A Review of Enablers and Barriers of Indigenous Drug Users Accessing Needle and Syringe Programs – a report for the COAG Multilateral Group on Needle and Syringe Programs

June 2008
A Review of Enablers and Barriers of Indigenous Drug Users Accessing Needle and Syringe Programs – a report for the COAG Multilateral Group on Needle and Syringe Programs

Prepared for Department of Health and Ageing
GPO Box 9848
Canberra ACT 2601
June 2008
## TABLE OF CONTENTS

### Executive Summary ................................................................. i

1 **Introduction** ........................................................................... 1  
   1.1 This report ........................................................................... 1  
   1.2 Background to the study ..................................................... 3  
   1.3 NSP services and policies in the States and Territories .......... 8  
   1.4 Research methods .............................................................. 10  

2 **Injecting Drug Use among Indigenous Australians** ................. 14  
   2.1 Information from previous research ..................................... 14  
   2.1.1 Levels of injecting drug use ........................................... 14  
   2.1.2 Characteristics of Indigenous IDUs .................................. 14  
   2.1.3 Patterns of drug use ..................................................... 15  
   2.1.4 Obtaining clean equipment ........................................... 15  
   2.1.5 Safe and unsafe injecting .............................................. 15  
   2.1.6 Suggested improvements .............................................. 16  
   2.2 Findings from the present study ........................................... 16  
   2.2.1 Levels of injecting drug use ........................................... 16  
   2.2.2 Characteristics of Indigenous IDUs ................................. 19  
   2.2.3 Drug choice and availability .......................................... 20  
   2.2.4 Drug user culture ....................................................... 21  
   2.2.5 Obtaining clean equipment ........................................... 23  
   2.2.6 Safe and unsafe injecting .............................................. 24  
   2.2.7 Remote communities .................................................. 26  
   2.2.8 Role of Aboriginal Medical Services .............................. 27  
   2.2.9 Imprisonment ............................................................. 28  
   2.2.10 Summary ................................................................. 29  

3 **Access to NSP services** ......................................................... 31  
   3.1 NSP access in general ........................................................ 31  
   3.1.1 Hours of operation ....................................................... 31  
   3.1.2 Location .......................................................................... 32  
   3.1.3 Design and layout ........................................................ 33  
   3.1.4 Staff attitudes ............................................................... 34  
   3.1.5 Range of services offered ............................................. 34  
   3.1.6 Supplies and cost ........................................................ 35  
   3.1.7 Legal and policing issues .............................................. 36  
   3.1.8 Politics ........................................................................... 37  
   3.2 Factors relating to Indigenous access in particular ................. 37  
   3.2.1 Stigma, shame, anonymity ............................................ 38  
   3.2.2 Indigenous-friendly services ........................................ 40  
   3.2.3 Views within communities and in the Indigenous health sector ... 43  
   3.2.4 Young drug users ........................................................ 45  
   3.2.5 Supporting access by women ........................................ 46  
   3.2.6 Different types of service .............................................. 46  
   3.2.7 Resources ....................................................................... 52  
   3.2.8 Urban, regional and rural locations ............................... 53  
   3.2.9 Good practice ............................................................. 55
## 4 Conclusions and recommendations

4.1 NSP access in general
4.2 Indigenous access
4.3 Types of NSP service
4.4 Other issues
4.5 Range of possible responses
4.6 Key recommendations

Appendix A  People and organisations consulted
Appendix B  Services and policies in the States and Territories
Appendix C  Literature review
Appendix D  Discussion guide for health services /NSP management and staff/other relevant community organisations
Appendix E  Discussion guide for injecting drug users
Appendix F  Plain English Information Sheet
Appendix G  Indigenous populations in each State and Territory
Appendix H  Examples of good practice
Acknowledgements

Urbis expresses its thanks to the members both of the Reference Group and of the COAG Group on Needle and Syringe Programs for their advice and suggestions over the course of the study. As Appendix A makes clear, many other people across Australia contributed to the project in various ways, and we have greatly appreciated their willingness to share their knowledge, ideas and insights. In particular we thank all of those working in Needle and Syringe Programs for their co-operation and assistance, and the drug users in various locations who made unique contributions from their own experience and understandings.

