



# New Zealand Needle Exchange Programme

National Office | NEST

## Quarterly Drug Use Report: October – December 2021

NZ Needle Exchange Programme

NEEDLE EXCHANGE SERVICES TRUST | April 2022

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Date: April 2022  
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## Background

This report addresses overall trends, drug use and client characteristics, with the aim of highlighting risks, barriers to service provision, mitigations and informing service enhancements. The report also serves to meet our contractual obligations to The Ministry of Health to provide a quarterly report on risks, barriers and mitigations to address emerging issues and changes in trends, drug use and clients.

Data contained in the present report are of two broad types: demographics, i.e. ethnicity and age; and type of drug injected by clients. Demographic data have been collected over many years while drug use data is a relatively new information source, with collection commencing in July 2020.

There are caveats regarding the quality of both types of data. Demographic data, for example, are not consistently being self-reported by clients but instead rely on assumptions by frontline staff, a practice we are in the process of changing to align with the Ministry of Health guidelines covering ethnicity data protocols (MoH, 2017:2). Full drug use data provided by clients for the full period of this report are available for three regional trusts – Midlands, DISC and TNET. The DHDP trust only reports drug use by clients for one month every 10 months, while the ADIO trust has provided these data for the final quarter of 2021 only.

In the present report data are accompanied by commentary summarising the most salient aspects of reported information. This is followed by a discussion at the end of the report that highlights particular risks, barriers to service provision and mitigation options to inform service enhancements.

## Occasion of service - Client numbers by ethnicity and age

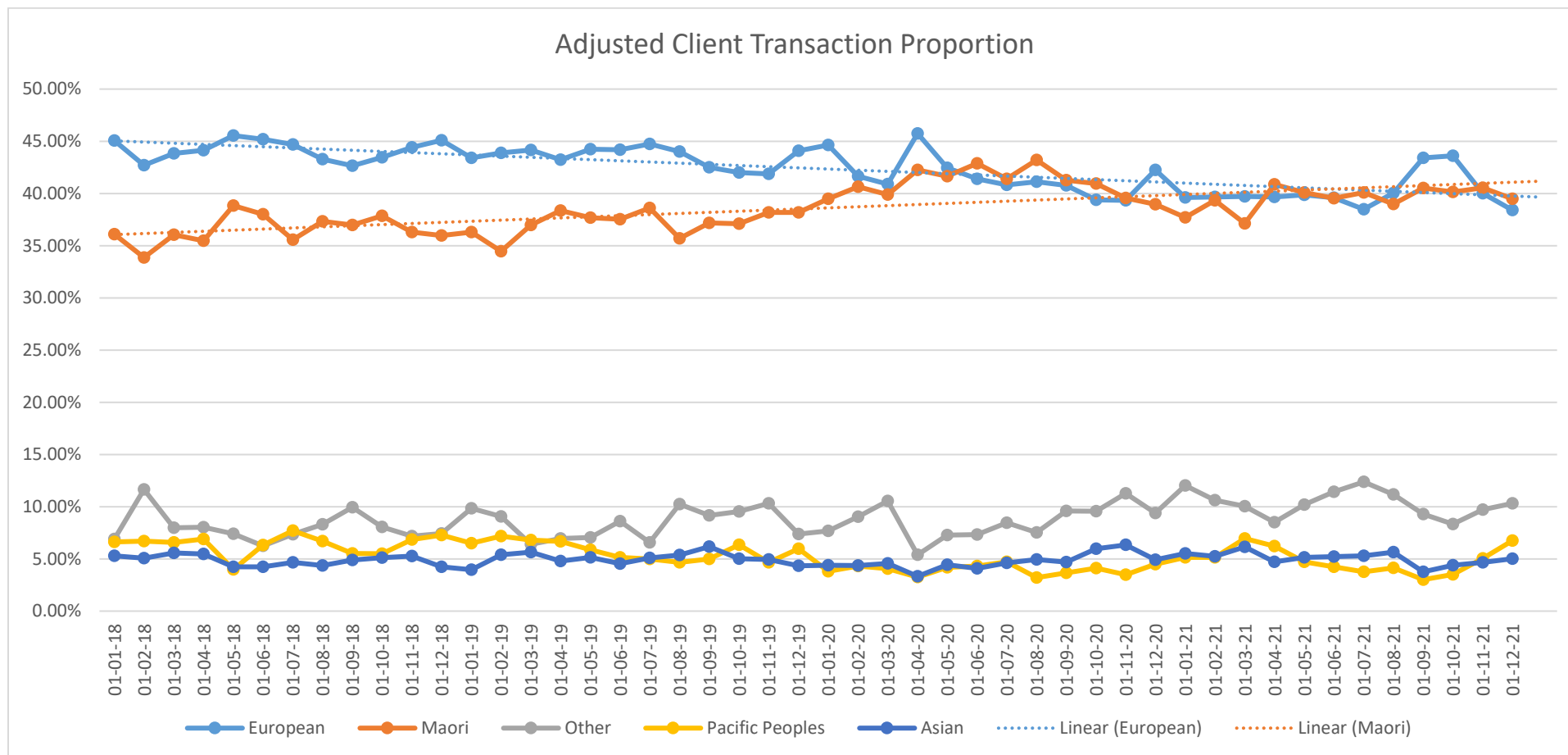


Figure 1: Adjusted client transaction proportions by ethnicity, January 2018 to December 2021

Comments:

*Figure 1* shows the demographics of NZNEP clients by transaction history from January 2018 to December 2021. The data have been adjusted using 2018 census, by assuming the populations are equal across the 5 ethnic groups. The data show European and Māori are the main ethnicities that use NEP services. Proportionately, the trend over time is for higher Māori client transactions relative to a decreasing trend for NZ European clients.

A risk with the current approach to reporting client ethnicity, i.e. that some staff have in the past guessed this, is that the data will inevitably be inaccurate, thereby potentially misidentifying a portion of clients who might be more appropriately supported, if their cultural needs were correctly understood. The programme is putting in place steps to ensure staff follow Ministry of Health guidelines in reporting ethnicity, which requires this to be self-identified. In asking clients their ethnicity, staff would create further opportunities to engage more fully with those using the service, thereby increasing the opportunities for harm reduction.

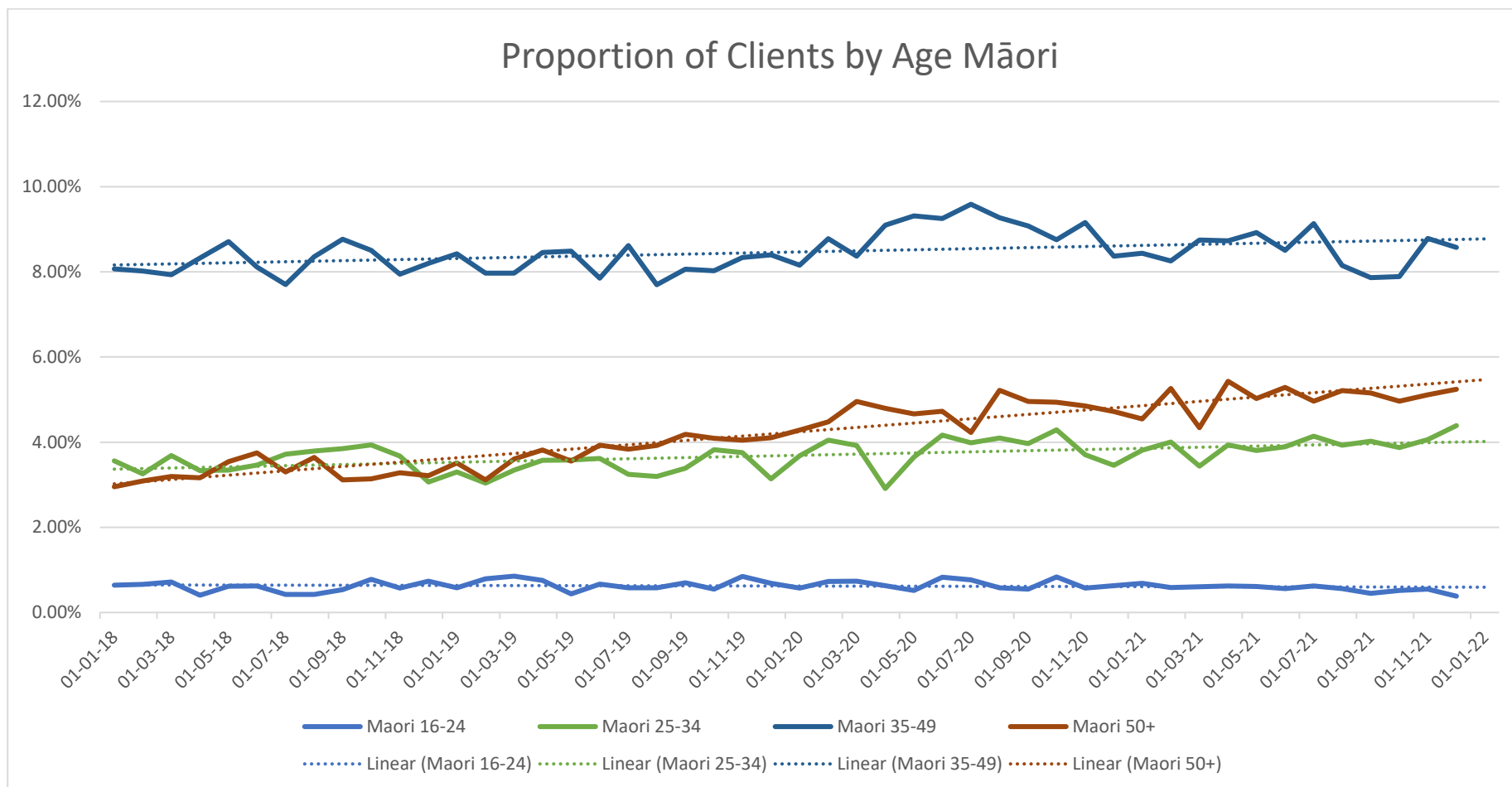


Figure 2: Māori clients as a proportion of all NEP clients, January 2018 to December 2021

#### Comments:

With the exception of those aged 16-24 years, there is a general trend for proportionately greater numbers of Māori clients using the NEP. This is most evident for Māori aged 50+ years and less so for the 25-34 and 35-49 age groups. Significantly, the youngest cohort, 16-24 years is not increasing.

