providing the means by which the poor may temporarily rise above the misery of daily life to draw breath before being submerged beneath the misery of poverty again. In this way, the evangelical work undertaken by the founding members of The Salvation Army was nurtured to give full expression to a theology of social mission that would build over the following decades spent working with the poorest, most marginalised members of the community in which they live. This was particularly notable, and was an exception to other charitable institutions, given the common tendency to regard poverty as a consequence of personal failure (as opposed to the barriers of a class-conscious England that kept ‘certain people’ in their place (Davies-Kildea 2007, 69-76)).

Ironically, as awareness of the structural causes of poverty have become more understood and justifiably called into question such discriminatory categories of persons as the ‘undeserving poor’, Davies-Kildea, among others, has noted that members of The Salvation Army’s corps have become distanced from the organisation’s social mission. This has been an inadvertent effect of a number of factors, including the increasing professionalization of social services, as reflected by the minimum standards of qualifications and training demanded by licensing authorities in respective government jurisdictions. As a consequence, the social mission of The Salvation Army is primarily delivered by professional social workers representing a variety of fields and specialties and includes only a minority of Salvationists. This has contributed to a separation growing between current

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13 This philosophy has been articulated by Ms Jenny Plant, current manager of the St Kilda Crisis Contact Centre. Seeking to use the different services that comprise the Crisis Services network – including accommodation support, income support, legal support, domestic violence counselling and health services among others – a user of the Centre might be case managed to address various needs and enjoy a prolonged period of stability and work with services to construct a sustainable approach as opposed to offering ‘band-aid solutions’ (see Rowe, 2006a pp. 101-103).

14 See Tresize & Porter (2001) for a concise but illuminating discussion on the differences between individual and structural explanations of poverty.
Theological formation among Salvationist congregations and the lived experiences of the poor. A key theme of Davies-Kildea’s Masters’ thesis, this separation is seen as responsible for ‘a gradual distancing’ of The Salvation Army from its social mission (Davies-Kildea 2007, 77). This is not unusual for faith-based organisations with streams that encompass both spiritual and social services. In 2012, the Vatican and Catholic nuns from the US came together for a national assembly in an attempt to reconcile diverging views as regards ‘the Church’s biblical view of family life and human sexuality. In contrast to the Vatican, the nuns in question had reportedly made statements and taken action that reflected ‘a prevalence of certain radical feminist themes incompatible with the Catholic faith.’ Jennifer Reyes, Coordinator for the Catholic Action Network stated in a not distant reflection of the divide between spiritual and temporal salvation:

> You see a difference in the theology of the sisters who are on the margins, who live with the people, whose theology is informed by the work they do and the theology of people who hold positions in the hierarchy who aren’t as connected to people and who can maintain black and white guidelines (Townsend 2012, 9).

The difference between maintaining adherence to a ‘black and white theology’ and the experience of working with those in situations of dire poverty and need would prove to be an issue when the need for a NSP was to become apparent to both social workers and those Salvationists – such as Eldridge and Hayes whose daily mission encapsulated this social mission at its most fundamental – working with the most marginalised of young people or chronic alcoholics respectively – and those whose primary focus remaining the faith-based principles seen as underpinning the ecclesiastical faith of members of The Salvation Army.

Indeed, in recalling the contention that greeted the initial proposal within the ranks of The Salvation Army, now retired Colonel Edwin Hayes noted ‘a moralist attitude among a number of members of The Salvation Army’ in the 1980s and 1990s. These Salvationists tended towards condemnation of drug users as sinners – further evidence of what Davies-Kildea saw as a consequence of ‘congregations … increasingly established in middle-class suburbia [that] have to a large degree lost touch with the poor and the marginalised (2007, 7)’. The result was perceived to be a divide between those in the pews of Salvation Army congregations and persons in very different circumstances, the latter being compelled to access the social services struggling to provide the material assistance needed by ever increasing numbers of a depersonalised and individualistic society. The committed work of David Eldridge and others in the Army, who, by placing as great an emphasis on the organisation’s social mission, would re-embed the roots of this mission in The
Salvation Army’s Australia Southern Territory. This would foster engagement with those on the margins of society – especially those with needs seen as beyond reach or ‘undeserving’ by other social services and charitable organisations.

The Salvation Army Crossroads program established its presence in St Kilda in 1984 when further funding enabled the development of ‘a network of supports for homeless young people’ (Salvation Army 1985, 7). These included the Crisis Contact Centre (CCC) in St Kilda as a source of referral information and support to people in crisis and a newly established Crisis Accommodation Centre to provide short term accommodation. At the time these services were co-located within the one building at 31 Grey St, a block up from the latter’s intersection with the bustling activity – not all of which was legal – on the commercial strip of Fitzroy Street. While subsequent developments took place under the direction of the Crossroads team, in keeping with the philosophy of that service, these developments were a consequence of responding to the needs of clients and shaping service delivery and allocation of resources to meet these requirements:

The most significant factor in the development of the Crossroads philosophy, programs and practice has been our interaction with young people. Due consideration has always been given to the expressed needs and interests of residents and reflection by staff with residents on current practice and future directions has been paramount to any planning process … [This reflected an] attempt to recognise the varying and changing needs of young people and, considering these, develop a range of appropriate services … (Salvation Army 1985, 8,9).

The philosophy of allowing clients’ needs to effectively prioritise the allocation of resources and funding of service provision found a committed advocate in Will Crinall. This client-centred philosophy continues to guide Crisis Services in St Kilda to the extent that any subsequent expansion of services delivery has been in a manner deemed most appropriate to existing and potential clients. It was in this way that client need was instrumental in recognising the need for a NSP operating from within the CCC. Will Crinall recalls coming to the Contact Centre when it was primarily staffed by uniformed Salvation Army officers who retained a conservative social welfare focus that prioritised the needs of the ‘deserving poor’. According to his recollection, assistance was primarily offered to families who, through no perceived fault of their own, were in ‘very early experiences of homelessness’, as well as the occasional ‘traditional’ vagrant alcoholic in need of overnight shelter (Crinall 2011). That Will Crinall arrived at the Contact Centre shortly after David Eldridge and the Crossroads program proved fortuitous given their mutual determination not
just to expand the reach of the service, but to see that assistance was made available to the most vulnerable of persons existing – if barely – at, or beyond, the edge of the community’s margins.

The ambitions of Crinall and Eldridge and their like-minded staff were yet to be reflected in the material resources available to them. The Salvation Army was yet to consolidate the current suite of services in and attached to the CCC which was then located in the same building that accommodated the Crisis Accommodation sector of the Crossroads Program at 31 Grey St. Still, the move into St Kilda was Crossroads first outside of Tranmere Street and the co-location with the Crisis Contact Centre was not without problems and, as one of his first initiatives, Will Crinall physically separated Crisis Accommodation from the Contact Centre with those seeking assistance from the latter entering through one door and those in emergency accommodation accessing the building through another. Still, it was a crowded and potentially fractious service. In 1989, crisis accommodation was sufficient to shelter 14 individuals as well as two families. There was no restriction enforced in respect of either age or gender, providing for a client profile that did not exist elsewhere at the time (McDonald 2011). What made the scenario manageable was a unity of focus among the staff. Workers were spread across the co-located services with accommodation workers rostered on to do desk shifts at the Crisis Contact Centre. This ensured that housing workers, including David Eldridge who shared weekend shifts with another Salvation Army officer, placed their primary reason for engagement with those in need (i.e. accommodation issues) into the context of the broader range of crises that workers at the Contact Centre were faced with daily (Crinall 2011).

By Crinall’s account, David Eldridge had actively sought him out for the service in St Kilda, bringing him across from YASNER to become the first non-Salvationist manager at the CCC. Crinall promoted a practical approach as regards the purpose and mission of the CCC. One initiative that would prove fundamental to the changing focus and culture of The Salvation Army’s St Kilda operations was the beginning of relatively detailed data collection. In the first year of operation under Crinall’s management, there were in excess of 600 contacts by individuals who required support in the form of material aid, referral to another service or assistance in solving a problem of importance (if not crisis to the person presenting to the responsible worker) (Crinall 2011). The collected data provided management with an insight into the needs of clients – and one of the

11 The ‘deserving poor’ was – and in some quarter remains, a phrase used to distinguish those whose need for material assistance occurs through no fault of their own. The distinction became legal – and thus widely entrenched – with the 1834 Poor Law in England stipulating that only those who could not work would receive material support (as opposed to those who would not). Ultimately, the need of the ‘deserving’ for charitable assistance was not their fault. The underserving comprised those who don’t actively make an effort to address their poverty. To provide material assistance to such persons was thought to allow them escape from their responsibilities as a member of the community. Such a view neglects to incorporate the potential influence of a disadvantaged environment, personal trauma, and / or a lack of opportunity –including structural factors over which they had little if any control.

16 The Salvation Army was yet to acquire the property at 29 Grey St at which the Contact Centre is currently housed.
early indications was of the manner in which the drug culture was taking hold among those who frequented the Contact Centre. This would prove useful information when presenting the case to the State Government as to the suitability of the CCC as a site for the establishment of an NSP. As Will Crinall remembered:

We began to record the profiles of some of the people coming in and the issues that [they were presenting with] … that was the beginning of a data base and [the use of the collected information for the purpose of] driving programs and policy with some kind of evidence base … we were looking at people who essentially had no other options because St Kilda at that time wasn’t a particularly attractive place for people, lots of [drug] dealing going on around Grey Street, lots of prostitution … it was very focused in St Kilda … so we were learning a lot about a group of people, a subculture in some ways, where people hadn’t really worked with them very much and certainly not from the point of view of what their circumstances were and what they wanted to do … so there was a shifting social model [in the service], a move [away from the needs of a so-called ‘deserving’ poor] towards a rights-based approach …

…We talked to people coming into the Centre about all sorts of things [including drug dependency and pending criminal charges] in a totally non-judgemental way. It was really about establishing a connection whereas they didn’t have to talk about those things but [if they did bring them up] we could connect them with a solicitor or if there were things around health, there were health services so there was our general support, which was our end [at that time, before] then connecting them with more specialist [health] services. And respecting their dignity and respecting them as a person in those early days of privacy [was of paramount importance]. As a result, in one way or another, people were starting to make a lot more [personal] disclosures [and there was trust and a relationship built up. There were disclosures about sexual abuse and a whole mesh of inter-generational disadvantage and poverty and, [at the same time], the effects of those sorts of things on individuals were becoming clearer along with [the role that these played as] the pathways into homelessness, crisis, prostitution and drug dependency. So we weren’t experts in any way, but we were starting to see examples of people self-medicating [with drugs] for example (Crinall 2011).

At the same time that clients of the CCC were building the trust necessary to disclose personal issues to duty workers, the latter were becoming aware of the links between injecting drug use and potential transmission of HIV / AIDS (the so-called ‘second wave’ of AIDS). Will Crinall remembers
his arrival at St Kilda coinciding with an increasing focus on this alternative route of AIDS transmission. A growing knowledge of the issues on the street as shared by clients of the Contact Centre – and the government’s adoption of a harm reduction as approach as an integral aspect of the first national drug policy – led Crinall to realise and seek to harness the potential role that the CCC could play in arresting the potential and greatly feared spread of the disease:

It was a real window of opportunity because we were one of the few services that had built relationships and trust with IV [drug] users. They weren’t a [unified] population, they weren’t a community, they were a disparate people down [in St Kilda] to score essentially. On the other hand, there was the emergence of the harm reduction approach and a different understanding about HIV and drug use … With HIV and harm reduction, it was really clear that needle and syringe programs were going to be an important part of addressing the transmission [of HIV], minimising the infection rates and protecting the population (Crinall 2011).

Given the current or impending crisis that characterised the lives of so many CCC clients, the use of drugs was a common feature of profiles collected by duty workers. For many, drug use was a means of self-medicating, a vehicle by which to move through either a period of crisis or the ongoing deprivation of poverty and / or mental ill-health. Consequently, the provision of sterile injecting equipment became a priority for the staff at the CCC if they were to meet the needs of presenting clients. This need was exacerbated by the high rate of needle sharing among IV drug users without access to clean needles or health education about the potential dangers of sharing injecting equipment.

We had [situations of multiple needle use, including] 13 people all moving into one private flat and all sharing ‘fits’, people coming out of jails [and sharing fits] and so on. The danger was always that if any one person was infected amongst that group of people, then the chances of them infecting a whole lot of young people were very high … there was a fair bit at stake [in terms of providing sterile needles and syringes] (Crinall 2011).

Will Crinall had already sought to respond to requests for assistance to address problematic and dependent drug use by contacting Dr John Sherman at the St Kilda Medical Clinic in nearby Barkly Street. In the late 1980s, Dr Sherman was one of the few practitioners in the vicinity who prescribed
opioid maintenance treatment (i.e. methadone treatment) to those seeking such assistance to manage problematic opioid use. Dr Sherman also attempted to organise detoxification and rehabilitation, if requested, by clients referred by Crinall and other workers at the CCC. Advocating for action to meet the needs of the young and drug dependent also led, by Crinall’s account, Melbourne’s St Vincent’s Hospital to ‘quietly accept’ young people referred by workers at the CCC who would advocate persistently on their behalf. Still, the need to keep injecting drug users healthy and free of infection – as well as engaged with, and trusting of, service workers until they were ready and, most importantly, willing to enter into treatment – remained the main concern of Crinall and others at The Salvation Army’s site.

David Eldridge was equally supportive of the establishment of an NSP as it reflected Crossroads’ philosophy of service provision being driven by the needs of clients coming through the door. Both men drew direct comparisons with the early work of The Salvation Army and the need for a consistent re-positioning of the organisation in a place of social relevance as envisioned by its founder. Although not a Salvationist, Crinall studied the writings of William Booth and other influential figures in the Army and drew encouragement and a means of engaging with the Army hierarchy through the pragmatic responsiveness to need reflected in these writings – for example, Booth’s willingness in ‘taking money from the devil and washing it in the tears of the poor’ if such money would lead them out of poverty. His reading of these early texts illustrated the history of Salvationists’ support of the ‘undeserving poor’ throughout East London of the late 19th Century. Crinall drew definitive parallels between Booth ‘seeing the face of Christ among the faces of alcoholics’ and the need for current workers in the Army to actively engage with intravenous drug users.

David Eldridge later recalled Will Crinall as being the person to first raise the notion of incorporating an NSP into the services at St Kilda, not simply as a public health response, but a means of engaging with injecting drug users on a regular basis, earning their trust and building relationships by offering a much needed, if contentious, service in a non-judgemental manner. It was hoped that users’ would then feel able to turn to these relationships when they reached a point at which they needed assistance to address their drug use. This was particularly pertinent for drug users who were homeless and / or in mental ill-health and living – as best as able – on the extreme margins of ‘mainstream’ society … if not already excluded. A fledgling network of NSP services had been established in NSW from late 1986 following Wodak and colleagues civil disobedience. Victoria had since implemented a four-site pilot program in November 1987. However, the provision of injecting equipment, while acknowledged as a vital aspect of harm reduction policy, remained controversial within both broader community and faith based organisations that continued to adhere to an abstinence-based model of treatment in the late 1980s. However, as
David Eldridge noted, Crinall prioritised his commitment to his client group above all else and it was this commitment that was ultimately responsible for his willingness to push against the accepted – and politically ‘safe’ – strategies of the time. As Eldridge remembers

I suspect it was Will [who first raised the idea of establishing an NSP]. Will was always pushing the boundaries – in a positive way … You wouldn’t say Will took reform just ahead of where it was, he took it right out there’ (Eldridge 2011).

Will Crinall used the opportunity that presented when senior officers of The Salvation Army visited the CCC to engage them in pointed discussion – supported by data collected during the course of operational duties – about the need for an NSP. Such discussions, he would later recall, were strategically couched in the rationale of the social service mission of The Salvation Army as envisioned by William Booth:

When the ‘brass’ would come to visit – Colonel Eddie Hayes, the State Social Secretary, along with another Colonel from social services – when they would come over to look at the work [we were doing] and we would get the opportunity to talk to them, I’d just tell them straight up about the sorts of things we required, including the need for that initiative [a NSP] … Colonel Hayes listened and was persuaded in some ways, he could see merit in that kind of approach (Crinall 2011).

In 1987, after an informal representation to Colonel Hayes, the State Social Secretary responded by requesting the young Centre manager commit his proposal and supporting rationale to paper. Crinall remembers two nights at his desk, scouring the literature of harm reductionists such as Dr Wodak as well as Salvationist historians to place the modern public health demands of the corporeal alongside spiritual salvation before hand-delivering his submission to Colonel Hayes, the latter apparently mildly surprised to have received the requested document so soon. Crinall’s writing not only spoke to the necessity of an NSP, but to the St Kilda Crossroads program as the ideal location for this service. Incorporated into the suite of services at the CCC, an NSP would ensure the continued health – or at least the public engagement – of the CCC’s most vulnerable clients with duty workers. Colonel Hayes was a pragmatic Salvationist, the legacy of many years spent working in person with chronic alcoholics. In contrast, the Territorial Social Services Secretary Lieutenant-Colonel Peter Rigley, Col. Hayes immediate ‘superior’ had an ecclesiastical background
and Col. Hayes saw his role as communicating to the Social Services Secretary the social reality that underscored the demand for an NSP so that his immediate superior could appreciate the Contact Centre’s engagement with individuals who were at the margins of society and, partially as a consequence, most at risk of contracting and consequently transmitting HIV. Lieut.-Col. Rigley’s support was thereafter influential among senior policy makers in the Army. It is instructive to briefly diverge from the story of the NSP’s establishment to place the proposal within the context of The Salvation Army hierarchical model of decision-making – so important was the need for endorsement of the proposal at ever-higher levels of the Army’s Southern Territory.

In Australia, The Salvation Army has a presence in two autonomous regions, known as the Southern and Eastern Territories. The autonomy of the respective Territories is demonstrated by the markedly different approach each has taken to numerous social issues, including how to best respond to illegal drug use. The Southern Territory, despite the geographical implications of the name, incorporates all states excepting New South Wales and Queensland (which, along with the ACT, form the Eastern Territory). At the frontlines of The Salvation Army’s work are the corps (Salvation Army churches, often with a community service component) and dedicated social programs and networks, the latter incorporating many professionals who are not themselves Salvationists. These networks are at the front line of engagement with the face of social need and may be better positioned to see the need for initiatives – such as the need for an NSP. New initiatives are considered via a program proposal to the responsible Headquarters. St Kilda falls within the Melbourne Central Divisional Headquarters, responsible for a broad geographical area stretching from Kinglake to Melton and down to Werribee. If the board at Divisional Headquarters approves of a proposal, it is then forwarded to Territorial Headquarters. As stated, Territorial Headquarters enjoy a significant degree of autonomy to make decisions and most major decisions are made by the Territorial Policy Council. Nonetheless, decisions are not made without careful consideration of The Salvation Army’s broader mission and a consistent approach to fulfilling it. If a particular proposal or policy issue raises ethical questions in the context of the work and principles upon which The Salvation Army rests, these questions are forwarded to the Moral and Social Issues Council (MASIC) – a point at which a proposal for The Salvation Army (Southern Territory) to officially support medically supervised injecting facility sits at the time of writing. MASIC is also responsible for developing The Salvation Army’s ‘Positional Statements’ on moral and social issues (e.g. euthanasia and abortion). Currently, a doctor and lawyer, along with people from different areas of The Salvation Army sit on the Council (Davies-Kildea 2011). The proposal for the establishment of an NSP was considered by an earlier incarnation if MASIC known as the Public Questions Board.

17 While most countries comprise a single national Salvation Army Territory, those with a numerically strong Salvation Army presence may be divided into autonomous territories (e.g. as in the United States and Australia). In contrast, a Territory may incorporate several countries (e.g. the Caribbean Territory comprises 18 separate countries, with headquarters located in Jamaica).
The Territorial Commander has ultimate responsibility for the decision to proceed with proposals forwarded by members of the broader Salvation Army network. In doing so, they bear responsibility for locating the reasons for their decision in the broader strategic direction envisioned for the Territory. The Chief Secretary of the Territory acts as second-in-Command and, in practice, ensures the Territorial Commander’s strategic vision is realised by through their ‘day-to-day’ responsibilities in line management involving through liaison with the various Divisional Commanders of the Territory. Further assistance is provided by three secretaries for programmes, personnel and business administration respectively. Together these five individuals form the Territorial Cabinet. Territorial Commanders report to the International Headquarters of the Army located in London, England. The main responsibilities of International Headquarters are strategic, long-range planning and facilitating policies in respect of The Salvation Army’s global operations in the countries in which it is active. It is also responsible for the allocation of resources. These responsibilities are directed by the Army’s General. The worldwide leader of The Salvation Army is an elected position, determined by ballot at the High Council. In a reflection of the relationship between Territorial Commander and Chief Secretary, the General makes strategic and political decisions and relies upon a Chief-of-Staff to implement these on a practical level. A Commissioner is appointed by the General with responsibility for the implementation of the General’s policy decisions and to liaise between Territories in doing so (The Salvation Army, 2012).

Table 1: Hierarchical structure of The Salvation Army (Salvation Army 2012)
Invariably, changes have occurred to the hierarchical structure of decision-making in the years since The Salvation Army hierarchy approved the initial establishment of an NSP within one of its programs. David Eldridge, for one, believes the different structure at the time ‘made it easier’ for such a contentious proposal to win approval. Recalling the comparative structure of the Territorial hierarchy in the late 1980s, Eldridge noted that the next level of management to whom frontline service personnel would be expected to put proposals was then a state-wide social service management structure. According to the former manager of the Crossroads Program, the social service background of this body ‘helped us’ given that the management structure included people such as (Col.) Edwin Hayes, ‘who had a background growing up in the Army through [its] social services’. In contrast, Eldridge observed that, while current management structures incorporate social service representatives on Councils and Boards, these are primarily comprised of Salvationists from an ecclesiastical stream (or with more corps (ecclesiastical) experience). Consequently, the presence of Col. Hayes – whose personal experiences in service delivery, in his own opinion, informed his sense of pragmatism and dislike of moral condemnation of drug users and others seen to have ‘fallen’ as ‘sinners’ (Hayes 2011) – ensured that the submission delivered to him and the arguments within were impressed upon Lieutenant-Colonel Rigley.

Will Crinall’s dogged pursuit as manager of the CCC determined to see a ‘rights’ based framework to inform service provision for young people – alongside the Crossroads’ manager David Eldridge’s own client-based focus – ushered in a major change in the philosophical and, consequently, practical engagement of the facility with its clients. These actions were instrumental in changing the culture of the CCC from a charitable approach that had extended moral judgements as to the ‘deservedness’ of certain clients to receive assistance to one widely recognised for its openness to working with any individual in need who entered through the doors. This openness extended to employing those workers best able to advocate for, and meet the complex and varied needs of clients coming through their doors. This led to a team at Crossroads that was characterised by an inclusive nature, bringing ‘together people with a shared concern but from very different points of [faith-based] view’. Manager David Eldridge reaffirmed the importance of assembling workers most able to meet client need at the frontlines of The Salvation Army’s crisis services rather than members of a particular religious faith:

I think we’ve been very fortunate to have the staff down there [that] we’ve had. They’re not judgemental, they’re not locked into particular ways of viewing the world whether they come from a Salvation Amy background, a Christian background or a non-Christian background – the important thing is that it’s about non-discriminatory intervention. That’s the reason the [Crisis Contact] Centre is so strong (Eldridge 2011).
This mindset continues to inform recruitment at the CCC where one’s respective faith is irrelevant in contrast to their professional capacity. However, while there are rarely uniformed Salvationists working in a full-time capacity at the CCC (with the obvious and important exception of the Chaplain at the site), this is not to question the compassion and dedication of Salvationists whose embrace of this philosophy at the frontline of the organisation’s social services only emphasises their mission to work with those at the outer margins of society, of whom many of continue to be deemed ‘too difficult’ to be taken on as clients by other social services. The priority accorded to client outcomes sustained the belief that an NSP could play an effective role in the maintenance of client health while building potentially constructive relationships that might make the difference at the very time a positive outcome might be achieved.

At the same time as reflecting the Salvationist commitment to working with those on the margins of society, it must be recognised – and given due emphasis – that establishing an NSP would represent a significant departure from the established Salvation Army policy as regards responding to the needs of drug users. The essential conundrum of the principle of ‘harm reduction’ is that services which embrace it are compelled to adopt a neutral stance towards the illegal nature of drug taking activity in order to reduce avoidable harms associated with it. To incorporate an NSP within the suite of services operating from within the CCC could foster the perception that the Crossroads program was not only accepting, but also facilitating continued injecting drug use. It must be underscored that, as noted by former Health Minister Blewett, this remained a deeply unpopular initiative in the broader community at the same time that those at the frontline of community services were advocating acceptance of harm reduction policies. Will Crinall, for example, had embraced the teachings of those medical experts, such as Alex Wodak, whose experiences in witnessing firsthand the shooting galleries of the inner-urban American cities were so instrumental in demonstrating the need for access to sterile injecting equipment. However, while Wodak and his contemporaries wilfully acted in contravention of the law by establishing Australia’s first – then illegal – NSP in Darlinghurst, Sydney in 1986, their faith in the need for the widespread acceptance of such measures was based in their knowledge of public health. This stood in stark contrast to the faith-based beliefs of The Salvation Army.

Will Crinall, and those whose daily lives revolved around trying to meet the needs of homeless, dependent and often chaotic drug users, accepted that providing sterile needles and syringes could reduce the harm that injecting drug users (IDU) were causing to themselves (and potentially others through the re-use and sharing of injecting equipment). However, the facilitation of continued drug use is contrary to teachings of the Christian Church and The Salvation Army’s entrenched belief in abstinence as the goal of intervention in drug use. Consequently, to undertake such a step would represent unprecedented departure from The Salvation Army’s established
philosophy and clear opposition to the use of drugs, in the pursuit of a healthy and spiritual Christian lifestyle. This belief does not reflect the somewhat arbitrary basis of state drug laws that allow for the legal use of tobacco and alcohol that, despite regulations of their use, cause demonstrably more damage to the community than illegal drugs. According to Salvationist teachings, a healthy lifestyle – physically and mentally – means refraining from the use of all harmful drugs, including alcohol and tobacco. This opposition is explicitly reflected in the Positional Statement on Alcohol and Drugs, approved by International Headquarters in July 1992 and issued by authority of the Commanders of the Australian Territories in 1997, which states:

The Salvation Army strongly opposes the misuse of mind-altering, mood-changing and/or physically damaging drugs of any kind, whether addictive or not, and whether illegal or not. There are many drugs beneficial to health but even prescription drugs can be harmful or addictive and therefore need to be monitored by an aware physician, weighing the advantages and risks.

However, again contrary to legislated drug laws that do not allow for consideration of context or the exercise of discretion in their determined prohibition of certain drugs, the same Positional Statements observe that ‘Scripture does not supply detailed and clear-cut rules of behaviour for every situation’. Despite widespread perceptions of addiction as an inevitable consequence of illicit drug use, relatively few individuals who experiment with, or occasionally use, illegal drugs, do actually experience a descent into the misery of drug dependence; related poverty; and exposure to the discriminatory stigma of mainstream society that views such activity as outside of accepted social norms. Of those who do, few would have foreseen their initial experimentation reaching such a level. The role that mental illness, personal trauma and ‘self-medication’ to deal with an otherwise unbearable existence play in the development of repeated and problematic use, leading to drug dependence, have been well documented. The black-and-white nature of current drug laws does not allow law enforcement authorities to recognise the influence that such factors can play in vulnerable members of the community developing problematic patterns of drug use. In contrast, workers at The Salvation Army CCC take a compassionate view of those whose circumstances are likely unknown and whose subsequent substance misuse may have only further disrupted their lives and living standards. It is seen as vital to continue to offer avenues of assistance for those affected so that they may regain physical, mental, emotional and spiritual health. Access to services that acknowledge the continued drug use of their clients – but do not turn them away as a consequence – may lessen the extent of the damage individuals do to themselves, (and others).

18 My emphasis.
Establishing the Needle & Syringes Program

Importantly, it also ensures drug using clients are able to access these avenues if they decide to do so at a later point. Jason Davies-Kildea, former crisis worker and Chaplain of the CCC and now Social Programme Secretary for the Melbourne Central Division, observes of strategic priorities and policies of The Salvation Army in the Southern Territory:

It is not coincidental at all that [The Salvation Army] put themselves in the midst of all that [high-levels of public and visible injecting drug use and related sex work]. At our best, that’s our tradition. We have always planted ourselves in the middle of that. There are a couple of things about the culture and mission of The Salvation Army. The Salvation Army does see itself as directly called to minister among those that the rest of society has forgotten and marginalised … but it is also the nature of our work that, if it’s pragmatic, if there is a simple, hands-on solution, then, for the most part, that’s the one we’ll set about doing … what’s the most pragmatic, straight-forward thing we can do to help this person in the situation they’re in (Davies-Kildea, 2011).

In this respect, the circumstances that workers at the CCC and accommodation centre were witnessing in St Kilda and among their clients demanded an intervention that recognised the reality of the use of drugs to self-medicate and resulting drug dependence among the most isolated and marginalised members of the community – i.e. key clients of the Crossroads program. These factors, coupled with the recognition that insistence of abstinence may drive vulnerable persons away from assistance and lead to further harm to such persons, meant the lack of precedence for such a step as an NSP did not necessarily rule such a step inadmissible to The Salvation Army hierarchy. As Davies-Kildea (2011) elaborated, while there was an existing Salvation Army focus on abstinence-based treatment for the drug dependent, this did not negate the arguments that the establishment of an NSP within the CCC would allow the staff to accept and work with clients as they presented, including those actively using drugs. One of the potential outcomes of such a service would be the ability to build bridges with some of the most marginalised members of the community. The trust that this approach might encourage amongst clients – in conjunction with their awareness of the service’s willingness to accept them without judgement – meant that should they make the choice to address their drug use, they may rely on the aforementioned relationship to do so:

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19 See for e.g. Sullum 2003; Carnwath & Smith 2002; Premier’s Drug Advisory Council (Vic) 1996; Davies 1986.
I have no doubt that the most powerful tool we have in the things we do are the relationships we have with people. That’s critical. And as soon as you cut people off from those relationships whether it’s by saying I’m not going to work with you unless you’re abstinent or by banning them for difficult behaviour – or whatever – you cease to have the ability or capacity to change anyone’s life or to implement something [for a positive outcome]. It has to be a foundation of trust that leads to change for people (Davies-Kildea 2011).

Of course, given the contentious nature of NSP in the broader community, faith-based organisations and certain political circles, the Victorian Government had only embarked on a cautious NSP pilot program by November 1987. This incorporated four NSPs in areas of known injecting drug activity (Department of Human Services (Victoria) 2001). The first, not surprisingly, was established in St Kilda, a reflection of the visibility and extent of what was then Melbourne’s largest drug market (a market further complicated by existing alongside Melbourne’s only visible illicit street sex trade). Following the large-scale importation of heroin that began in the late 1970s and had escalated in the years since, the street sex trade had become inextricably linked with drugs as increasing numbers of heroin dependent women and, to a lesser degree, men, sought to meet the costs of their dependencies through heretofore unimagined earning opportunities.

The history of St Kilda street sex industry has been documented in some detail elsewhere (e.g. Rowe 2005; Rowe 2010). It is suffice to note, for the purposes of this paper, that the presence and influence of drugs radically changed both the nature of, and participants in, street-based sex work. Following the legalisation of brothels in Victoria in 1985 Prostitution Control Act, the greater majority of those working in the illegal, primarily female, street sex work industry were now doing so to finance the demands of drug dependency. The main ‘sex circuit’ was, at the time, located along the commercial strip of Fitzroy Street and in the upper parts of intersecting Grey Street where the CCC was located. The connection between street sex work and drug dependency was enhanced in the public consciousness by lurid coverage in the mainstream media. It was the then Prostitutes Collective of Victoria (PCV) that took the brave step of agreeing to house and manage the pilot NSP in St Kilda, incorporating the program into its premises then located at 131 Grey Street. As was later noted by a worker at the NSP:

21 See Rowe (2006b) Streetwalking Blues.
In 1988, no other organization was prepared to have a needle exchange. Being in St Kilda made us well placed for one and also the PCV recognised the need for an exchange among the small population of injecting drug using sex workers. With HIV / AIDS education being paramount in reducing the spread of the illness among [the broader population of injecting drug] users, the PCV felt it was an imperative step to take in the effort to save literally hundreds of lives in the future (‘Sheranne’ 1990, 5).

The NSP established on the premises of the PCV was immediately catering to a broad range of people. As Jo Snow, a former volunteer and then brothel outreach worker at the PCV recalled:

> It was certainly busy – you didn’t have to sit there waiting for people to come in and get their syringes … We had a range of people [collecting injecting equipment], it wasn’t just people from the streets. I used to get quite shocked at the cars pulling up. We would get Mercedes and men in suits, BMWs, a lot of business people, not [sex working] women, but men and they were collecting, from memory, I think we were allowed to hand out 100 … boxes of syringes [at a time] (Snow 2011).

Injecting equipment was delivered to the PCV (and the other pilot NSPs) by the Department of Human Services which kept supplies of needles and syringes in a warehouse on the first floor of the Department’s then headquarters at 555 Collins Street. Former coordinator of NSP services in Victoria Alan Murnane confirmed the PCV’s handing out of boxes of syringes to clients although he noted that certain political figures sought a more cautious approach in keeping with the mindset that:

> …we shouldn’t be giving out boxes [of needles] because that would be [seen to be] encouraging ‘drug use’ … it took some time to be acceptable practice.’

At the same time, Murnane confirmed the value of giving out large volumes of injecting equipment by noting that many were ending up in the hands of drug dealers who were providing needles with the drugs they sold to their clients on a regular basis – ‘Certainly we were hearing those stories from the very beginning [of the NSP trials]’ (Murnane 2011). These ‘stories’ were confirmed by drug user activists, including Alan Winchester in NSW who, although he would ‘patrol’ Sydney’s Kings Cross with a backpack of clean injecting equipment to distribute to users, made clear his preference for targeting dealers who would associate with the same number of injecting drug users in the one day that would take health professionals months to contact: ‘It made it much easier to drop off 20
needles at one place’, the pioneering and now sadly deceased drug user activist Winchester said, ‘than it did to go around to 200 places’ (Chapman 2007).