It is probable that a significant number of the increasing proportion of Māori aged 50+ years are using opioid drugs, although as *Figure 18* indicates, all Māori age groups also disproportionately use methamphetamine. Irrespective of drug type, this group is of particular interest as their longer career of injecting would typically be associated with an increased risk of exposure to HCV. Being aware of this in turn provides the opportunity to offer testing. Alternatively, not monitoring the liver health of this group risks increased incidence of significantly compromised health among this cohort and significantly increases healthcare costs.

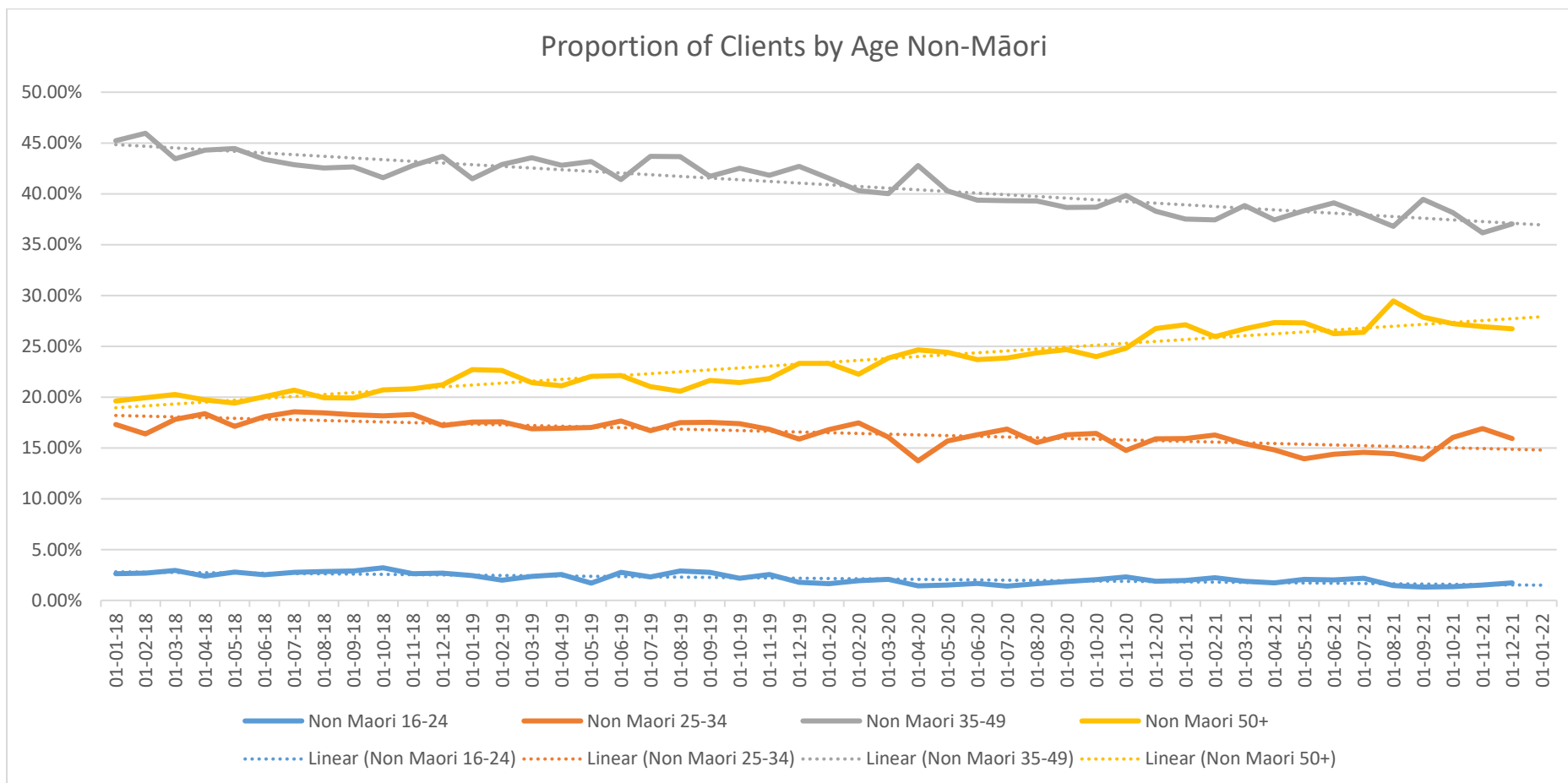


Figure 3: Non-Māori clients as a proportion of all NEP clients, January 2018 to December 2021

**Comments:**

With the exception of those aged 50+ years, the proportions of non-Māori clients accessing the NEP are decreasing across age groups. This is most evident for those aged 35-49 years, though less so for the 25-34 and 16-24 age groups.

By contrast, the oldest cohort, 50+ years, is steadily increasing proportionately. As with preceding comments on Māori clients in this age group, it is probable that non-Māori clients aged 50+ years are using opioids and therefore will be more likely to experience higher levels of compromised health generally, as well as HCV-specific risks. In this regard they are a sentinel group and frontline NEP staff should be encouraged to engage with them at every opportunity. This is particularly important where HCV is concerned, as this cohort is most likely to potentially hold negative views about the viability of treatment, i.e. in terms of not being aware of the efficacy of new treatments with DAAs.



## Occasion of service - Drug use - all clients

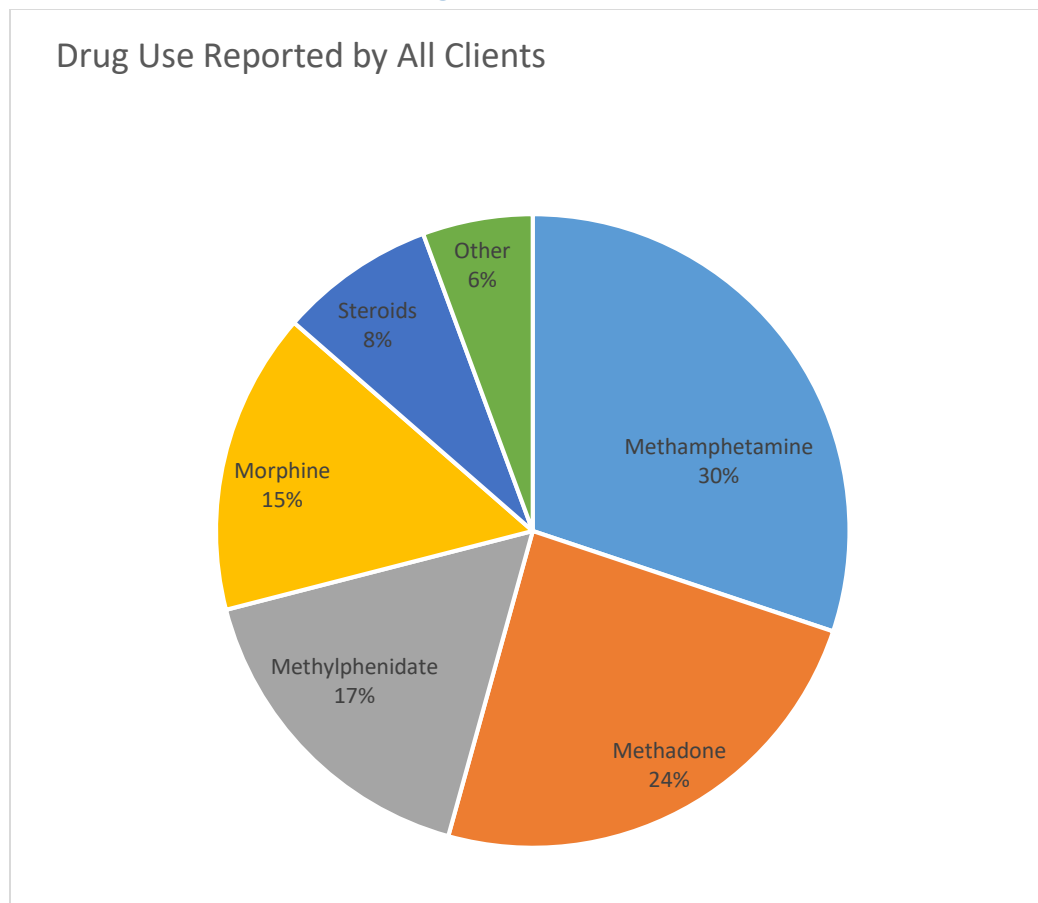


Figure 4: Proportions of drugs reported injected by all clients, Data of four regions July 2020 to December 2021, and one month of Northern Region December 2021