By 1989, the obvious success of the pilot program in distributing clean injecting equipment to injecting drug users saw the State accept the inevitability of a comprehensive state-wide NSP network (Department of Human Services (Victoria) 2001). By 1989, however, the PCV was struggling to meet burgeoning demand of IV drug users who comprised a far broader population that the sex workers who the service was established to represent. Writing in the PCV publication Working Girl in 1990 ‘Sheranne’ noted that a number of sex workers at the time made the decision to stay away from the premises of the PCV due to the NSP effectively perpetuating inaccurate stereotypes that linked sex work with dependent and problematic drug use. Former PCV brothel outreach worker, Jo Snow remembers that ‘brothel [based] girls didn’t want to come into the PCV because they didn’t want to be affiliated with injecting drug use and understandably so’ (Snow 2011). In addition to sex workers refusing to set foot on the premises, staff at the PCV found themselves increasingly diverted from engaging with their intended clientele. The constant thoroughfare of injecting drug users compromised the PCV’s ability to engage with sex workers and discuss work-related issues in what no longer represented a ‘discrete’ environment dedicated to meeting the needs of the workers.

The PCV needle exchange is a generalist, not sex worker specific service and people using it come from as far as Ballarat and Bendigo (Sheranne 1990, 5).

The distance travelled to the NSP at the PCV reiterates the patronage of the service, as well as a lack of alternatives at the time of its trial. By 1989, the PCV were finding that not only had their selfless decision to operate the NSP in St Kilda compromised their primary purpose but that demand for needles and other equipment provided by the NSP outstripped their ability to meet it. It is important to note that while the then DHS provided injecting equipment, including sterile water, to NSPs, it did not fund the salaries of staff needed to operate and manage NSPs. Despite a limited roster of paid staff, the service had managed to thrive under the PCV due to volunteer commitment – especially by those within potentially affected communities. This was a powerful endorsement and vindication of policy makers belief that common sense would lead to behavioural change among drug users if the latter were furnished with knowledge and understanding of the means of AIDS transmission and the role that sterile and hygienic injecting practices played in minimising not just the potential transmission of HIV, but of other viral infections. As Sheranne Dobson, an employed worker at the PCV, remembered with pride:
One of the beautiful things about the PCV and the needle exchange, at the time, was the huge embracing of both of those services to prevent HIV among peers. If it hadn’t been for the volunteers and the people who came on board to support [NSP] outreach [it could not have functioned]. We didn’t have any money for outreach, [but] it went practically 24 hours a day … People who were injecting really came on board. They had opportunities for other forms of education, so they became peer educators because we had access to training … Everybody really just came on board, particularly around keeping HIV out of the injecting drug use community … [they were] very, very committed to that … [The NSP] wasn’t open 24 hours a day but certainly people on the street with boxes [of syringes and condoms] were (Dobson 2011).

Ironically, it was this same commitment and effort that was responsible for the patronage of the NSP growing beyond its capacity. As Sheranne Dobson would stress:

We couldn’t keep running it 24 hours on the smell of an oily rag and doing that volume [of output] as well as do all the other things we were supposed to be doing in relation to sex workers (Dobson 2011).

The PCV was funded primarily to provide sex worker support and, despite taking on an NSP in the Victorian Government’s pilot program, was only funded for 35 operational hours per week. Consequently, volunteers were needed to ensure that needles and syringes were available across additional hours. However, this was not sufficient to meet growing demand as awareness of the service spread while the operating hours of the fixed site remained the same (including closing one day per week). Further, the internal political arguments within the PCV as to the organisation’s purpose and the rightful location of the NSP had intensified. A November 1988, an internal review of the needle and syringe program operated by the PCV concluded:

The demands on staff at the NSEP [sic] has also been shown to be high and there is some conflict and difficulty in meeting the demands of both IV drug users who use the programme [sic] and Sex Industry Workers who are not involved in drug taking (cited in McDonald 1989, Appendix 1)
In 1989, a landmark Human Rights and Equal Opportunity Inquiry into homelessness among young people was held. The resulting report Our Homeless Children: Report of the National Inquiry into Homeless Children, became widely referred to as the ‘Burdekin report’ after the inquiry’s chair Brian Burdekin. Youth homelessness became an identifiable community problem and impetus was given to important initiatives that highlighted a preventative approach and outlined a comprehensive early intervention agenda aimed at supporting young people at risk of homelessness. Late in the same year, Will Crinall left the Crisis Accommodation Service to take up a secondment to DHS in the SAAP Unity Supported Accommodation Assistance Program late 1989 – one of numerous responses to the aforementioned Burdekin report. Paul McDonald was subsequently employed by Crossroads, becoming its Program Director as well as directing the further development and expansion of The Salvation Army’s St Kilda based Crisis Services Centre.

Like Crinall before him, Paul McDonald was a passionate advocate of young people’s rights who also recognised the need for NSP services in St Kilda and, specifically, in the CCC. Another worker to be employed at this time was Andy King who reported specifically to Paul McDonald. Another outcome of the Burdekin Report was funding of two positions at Crossroads for a period of three years – a drug and alcohol worker and a health officer. The latter position was filled by Andy King who was briefed to educate both clients and staff as to the transmission risks and prevention of HIV and other blood borne viruses, infection control and to implement universal practices across the network of services. As noted, David Eldridge had ensured Crisis Accommodation staff spent time on the Contact Centre’s reception desks as an introduction to the issues of crisis that came off St Kilda’s streets seeking some form of assistance or resolution. This resulting knowledge – in addition to their familiarity with the issues that their young clientele brought with them to the crisis accommodation service – increased awareness of the circumstances in the immediate area. Paul McDonald remembered the drug scene in St Kilda at the end of the 1980s in the following terms:

“...There was a lot of whacking up, a lot of people doing gear. I don’t recall the streets being littered in syringes [not surprisingly given there were few outlets distributing fits] but there was a lot of action going on, heaps of gear ... heaps of gear. You had your hard-core working girls, street users, those young adults 19-20-24-25, out of prison, into prison, out of prison, all coming (McDonald 2011).”

Located within the midst of this behaviour, Andy King, along with other Crossroads workers felt that the continued absence of an NSP reflected the failure of The Salvation Army to embrace its potential to work with the very isolated and marginalised young people who supposedly were
its alleged focus. He argues that The Salvation Army initially failed to appreciate the potential of the principles of harm minimisation adopted by the federal government in the first truly National Drug Strategy launched in 1985. By late 1986, following the actions of Alex Wodak and like-minded health professionals, harm reduction measures had expanded to include Needle and Syringe Programs providing clean, sterile injecting equipment to injecting drug users in NSW, with Victoria following suit the next year. For those workers at the Contact Centre who placed greatest priority on the maintenance of client health to the extent possible, the lack of an NSP at the site was seen as an obstacle to the many clients for who IV drug use was a reality. Further, the absence compromised the ability of duty and social workers to establish trusting relationships so integral to the success of The Salvation Army’s social mission. Despite the services and material assistance offered via the Crisis Contact Centre, the refusal to provide clean and sterile injecting equipment amounted to an implicit refusal to meet the needs of some of its most vulnerable clients with potentially devastating results (to both the individual concerned and the broader community).

Still, the decision to provide needles and syringes represented a contentious issue for a Christian community-based organisation on the basis of drug-related activity conflicting with the faith based principles of The Salvation Army, the illegal nature of the drug use and because of related adverse publicity associated with being seen to be facilitating such activity which also affected local amenity via discarded syringes and associated detritus. Nonetheless, many of the professional staff at the Crisis Contact centre saw the lack of an NSP as a weakness on the part of a service supposedly devoted to addressing the social crises of all those who came through their doors, whatever the nature of that crisis might be. As Andy King elaborated:

[That area of St Kilda] was a red-light area. It had a very active role with drug supply and access at all hours and had the street prostitution and the networks people had to move in to gain access to the drugs were all based around that area of St Kilda … at that time, in 1989, it was a hub for that kind of thing for Melbourne. So, if you’re operating a crisis service in that context, in that area, and the Salvos saying we’re there for those people that nobody else is there for, then part of that is [to take measures to safeguard] their health. If we ignored some of those harm minimisation initiatives [like NSPs], we would have been saying to people, ‘well, we care for you, but, we’ll stand by while you do harm to yourself which may impact your ability to make a choice later in terms of getting away from the lifestyle or seeking assistance to.’ They were going to be impacted upon in terms of being able to make that change [further down the track] (2011).
To underscore the importance of such a bold step furthering The Salvation Army’s social mission with the marginalised members of the community, Army officers such as Major Eldridge constantly emphasised how providing workers with the means to engage – without judgement – with their most isolated clients could build both a rapport and trust. The subsequent relationships built between client and worker may then place the latter in a position to respond to the needs of clients if they sought assistance to address such issues. As Major David Eldridge recalled:

One of our arguments around the syringe exchange … was you don’t deal with people’s drug and alcohol problems by not addressing them. What are the critical life issues for them? We always felt we were in a position, by engaging, almost intimately [with injecting drug users], through what a syringe exchange does. It was always a drop in, drop off, but you do develop relationships with people. We weren’t going to push detox on people but you’re in a position where if it happens, if they raise it, you’re a trusted part of their life, not some alien creature who is making assumptions about who they are and who they aren’t (2011).

This would prove to be the most decisive argument behind the approval of an NSP on Salvation Army premises by the Territorial hierarchy – and one that The Salvation Army’s International Medical Advisor, Dr Ian Campbell, would return when asked to evaluate the constancy of an NSP with the Army’s theological principles and beliefs. Nonetheless, in 1989, the establishment of a fixed site NSP at the CCC was some time off. In the interim, a number of Crossroads workers took proactive, if not officially approved, measures to address the potential health needs of their clients. These workers stored syringes – provided by the Health Department – in the CCC’s reception desks and distributed them to those users so desperate to inject drugs that they would use whatever means available, including retrieving and reusing ‘dirty’ needles if sterile equipment was not available. As Andy King related:

[Prior to the NSP opening], we would go in and get boxes of supplies from the Health Department to have in our storeroom … they’d be in the bottom drawer of both Crisis Centre offices because the pharmacists would close [and] they’d be no other exchange [once the PCV was closed]. It was before the days of mobile needle syringe programs … prior to having dial-a-fit, we were it. Partly that was the demand that was being illustrated. People were scoring within half a kilometre to a kilometre of us or within the suburb and if they were mobile they would pull up in the car and we were the only late night place that could get stuff. [Further], some of the chemists that did have supplies, people went to for their methadone so there was a conflict of interest.
[We were] picking up boxes of 10,000+ needles. I did that trip pretty regularly. It was good to build up a relationship with the Health Department. I’d probably go in there once every couple of months … and they’d drop them off. We had a really good relationship with [staff] in there and [they were] aware that we were doing a tremendous number of [needle hand-outs] (2011).

Meanwhile, the PCV struggled to reconcile roles as St Kilda’s primary NSP and as the representative body for all (both legal and illegal) sex workers throughout Victoria. Paul McDonald was another senior member of the Crossroads Program who acknowledged a need to provide syringes to injecting drug users to meet the immediate needs of the Centre’s target population (only diverging from Andy King’s account in respect of the observation that: ‘we had them in the top drawers’ of reception desks). As King related:

Paul could see that, being on that turf, [St Kilda], with the presenting issues coming in the door, [an NSP] was an essential thing we had to get up and going. It was almost like a non-optional [objective]. The discussion hadn’t even started about Safe Injecting Rooms [as a harm reduction measure]. That was leaps and bounds away at that time. The mid- to late-80s there was an acknowledgement that HIV / AIDS was in the community, but it was the marginal communities [that were at risk]. It hadn’t really come into the mainstream. That was the public’s view. But we were working with people working in street prostitution and escorts and working with people who were or had used intravenously. So being an agency that worked with, and marketed itself as working with the down-and-out, that was our patch so my sense was that Paul was the key driver to get [an NSP through] through but obviously he must have had support to do that from the other Crossroads management.

As King’s vividly illustrates, the surreptitious provision of injecting equipment was informed by workers’ awareness of what was occurring on the streets outside of the Centre’s doors and ‘shooting up’ drugs was very much a part of this culture. While aware of this constant activity, Crossroads Director Paul McDonald cited ‘pivotal incidents’ as responsible for his determination to see sterile injecting equipment made available to Centre clients.

Many of those the PCV was established to represent were legally employed sex workers, far removed from illegal, let alone, IV drug use. As detailed elsewhere, this led to internal dissent, not just for those sex workers who felt that PCV management of Victoria’s then largest NSP was inadvertently misrepresenting them but was also detracting from the time and effort needed to represent their core constituency.
One [such incident] was [when] ‘Ron’23 comes walking in the room, 19 or 20 [years of age], and been around [in terms of street experience]. He bangs on the [office] door, opens the door: ‘Paul, you got any needles? You got any fucking needles!’ I go, ‘Well, just hang on …’ because we had them in the drawers and I was [in the process of] saying ‘oh, I don’t know’ and he brushes past me, he puts his hand in the used [disposed needles] bin, pulls out a handful, [of used needles] goes, ‘OK, good’ and out he goes, off to whack up [with a ‘dirty’ or used syringe] (McDonald 2011).

To be exposed to an act of such a defiant, almost violent, disregard for personal health and safety had a profound impact on McDonald’s determination to see an NSP established and accessible to those such as ‘Ron’ whose actions encapsulated the complex needs of clients of the Crossroads program and of the Crisis Centre in general. The clear risk inherent in thrusting one’s hand into a container of used syringes, some with exposed needles, is not reflective of a bravado on the part of the young man, but rather an absence of any self-perception of worth and esteem – his sole goal being to inject his drugs and, in doing so, exercise some form of control over the hopelessness or trauma that are sufficient to drive such desperate actions. To numb the immediate cause of distress is not only prioritised over long-term health consequences for people in the circumstances of desperation so vividly and disturbingly reflected in the actions of ‘Ron’, they are the only priority. Research had already provided a thorough basis to the understanding of service workers that a willingness to share and / or re-use syringes was closely related to social circumstances and deprivation rather than the result of individual choice (e.g. Donoghoe et al. 1992). Further, the scenarios articulated by Crisis Centre health worker Andy King, when he raised the likelihood of clients sharing needles in group scenarios clearly indicates the broader threat of HIV spreading rapidly outward if contracted by one member of a relatively fluid population in which ‘friendships’ are temporary, many individuals are seen as ‘associates’ and are, by nature, highly transient moving between groups and potentially exposing an increasing number of individuals to blood borne viruses including HIV (e.g. Bessant et al. 2003). The public health risks associated with sexually active and HIV positive drug users – regardless of sexuality demonstrates further risks that ‘positive’ individuals pose.

While Paul McDonald was determined to see similar occurrences avoided, he also wished to avoid compromising The Salvation Army and their invaluable community work were others to become aware of the informal distribution of syringes by certain workers at the CCC. Public knowledge of

23 See Rowe (2006b) Streetwalking Blues.
such activity would only threaten the reputation of the organisation given the continued debate surrounding needle and syringe programs and the alleged ‘message’ – perceived by critics – that such services legitimised intravenous drug use (e.g. Gawler 2000; Sullivan 1999 Wood 1997). While the Health Department was willing to provide the equipment to be distributed, having rejected such arguments in light of the epidemiological evidence that emphasised the drastic reduction in the re-use of syringes and needles (e.g. ANCAHRD 2000; Crofts et al. 1999; Hurley et al. 1997; Loxley 1996), McDonald wanted to establish an open, accepted and legitimate service that could operate with the authority and sanction of The Salvation Army hierarchy:

My memory is that [the Health Department] did [know], though they weren’t [recording it]. They understood the arrangement. One of the troubling aspects about that arrangement was that I wanted to operate [an NSP] inside an authorising environment. We had made a decision that we must do it as an operational facility [to meet the needs of clients such as ['Ron'] and I was OK, in one sense, but I wasn’t Ok in another. I didn’t want the Army to get in trouble and [at the same time] I didn’t want us to ignore the clear public health crisis that was going on in front of us … So there were two things. One, I felt uncomfortable – as well as duty bound – to run this [unofficial program], but I felt uncomfortable because I didn’t want to embarrass the Army or get them into trouble. So I wanted to have the conversation with the Army … (McDonald 2011).

A number of members of The Salvation Army corps were aware of the pragmatism that was required given the potential public health disaster that HIV presented, particularly given that the only NSP in the area was struggling to meet demand. Jason Davies-Kildea, a uniformed service worker at the CCC was aware that the ‘unofficial’ nature of syringe distribution from the service was both justified by, and in response to, real problems:

Our response at that time was pragmatic, not systemic. There were certainly some unofficial clean fits [injecting outfits: needle, syringe, cotton wool and sterile water] being handed out from the drawers of the Crisis Services and condoms in recognition of the real problems associated there … but [the service] hadn’t yet got up the momentum to systemise it and I suspect, already at the time, there were conversations about this … The PCV had a wider target group, but also a larger volume [of clients] than they were able to deal with (Davies-Kildea 2011).
Indeed, much of the rationale and need for the facility was communicated by those workers who saw its necessity as a consequence of working with those clients putting themselves at risk by continuing to inject drugs using whatever equipment was available. Consequently, ‘the conversation’ initiated by Will Crinall and continued by Paul McDonald began to reach further members of The Salvation Army’s command structures. Below, McDonald expands on the manner in which an NSP would address the public health concerns associated with injecting drug use as a potential vector of HIV / AIDS while providing the means of engaging with clients who might later be steered towards treatment services managed by other areas of The Salvation Army organisation. These immediate and long-term aims made such a facility attractive to both clients and members of The Salvation Army hierarchy respectively:

I told [‘Ron’s’] story to a couple of [Salvation Army] Commanders and said, regardless of our position, our view, they’re going to [inject drugs] and they’re our people and we’ve got to protect them, look after them. And if we do that, they start to see other things that we’re offering and then they may take their path into treatment ... that was one motivation ...