### Comments:

Overall Methamphetamine is the most commonly injected drug, Methadone is 2<sup>nd</sup>, Methylphenidate (Ritalin) 3<sup>rd</sup> and Morphine 4<sup>th</sup>. Steroids/Performance & Image Enhancing Drugs (PIEDs) are 5<sup>th</sup>

In terms of drug “classes”, stimulants (methamphetamine, methylphenidate) are most commonly injected at 47%, with opioids (i.e. CNS depressants; methadone, morphine) second at 39%

A caveat is that the “other” category of drugs would likely include further opioids (e.g. codeine, heroin, oxycodone, poppies etc.) and CNS depressants (e.g. benzodiazepines); therefore, CNS depressants are likely injected almost as frequently as stimulants

The increasing use of steroids is of significance due to clients using these not being traditionally associated with the NEP. Less is known about these clients and their needs, and they in turn often do not identify as “PWIDs”. The NEP would benefit from developing greater knowledge about this cohort, which would make it more attractive to clients using PIEDs (performance and image enhancing drugs) in terms of providing harm reduction services. In this regard NEST has recently partnered with researchers from the University of Auckland's School of Pharmacy. The project has recently completed its pilot phase of the study, examining the knowledge of NEP staff regarding clients injecting PIEDs, including staff understanding of PIEDs drugs. Initial insights include that many NEP staff have limited knowledge of the needs of clients who use PIEDs, that clients who use PIEDs themselves are in some cases wary of attending NEP outlets and / or view NEP staff as lacking the relevant expertise and that increased resourcing for and support of this group of clients is necessary. Pilot data also suggest that the use of PIEDs is more prevalent in the north of the North Island, with some staff perceiving that up to 50% of NEP clients they serve may be doing so in relation to their use of PIEDs. While VEND data do not support these perceptions, i.e. drug use data self-reported by clients at these outlets indicate 16-32%, the fact that some staff hold these views suggests there is a significant population of people who inject PEIDs.