When I talked to the Army about the possibility of running a needle program, I always said a few things. One, we don’t want to make a song-and-dance of it. We don’t want to make a big public display of it ... I just need an authorising environment so I can start doing this properly. Two, I think this is a pathway to treatment – and you’ve got to be with the punter to actually talk to the punter about that. If you’re not with them, you’re not going to able to talk to them about the path of treatment. Although the policy in the Public Health [section of the Department of Health] is nothing about treatment – it’s all about public health – my commentary to the Army was, [an NSP is] the means to the ends [of treatment]. It was important to talk about the method in our madness ... [At the same time], we never overplayed it. [We did not say to clients]: ‘we are a treatment facility’ because we would never have got the punters in, but we never said our only mission is about public health (McDonald 2011).

Like Will Crinall before him, Paul McDonald received significant support from Major David Eldridge who, as a uniformed officer of the Army, drew upon his understanding of The Salvation Army’s social mission, building upon the approach adopted by Will Crinall in the submission he had drafted and delivered to Social Services Secretary Edwin Hayes. As McDonald recalled:
Dave Eldridge was able to relate the William Booth mission of The Salvation Army, going into the streets, the poor streets of London as a pathway to what they did ... I remember sitting in Eldridge’s office and putting together the case in a letter that David was writing and was signed by him and was to go through the Commander to go to the international committee and I’ll always remember this phrase that David used –that ‘It would be a travesty to the mission of The Salvation Army if we don’t act in this way.’

McDonald would also prepare a discussion paper for The Salvation Army’s annual Social Service Secretaries Conference proposing the establishment of a needle and syringe program at the Crisis Centre. Before doing so, he visited the PCV to ensure that there would be no perception of The Salvation Army usurping a service already being provided in the near vicinity. The response he received was one of grateful thanks. The increasing difficulty of meeting the demand (and addressing internal political arguments about the provision of needles and syringes interfering with their core responsibilities to their clients) was noted in the aforementioned discussion paper prepared by McDonald, who cited:

This demand by all IVDU [intravenous drug users] on the service has reluctantly forced PCV to move its stated primary objective away from working with people involved in the sex industry to servicing the needs of all IVDU (McDonald 1989, Appendix 1).

The paper was set within the context of the emerging AIDS epidemic and the so-called ‘second wave’ of the AIDS epidemic with the potential spread amongst injecting drug users and, through them, to the broader public.’ However, in contrast, to personal discussions that prioritised the notion of an NSP as a means of building relationships and a potential pathway to treatment, the primary focus of the discussion paper was on the location of the Crisis Centre where such a facility was most needed – in the heart of high-levels of often chaotic injecting drug use – in many cases by clients of, or people known to, the Centre’s staff:

Salvation Army centres, such as the St Kilda Crisis Centre, by their very nature and mandate are dealing daily with the highest ‘at risk’ sector of the community (i.e. intravenous drug users, prostitutes etc.)

Appropriate Salvation Army programmes have a critical function to play in the fight and prevention of the spread of the HIV infection...
The St Kilda Crisis Centre … is situated in the heart of an area that is well known amongst [drug] dealers, IVDU and drug agencies for its availability to purchase ‘hard’ drugs (i.e. heroin, amphetamines). The area attracts habitual IVDU to both purchase and support their habits (i.e. prostitution, petty crime) … (McDonald 1989)

In addition to urging the gathered social secretaries of the Army to consider the approval of a facility to distribute injecting equipment to intravenous drug users, the discussion paper sought support for ‘the availability of condoms within selected Salvation Army Centres.’ The discussion paper, prepared for and presented to The Salvation Army’s Annual State Social Services Secretaries Conference in July 1989, consequently presenting the arguments at the core of the harm reduction message that sought to contain and eliminate the potential public health threat posed by high risk sexual and drug use activities. While this made perfect sense if the issue was approached from an epidemiological point of view, the discussion paper caused real concern for Salvationists whose main approach to addictions had been to counsel abstinence. It would fall to another uniformed officer of The Salvation Army Corps to address these concerns and counsel those officers for whom an NSP represented a radical shift from an abstinence-oriented approach to drug use.

Prior to being employed by the Salvation Army, John Dalziel, a soldier of the Camberwell Corps, was a Director and partner in the successful advertising firm of Dalziel, Harper & Grey. Given the skills he brought to the Army, it was little surprise he assumed the position of The Salvation Army’s Southern Territory Media and Communications Director in 1990. Asked about the manner in which the discussion paper prepared by Paul McDonald had been received, Dalziel recalled a conversation with Lieutenant Colonel Peter Rigley shortly after the aforementioned 1989 Conference. Dalziel remembered the discussion paper – or ‘application’ as he referred to it – as having been rejected by the Army hierarchy. Lieut-Col. Rigley explained this rejection in the following terms:

The reason we [the Army] rejected it was because of total abstinence and because it [an abstinence-based focus on treatment] was an international view of the Army and it had already rejected similar requests from America and England’ (Dalziel 2011).

John Dalziel is unaware as to whether or not the rationale for rejecting the arguments contained within the discussion paper were communicated to Paul McDonald, but he stressed the belief implied by Peter Rigley, that the proposal was not simply facing a ‘no’ from a Territorial level but
from an international level. This led to a number of initiatives that would ultimately lead to the introduction of the NSP. One of these was the redrafting of the proposal to establish an NSP by John Dalziel after the need for the service was impressed upon him by Paul McDonald and David Eldridge – or as he related: ‘I had a long chat with Paul and David Eldridge … and David is a very persuasive character.’ He subsequently reapproached Peter Rigley to request an opportunity to put the proposal to The Salvation Army hierarchy once again, only this time from a perspective that would reflect the theological principles of their faith-based mission – while doubtlessly employing abilities developed over the course of his successful career as an advertising executive.

Instead of it being the way that Paul put it as a professional social worker, I was putting it from a Salvation Army doctrinal point of view. The way I positioned it was ‘we’re in the business of helping the people who are homeless, the drug-addicted, the alcoholic, the street [sex] workers … we all believe in helping those nobody else will but we don’t want to assist them with taking drugs – now this is not assisting them with taking drugs. [Opponents would argue] that it’s assisting them to take the drugs. I said, ‘no, it’s not. It’s assisting them with not getting infections while taking drugs because they share needles because needles are expensive [and difficult to access]. So we give them the free syringes that we don’t have to supply, they’re supplied by the Health Department, then we are encouraging them to be responsible – for those who already have the disease (HIV and hepatitis C] not to share it, and for those who don’t, not to get it .It was a change in direction that was really where I was coming from (Dalziel 2011).

Ultimately, given the hierarchical nature of The Salvation Army, any application to establish a NSP as part of a local program response would require the formal approval and support of the Territorial Commander, who, at the time of the proposal, was Commissioner Bramwell Tillsley. John Dalziel remembered Tillsley as ‘a very good man who went on to become General of The Salvation Army’ and a man with ‘a natural prejudice’ against the concept of needle and syringe provision, but also a person who ‘can be convinced by the arguments’. This pragmatic willingness provided the space needed for the redrafted proposal and David Eldridge’s continued advocacy. The latter was aware of continued and vehement international opposition to harm reduction and needle and syringe programs from within the broader Salvation Army – particularly in the United States. In remembering his fears that this international influence would prove an insurmountable obstacle to the proposed initiative, ironically, it would prove to be a crucial factor in winning in the favour of the Southern Territory Cabinet and Territorial Commander:
Bram Tillsley was a great supporter of Crossroads and quite alert to social issues. He was concerned about them. He was a North American and, at the time … there were certainly very few needle exchanges [in the US], none in New York. He listened to our arguments – very fairly – he was concerned about the public outcry but was more concerned about whether it would be effective tool in helping people so he contacted Dr Herb Rader who was a Salvation Army officer who managed a very large hospital for the Army in New York. I must admit, at that stage, I started to prepare people for it not being successful given that New York was so anti-harm minimisation as a town, but also the Army is more conservative in America than the Army in Australia, so I thought we had no chance. But basically, in a nutshell, according to Bram Tillsley, Herb Rader’s response was, ‘Great idea. I wish we had one here’ (McDonald 2011)

David Eldridge recalls that following this enthusiastic endorsement, any remaining sense of opposition within the Southern Territory headquarters was replaced by a sense of caution:

The fact that Bram Tillsley was open and then contacted Herb who was very open to the idea [meant] there wasn’t a lot of opposition … I can’t think of any opposition from within the Army hierarchy except for a bit of caution (Eldridge 2011)

Rather than see the initiative as something outside of the realms of the Army’s possible engagement, an NSP became an idea that required careful thought as to how to best manage its potential establishment. In this context, Eldridge credits John Dalziel with settling the discomfort of many within the uniformed Salvation Army hierarchy, portraying his assistance in the following terms:

[John Dalziel] is actually quite a conservative man on one level, but he reads the community well and reads what’s necessary to be put through well [in terms of social programs] so he was a great supporter of Crossroads at the time. Also in the corridors of Territorial Headquarters, you had someone like John. You had people [in the Army] going to John, asking, ‘What will this mean? They’ll be chaos, we’ll be splashed all over the press!’ John would say, ‘No, no, we can manage this. We just say it’s motivated by our concern for people.’ John always managed those internal processes very well. At Crossroads, we saw John as a great ally.
Establishing the Needle & Syringe Program

Such an ally was particularly valuable given fears of a potential public backlash amongst the Army corps. Indeed, the potential opprobrium of the general community, within which lay a tremendous amount of respect and support for the charitable work undertaken by The Salvation Army, could prove disastrous for the continuation of that work. Public goodwill is central to the Army furthering its mission. The annual Red Shield appeal, held in Australia since 1965, is a core means by which the Army raises financial support from the general public to meet the consistently expanding demand for its services in the community. However, there were fears that a public exposed to a half century of anti-drug hysteria and the association of injecting drug use with ‘junkie’ stereotypes would withdraw support from any organisation providing any means of support to drug users. Further, there were fears that an NSP would draw IV drug users – and potential carriers of HIV – into the area (see for e.g. Sullivan 1999). In this respect, the proposal to provide intravenous drug using equipment to drug users was seen by some as potentially endangering a core source of Salvation Army funding. The contentious nature of the NSP as a public policy response to HIV in 1989 must be emphasised in order to fully appreciate the courage that would be required to act upon the contents on McDonald’s submission to the Annual Social Secretaries Meeting. As Caesar (1989) observed in an article for the National AIDS Bulletin:

AIDS and intravenous drug use are very sensitive issues, both surrounded by fear and value judgements, and a lack of understanding. Together these issues seem to be so difficult that one would rather not have to look at them, much less in detail … Prior to the advent of AIDS, almost everyone who was not directly involved in the issue of illicit drugs, believed that ‘wars’ on drugs ought to be fought. We were led to believe that the police around the world were having a growing level of success in combating the drug trade. We were also given the handy stereotype of an intravenous drug user by the media (1989, 25)

Lee McIntosh, who would later provide training to the workers at The Salvation Army NSP, remembered of the local response to her pivotal efforts to successfully introduce the first needle and syringe program to the suburb of Frankston:

[It was] aggressive … I’ve been thrown out of pharmacies. I’ve been blamed in [local] Council meetings, in Chambers of Commerce meetings. I’ve been blamed, as a person, for all the business failings in Frankston – ‘If the businesses in Frankston fail, it will be because of you and what you have done. You should be ashamed of yourself (McIntosh 2011).
Nonetheless, the redrafted proposal for an NSP as prepared by John Dalziel, was put to Peter Rigley who, in turn, take it on to the Territorial Cabinet. Lieutenant Col. Rigley subsequently reiterated Commander Tillsley’s concerns about adverse publicity to Dalziel as the Army’s media officer.

He said we need to keep this to ourselves, we need to keep it secret. I said, ‘how can we keep a public program secret?’ He said, ‘well, every time the media want to do anything, they always talk to you [as the Army’s Media Director], so you’ve just got to be able to play a straight bat and not talk about it because our colleagues in Sydney, a different Territory, do not approve of what we’re doing.’ (Dalziel 2011)

As noted earlier, Salvation Army Territories are autonomous in nature. Still, it is surprising to note that the two Territories that comprise the Army’s operational presence in Australia stood in stark contrast in respect of the issue of how to best address rapidly escalating rates of drug use in the wake of the emergent public health threat posed by HIV / AIDS. The Eastern Territory, in contrast to its Southern counterpart, continued to maintain a steadfast commitment to abstinence. This was informed by a deliberate position of support for the criminal prohibition of proscribed drugs and a corresponding (and active) opposition to the philosophy of harm reduction. The Eastern Territory’s spokesman of drug policy, Major Brian Watters, was an outspoken opponent of measures to broader harm reduction in Australia, vocally opposing such measures (e.g. such as installing needle disposal bins on Australia’s international flight carrier Qantas) and continuing to describe drug use in moral terms as ‘a sin [before elaborating] I know it’s a medical and psychological problem, but the Bible tells us that sin is falling short of our potential’ (Bush & Neutze 2000:135) He greatly offended prominent advocates and practitioners of harm reduction – including Alex Wodak – when he stated that, ‘there are worse things than death when it comes to drug addiction’ (Mendes 1999, 9) – a view that seemed to suggest that death was a preferable outcome for the drug dependent (i.e. that they had little or no chance of successful treatment). In 1997, ‘zero tolerance’ was a popular catch-phrase at the level of federal politics and saw then Prime Minister Howard elevate Major Watters to the Chair of his newly constituted National Council on Drugs on the basis of receiving advice that would fit with his own views of zero tolerance.24 Indeed, as the PM noted to the Parliament, Watters’ public views were the very basis of his appointment:

24 ‘Zero tolerance’ is defined as the absolute prohibition of illicit drug use under any circumstances. Abstinence is the goal of drug treatment – there is no facilitation of drug use even if the reduction of harm is lesser in respect of public health outcomes – and prohibition is the only acceptable illicit drug policy.
I deliberately hand-picked Major Watters to chair the Australian National Council on Drugs ... It is no secret that Major Watters adopts the view, as do many others, including myself, that the policy of zero tolerance is a highly credible policy that ought to be pursued more vigorously (Commonwealth Parliamentary Debates 1998: 3553).

As David Eldridge observed in retrospect:

They [the Eastern Territory] maintained a very anti-harm minimisation stance for a long time. They say they do harm minimisation now ... but because Brian Watters was so strong about it and because he had such a strong profile with John Howard, they held to quite an anti [harm minimisation] line. It may have cost drug and alcohol programs in this Territory a little money over the years, during those Howard years, because Brian was always differentiating between Eastern and Southern.

In terms of the need for the Southern Territory to ensure that any movement associated with the establishment of an NSP remained discrete, John Dalziel simply referred to Watters as ‘a real thorn in my side’ (Dalziel 2011). The level of risk to the public image of The Salvation Army in the Southern Territory only underscores the level of courage needed to step into a highly controversial area of public policy, regardless of supporting epidemiological evidence supporting the fledging NSP pilot program in Victoria. Before proceeding further with the initiative, its potential ramifications prompted Commissioner Tillsley to gauge the level of support at the Army’s International Headquarters. The Army’s international health advisor, Dr Ian Campbell had already had discussions regarding the potential benefit of an NSP at Southern Territory Headquarters. Dr Campbell recalled discussing the issue with Colonel Ken Hodder, the Southern Territory’s Chief Secretary, when on a visit to Melbourne from his then base at Chikankata Hospital in Zambia ‘in the late 80s ... probably 1988.’ However, it was as Army health advisor, stationed at the Army’s International Headquarters from 1990 (until September 2007) that he received a question from the Territory about the potential conflict of such an initiative with the faith underpinning The Salvation Army mission. The question, as he recollected, was posed in something approaching the following terms:
Is it consistent with the ethos of people-focused, grace-based theology (and the dominant pattern for Salvation Army substance abuse approaches of abstinence programming) for The Salvation Army to be handing out needles and condoms?