## Occasion of service - Drug use by regional trust

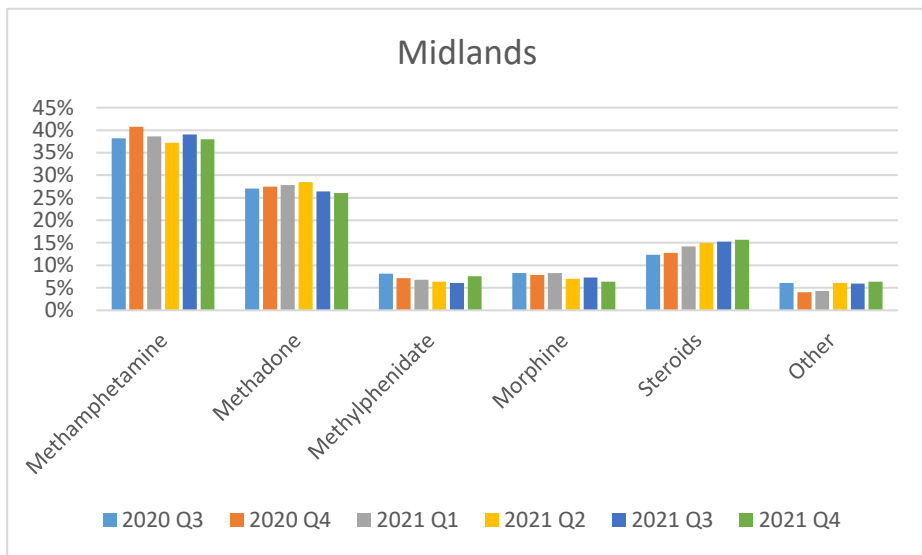


Figure 5: Quarterly drug use reported by Midlands, Jul 2020 -December

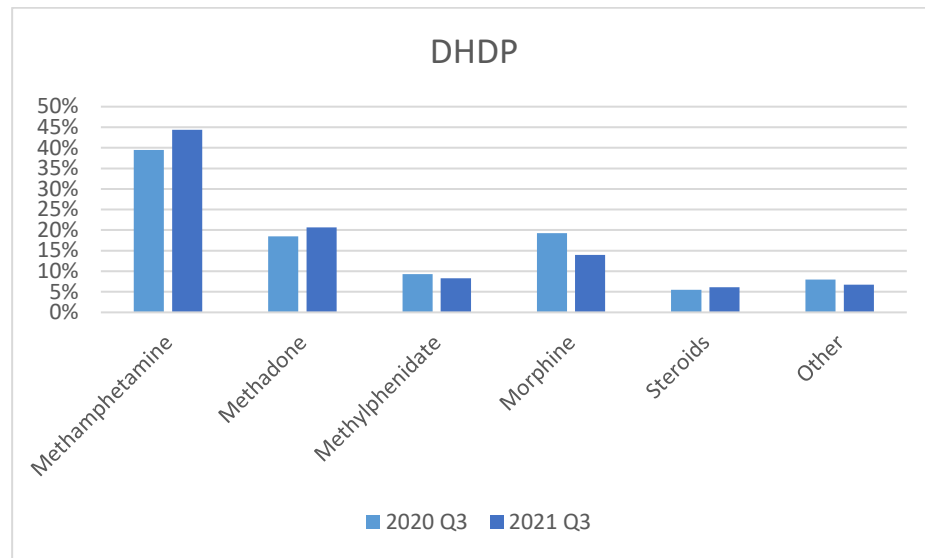


Figure 6: One-month drug use reported by DHDP, 3rd quarter 2020 & 2021

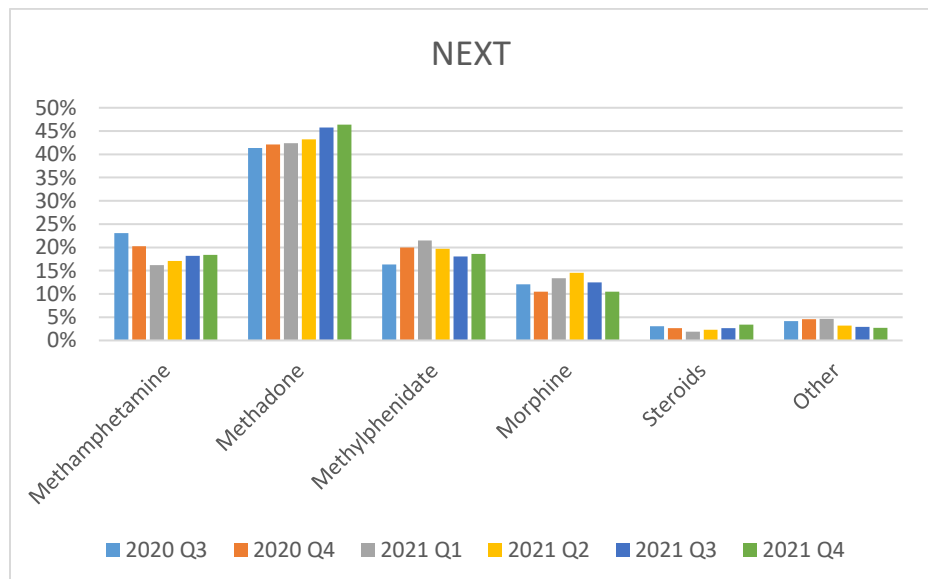


Figure 7: Quarterly drug use reported by TNET, July 2020 to December 2021

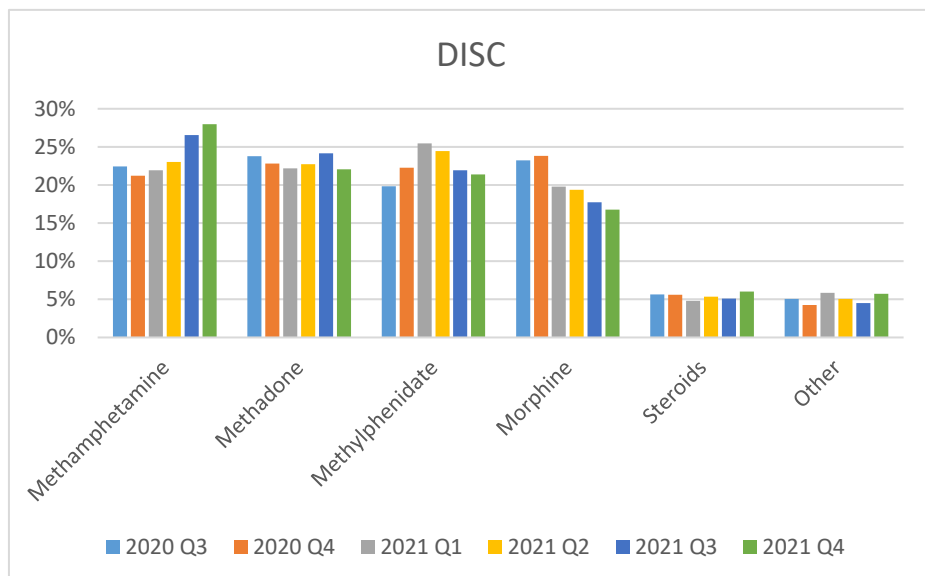


Figure 8: Quarterly drug use reported by DISC, July 2020 to December 2021

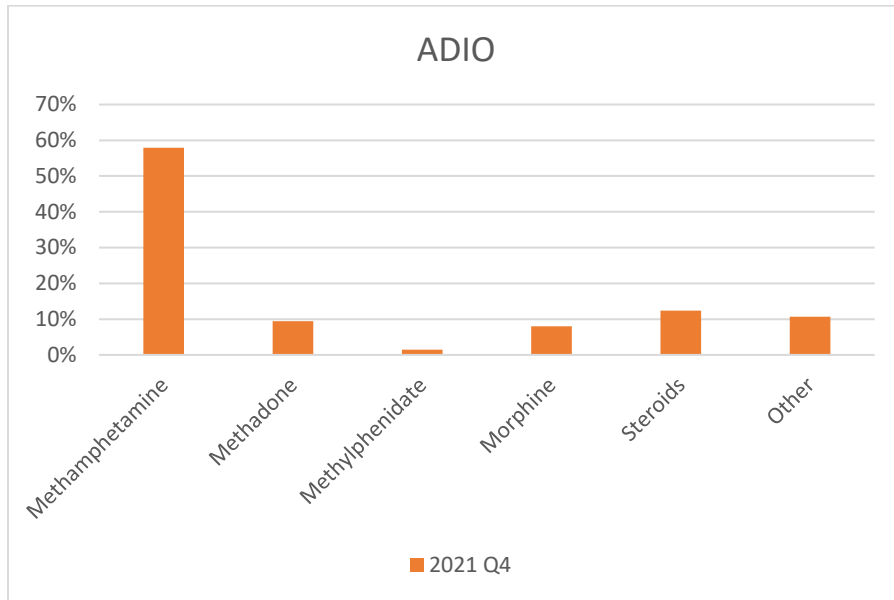


Figure 9: Quarterly drug use reported by ADIO, December 2021

**Comments:**

As noted previously, the collection of drug use data from clients is a relatively new initiative, having commenced in July 2020. Full data, i.e. all clients presenting are asked what drugs they are currently injecting, is only collected by three trusts: Midlands, the Timaru-headquartered TNET and DISC trust, headquartered in Christchurch (*Figures 5, 7 & 8* respectively). It is nonetheless evident from these data that there is considerable variation in drug use trends across the country, which is clearly of interest regarding specific drug harms and which the knowledge of facilitates more targeted harm reduction advice. As an example, of interest in the last quarter of 2021 is the increasing trend in the reported injecting of methamphetamine, from DISC trust (figure 8), which is the largest distributing trust in the country. The predominance of methamphetamine in the North Island therefore appears to be occurring in the South Island now as well. A second example, relevant to the preceding discussion on PIEDs, concerns the relatively high proportions of clients in the Midlands and ADIO trusts, reporting their use (Figures 5 and 9).

As discussed in the previous report, problematically, drug use data collection is not consistent across the country, with the Wellington-headquartered DHDP NEXs only collecting snapshot data for one month every 10 months. For the last quarter of 2021, however, Auckland-headquartered ADIO trust has provided data for the first time. This provides a useful insight into drug use trends in the north of the North Island (Figure 9), underscored by the massive predominance of reported methamphetamine injecting. Given its value, all NEXs should be encouraged to collect drug use data as they not only provide an understanding of the acute needs of clients, but also as with any interaction with clients, opportunities exist for greater engagement with a broader range of harm reduction activities, including testing and referrals, where appropriate.

## Occasion of service - Drug type - By Age, all clients

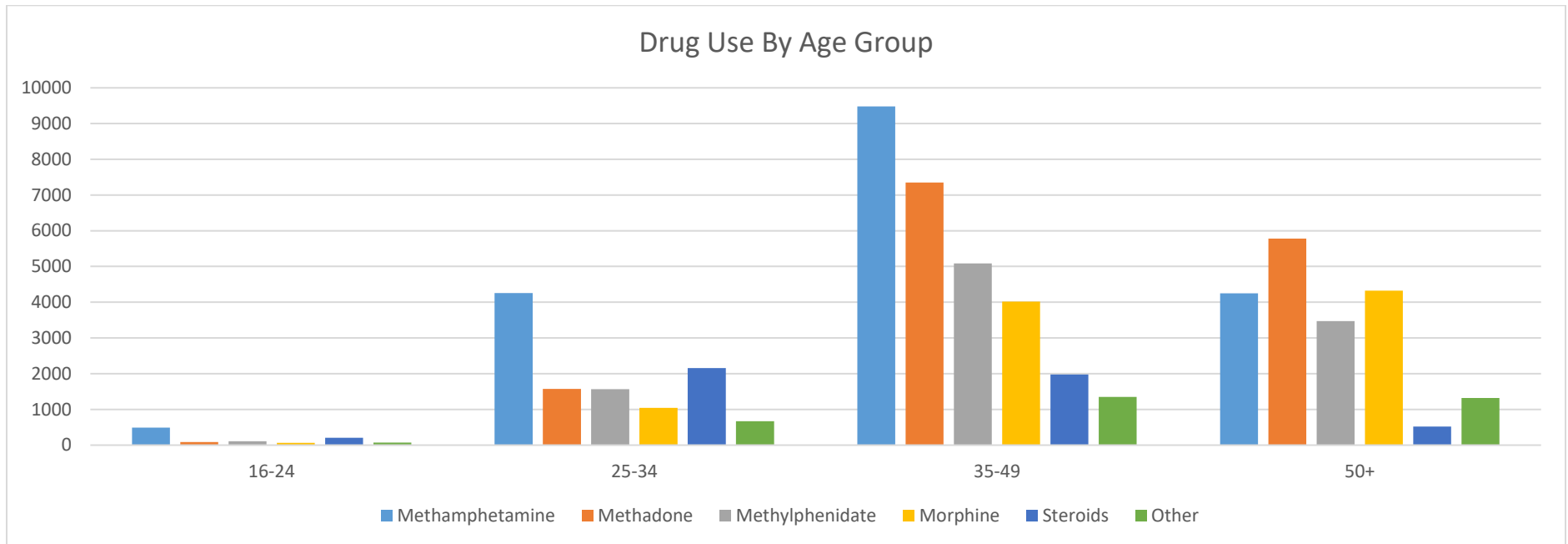


Figure 10: Proportions of clients reporting drugs injected, by age, from four regions July 2020 to December 2021, and one month of Northern Region December 2021

**Comments:**

*Figure 10* reports drug use by age for all clients. Most salient is that for all age groups up to 49 years, methamphetamine is most prevalent, with methadone second in most groups, with the exception of those aged 25-34, where methadone is third. However, for the 50+ group, methadone is most common, with morphine second. These data highlight that there is an older cohort of clients who have likely primarily always injected opioids. Given their lengthy injecting careers and concomitant risk for HCV exposure, they will be a high priority group for testing, and for monitoring their health generally, where clinical services are available. As clients age, the latter issue of general health will become important for the programme and therefore the onus on it to either develop in-house clinical services or to establish meaningful linkages with primary care will increase.

By contrast, issues related to methamphetamine use, which may not currently be fully appreciated by the programme, in the context of targeted harm reduction activities, become more relevant to clients aged up to 49 years. This is likely to be especially relevant in the future for the younger clients, with those aged 25-35 appearing to significantly favour methamphetamine, for which there is a growing body of evidence linking to multi-morbidities, e.g. cardiac damage, psychiatric disorders due to neurotoxicity etc. (see e.g. Darke et al., 2008). Of particular concern will be the long-term impact on Māori clients, among whom methamphetamine use is very prevalent and who already experience poor health outcomes. These issues pose a significant challenge to the programme, as does better Māori engagement generally.

Occasion of service - Drug type - By age (all clients) and with Māori ethnicity

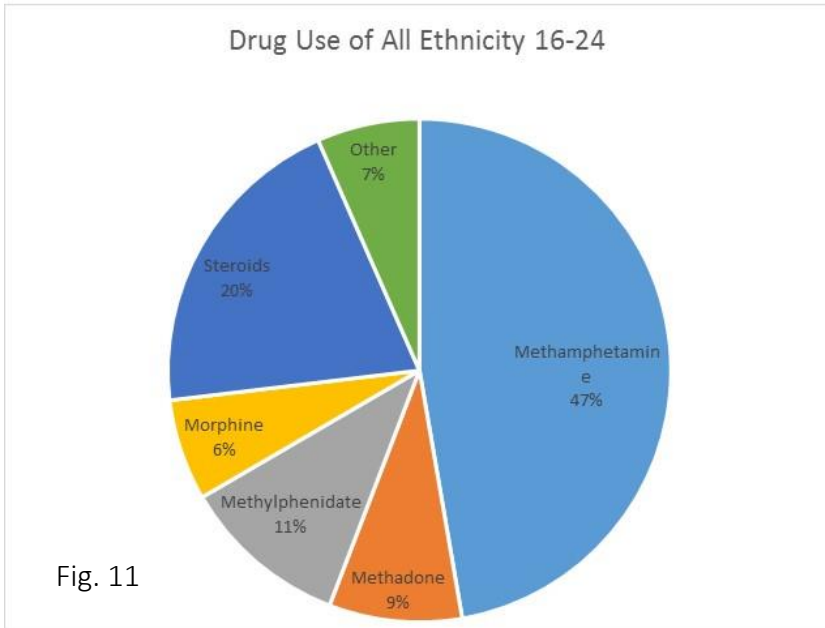


Fig. 11

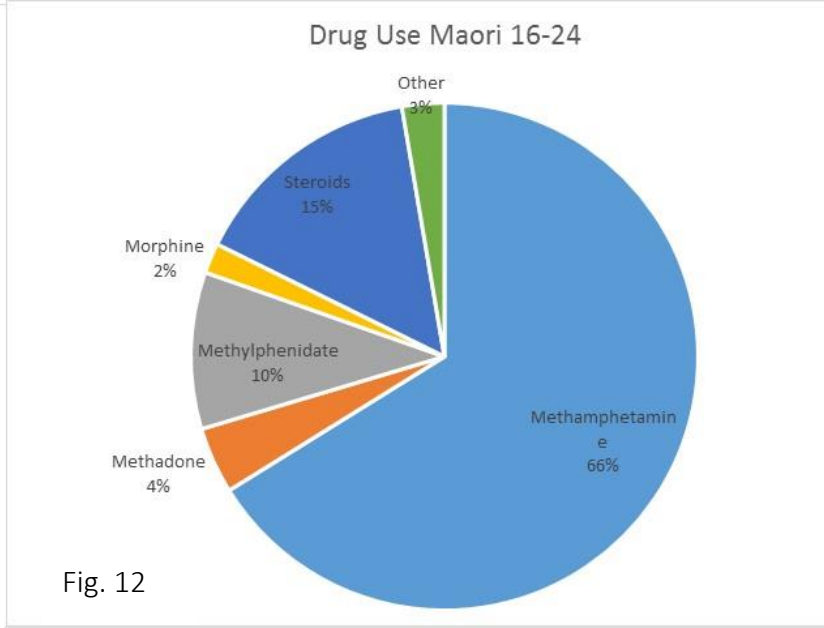


Fig. 12

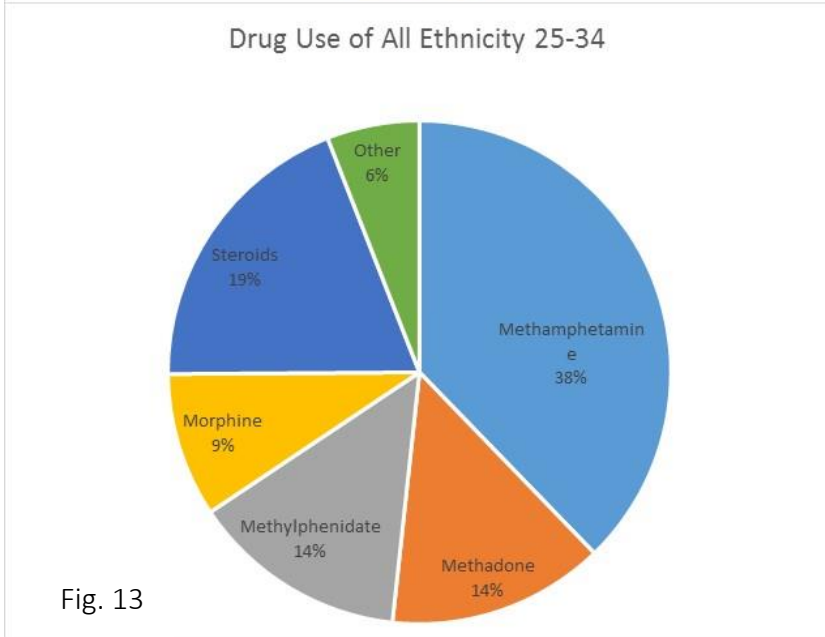


Fig. 13

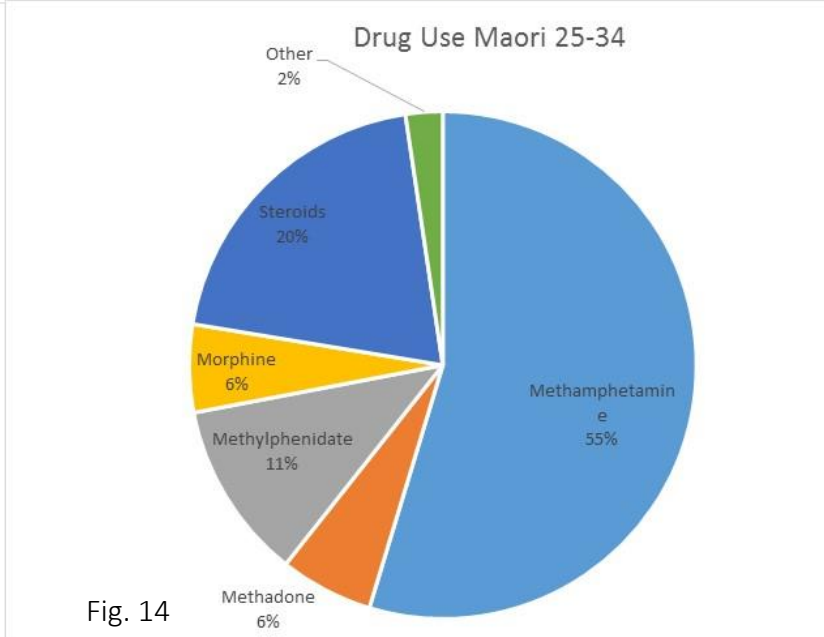


Fig. 14

Figures 11-14: Proportions of clients reporting drugs injected, by age (16-24, 25-34) and ethnicity (all and Māori)

Drug Use of All Ethnicity 35-49

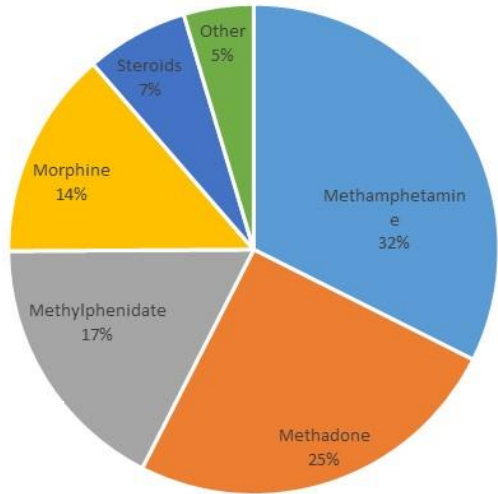


Fig. 15

Drug Use Maori 35-49

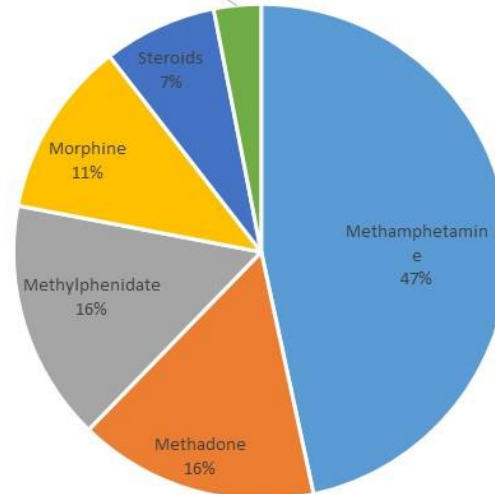


Fig. 16

Drug Use of All Ethnicity 50+

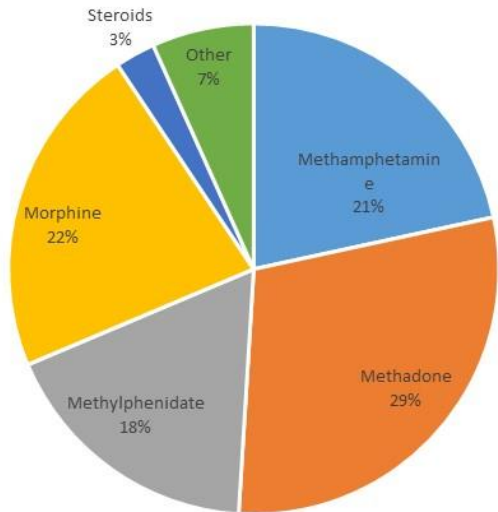


Fig. 17

Drug Use Maori 50+

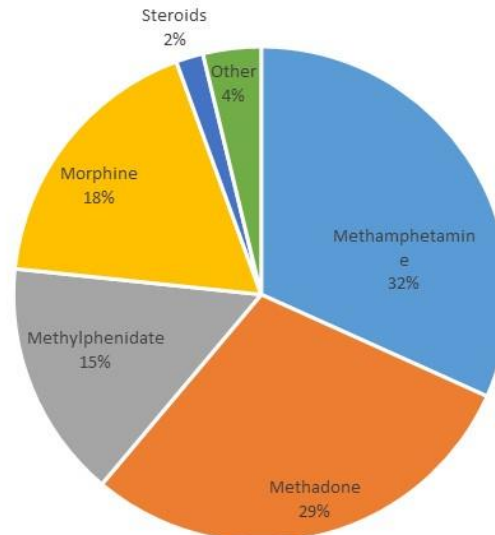


Fig. 18

Figures 15-18: Proportions of clients reporting drugs injected, by age (35-49, 50+) and ethnicity (all and Māori), from four regions July 2020 to December 2021, and Northern Region December 2021

Comments:

*Figures 11-18* combine drug type by age for all clients and for Māori specifically. Two general trends are evident across the data with

- a) methamphetamine use predominant but decreasing in prevalence with age, for both Māori and all clients, and
- b) the predominance of methamphetamine for Māori generally.