Revisiting the question some 21 years later, Dr Campbell noted that, over approximately 45 minutes, he provided a ‘reflective response’, based in part on his experience of ‘community counselling’ as the most pragmatic and practical response to the threat posed by HIV in Zambia. This was an answer that connected with the aims of the Crossroads team and as articulated above by Jason Davies-Kildea. The provision of the means by which to avoid transmitting or becoming infected with the HIV virus – needles / syringes and condoms in this case – would provide the means for workers to connect with at-risk people on a personal level and establish a relationship through which ongoing care could be provided, and notably when an individual sought assistance to address those behaviours perceived to be placing them at risk. Consequently, as to whether the provision of injecting equipment and contraceptives was consistent with The Salvation Army ethos, Dr Campbell wrote:

It can be, if, surrounding the [provision of the] commodity (which could be needles, condoms, information or any other technology) is face-to-face engagement is the dominant motive and practice via counselling which needs to be available as long as it takes and as far from the centre [i.e. NSP] as it can go (i.e. extruding from the centre to the place of living and local relationships whether the street, home or the broader neighbourhood). This engagement must be in response to an invitation from the person with addiction issues and is done by a team and embraces a ‘care to change’ approach (i.e. to stand with a person in loving presence and practical action and expect to see an influence for positive change happen with the people relationally connected [to that person] especially close friends and often family and neighbourhood and other forms of local community).

In short, the initial opportunity to provide care will present itself as a consequence of the past willingness to meet the immediate needs of vulnerable, marginalised – and socially stigmatised – individuals on the edge of society (i.e. by providing injecting equipment). The act of providing that equipment is effectively a means by which service workers might be present for an individual in need, leading to a wider local ownership of their problems and leading to greater potential for positive change as a result. In Dr Campbell’s words, an NSP could thus perceivably form the
basis of a personal ‘prevention movement’. He did not believe the simple provision of a needle or condom was enough to justify support for the establishment of an NSP if the service was to be consistent with The Salvation Army's people-focused theology. Simply providing a resource or commodity would not be a useful solution or positive response. It was the motives and practices surrounding the provision of this commodity that Dr Campbell argued was integral to positive change and, in this respect, the Army – as an organisation dedicated to a social mission that sought to tend to the most marginalised and vulnerable members of the community was ideally placed to offer care and counselling and potentially build upon the immediate face-to-face engagement developed via the functions of the NSP. It would be, as articulated above by Captain Davies-Kildea, this engagement that became the opportunity to assist with the transformation of drug dependent individuals voluntarily seeking to change their lives - and subsequently the lives of those their drug use affected. This represented a western cultural application of the aforementioned ‘community counselling’ model practised in Zambia. Since recommending its use as the means by which to establish an NSP consistent with The Salvation Army ethos, Dr Campbell notes that the use of a ‘care to change’ model has been observed increasingly across the globe as a response to public health issues inextricably linked to behaviour and the environment that may influence and shape that behaviour. It is a model based on the positive outcomes achieved with marginalised persons if they are accorded respect and spiritual sensitivity by those responsible for providing a public health response. Dr Campbell concluded that The Salvation Army – and especially the network of services in St Kilda – was able to demonstrate loving care that would be demonstrated both by the immediate concern to prevent harms caused by risky injecting practices while transforming people (who are seeking change) in circumstances of dependency, along with their affected others and, ultimately, in the long term, The Salvation Army itself.

The provision of needles and syringes to individuals whose intention is to use this equipment to inject illegal drugs has been an issue of great contention for faith-based organisations and continues to present challenges across the different denominations of the Christian faith. This is most clearly manifested in Catholic stream of Christianity under Pope Benedict XVI. Brought to Rome in 1981 by his papal predecessor as Prefect of the Congregation of the Doctrine of the Faith – that position responsible for maintaining and enforcing Church doctrine – then Cardinal Ratzinger made clear his belief in conservative Church teachings such as those articulated in the Pontifical Council for Pastoral Assistance for Health Care Workers, the Charter for Health Care Workers. The Charter spoke of the need to refrain from condemning the dependent drug user and emphasised the importance of access to rehabilitation. Still, Section 94 states:
From the moral viewpoint, using drugs is always illicit, because it implies an unjustified and irrational refusal to think, will, and act as free persons ... using drugs is anti-life. [There is no freedom or right to use such drugs] and even less do they [the drug dependent individual] have the right to make others pay for their choice (in Santamaria 1999, 3).

The author citing the Charter, Dr Joseph Santamaria stated with no room for discretion: ‘On the basis of this official teaching, it is apparent that the taking of mind-altering drugs for non-therapeutic reasons is intrinsically evil’ (Santamaria 1999, 3). Then Cardinal Ratzinger’s acceptance and support of such notions is clear in a 1988 letter to Catholic bishops on the church’s dogma relating to sex and family which included explicit directives: no divorce, no contraception, no sex outside marriage, no homosexuality, no drugs. This letter, notably released as the devastation of AIDS was being manifested around the world, was focused on condoms. The firm opposition to any exemption that would allow condoms to be used to prevent pregnancies that would only result in the suffering of mother and child could be extrapolated to the notion of sterile injecting equipment and HIV. As Ratzinger would declare:

To seek a solution to the problem of infection [with AIDS] by promoting the use of prophylactics would result in at least the facilitation of evil [i.e. permissiveness]. The only medically safe means of preventing AIDS are those very types of behaviour which conform to God’s law (Agencies 2005).

Ratzinger spoke of homosexuality as an ‘intrinsic moral evil’ and, from inside the walls of the Vatican, managed to find the source for gay bashings in the existence of the victims:

When civil legislature is introduced to protect behaviour to which no one has any conceivable right, neither the church nor society at large should be surprised when distorted notions and practices gain ground and irrational violent actions increase (Agencies 2005)

In conveying the above, I have no intention of conflating Catholic moral stances with those of The Salvation Army. The latter is an organisation that, as is demonstrated, places as much importance
on reaching out – and providing material assistance – to those on the margins of society and struggling to survive due to social inequity as it is to evangelising. Similarly, there are charitable aspects of other Christian faiths (Catholicism included). However, the social mission of The Salvation Army, as made explicit by William Booth, was to devote as much effort to easing the suffering of the most vulnerable members of society’s mortal existence as to the saving of ‘souls.’ In its ethical guidelines, Salvationists are reminded that they are not to become a church of the middle classes, separated from those most in need. That said, one of the purposes of this review is to show that emerging social issues – even if deeply rooted in human behaviour – present all faith-based organisations with the challenge of finding the courage to respond appropriately for the greater good or, alternately, adopting a cautious stance by following, without question, the doctrines demanded by such religious institutions as the Vatican’s Congregation of the Doctrine of the Faith. Notwithstanding such doctrines, Catholic theologians have been compelled, perhaps reluctantly, to respond to issues such as Church sponsored bodies operating NSPs.

In 2012, Daniel Sulmasy engaged with the absence of any formal theological literature on a Catholic position or focussed theological discussion on the specific case of NSP as a harm reduction measure (Sulmasy 2012). As had been clear to front line social workers at The Salvation Army’s St Kilda base of Crisis Services, dependency on drugs administered intravenously invariably means continued IV drug use. The user’s focus is, in the overwhelming number of cases, on keeping at bay, or the immediate relief of, symptoms of withdrawal from drugs. As a result, a referral into an abstinence based treatment program is not a realistic goal for many clients. Sulmasy subsequently posed the question as to whether ‘sponsorship of such [needle and syringe] programs constitutes immoral cooperation by the church in the sin of drug abuse’. On this matter, he concluded that the cooperation in free distribution of the drug using equipment in question ‘is not intrinsically evil’ on the understanding that harm reduction does not comprise formal cooperation in the use of drugs (Sulmasy 2012), that being a necessity for assistance to be condemned as sinful as is argued by Santamaria above.

**Formal cooperation requires that the co-operator share in the actor’s sinful intention to do evil**25 [and] no Catholic organisation would explicitly intend that anyone should abuse … drugs (Sulmasy 2012).

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25 It must be stated that in citing these sources, the author, while not representing The Salvation Army, would draw attention to the nature of drug use – and particularly dependent drug use – which often begins as a form of medicating the despair of the present, regardless of whether despair is a consequence of past, unaddressed trauma or the ‘emptiness’ of a life devoid of meaning and characterised by poverty, repression and abuse. Many so-called members of society are compelled to cope with as best they can with lives that are characterised by ongoing hardship and do so in isolation and without support, especially if discriminatory attitudes that label them ‘sinners’ only serve to further marginalise them from potentially helpful social services. This introduces issues in respect of the reasons for the initiation of drug use and continued harmful drug use that are beyond the purpose of this publication.
Further, he argues that harm reduction begins with a repudiation of the actual evil act (Sulmasy 2012). Even if not seen as ‘evil’, there is little doubt that those staffing and engaged in the work of the NSP would view abstinence as the preferred outcome. This is indeed the preferred outcome of any drug policy underpinned by the principle of harm reduction (see Mendes & Rowe 2005, 4). As the author explains, approval of, and cooperation in facilitating, a client’s drug use is not part of the provision of services through an NSP. Support is provided without judgement in the hope that, given IV drug use is going to occur, it will be with sterile equipment and in an informed manner so as to avoid the activity leading to any unintended additional harm to both drug user and wider community. The point is reinforced by reiterating that condoning the activity would involve sharing the intention of the user accessing the service. As Sulmasy explains:

One simple test of whether [providing needles and syringes] lies outside of the scope of the intention of the act [injecting drugs] is a counterfactual question ... what would be the attitude and actions of the [NSP worker] were the event [IV drug use] outside of the scope of the [worker’s] intention not to occur? Would the agent sense frustration or failure of the intention? ... if not, then the event could properly be considered outside of the scope of the [worker’s] intention ... it would thus need to be the case that no reasonable person could believe anything other than that, were the evil event [sic] to fail to take place, the agent would be frustrated and / or sense failure and begin to take alternative actions to make the allegedly, unintended evil [sic] take place (Sulmasy 2012).

Again, while acknowledging and emphasising the core theological differences between The Salvation Army and Catholicism, Sulmasy, a practising medical professional whose professional experience has involved the treatment of ‘hundreds of people dependent on heroin or cocaine’, takes each argument put forward by critics of the Catholic Church’s involvement in harm reduction activities and demonstrates that the provision of needles and syringes reflects a charitable approach towards persons afflicted by drug dependence and, if removed from faith-based considerations, a commitment to the common good that would alone justify such programs (Sulmasy 2012). Finally, Sulmasy adds a further voice to that substantial body of research demonstrating that abstinence only treatment services have clearly limited success with ‘rehabilitating’ drug dependent individuals when compared to an integrated program of counselling services that operate in conjunction with harm reduction initiatives that are able to meet drug users immediate needs until the former measures are – if ever – in a position to bring about a firm commitment to seek personal change. This further emphasises the suitability of The Salvation Army Crisis Contact Centre network, not
only geographically, but given the suite of services available to those seeking assistance, including active IV drug users.

Similar to the Catholic Church, the Salvation Army’s principles are clear in the rejection of alcohol, tobacco and illegal drugs as well as the close monitoring by medical professionals of prescription drugs (The Salvation Army 1992). However, with the support of The Salvation Army’s international advisor on health and medical policy agreeing that an NSP – and one that provided condoms in addition to injecting equipment – could meet the faith-based Christian ethos of The Salvation Army, the Territorial Commander, Bramwell Tillsley and his Cabinet approved the establishment of the facility. Many within the Army continued to hold the belief that such a momentous policy change must have been approved from the International Commander of The Salvation Army. At that time, this was General Eva Burrows, an Australian. In an informal conversation in late 2011, the retired General Burrows reiterated her support for the establishment of an NSP within the St Kilda Crisis Services at the time the proposal was raised. She also expressed regret that the Eastern Territory had not seen the value of introducing a similar scheme and found the continued adherence to the prohibitive regime a significant disappointment. Further, General Burrows articulated the fact that the responsibility for the decision to establish the NSP under the management of The Salvation Army was a decision taken by the Commander of the Southern Territory. As she recalled in a brief conversation: ‘It wasn’t decided at the international level but rather at a lower level – Bramwell Tillsley.’

This ability of Commissioner Tillsley to approve such a measure and his willingness to do so was an example, not just of the level of autonomy enjoyed by The Salvation Army Territories, but also of the willingness of the Commissioner to be persuaded by rational, evidence-based argument. Speaking about the momentous decision taken by a man who went against his own natural prejudices to wield the significant authority available to him, Dalziel recalled:

In the end he approved [the establishment of the NSP]. He was won over by the argument and that takes a strong man to know there’s an international thing against it, that he has a natural prejudice against it, but can be convinced by the arguments. The way The Salvation Army operates, it has all these Committees and its Cabinets but it’s a bit like a King and his kingdom. [The Territorial Commander has] got to listen to the parliament and all, but in the end, he does have the right to say, ‘yes, we’re going to do it.’ That is a strength of The Salvation Army. If you have a good person there – and there have been a few examples of our history here - They Army can just have a wonderful impact because they’re not answerable to anyone, they can make that decision. Occasionally if they go against an international understanding they have to answer to London but it is a very, very rare event, if that happens (Dalziel 2011).
And in this case, it didn’t. John Dalziel still faced fears that the story would break in the media and that there would be a terrible fallout in respect of public opinion of The Salvation Army and, more specifically, Crisis Services and the Crossroads network. In contrast, Health worker and later coordinator of the NSP in its initial days, Andy King, saw the perceived separation between The Salvation Army and the Crossroads network as a potential benefit that allowed the Army command to distance themselves from the program if the service was to be seen in a negative light. While ‘on the positive, it was happening in the name of the Salvos’, King went on to observe:

The thing I really admired about the Crossroads network is that they did take risks and perhaps it was a risk the Army were prepared to take because it has the name Crossroads youth project – which was an arm of The Salvation Army – but it wasn’t the Army. It took risks because of the population it was working with and the new and emerging needs of that population.

Regardless of such scepticism, a proposal to establish an NSP at the Crisis Contact centre in Grey St, St Kilda was approved. It did so also with the public support of notable overseas officers Lieut-Colonel Paul du Plessis and Major Paul Rader (later appointed General of the International Salvation Army 1994-1999) among others. On 16 November 1989, Chief Secretary Gordon Fisher, on behalf of the Territorial Commissioner, gave approval to the NSP on a pilot basis. Subsequently, a submission for funding to staff and equip an NSP was sent to the Victorian Health Department in February 1990 with a service agreement seal presented in July of the same year in response – containing agreement for funding for 54 staff hours, on costs and renovations that would see the NSP established within the foundations of the CCC. On 3 March 1991, the as yet unnamed NSP opened for business.

As opposed to a formal public opening ceremony, the facility’s operations would be popularised via word of mouth and would travel throughout drug using networks as quickly as news of a potentially hazardous batch of heroin spreads throughout the underground drug user network (McDonald 2011). John Dalziel had felt the pressure of the demand for an embargo on media reporting of the initiative – mindful of the concerns of Commissioner Tillsley and other leading members of the Army’s Southern Division. However, to his surprise, the media did not learn of the planned opening of the service – or at the least, did not report the plan. As he recalled, I said [to Peter Rigley], ‘look, I’ll do my best, but you know the media. If they get on to a story, they’re going to run the story. Anyway, to cut it short, it never did break, it never leaked.’ This was indicative of the conviction that the NSP would be a success on the part of workers at the Crisis Centre and demonstrated a
commitment that was focused on clients and not publicity.\textsuperscript{27} As indicated by Alan Murnane, funding was granted for the first time to a NSP – largely on the basis of the credibility that The Salvation Army’s endorsement brought to the initiative, easing continuing nervousness on the part of many in the State Government and Health Department who felt that their sponsorship of what was, prior to the emergence of HIV, an unimaginable public health action, could prove politically dangerous and counterproductive to The Salvation Army’s mission. Nonetheless, as further evidence of the courage that underpinned the determination to see the NSP succeed, The Salvation Army facility did not ever operate on a one-for-one exchange basis – the service never formally operated as a needle exchange. The model of the Victorian Health Department was adopted, with syringes and needles being distributed in as great a number as clients desired to ensure they were distributed as widely as possible. To operate strictly as a needle exchange is to insist a service user deposit a dirty syringe before providing them with a clean replacement. Such stipulations would limit the efficacy of any program given that the realities of using illicit drugs in public places which include users ridding themself of evidence of illegal activity, including used syringes. The punitive penalties of a prohibitive regime mean that homeless and street-based drug users are less able to retain used syringes for return to NSP services. This does not necessarily mean that such materials are disposed of irresponsibly. The proliferation of disposal units of varying size in public areas of known drug activity lessen the need to travel to fixed site NSPs and the danger that used needles and syringes present in the broader community.\textsuperscript{28} Consequently, limiting distribution of clean syringes to those presenting with used equipment would be counterproductive. The absence of limits on the number of syringes available to service users doubtless led to some of the concerns subsequently expressed by residents and stakeholders about drug injecting detritus ruining amenity and endangering children, pets and themselves. This would prove to be one of the teething problems that would be faced by the fledgling service in its initial months of operation.

\textsuperscript{27} The Salvation Army Southern Territory operated on a ‘standard policy’ that any contact with or release of information through the media communication would be organised and coordinated by the Region’s Communications Officer, then John Dalziel. Dalziel, while in this position, employed his own policy of never commenting on a particular service or branch of The Salvation Army without going to the management of representatives of that service to ‘ask them: what do you want me to say? What are the issues?’ However, he referred to a reticence to engage with the media on the part of workers at Crossroads and the CCC. Noting a tendency of certain media organisations to isolate sensational aspects of a story as opposed to presenting an issue in its full context. Dalziel noted of the manner in which he and the management of the aforementioned services collaborated together: “… to this day, David Eldridge [CCC Manager] and Jenny Plant don’t like speaking to the media. One of the reasons is that the media will take a phrase and run with it … That’s always the potential problem with these kind of stories but because I’ve spent all my life in the [media and communications] area I know how to tip-toe over things. I had that trust [from the relevant managers] but I also adored what they were doing and would never dream of speaking without speaking to them first … It’s a good system” (Dalziel 2011).