The latter extends even to the 50+ age group for Māori, with 32% reporting injecting methamphetamine compared with 21% for all ethnicities. These data highlight the significance of methamphetamine for NZ PWID, particularly for 16-24 year-olds of all ethnicities (47%), and especially for young Māori (66%). This high prevalence emphasises the need for specific focus on the implications of methamphetamine injecting which, as noted above, is increasingly being associated with multi-morbidities, particularly regarding mental ill-health.

Additionally, the 50+ age group for both Māori and all clients reports the highest use of methadone (29% each) and morphine (18% and 22% respectively). If these two drugs are combined, 50% of the 50+ age group is injecting opioids. This is consistent with older clients having likely started injecting before the greater availability of methamphetamine, thereby signifying their lengthy injecting careers and concomitant higher risk profile for HCV exposure. The latter in turn emphasises the need for heightened engagement with and surveillance of this sub-population of NEP clients.

Also of significance is the relatively high use of steroids (i.e. PIEDs) among younger clients, with all clients aged 16-34 years reporting 20% use, while for Māori PIEDs injecting expanded from 15% for 16-24 year-olds to 20% for 25-34 year-olds. As previously discussed, this is an increasingly prevalent drug category differing from more commonly injected psychotropics and is potentially also associated with clients who do not see themselves as “drug users”, i.e. a stigmatised group. This is a phenomenon that potentially adds risk, where clients ignore safe injecting practices and harm reduction education relating to this. As noted above, NEST is currently exploring the implications of PIEDs injecting and staff knowledge of these clients and PIEDs use, through a research partnership with Auckland University's School of Pharmacy.



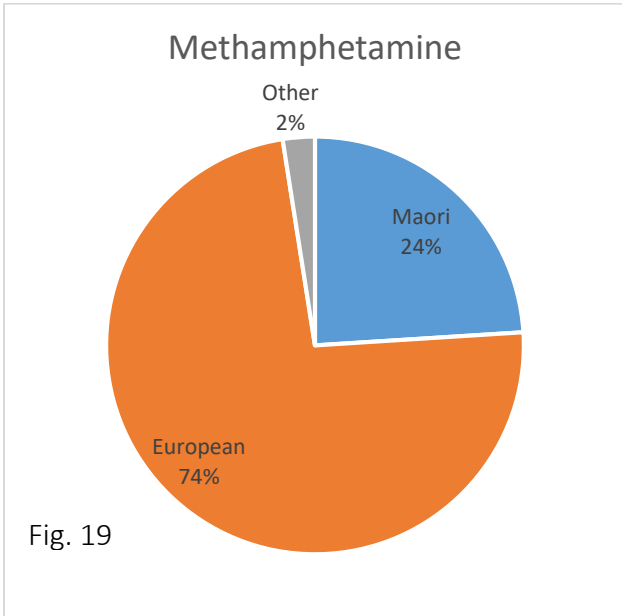


Fig. 19

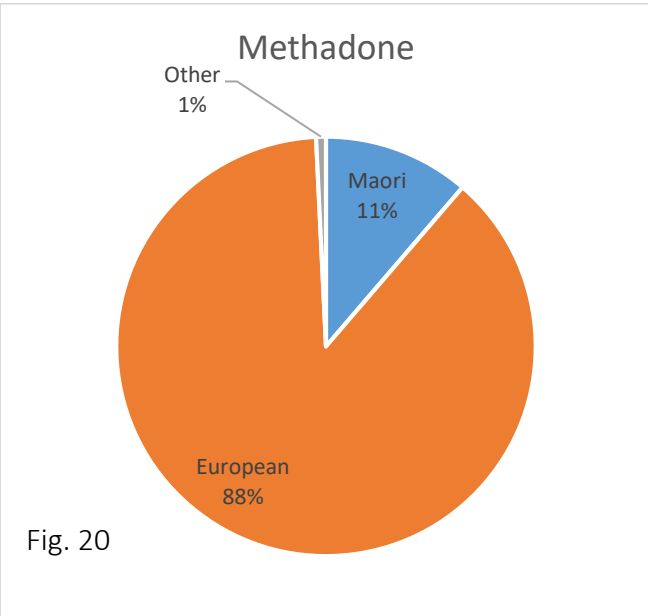


Fig. 20

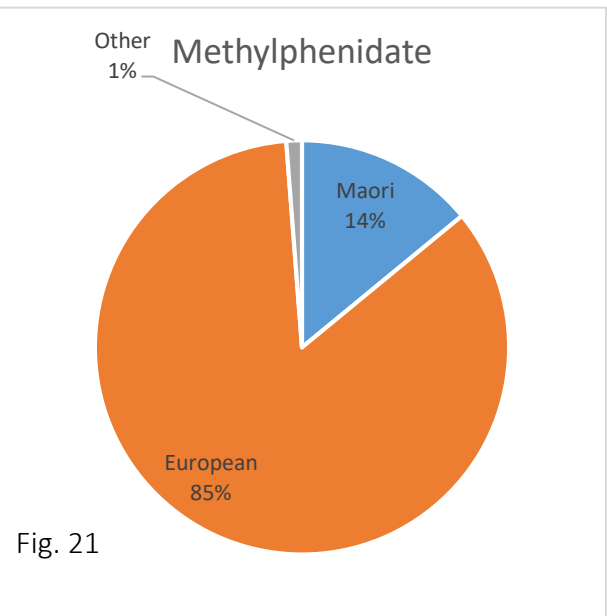


Fig. 21

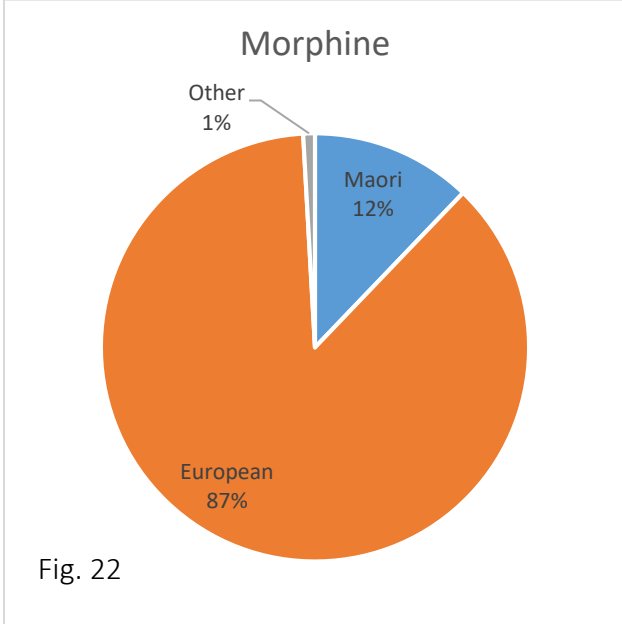


Fig. 22

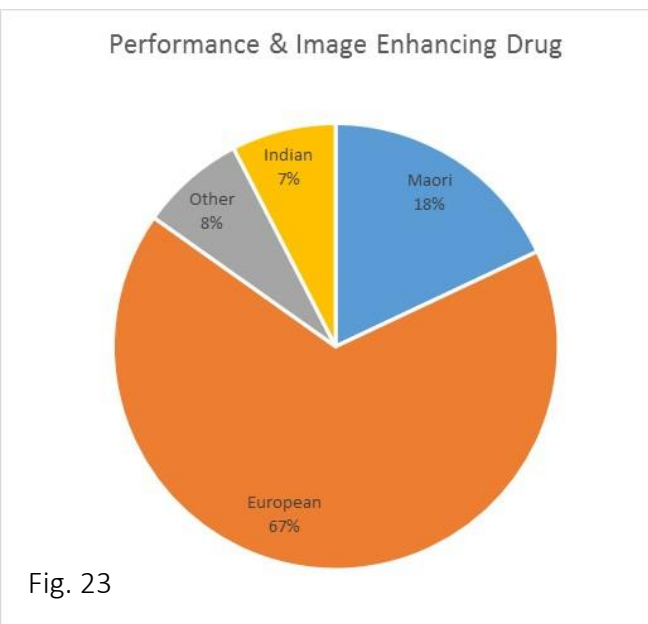


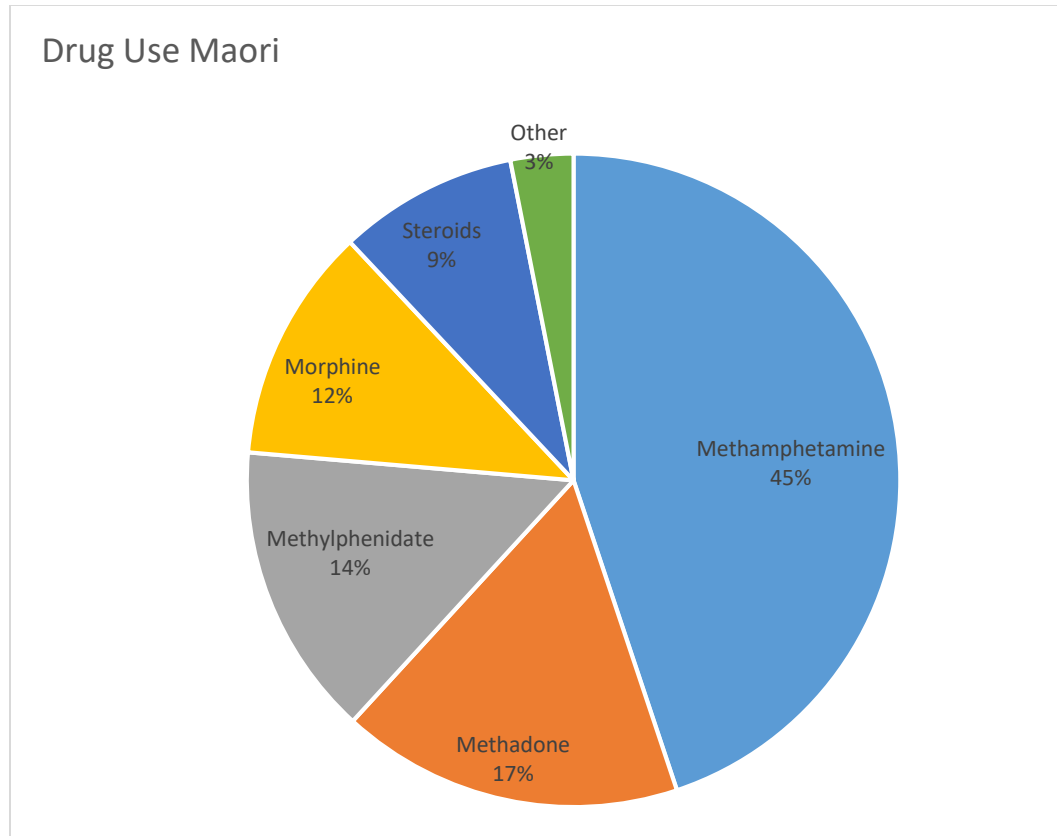
Fig. 23

**Comments:**

Methylphenidate, methadone and morphine are equivalently and most commonly injected by NZ European clients (85-88%) compared with Māori (11-14%). Methamphetamine is disproportionately injected by Māori (24%, Fig. 19) relative to their population percentage nationally (16%). While NZ Europeans are overall the largest injectors of PIEDs, proportionate to their percentage of the national population, they are less likely to inject these drugs, compared to some extent with Māori (18%), and notably 'other' (8%) and Indian ethnicities (7%), who are over represented. The Māori and Indian statistics suggest that increasing attention should be paid both to methamphetamine and PIEDs drugs, and the populations that are using them disproportionately, i.e. respectively Māori, and non-NZ European 'other' and Indian ethnicities.

Figures 19-23: Drug use by ethnicity, from four regions July 2020 to December 2021, and Northern Region December 2021

## Occasion of service - Drug type - Māori



### Comments:

While Māori are slightly over represented amongst NZNEP clients (18.2% v 16.6% of the national population), as previously discussed, they are disproportionately using methamphetamine compared to NEP clients generally (45% vs 30% in all ethnicities [Figure 4]). This is most evident in the preceding figures, for example, in the 16-24 age group two thirds of young Māori reported injecting methamphetamine, with the trend extending across all age groups. Along with negative consequences of use of methamphetamine per se, its use with other drugs, particularly alcohol and opioids, is known to increase harmfulness (Darke et al., 2008), thereby adding further impetus to the need for the NEP to support this client group.

Figure 24: Proportions of drugs reported injected by Māori clients, Data of four regions July 2020 to December 2021, and one month of Northern Region December 2021

## Naloxone

### Comments:

NZNEP Outlets have distributed 304 Naloxone kits since they were first made available in May 2020 (*Table 1*). Distribution is facilitated via Opioid Substitution Treatment services (OST) and drug treatment (AOD) services, with 12-month's funding initially available via the Ministry of Health's Acute Drug Harm Discretionary Fund. However, this funding ceased in July 2021, leaving it to individual DHBs and OST services to determine if further kits will be funded in their regions. Additionally, national availability has not been consistent due in part to availability of kits being dependent on the attitude of OST and AOD services and their interpretation of regulations. For example, DHDP's Palmerston North and Whanganui NEXs only recently (i.e. October 2021) received kits diverted from DHDP Wellington, due to services in the former areas being unable or unwilling to supply directly to those NEXs. These inconsistencies, i.e. both funding generally and varying across regions, highlights the vulnerability of clients to overdose, where kits may not be available or there is reduced availability. The inequities associated with varying availability reinforce the need for nationally consistent service provision, where all PWID have equal access to potentially lifesaving product.

Two types of kits are available: nasal spray and ampoule. The latter come in 2-ampoule and 5-ampoule kits, however, the nasal spray kits are preferred due to ease of use. The NEP is currently aware of three reports where Naloxone supplied by the NEP has been used in an overdose situation to save lives.

While distribution from NEXs is recorded on VEND, the *ad hoc* nature of Naloxone provision has resulted in variable distribution across regions, which will potentially have impacted on clients' opportunities to learn about and receive the kits. Due to this and the issues noted above, NEST undertook to evaluate distribution and uptake of Naloxone nasal spray (Nyxoid) kits at two NEX sites (Palmerston North and Nelson), in partnership with the NZ Drug Foundation, who have funded a further 60 kits via a public fundraiser and are also partially resourcing the project. The evaluation was originally timed to commence before the end of 2021. It was delayed beyond the end of December 2021 as there had not been sufficient time for frontline staff to receive the required training for delivering the Naloxone and overdose training to clients, and conducting the evaluation, including administering the questionnaire. Further delay ensued due to COVID and reduced onsite staffing levels at both Nelson and Palmerston North. However the evaluation is now well underway.

Table 1: Distribution of Naloxone kits per NEX for the period May 2020 to December 2021, and current stocks

OUTLET	KIT TYPE	To Sept. '21	Oct-21	Nov. '21	Dec. '21	Total Sold	Distribution per trust	# of kits currently in stock
EAST ST AK	Nasal Spray	10	4	17	9	40	52 ADIO	85
AK SOUTH	Nasal Spray	4	0	0	0	4		6
WELLSFORD	Nasal Spray	1	5	2	0	8		6
HAMILTON	Ampoule Kit	74	2	2	1	79	100 MIDLANDS	14
NEW PLYMOUTH						8		7
ROTORUA						6		7
MT. MAUNGANUI						7		
WELLINGTON	Ampoule Kit	79	1	3	1	84	112 DHDP	29
WAIRARAPA	Ampoule Kit	7	0			7		4
NAPIER	Ampoule Kit	13	3	2	0	18		23
PALM. NORTH				0	3	3		32
WHANGANUI								4
DUNEDIN	Ampoule Kit	27	0			27	31 DISC	
NELSON	Ampoule Kit	4	0			4		
TIMARU/ASHB.	Ampoule Kit	6	1	2	0	9	9 TNET	

## Discussion

In the present report (to the December 2021 quarter) there is only limited change in reported data from the preceding quarter. This is reflected in the following discussion. There remain five areas requiring further comment in this report:

- NEP client characteristics
- Drug use, i.e. the association of drug type with specific NEP client groups
- Trends in specific drug types and in particular regions
- National consistency regarding data collection
- National policy where this intersects with the needs and obligations of the NEP.

It is evident that while some client groups are declining in terms of NEP service utilisation (e.g. NZ European clients) there is simultaneously an emerging cohort of younger Māori. This group will become of increasing significance to the programme due to the aging of longer-term clients, a majority of whom are of NZ European ethnicity. This should be of concern to the NEP as culturally, its origins and focus historically lay with NZ European injectors. The culturally homogeneous orientation of the NEP is evidenced by Stephen Luke's otherwise excellent PhD study, a theoretically informed social history of the programme, failing to even mention Māori (Luke, 2007). As the programme develops, therefore, it should be encouraged to build networks and alliances with Māori health providers, as well as services appropriately culturally aligned with these, particularly those with a harm reduction focus. Consequently, whakawhanaungatanga should become a key component of any developmental strategy planned to be implemented by the programme going forward.

Having noted the above, at the time of writing (March 2022), the Ministry of Health is in the process of reviewing proposals for a reconfigured harm reduction and needle and syringe programme, following its release of a request for proposals (RFP) in January 2022, for a single provider to deliver a revised programme. Consequently, it is likely that some of the issues identified above will be required to be addressed by the new iteration of the programme.