\textsuperscript{28} At the time of writing there are 157 syringe disposal units located in the City of Port Phillip. These are emptied monthly or at more frequently if required. Approximately 35,000 syringes were collected in this way in 2011. (see: http://www.portphillip.vic.gov.au/syringes.htm ). Similar programs operate in other municipalities with the City of Melbourne having approximately 400 disposal units located across the area.
MEETING NEED ON THE STREET: THE CRISIS CONTACT CENTRE NSP
Although it began from humble beginnings, the newly established facility was soon servicing large numbers of clientele despite having become operational without any publicity within, let alone the knowledge of the mainstream media. This was testimony to the unity of spirit shared by both workers and clients well aware of the need to see the service survive and its vulnerability in an environment of overwhelming public hostility to harm reduction measures. Lee McIntosh, one of the first pioneers, advocates and state-wide trainers of NSP staff agreed that The Salvation Army service needed to work quietly to establish the service if it was to become accepted as a long-standing fixture of the Crisis Services network. At the same time, she marvelled at how quickly the numbers accessing the NSP grew in comparison to those established elsewhere:

If they had have chosen any other way of going about it [entering the field of needle and syringe provision other than a ‘quietly, under the radar’ approach] it would never have got off the ground ... talk about conservative [public perceptions]. Really, for the people of that day, to be supporting the implementation of a needle and syringe program was just amazing. Such vision and such foresight and [in a] totally non-judgemental [manner]. Imagine how their life might have been if it had have got out in a big way – in the organisation, in the Army ... back then, needle and syringe programs were banned in America and it was a crime to have any injecting equipment in your possession ... so the implications of The Salvation Army staff at that time, whether officers or not, the consequences of them doing it would have been enormous ... The Salvation Army over in America are very strong and very abstinence based.

[At the same time], it was really interesting back then for us workers, how quickly and how little work the Salvos had to put into that thing [before it was] just ‘blowing out of the water’. For the rest of us, who were not in Salvation Army centres, in Community Health Centres, secondary centres, AOD centres etc. we had to work really hard to get people to come in, and yet, it was like this magical trust because it is the Salvos, it must be because it’s the Salvos. All we could put it down to [was] people trust the Salvos; they genuinely do ... (McIntosh 2011).

The first day of operation provided Crossroads workers – and specifically manager Paul McDonald, with a vivid example of how the acceptance of harm reduction could realistically be incorporated into The Salvation Army ethos and a ‘care to change’ philosophy could underpin the practical realities of running an NSP.
I remember Lieut. Colonel Poke, the Social Services Secretary, who was there after approval was given and keen to come down on the first day ... so he comes in [on the first day], he walks in, lovely bloke and unfortunately, here’s a couple of guys who have just got their syringes and they’ve gone in and then come down the driveway [of the Contact Centre] at 29 [Grey St] and they’ve whacked up and he’s walked outside and said, ‘now let’s have a look at this new syringe ... whoa oh!... [recoiling at the shock of seeing injecting occurring in public]. To his credit, he said, ‘you OK there sonny? Everything alright?’ It was this is what we’re here for. It was day one, the first day ...
(McDonald 2011)

As Dalziel recalls, the initial operation of the NSP ‘started out in a very amateurish way’. The initial NSP, when it opened for business, consisted of a table in the corner of the [Crisis Contact Centre] office. ‘It was right at the entrance, there was no privacy … it was just a desk and a couple of chairs and everybody knew what [the clients] were doing there. It was terribly unprofessional’ (Dalziel 2011). Of course, the small beginnings – partially to avoid public attention – would grow exponentially with the passing of time and the patronage and broader acceptance within the local service and residential community of the service.  

We got the approval to go ahead which was a great relief to me because I was managing the Crisis Centre and we were starting to authorise what we were already doing. Then there was negotiating with the Department about what sort of profile they were wanting from us. They were very keen for us to be on board ...

... We saw it as a world first for the Army ... we managed to get some funding ... [the Health Department] gave us some supply [of needles and syringes]... and we started to get the numbers and soon we become the largest stand-alone needle and syringe program in Victoria very quickly and then they gave us some funding to staff it one on one. We got some renovations in and a [opening] ceremony without great fanfare (McDonald 2011).

29 Although the service has developed into a very professional and accessible service, it remains a very small service with the facility built in an area of the CCC once occupied by little more than a janitor’s supply cupboard. The size of the service - and the clinical separation of the space with the NSP worker located behind a desk from which they serve individual clients – has encouraged the formal process of dealing with no more than one client at any time. This protects client confidentiality and allows them to engage in private discussion with the NSP staff member if they desire. (Waiting clients are aware if the service is already occupied as entrance to the service area is via a glass door). This contrasts greatly with those services that adopt a model that more closely resembles a ‘drop-in’ centre with seating and coffee / tea making facilities. However, the CCC design serves a purpose. As long-time manager of the NSP, Sally Finn noted of the design:  

I used to think it was deficient because of its size and its clinical look [in comparison to] a big open space and colours and couches ... I’ve come to realise that there’s clients that really love being short, sharp, one-off [exchange]. I [also] mean [being a] one on one [service], nobody can come in while you’re having a conversation with the exchange worker. That leads to frustrations obviously. Mostly the clients monitor that – if there’s someone waiting, the client closes off the conversation because they know it’s like to wait … but we have to remind ourselves that they do have the ability to wait (Finn 2012).
Then coordinator of harm reduction programs in the Department of Human Services, Alan Murnane, drew attention to the unspoken gratitude of the Victorian government, when The Salvation Army, a respected community institution, was willing to put its established reputation as a religious organisation and social service behind the NSP. Indeed, he recalls, The Salvation Army’s involvement as the moment that the government was prepared to begin funding and extending the State’s NSP – which had remained a limited pilot program since its initial launch in late 1987.

The Salvation Army… the credibility they brought [was greatly valued] … I think that was the first funded outlet. For the government to be funding staff was another step [of confidence and faith in the NSP program] and to do that with the Salvos made it easier. If we were giving the PCV $100,000 to give out needles there would be much more room for criticism than if we were giving it to the Salvos. It clearly was a significant win for the Department and Government to get the Salvos involved. In the end, the government had taken and committed to the NSP and it needed to bring the community with them. To have someone as credible as the Salvos, that was a big win (Murnane 2011)

A significant role was played by the PCV with their (unfinanced) commitment and dedication to spreading harm reduction messages throughout their fixed-site and outreach needle and condom distribution. However, there is little doubt that a respected, faith-based institution such as The Salvation Army brought a moral authority to an initiative that remained controversial in the broader public sphere.

The Army had agreed to the establishment and opening of the service in March 1991. Five conditions were attached to this approval:

1. That the program be kept low key and that no media be involved in any of the programs activities [including its opening];

2. A 6-month report be produced to assess and appraise the project to inform a decision as to the continuation of the project;

3. That the project be run by – and restricted to – the St Kilda Crisis Centre;

4. That the project be accompanied by educational information – delivered through staff and literature – including information about rehabilitation treatment; and

5. That condoms – in the initial stages – not be distributed (McDonald 1991)
An evaluation conducted after the service had been operational for 6 months – in keeping with the above conditions – confirmed the efficacy of the NSP in distributing large numbers of sterile injecting equipment to IV drug users. Staff at the NSP individually coded 1,371 registered clients (and 6,064 contacts) in the first 6 months of operation (McDonald 1991, 5, 10). The recording of operational data including client contacts and numbers of syringes dispensed (and returned) allowed the degree to which IV drug users accessed the service to be clearly charted from the 8,834 syringes distributed in its very first month of opening to some 13,289 in August 1991 (McDonald 1991, 7). The decision not to restrict distribution to a one-for-one exchange model had seen a growth in the number of boxes containing 100 syringes expand from 35 to 83 over the same period, the ‘box distribution’ method ensuring the contents of the boxes were reaching hidden networks of IV users perhaps still wary of exposing their drug using practices to public services in light of the enforcement of past punitive laws prohibiting the possession of syringes for the purpose of injecting illegal drugs. It allowed those HIV-aware members of the community to distribute needles to fellow users and, in the case of drug sellers, to customers – a common means of early distribution in the St Kilda area (Dobson 2011). Some 5,995 contacts at the NSP in its first 6 months involved persons who reported collecting syringes for persons in addition to themselves. The breadth of the service reach was demonstrated by a survey conducted of clients in July 1991 which demonstrated that while 51 per cent lived in St Kilda, remaining contacts were with persons living outside of the area but who were travelling sometimes long distances to access sterile injecting equipment, demonstrating the need for and awareness of the service outside of St Kilda. Indeed, a number of clients collecting boxes of syringes cited regional and country centres as ‘home’ (McDonald 1991, 11). Meeting the objective of providing information to its clients via staff engagement and printed materials, the evaluation noted that: ‘it is impossible to estimate the number of conversations that staff have had with service users over their lifestyles, aspirations and dilemmas’ it also noted that many of these conversations ‘are vital in helping the individual in their quest for quality of life’ (McDonald 1991, 12). This clearly demonstrated the relationships being formed as part of the ‘change to care’ model that prioritised that building of relationships of trust as foreseen by Paul McDonald and seen as pivotal to the service’s success by International adviser Dr Ian Campbell.

The evaluation noted the NSP’s primary function being to distribute needles and syringes ‘without compromise’ but did give particular weight to the manner in which staff were able to use contact with clients to address other aspects of the latter’s life when these were voluntarily brought to the fore (McDonald 1991, 12). Consequently, staff had made numerous referrals to appropriate services, the unique nature of the NSP operating within the CCC – the central point of a network of services including the Crossroads Program and other crisis services – allowing a ‘smooth, effective
and responsive referral to both workers and resources’ within this network. These referrals and provision of other resources included:

- Thirty persons referred directly through CCC workers to drug detoxification or rehabilitation services for drug use;
- The distribution of 200+ comprehensive information booklets titled Drug & Alcohol Users Guide that provided detailed information about available Drug and Alcohol services including the respective foci of these services (i.e. alcohol specific or services for poly-drug use);
- Five persons directly referred to Crossroads’ Drug and Alcohol worker;
- Ten persons referred to the on-site lawyer located at the Centre on a specific day each week; and
- A countless number of clients referred to CCC workers for direct financial assistance, or assistance with accommodation, food security and other life necessities (McDonald 1991, 13).

The distribution of such large amounts of needles and syringes for the purpose of injecting drugs also meant that a great deal of injecting drug use in the immediate area – whether in public toilets, backstreets, laneways and car parks. As noted in the evaluation this had led to circumstances in which users had overdosed and Crisis Centre workers, responding to calls for assistance, had actively responded to these circumstances. Overdose is a harm associated with street drug use, regardless of the sterility of a syringe. The lack of quality control that characterises the underground, criminal drug market means highly potent drugs such as heroin are of unknown and highly variable purity. An unexpectedly pure batch of heroin is invariably reflected by a spate of unanticipated overdoses and such medical emergencies quickly became an eventuality that workers had to be trained to respond to. The 6-month evaluation noted six responses in this initial period of operation. Paul McDonald (2011) later noted:

The other thing was how many people dropped [overdosed] around the place. We [revived] quite a few – I and other workers revived a lot of people around the place. …One of the problems was we had a few nooks and crannies around 29 Grey St [the Crisis Contact Centre] in which [people could sneak into to use] but generally speaking, the way we tried to design things at 29, was you’re in and very quickly you’re out and you’re out onto the street. And that was very important given we were doing 50,000 syringes a month in the early days.
This was recalled as one of very few teething problems that one might have expected to have been associated with such a facility.

... I don’t know if this is history looking fondly but it was a remarkably low maintenance program to run. We had quite a few ‘drops’ but few [real incidents]’ (McDonald 2011).

Another initial problem was ‘growing’ the return rate of used syringes. The latter was essential to address one of the concerns of members of the broader public who had opposed the NSP on the basis of neighbourhood amenity being irretrievably lost if IV drug users who entered the area were to discard used and bloodied needles in suburban streets. After 6-months, the return rate may have seemed low at 16 per cent of those syringes handed out by staff at the NSP being returned (McDonald 1991, 8). However, the breadth of distribution across metropolitan Melbourne and even regional Victoria meant that many clients reported returning syringes or disposing of them responsibly in other locations. This, in combination with a large disposal bin affixed to the exterior of the Contact centre, the contents of which were not recorded in return rates led to a conclusion that the return rate after six months was 37 per cent (McDonald 1991, 8). This remained an area of focus for NSP management and the broader CCC staff and, as addressed below, the return rate has increased consistently since the service opened.

In conclusion, the evaluation noted that the NSP had been ‘an outstanding success’ (McDonald 1991, 15). It had operated as Melbourne’s only late night needle and syringe distribution outlet over six months without incident while growing to have the highest throughput of the State’s numerous NSP services by the end period of the evaluation (McDonald 1991, 15). In doing so, it had established a practical and effective strategy to arrest and contain the spread of HIV among the injecting drug using community (and through them, to the wider public body) and had, via its contact with clients on a personal and non-judgemental level ‘offered hope, comfort and opportunity’ to isolated and alienated persons on the very margins of society.’ Consequently, it is recommended that the Salvation Army continue its commitment to the NSP operating at the St Kilda Crisis Centre by removing its ‘pilot’ status and affirming it as an ongoing program (McDonald 1991, 17).
Perhaps the only issue that had presented itself was the large number of clients who had entered the premises seeking condoms – perhaps an expected outcome given the services’ proximity to the street sex circuit in the immediate vicinity. This led to a recommendation that The Salvation Army revisit the question of condom distribution to make use of its unique position in this respect – both geographically and as a consequence of many street-based workers being IV drug users – so as to strengthen its role in the prevention of HIV transmission. David Eldridge gave voice to this issue when recalling the initial issues that emerged in conjunction with the NSP’s opening:

*Because we were based in an injecting drug using environment as well as street prostitution, we wanted the service to include syringes and condoms and for many people. [Unfortunately], condoms were more of a problem than syringes – partly I think that’s due to moral dilemmas about sex … some people could write off syringes as being a medical implement, so could rationalise [the service] as a medical intervention but a condom can only be used for ‘filthy purposes’* (Eldridge 2011)

Still, it would only be a relatively short time before this need was being met, although initially the provision of condoms began somewhat surreptitiously just as had the ‘bottom drawer’ distribution of injecting equipment. Speaking of this period, Eldridge confided:

*‘We also recorded [condoms] use for some years, if I remember rightly, as accoutrements. So we would count syringes and accoutrements [in reports listing the numbers of resources distributed] … and accoutrements would have been condoms. We were very creative in the use of our nomenclature. Crossroads became very wise in wording things in the appropriate way* (Eldridge 2011).

Once the 6-month evaluation was passed, Paul McDonald does not remember the issue of the NSP appearing as a problem for the hierarchy of The Salvation Army Australian Southern Territory again:

*After that [evaluation] the Army never really queried what we were doing … there was not once that I got a sense from anyone, of ‘Um, should we really be doing this?’ A lot of officers went through that place and they just saw it as the Army’s mission* (McDonald 2011)

Despite its establishment in the network of services connected to the CCC, the NSP remained an issue of contention in the local community, elements of whom maintained a vocal opposition to the
service. The vehement opposition to the establishment of the NSP did not abate with its opening or the passing months and when appointed as Crisis Centre manager in 1991, Jenny Plant noted that addressing the concerns of both residents and traders consumed a great amount of her time. Community fears should not be downplayed considering that the wider public were primarily informed about HIV and potential threats that might expose to ‘the mainstream’ to the virus via a tabloid media particularly partial to sensationalism. While challenging, Plant, in retrospect, remembers the residents’ proving relatively amenable to information and assurance. This was assisted by ensuring that all involved in upper management at the Crisis Centre were thoroughly briefed so as to conscientiously respond to complaints, fears and concerns that invariably arose at public meetings that were called and coordinated in conjunction with the Port Phillip City Council. Jenny Plant emphasised the Council’s commitment to social inclusion and community equity and the manner in which the City of Port Phillip actively pursued community awareness and support of initiatives that might achieve this vision via public meetings and briefings. Establishing a Social Inclusion Unit to guide this process ensured that contentious social issues were addressed through a deliberate and proactive policy of consultation and feedback with all members of Port Phillip community (See, for example, Longmire 1989; Harris 2000; Press 2000; Press & Szechtmman 2004; Rowe 2006). This, in some ways, continued the long-established heritage of St Kilda as a place of diversity and tolerance. From the years of WW2 through to the 1980s, the Port Phillip community had accepted and celebrated difference.

The St Kilda community in the late 1980s included but was not limited to a genuinely eclectic mix of liberal families, educators, artists, drug users, of street sex workers, and social services – all of which opened up the eyes of neighbours to the value inherent in a diverse but nonetheless inclusive community. The Port Phillip City Council typically recognised the social issues unique to a municipality of such diversity and sought to involve residents in discussions and proposals to address problems that arose from illegal or contentious activities. Gentrification and an influx of the tertiary educated, white collar professionals would change this character, despite being the very people attracted to real estate agents glowing emphasis of the cosmopolitan lifestyle that new residents would be buying into (Kerkin 2003). This did not include the realities that accompanied their proximity to street sex work and the associated detritus, such as used condoms and syringes, as evidence of the nature of the area’s nocturnal activities. What may have made for an adventurous weekend to the ‘red light’ district was a constant nuisance and a source of fear and harassment for many reside particularly those who moved in with rising house prices and the influx of restaurateurs and a concomitant decline in cheap rooming house accommodation that saw both tourists and a ‘new class’ of resident arrive in the beachside suburb.
Nonetheless, years of communication between residents and local government allowed Jenny Plant to be heard by a receptive audience of community residents who were willing to afford her the respect to speak of the value and potential ‘win’ for the broader community of an NSP in the local area. This included Council initiated consultations by community development officers who had already laid the groundwork in terms of informing residents and commercial interests of the rationale behind the facility. As Plant remembers:

> For the first 18 months or 2 years of work for me at managing St Kilda, the [Crisis Contact Centre], a lot of work was put into attending community safety forums. Marg Welsh was the Community Development Officer at the City of Port Phillip at the time [and] she was the one who, with [other Council community development workers] like Peter Strecker and Robyn Szechman, were putting together these community forums to get information and education out into the community about issues like the [NSP] ... (Plant 2012)

The decision to inform and involve the local community in respect of contentious social issues made people far more willing to listen to policy notions that might be considered ‘controversial’—particularly if they understood and appreciated the consequences different responses. Residents of South St Kilda were well aware of the diverse and sometimes difficult social concerns in their local area, no better characterised by the presence of a Melbourne’s only visible but entrenched illegal street sex trade. Despite the best efforts of law enforcement campaigns and the customary, occasional ‘blitz’ on those soliciting and propositioning, all police operations succeeded in doing was moving the street sex trade. It shifted from its original location on the then well-lit strip of commercial Fitzroy Street into the lower reaches of Grey St and adjoining streets, including Robe Street. The gentrification of the area (Kerkin 2003) brought pressure to bear on police – along with planning initiatives on the part of the Council (e.g. blocking off Robe St as a thoroughfare by constructing a traffic island in the middle of the street). This again saw it forced the sex market into new areas – somewhat predictably dark and poorly lit streets (reducing risk of arrest and / or questioning by police) but also a constant stream of traffic including both prospective clients and voyeurs (Rowe 2006). The constant struggles with street sex work and Council’s attempts to meet community concerns without resorting to a punitive approach that denied those involved in the trade their own standing as a part of the Port Phillip community provided the basis for a (largely) respectful dialogue on issues given the social awareness and informed nature of the local community.
The commitment of the St Kilda Council was very much around citizenship, that it had been a centre of illicit sex and drug trade and had an ignoble history for 140-odd years and that was very much a part of the history and culture of St Kilda … [Consequently], in implementing the safer cities planning [the priority was] that everybody had a right to feel safe in St Kilda and that included street sex workers and IV drug users and they were included as stakeholders from the very early days of the planning of community forums and were seen as being given voice, trying to have voice in that process. It’s an important cultural difference in the community for me as the manager of a needle exchange that initially, met with quite a bit of resistance from the traders group in Fitzroy St and local residents. It would be an understatement to say they weren’t happy about the movement of the exchange to the Salvation Army in Grey St near Fitzroy Street (Plant 2012).

The role that the Council played, not only in facilitating meetings in which residents and traders could give voice to specific concerns, but by acknowledging and even respecting ‘the ignoble history’ of the area, ensured there was never a loss of continuity with a past of tolerance. Informed and those who wished to become informed residents were provided opportunities to be made aware of this history – and many would soon discover that they were part of an inclusive community that continued to exist, side-by-side, with the surviving elements of that history. Consequently, when funding was made available through the Victorian State Government’s Safer Cities & Communities initiative, (an initiative that delivered funding to local Councils every five years in the interest of measures to foster community safety and inclusiveness), the City of Port Phillip sought to use this money to gauge and compile community opinion. As one example, regular consultative meetings were held to address specific issues for the benefit of social inclusion across the community – which thereafter became a fundamental aspect of the way the City of Port Phillip managed social ‘issues’. Dr Lisa Harris, a consultant was employed by both the Port Phillip and Maribyrnong City Councils in 2000 to evaluate community responses to the then State Government’s proposal to introduce safe injecting facilities in the respective municipalities. She very quickly became aware of the manner in which the socially inclusive approach of the Port Phillip Council contributed to a community response that recognised the need to respond to a social issue (e.g. injecting drug use in public) that was very much a local issue. In contrast, the thinking Dr Harris observed within the City of Maribyrnong, was that the then highly visible street trade in heroin within the commercial hub of Footscray was a problem that ‘outsiders’ had brought into the municipality. As she explained:

The initial concept of Safer Communities or Safe Cities emerged in 1989 following a pilot project in a Swedish municipality which, after a number of local initiatives were trialled, saw a 23% decrease in personal injury. The theory behind the concept was that safety could be achieved through integrated and collaborative efforts in local communities that are implemented in a social and cultural environment of which the community are supportive given that they are informed of local community issues and involved in a leadership role in designing and delivering the response to these issues (Victorian Community Safety Network).
While other municipalities took the money and did such things as improve lighting and install CCTV cameras, St Kilda thought it’s about how people feel in this – how do we address their fears – certainly not by ways such as demonising marginalised individuals and groups …

… Right from the beginning, there was a readily identifiable difference between the two councils, a very different sense of the problem. The City of Port Phillip [took the approach that] these are people who are here [as members of the community] and we’re working out the best way of working with them. In Maribyrnong, there was a belief that people were coming from outside and into the area to use drugs. There wasn’t the same ownership of the problem. St Kilda had previously had a 10 plus year history of community development. That had built a capacity within the community to discuss difficult problems. The awareness of everybody – from the residents to the traders – those who were for it [a harm reduction response] to those who were against it – all had a strong understanding of the issues, they had a strong understanding of what I would call citizenship and what they would expect of the municipality. Many, a very large percentage [of those residents and traders] already had an understanding of harm reduction. There was no question of should we go down the path of harm reduction – rather it was a question of how will it look when it is implemented. How will you understand if it's working? How will we continue to get a voice through?

[In contrast] Maribyrnong was light years behind that – it was ‘not in my backyard, it’s not our problem, why aren’t the police dealing with this?’ That sense of the years of work that had been put in by the City of Port Phillip to educate the community but also to establish community communication forums. (Harris 2012)

This encouraged and laid the ground for Jenny Plant to attend local consultation meetings, where resident’s concerns were somewhat tempered by an appreciation of the issues as dictated with HIV / AIDS and the need to respond in a way that balanced concerns with a right to continued social amenity.

At local Neighbourhood Watch meetings I would go along and say, I’m from the Salvation Army … we run these sorts of services, including needle exchange and [I] would essentially listen to people’s anxieties and grief about that. I would say that what made that possible and what made that an alright space to go into was that it was with the full knowledge that the City of Port Phillip were setting the ground to ensure it wasn’t: ‘we’re going to drive these people out? Not in my backyard’ but rather, ‘How do we incorporate this? How do
In subsequent meetings, residents raised specific issues that were typically related to the amenity of local areas being affected by public drug use. As Plant notes, however, such contact often served as the conduit for useful information regarding just what resources were required to ensure that the NSP was equipped to meet the needs of its clients as best as possible. As one example, complaints against drug users entering residents’ properties to obtain water with which to mix their drugs prior to injecting opened up the whole issue of the need for sealed vials of sterile water prepared for injecting – as opposed to users potentially injecting microscopic organisms and impurities:

The interesting part for me was [interaction] with the residents associations. They said ‘well, people come in and use our garden taps to get water [to prepare drugs for injection].’ We would [then] say to the Department [of Health] ‘well, you need to provide us with sterile water and I would say [in return] the residents, ‘Yes we’ll take that on board and it’s incredibly important because if people are just using tap water there’s a potential for vein care issues, people might get infected, so thank you for informing us about that health issue’. That immediately changed the dynamic from one of trespass to one of confronting a health issue and meanwhile we started providing sterile water at a huge cost ... and we still do, it still costs between 25-$34,000 dollars a year (Plant 2012).

The other main concern of residents was the continued – and undeniable – affect that irresponsibly discarded syringes had on local amenity. This – and the related need to continue to improve return rates at the NSP – saw staff at the CCC respond to residents’ concerns in emphatic fashion. Lisa Harris, later became a resident of St Kilda and a worker at the NSP. She recalls the ‘leadership’ shown by The Salvation Army Crisis Contact Centre. While protective of their clients and willing to defend them against unjustifiable accusations, the focus on a need for the NSP to be established as a permanent service informed the strategic need to avoid relationships degenerating into a ‘us and them’ scenario. Consequently, while discarded syringes would be collected upon a phone-call, clients using the service had the importance of returning syringes – or at least disposing of them responsibly emphasised to them in their interactions with NSP staff. Harris was in a unique position to consider the strategy from the respective perspectives of resident and, subsequently, NSP staffer:
It became about amenity. It was a very practical question of what exactly are you [as a resident] concerned about and how might we address that? So, for instance, for the first few years any trader or resident [was able] to ring at any time if they discovered discarded syringes, which would be safely collected by NSP staff. I do remember as a resident it was a pain in the ass to think well, there’s 50% [of needles distributed] not being picked up … but that’s where the service came in saying that they would come and pick them up … and [the Contact Centre staff] did …

... At the same time, the message that was given at the exchange every time they gave needles was that ‘you need to bring these needles back, every time you use. What was being said to people was that ‘you need to be responsible in your drug use. If you’re going to use, then bring these needles back and that makes it OK for everyone.’ It was done in the prompting of questions. When people popped in, they’d ask, ‘how many are you bringing back’ and that enabled the service to provide quite hard data … but they were able to say that there was a 50% return rate and show that everyone was trying to be respectful of the [local] space. Everyone was trying to work out the best way to work through this (Harris 2012).

The onus often fell directly on Jenny Pant as manager of the CCC or upon Doug Parker as Operational Manager. As the former stated:

The thing with the residents was, ‘there’s a fit, what about my animal or my child?’ We would say, ‘absolutely, we will come straight out and get it’ and we did that within a four-block radius. We didn’t say we would cover all of St Kilda but the residents we would have to respond to, those who were around us, those in the four-block radius of the Neighbourhood Watch Committee we said, absolutely, 15-hours a day, seven days a week, you can ring us and we will come and pick that up if you tell us where it is (Plant 2012).

In comparison to the concerns of residents, Plant would find the financial concerns – and fears as to the impact of an NSP and implicitly its clients – would have upon patronage of their nearby commercial business interests. This was especially the case for business proprietors located in the vicinity of the CCC in nearby Fitzroy Street, many of whose properties backed onto laneways and side streets that were perceived as potential areas of injecting drug use, let alone toilet facilities on the premises. Jenny Plant remembers an ongoing – and unhealthy- dialogue with the traders association that did not seem to be making any headway:
The problem was the location – moving closer to the Fitzroy St traders … so I spent two years doing meetings with local trader groups in Fitzroy St and Acland Street as well. The Traders Assoc meetings were, what ‘I would call’, ‘fairly heated at times’ … Two or three people in Fitzroy St who were ‘lefties’ wanted to support it ‘but in the general din of the traders meetings they didn’t have much of a voice and they also had concerns’ … The residents had real concerns that we could provide a response to … ‘and 20-odd years ago, the residents of St Kilda were a left-leaning bunch … the traders were a more challenging environment to walk into and have the debate every few months. ‘I think I did three [traders meetings] a year for the first two years …It was critical because they were the sort of voice that we needed to keep on side because if at any point the Council became any less left-leaning then the traders had a significant voice in Council policy making and so, for me, it was strategic for us to be seen as part of the traders group in some respects, so if they had issues with us, they would go, ‘Oh, there’s Jenny, we’ll have a chat with her before we take it anywhere else.’ So certainly, strategically, that was a major part of my role initially, in terms of trying to swing opinion around about having the exchange there and particularly because … as we opened and it became clear that we were open for business the growth was exponential (Plant 2012)

Eventually, as Jenny Plant remembers, the turning of the debate that brought the traders onside and eased the pressure on those concerned to ensure the NSP remained a fixture of the service environment came after two significant conversations between the manager and prominent members of the Traders Association. The first was as a consequence of an initiative taken by the late Donlevy Fitzpatrick, the restaurateur who had refurbished and marketed the George Hotel, transforming the derelict establishment into the fashionable and, in its time, visionary Melbourne Wine Room. Jenny recalls the ‘breakthrough’ coming when Fitzpatrick came into the Centre unannounced one day and expressed a desire to speak to the manager:

We had seen each other at the traders’ meetings and he and I had a discussion that day and he said, ‘Look, there are some of us who have real issues about [drug] use and people who pick up the syringes at your place walk across the road and use in the toilets … I understand that these people have a right to be here in the community and I understand you need to provide the services you do, but what can we do, what can you do? What needs to happen to make it alright? I can’t ask my staff to clean the syringes out, it’s unsafe.’ I said, ‘How about we pay for syringe bins to go into all your public spaces, bathrooms in the hotel and anywhere else you see as necessary and we will arrange for those to be emptied as often as necessary, we will pay for that?’ He said, ‘OK. Alright. That’s all that I need … you won’t have any more opposition from me and I’ll talk to the other traders.’ That was the turning point in the relationship for us’.
Donleavy Fitzpatrick saying ‘I don’t want to be a part of this process of trying to move you off the block but what can you do to make it alright for me’. So we paid for 10 or 12 ‘fit’ bins to go into his hotel and Council paid for those to be emptied on a weekly basis or whenever he phoned and said, ‘height of summer, twice weekly basis. We said, we’d pay’ (Plant 2012).

The participation of the owner of the Wine Room was crucial. As Lisa Harris reflected, the willingness of Fitzpatrick to have disposal units installed in his establishments’ toilet cubicles was an implicit acknowledgement that IV drug use was part of the activity taking place in these publicly accessible areas:

As the needle exchange became busier and busier, the traders had to deal with the reality of the situation which was, for many of them, overdoses in toilet cubicles and other things. So many traders had gone down the path of installing ‘blue lights’ so it was a real turning point because I think, [Donlevy] was at that point, when he went, ‘Yes, well, they can use there, that’s fine.’ It actually meant a real shift because the cinema there, the Palace, they had installed all the blue lights into their bathroom... 31

Once again it’s the question about [the IV drug user] feeling safe vs. ostracising the group who then becomes the problem. So in putting in fit bins it’s like accepting that people do other things in here, sometimes they inject and they need to use fit bins. In contrast, putting in blue lights [is saying], we want to keep these people out. So that point where he’s going ‘OK we’re going to deal with this situation.’ It was a real harm reduction concept rather than a ‘not in my back yard ... or toilet as it may be’ and that was a real shift because basically once he was able to say we haven’t had any problems since we put the fit bins in and it’s all good, then that allowed other traders who were more on the edge to be able to go, well maybe that’s what we can do rather than go down the blue lights path, which is about we don’t want these people in our space (Harris 2012)

31 Although highly questionable in terms of efficacy, blue fluorescent lights are installed in selected public toilets with the objective of making it difficult for IV drug users to locate their veins and dissuade them from using said facilities to inject drugs. However, drug users who have accessed a private space to use their drug without being disturbed are not easily discouraged and the greater majority can easily find a main vein by touch and sight without the benefit of vein colouration being apparent. Those who might struggle to find a vein easily are simply more likely to persevere until they succeed, potentially spilling blood about the toilet cubicle as they unsuccessfully pierce veins and draw blood without satisfactorily placing the needle inside a vein ... only to have to start the process again. Although this is not the place to detail the issues raised by such lighting for sight-impaired customers, it is worth noting these also exist.
The other turning point was a conversation that, Plant remembers resulting from ‘a sense of frustration for me’. This frustration had been sparked by the on-going need to justify the existence of the needle exchange with some traders who continued to be concerned about the effect on amenity in the local shopping precinct, and expressed the wish to close the Salvo centre altogether.

There was a sense of frustration for me where I found myself saying at one of the meetings, ‘You know, you need to understand that, if you continue to push for the closure of the service, the Crisis Service at The Salvation Army, you need to understand that we have a staff of 40 and that we put in an estimated quarter of a million dollars a year into just the local economy here in Fitzroy Street here … at that time we provided vouchers for The Regal and The Gatwick and another hotel further up near the Junction for emergency accommodation. We provided food vouchers. We provided both methadone support and chemist vouchers … so that was about $50 thousand going into pharmacies … I said, ‘and, we’ve a staff of 40 that buy lunch and dinner here in these cafes along here, so best estimate would be that it’s close to a quarter of a million here that you’re seeking to take out of your own pocket if you close us down’ …

… ‘Interestingly enough’, she reflects, ‘that was the end of it … the economic argument. I can remember thinking at the time, ‘I wish I’d done that two years ago’ (Plant 2012).

Despite her fears, the potential change of Council members and an accompanying backlash never did occur. Following the spending of the first block of Safer Cities funding on inclusive community consultation methods, a very progressive and left-leaning council was elected.