Notwithstanding the above, the most salient issue regarding drug use by client type concerns Māori clients and their use of methamphetamine. As noted in preceding comments (e.g. regarding *Figures 2, 12, 14, 16, 18, 19* and *24*), Māori and particularly young Māori (16-34 years) report a significantly higher prevalence of methamphetamine injecting. Along with the acute harms associated with its injecting, including those associated with combining methamphetamine with other drugs such as alcohol and opioids, as well as risks of BBV exposure, its cumulative harm due to use over an extended period is increasingly recognised (Darke et al., 2008). Therefore, given the emerging cohort of younger Māori clients, it is likely that this group will experience significant physical and mental health issues as they age. While dedicated health services will be faced with meeting the future needs of this cohort, the NEP's position as a current service provider to them places it in a crucial position to be able to ameliorate harm or reduce its severity. Hence it is vital that the programme recognises this opportunity and increases its capacity appropriately. Again, whakawhanaungatanga becomes essential and along with Māori service providers the NEP should continue to nurture its relationships with research partners. In this regard the partnerships it is presently developing with researchers at Auckland and Otago Universities are of significance and should be encouraged. Additionally, while improving cultural capacity and appropriate service delivery, existing clinical services should not be neglected in the face of

changing drug use and client makeup. Attention will need to be paid to increasing the number of NEXs with nurses, nurse specialists, GPs and clinics, as the NEP provides a trusted front door to a cohort of vulnerable clients with multiple needs who are reluctant to utilise mainstream services. While addressing these needs will inevitably entail increased resourcing, this should be viewed as an investment in the avoidance of future health costs, as a recent report commissioned by NEST indicates, where it was calculated that every dollar invested in the NEP returned \$6.79 on avoided health care costs (Keen and Western, 2021).

A trend worth noting seen over several quarters in the DISC and NEXT regions, is the relationship between methamphetamine and methylphenidate use. When reports of methamphetamine use decrease in these regions, a corresponding increase in methylphenidate use is seen. This trend is also present in the DHDP region but due to the limited data available, it is difficult to draw conclusions. A similar pattern can be seen when methamphetamine use increases as there is a corresponding drop in methylphenidate use in the DISC and NEXT regions. This trend can also be seen in the Midlands region in two separate quarters, though not as consistently as seen in the DISC and NEXT regions. The trend could be explained by people who use methamphetamine using methylphenidate as an alternative when methamphetamine supply is limited and/or price increases and then returning to methamphetamine use when supply increases and/or price decreases. The changes in methamphetamine supply can likely be attributed to the ongoing Covid-19 pandemic and its impact on international borders and shipping and the periodic lockdowns within New Zealand.

Injecting methylphenidate tablets can be particularly harmful, particularly if PWID do not filter their drugs using a micron wheel filter (Farquhar et al, 2002). People injecting methamphetamine in NZ commonly do not filter their drugs at all (Ponton et al. 2020). There is high risk for potential harm if people who typically inject methamphetamine switch to injecting methylphenidate and apply their usual practice of not filtering or only using cigarette filters. Whilst it is best practice for PWID to wheel filter all injections, it is particularly important for methylphenidate as methylphenidate formulations contain binders and fillers that can cause pulmonary emboli, talcosis and other serious complications (Roux et al, 2011). Frontline staff should be encouraged to discuss wheel filtering with any clients who use methylphenidate who do not purchase wheel filters with injecting equipment. This emphasises the importance of wheel filters being added to the list of free equipment.

Also of note is the decreasing trend of morphine use, particularly in the DISC and Midlands regions, though this trend is also apparent in the NEXT region over the last 3 quarters. The trend is also apparent in the limited data available for the DHDP region. A likely factor contributing to this is the changes to the morphine formulations available made by PHARMAC in late 2019 and the increased prevalence of morphine / homebake powder (Ponton & George 2020). Many NZ PWID consider powdered opioids less desirable than opioids in pharmaceutical form due to the unknown purity and potency of powdered opioids and the potential for adulteration. A trend potentially related to the decreased use of morphine is an increase in methadone use in the DHDP and NEXT regions which roughly corresponds to the decrease in morphine, suggesting people who used morphine may have substituted it for methadone as supply of their preferred morphine formulation decreased or because the replacement morphine formulation was not as desirable to them.

While methamphetamine is a clearly significant and emerging concern, it should not obscure the need for the programme to maintain close relationships with its aging cohort of clients who use opioids. This group will likely experience significant health issues associated with their lengthy injecting careers, including vein damage and greater likelihood of having been exposed to HCV. Additionally, as with all people using opioids chronically, they will face other issues including bowel dysfunction due to chronic constipation. Consequently, they should become a priority focus of the programme and their needs add urgency to establishment of broader health services at current NEP dedicated NEXs where these do not exist, as well as the extension of services where they do and, again, the development of relationships with relevant services where the establishment of on-site services is not practicable. Regarding BBVs generally and especially HCV, it goes without saying that those younger clients within their first five years as PWID should also be a high priority, in terms of prevention, testing and early treatment. In this

regard the programmes peer workers are ideally placed to provide expertise and support, but require the appropriate resourcing to do so. An example of this would be the establishment of a peer navigator component of the programme, such as exists at DISC's Rodger Wright Centre, with their Māori outreach worker, Patchz Mackinnon.

A final group of note is the increasing cohort of clients who use PIEDs. In terms of ethnicity, at 18% Māori appear somewhat over represented in this group, while the catch all 'other' ethnicity (8%) and notably, Indian (7%), certainly are. The latter are of particular interest as they represent a specific cultural group that historically have not been focused on by the NEP. Their high profile as people who use PIEDs underscores the need for the NEP to change with the times, as in fact the cultural make up of Aotearoa NZ is, a phenomenon highlighted by the recent release of a report into the diversity of Asian youth in Aotearoa NZ (Peiris-John et al., 2021). In general terms, the programme has less knowledge about clients who use PIEDs and their needs, and therefore there is an opportunity for staff education and potentially a reorientation of services to encourage engagement with this group who tend not to view themselves as 'drug users'. It is pleasing in this regard that the programme's national office (NEST) has initiated the above pilot research project with the University of Auckland's School of Pharmacy, to understand staff knowledge of these clients and their drug use. At the time of writing the project is on-going, with data analysis of the pilot presently occurring and consultations on its next phase being undertaken.

With the programme currently under review in the context of the Ministry's pending decision on its RFP, the issues relating to inappropriate collection of data on ethnicity may be set aside, other than to reference that the previous report discussed these in greater detail. The interested reader is therefore referred to the preceding report.

Additionally, the matter of correctly reporting ethnicity is not merely one of appropriateness. Given the needs of specific groups and obligations to them - Māori being an obvious example - improvement of service delivery and appropriately targeted harm reduction information is facilitated by having a clear understanding of the client groups utilising the programme.

As also discussed in the preceding report, data collection generally lacks consistency across the programme, with an important example being the recently initiated practice of asking clients at each visit, what drugs they are using. It will be evident from preceding comments (e.g. *Figures 5-9*) that there are significant variations in drug use patterns across regions. The advantages of knowing about these patterns is equally obvious, with opportunities to target clients likely exposed to harms associated with specific drugs, such as the relatively large group injecting methylphenidate (a drug with a particularly harmful profile) reported from the Timaru service. While it is frustrating that not all regions consistently supply client drug use data, as with the earlier discussion regarding ethnicity, the pending RFP referenced the need for greater consistency in this area, including the establishment of a national minimum data set. NEST has already proposed an example of such a data set to the Ministry, which was received favourably.

The two preceding issues, i.e. drug use data generally and the collection of client data highlight the extraordinary value of undertaking regular seroprevalence surveys, which enable the collection of a range of risk behaviours along, with BBV prevalence. It is now almost a decade since a national seroprevalence survey (BBVNEX 2013) was undertaken and the lack of up-to-date data associated with such a survey is ever more keenly felt. The national office has recently undertaken meetings with the NEP's Australian counterpart regarding options for participating in the 2022 iteration of their annual survey and while the Australians are supportive of such a partnership this will not occur without specific funding from the Ministry. Additionally, the establishment of the National Hepatitis C Action Committee and the involvement of NEP staff with this initiative has added impetus to the reimplementation of the serosurvey. The value of this enterprise cannot be overstated and it is hoped that the Ministry will be supportive of this.

The final issue highlighted in the present report concerns the lack of consistency in the availability of Naloxone, where this is supplied via AOD and OST services, to NEXs for subsequent distribution to clients as take home kits. This is a complex issue that captures both the actual commercial availability of Naloxone in different formulations, i.e. ampules vs pre-loaded syringes vs nasal spray, and government policy (funding and regulations). There is no question that it is desirable for clients to have ready access to Naloxone and this is supported in many parts of the sector. The programme is aware of at least four reports where Naloxone distributed via NEP outlets was administered to reverse an overdose. It is likely, therefore, that the Naloxone provision will require intervention at the government policy level, both an example of the programme's limited resources being diverted to push for what appears to be important yet obvious solution to a genuine harm, but also an example of the NEP's effectiveness as an industry shaper in a sector aiming to meet the needs of a vulnerable population. It remains to be added that the now up-and-running Naloxone evaluation, timed to run for approximately three-months, will hopefully generate sufficient data to further demonstrate the usefulness of Naloxone's availability for NEP clients.

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