The voting in of the Turn the Tide grouping into City of Port Phillip Council ensured like-minded peoples at the local government level. It was really an anti-development group in St Kilda, the old skating rink had been knocked down, there was basically a fundamental shift in demographics and Turn the Tide came about. There was a lot of overlap in people and relationships in social service workers and people who were on the Council – so you had people who could relate to each other or who had been actually working in social services who had run for Council. A really strong and informed view about how to coordinate issues and live together. That was in the late 1980s and early 1990s …
Originally, a team united to oppose development in the St Kilda area, the ticket contained many people who were actually employed in the management and delivery of social services, ensuring the ability for the NSP to become bedded down and moved into a separate office space that could be discreetly entered after operating next door in its initial months within the Crisis Accommodation Centre. Rob Moodie, Victoria’s Senior Medical Officer in respect of HIV / AIDS in between the years of 1988-1991, confirmed the credibility and value that The Salvation Army brought to the State’s busiest NSP. He does not downplay the courage that was needed.

I think the fact that the Salvation Army came on board was particularly useful, a credible, well-known brand to pick this issue up was great and wasn’t necessarily all that easy for them to do I guess … I thought it showed a lot of courage. I would be very positive about the role of the SA in this, both in terms, of not only being through harm reduction but working with people at risk and vulnerable marginalised and demonised and stigmatised, so it shows a remarkable level of leadership to get out of there … as distinct from the later work of Brian Watters which was the dark ages of the Salvation Army really (Moodie 2011).

In 1995, after its acceptance as part of the fabric that comprised the network of social services in the Port Phillip, the NSP at the Crisis Contact Centre was renamed the Health Information Exchange (HIE). The renaming of the facility was, at least partially, to deal with the negative connotations that those opposed to harm reduction continue to associate with a facility that distributes needles and syringes to illicit drug users. More so, however, was the desire to reflect the reality of a service that was a primary provider of information and education in respect of injecting drug use as well as associated services to its clients. Workers at the HIE are very deliberate in not making every contact a discussion about the welfare of the client. It is a mark of their respect for the people that come through the doors that they will wait until the client raises an issue for it to become the topic of further conversation. As a later manager of the HIE, Sally Finn, related:

The majority of conversations that go on in the HIE are really very mundane, quite calm. The clients love the fact that I don’t have to get into a conversation with them about legal or health concerns over what they are doing. They love that they can get into a conversation with me every day and not have to finesse that conversation – they’re picking up and I’m just going to give them the equipment without any fuss. Imagine, any of us having to go into a service that we’re asking something from, every day, and
having to interact every day with the same person who’s seeing what you’re going to
do … a window into someone’s personal life … absolutely, and a personal life that some
clients aren’t very proud of or they have strong feelings about. So there’s a real skill in
not entering into conversations that are going to make them think twice about coming
in the next time. It’s about being caring but also being matter of fact. And that’s fine –
that’s the relationship.

The exchange is amazing in the sense that it provides a spot where people can test out
ideas of where they want to [be] … they can really talk candidly about where they’re
at with their drug use because I would say most of the people who come into the
exchange want to give up … that’s where there head is at when they’re calm and quiet
and considering their life … so it gives them a spot at least to test out those ideas of
what’s possible. Where they can go and where they should start … they’re not always in
that mood of course but it’s a wonderful avenue for somebody to talk to a person that’s
really – not necessarily outside the scene – but certainly not a friend, somebody who’s
paid to respond to them in a way in which they’ll get something out of the conversation
they’re having. If they want a shift in their life, then that’s the direction they can go in …

… I really do feel that the model of service has allowed us to not interfere beyond
the bounds of what the client is asking of us and that in itself has encouraged the
relationship because they don’t feel that we’re going to step in and try to talk them into
something (Finn 2012).

The success of the HIE model has been recognised and supported by the Victorian State
Government. In late 2007, funding was provided to run the NSP as a 24-hour service on a pilot
basis (Hagan 2010). In doing so, it became the Victoria’s only 24-hour NSP. Monash University was
engaged to provide an evaluation of the Health Information Exchange 24 Hour Access Project at
the end of that year and published its findings in August 2008. The evaluation was positive with
a number of key findings pointing to the value of the increased accessibility of the HIE. These
included:

- The introduction of 24-hour access resulted in a substantial increase in demand for
  HIE services, estimated as 41 per cent greater than the corresponding period a year
  earlier. The trend was expected to continue and demand continue growing;

- A slightly greater increase in clients aged 36 and above was evident amongst an
  increase across all age groups;

32 Funding has since been earmarked for a second 24-hour service to be run in Frankston.
• The proportion of new service users was estimated at between two and eight per cent of all HIE service users;

• Harm reduction behaviour ‘appears to be occurring and occurring at relatively high levels. In spite of increasing occasions of service self-admitted equipment sharing remains low (i.e. less than 0.5%); requests for information regarding safer use is increasing; and, the quantum of condoms being distributed per month has increased by an average of 25 per cent’ (Thomacos & Brown 2008, 3).

Following further evaluation and consideration of the benefits of the increased accessibility in comparison to the relative costs of staffing the facility across the previously non-operational hours of 11.00 pm – 9.00 am, the State Government announced on 18 August 2010 the provision of $2.2 million in funding every four years to allow the facility to continue operating for 24-hours on a permanent basis and, significantly, to expand its work to provide on-site health services including the prevention and treatment of hepatitis C (Hagan 2010).

Although a significant extension of the services provided by the HIE, the health services that the aforementioned funding would support were dwarfed by the opening of Access Health on 1 September 2004. Access Health is a primary health care centre that occupies the building adjacent to the CCC and is another of The Salvation Army Crisis Services network that was opened to meet client-directed need. In 2003, the State Government provided grants to five identified hotspots of illicit and public drug activity, one of which was the City of Port Phillip. The funding was allocated by the Department of Human Services:

To provide a primary care service to enhance the health and welfare of street based injecting drug users (Department of Human Services 2001b, 8).

The Salvation Army Crisis Services subsequently initiated a comprehensive research project undertaken by the Centre for Applied Social Research at RMIT University. This research – with a view to designing a primary health care facility to service the prioritised population took the form of a health needs analysis of clients of the HIE, which has remained the municipality’s primary NSP. The results were published in the Who’s Using? Report (Rowe 2003). The research confirmed the vulnerability of street-based IV drug users and the association of injecting drug use with a range of potentially serious health problems. For those without stable and secure environments, problems were exacerbated by poverty and deprivation, which often hindered the access of injecting drug users and other marginalised individuals to mainstream health services.
Following the completion of the health needs analysis and a feasibility study to outline the rationale, staffing and design of the then tentatively named Access Health, Crisis Services submitted plans to the DHS to establish the facility at 31 Grey Street. In addition to providing the building in which the proposed health service would be housed, the Salvation Army committed the resources for refurbishment. A Funding Service Agreement was signed by the Salvation Army Crisis Services and the DHS in 2004 under which the latter would provide funding of $615,000 per annum to finance the operation of Access Health to be managed by Crisis Services. Access Health now provides a range of primary health care responses to three ‘populations’ within Port Phillip:

- Street-based injecting drug users;
- Street-based sex workers; and
- Homeless and transient individuals.

Access Health and the HIE are considered to be linked services within the Crisis Service network. The initial needs analysis – and subsequent feasibility study – concentrated on the complex health issues that clients were presenting with. While staff at the HIE had long made referrals to meet the volunteered needs of clients, these had long been primarily health related as demonstrated by Table 2 taken from the aforementioned needs analysis.

Table 1: Total referrals made by HIE staff by service 2000/01 – 2001/02 (Rowe 2003)
As noted, Access Health was specifically established to meet the needs of street-based injecting drug users – other populations were incorporated as part of the funding agreement between the DHS and The Salvation Army. Its location in the immediate vicinity of the HIE, the one health service where intravenous drug users are known to congregate, was part of the rationale for locating Access Health next to the HIE. HIE workers have subsequently been able to directly refer clients to the neighbouring health service – even using a passage joining the two facilities if the need for anonymity or confidentiality arises.

Anecdotal evidence collected during an evaluation of Access Health (Rowe 2006b) allowed for reflection on the links between the two services. Karyn Gellie, then team leader of the HIE and the health promotion worker at Access Health’s team leader – was able to offer a unique perspective of the cross-over between the two services. She suggested that a significant number of HIE clients were being introduced to Access Health via ‘advertising’ at the HIE, a perspective shared by the former services then manager. A number of events have involved staff from both programs (e.g. Overdose Awareness Day). Gellie noted at the time of the aforementioned evaluation:

> Probably about half [of attendees at regular Wednesday ‘drop-in’ that ran at Access Health on Wednesdays] are regulars [of Access Health] … the other half are new and they’ve usually been in the HIE and staff have told them about it or they’ve been next door at the Crisis Contact Centre, they’ve been waiting there and they come over for something to eat. There is a poster [advertising the drop-in] in the Crisis Centre waiting room and in the HIE and every Wednesday I put flyers on the front bench [of the HIE] for people to see when they come in. If people [using the HIE] are chatty about their health, one of the benefits of having myself there, with a health background, is I can say, ‘that’s something you can see the psychologist about’ or ‘that would be something you could see the nurse about’ and maybe just take their hand and introduce them to Christian [the duty worker] who’ll help make an appointment and just make it a bit easier for people (in Rowe 2003, 134-135)

In the years since its opening, Access Health has continued to provide medical assistance via nurses (employed from the RDNS Homeless Persons Program) and a General Practitioner (who also prescribes pharmacotherapies for opioid dependence). Other services include drug and alcohol counselling, mental health practitioners, specialist indigenous access workers and, as a more recent addition, not just support but funded treatment for injecting drug users (or former IV drug users) who have been exposed to hepatitis C, a treatment that could well prove beyond the financial and personal resources of clients without the support of staff at Access Health and the HIE.
The establishment of Access Health grew from within the HIE and was a deliberate case of responding to the needs of the clients who were presenting at the NSP and raising health concerns with workers. When an individual presents at the HIE and draws attention to a health-related need – physical or mental – workers are now able to offer a response instead of a referral that may or may not be followed up given the transient and often unstable lives of the most marginalised and, consequently, those in most need of such a response. As CCC Manager Jenny Plant noted of the links between the service:

We have managed to do what we needed for 10 years and that is to provide an opportunistic response to people coming in and saying I need to do something about my health now. All that stuff has sat behind people presenting at the CCC and the HIE. Health issues come with poverty but they have such a low priority in people’s lives that they are managed by crisis – having the resources to take advantage of that opportunistic moment [is fantastic]. You can say, it’s here, let’s go next door (Rowe 2006b)
CONCLUSION
An issue that once caused a great deal of angst within the upper echelons of The Salvation Army hierarchy is now a proud monument to their courage and willingness to put their love for all of society before the potential condemnation of the ill-informed. The manner in which this courage has strengthened The Salvation Army in the Australia Southern Territory and better equipped its members to respond to the needs of the marginalised and forgotten is perhaps best reflected by events in Launceston Tasmania, where uniformed Salvationists have established a NSP to be managed and staffed by the corps themselves. As noted in a recent report:

In early 2005, the Department of Health and Human Services approached The Salvation Army with a request to deliver the Needle Support Program (MNP) in Launceston. Following discussions with key stakeholders it was thought the best place to locate the program was within the [Salvation Army] church building… The location of the Needle Support Program within a church building was both innovative and courageous. Whilst The Salvation Army has operated an NSP in Melbourne for more than a decade, it has been from a purely social service location with almost no ties to our evangelical arm (Begent 2007, 1)

While the steps taken by the Southern division to locate an NSP in the corps building was no doubt courageous – and, as written in a report on the facility – only proceeded, according to Major Jenny Begent ‘after we were able to allay the fears of corps members’ following ‘significant prayer’ (Begent 2007, 1), there is no doubt it would never have been a reality if not for the initiative taken by CCC staff and the trust placed in them by The Salvation Army hierarchy in Australia’s Southern Territory. As for the HIE, this continues to operate in an open and judgement free manner that sees a great number of clients continue to access the services and receive a range of sterile injecting equipment. This has even surprised some of the most senior staff at the site, Finn acknowledging:

One of the things I think is really amazing about our exchange is that it’s been going for all these years and it’s still incredibly well used – I’m kind of amazed that exchanges have been as successful as they are … the fact that we get people coming to get clean equipment is quite an achievement  (Finn 2012)
And indeed, the HIE has continued to dispense this equipment, the value of the service affirmed by the State Government’s decision to expand funding to allow it to become the State’s first permanent, 24-hour staffed NSP, open each and every day of the year. It is truly the most accessible service in the State for injecting drug users, ensuring there is always access for this population in a time of crisis. In the most recent year of recording, the HIE distributed some 997,542 needles over the course of 50,213 client contacts (Salvation Army 2012, 11). In a testament to the continued work of management in community education and the self-responsibility undertaken by those who inject drugs, the return rate of needles to the HIE over the past financial year was 63 per cent with a further 28 per cent of used needles disposed of via public disposal containers (Salvation Army 2012, 11). Referrals continue to be made to those clients who request further assistance.

The establishment of the primary health care centre Access Health in the adjoining building since September 2004 to meet the mental and physical health needs of target groups including street-based injecting drug users,33 has meant that the most pressing subject matter for referral – health needs – are now addressed through an immediate co-ordinated response. In the financial year 2000/01, HIE workers made 8,301 referrals to health services, comprising 53 per cent of all referrals. In 2011/12, health related referrals were only responsible for 10 per cent of client requests for further assistance. Access Health is now accepted by the clients of the HIE as a service to meet their needs and in which they will be treated equitably and without judgement (see Rowe 2006).

Of course, relationships remain the key to the success of the facility. This is not to state that every worker seeks to evoke information of a personal nature from each client that walks into the service. Rather it is about being there for people at all times, regardless of how they may be feeling. The decades that the service has provided this manner of care has invariably established a culture around the service that is inclusive and accepting of all persons, no matter the situation of circumstances they find themselves in.

Relationships are still around in relation to the exchange workers and the street scene. That [trusting bond] has never been broken. It feels as if the service users of the exchange at the Salvos feel that it is their exchange which is really extraordinary and … I’m not sure how, some of those things are very hard to pin down as to how they occur … It’s about the culture that’s created. Jenny Plant has always been extremely vocal about how important it is to treat everybody in a consistent, non-judgemental manner. That is extended then to everybody’s mindset around open doors, not taking on the clients’ ups and downs that clients might present to you but being a little bit forgiving, I guess, not taking things personally which means having a thick skin sometimes in regard to what’s going on the other side of the desk (Finn 2012)

33 The service was also established to meet the needs of street-based sex workers and the homeless and transient populations that survive as best they can via the network of services in the City of Port Phillip
Even in instances in which a client has been angry and frustrated enough to lay waste to the HIE, this has not been seen as sufficient reason to withhold access to such a valuable service. As former HIE manager Sally Finn observes:

*I don’t think we’d consider that a possibility because our mandate is to give out clean needles to everybody and anyone – So I’ve never known anybody to be banned from the exchange since I’ve been here – for 13, 14 years – even when they’ve trashed the exchange. We want them to use as safely as possible. That becomes the priority…*

Despite the fact that the HIE is now established in the sense of its position in the suburb and in the [drug] sector, 1991 was hardly a time in which harm reduction and associated initiatives were unquestioningly incorporated into the public service structure. The move by The Salvation Army is put into some context when one considers that the national body representing NSPs – named the Association of Needle and Syringe Programs Inc. (better known by the name ANEX) was not formed until 1995, a full four years after the opening of the HIE. ANEX initially had a strong presence in Victoria where it was formed and is still based (on the fringe of the city in Fitzroy). This was a consequence of the body forming to further the aims, and subsequently superseding of the Needle Exchange Workers Network (NEWN), an outcome of workshops to provide training and information to staff at newly established NSPs, an initiative sponsored by the (then) Health Department of Victoria (ANEX 2002). Despite forming in 1995, the first national meeting facilitated by the NGO was not held until June 2002, a time at which, despite more than 3000 NSPs operating in Australia, continued contention surrounded the initiative in parts of Australia (and particularly the conservative and reluctant states of Queensland and Tasmania).

The path determined by the Australian Southern Territory of The Salvation Army some 21 years ago is now internationally recognised as one of the primary means by which the potential public health threat posed by the potential spread of HIV / AIDS via injecting drug use has been countered. Some 26 years after Dr Alex Wodak first risked imprisonment by opening a service that distributed free needles and syringes to drug users, even opponents of harm reduction could not deny the role the NSP had played in protecting the wider community from a virus that does not discriminate in the manner of those who question the value of assisting drug-using ‘junkies’. In the knowledge that many a drug user would not access any other community service, establishing the HIE allowed those injecting drug users in St Kilda to build supportive relationships with the facility’s staff and,
oftentimes, to later seek assistance and referral to other services, including drug treatment and rehabilitation. This access would not be possible without the HIE having provided the means of building that capacity for support in the first instance. In the meantime, until ready to step forward and voluntarily ask for assistance, injecting drug users are kept safe from infection and a potentially devastating and unnecessary death.

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A PRAGMATIC EXCHANGE
A SHORT HISTORY OF THE HEALTH INFORMATION EXCHANGE AND THE RECONCILIATION OF CHRISTIAN FAITH AND HARM REDUCTION

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