Urbis remains responsible for the report and its findings.
Reference Group
Dr Cindy Shannon, Chair
Dr Linda Banach, National Aboriginal Community Controlled Health Organisation (NACCHO)
Michael Costello, Australian Federation of AIDS Organisation (AFAO)
Meghan Hayes, The Pharmacy Guild of Australia
Christopher Mackenzie Davey, Office of Aboriginal and Torres Strait Islander Health (OATSIH)
Sue Morley, National Indigenous Drug and Alcohol Council (NIDAC)
Tamara Speed, Australian Injecting and Illicit Drug Users League (AIVL)
Dr Carla Treloar, National Centre in HIV Research, University of NSW
John Van Den Dungen, The Connection
Gino Vumbaca, Australian National Council on Drugs

COAG Group on Needle and Syringe Programs
NSW: Owen Westcott
ACT: Helen Delany
Victoria: Roland Jauernig
South Australia: Stephen Lymb
Western Australia: Jude Bevan
Northern Territory: Jamie Broadfoot
Queensland: Robert Kemp

Study Team
John Schwartzkoff
Kerry Reed-Gilbert
Karen Milward
Samantha Ross
Nichola Keevey
Murray Benton
Executive Summary

Introduction
This report was commissioned by the Department of Health and Ageing (DoHA) in consultation with members of the COAG Multilateral Group on Needle and Syringe Programs. The purpose of the study was to examine factors that either deter or support access to Needle and Syringe Program (NSP) services among Aboriginal and Torres Strait Islander injecting drug users (IDUs). The importance of this issue reflects, among other things, the fact that rates of hepatitis C (which is closely associated with infection as a result of unsafe injecting) are disproportionately high, and apparently continuing to increase, among Indigenous Australians.

The main elements of this qualitative study were a review of the findings of previous research on relevant topics; consultation with Health Department personnel in the States and Territories; consultation with other experts and stakeholders; and fieldwork visits to 14 metropolitan, regional and country locations in seven states and Territories.

Findings
Several earlier studies have examined aspects of injecting drug use and blood borne virus (BBV) infection among Indigenous Australians; in general the findings of the present study were consistent with the outcomes of previous research. Key findings include the following:

- There are no comprehensive data on the numbers of Indigenous Australians who inject drugs or on the numbers of Indigenous IDUs who currently access NSP services. However the available evidence suggests that, if anything, injecting drug use may be more common in the Indigenous than in the non-Indigenous population, and that there are substantial numbers of Indigenous IDUs who do have some contact with NSP services.

- There appears to be much in common between Indigenous and non-Indigenous IDUs. Among both groups, for instance, the average age of first injecting is evidently around 18 years; in both groups female injectors represent a significant minority; and the drugs most commonly injected in various locations appear to be similar as between Indigenous and non-Indigenous IDUs.

- It is common for Indigenous IDUs to inject drugs in the company of friends, relatives or a partner. Often these companions may be Indigenous also, but there are nevertheless high levels of interaction between Indigenous and non-Indigenous IDUs.

- NSP outlets mostly see IDUs, both Indigenous and non-Indigenous, aged between about 25 and 45. Younger IDUs - including Indigenous IDUs - may be at significant risk of BBV infection as a result of inexperience, lack of knowledge and reluctance to use NSP services.

- Many of the stakeholders who contributed to this study believed that understanding of the risk of contracting HIV and hepatitis C from sharing a needle was widespread among Indigenous IDUs. Sharing of injecting equipment - with or without an effort at cleaning needles between users – was nevertheless reported as fairly common. Reasons for sharing include lack of sufficient equipment, being part of a group that acquires and uses drugs together, confusion, lack of knowledge, and sometimes a lack of concern with the consequences.

- It was generally thought that there was at present little drug injecting in remote Indigenous communities – with Cape York possibly an exception. However the situation in remote areas needs to be kept under review because there are likely to be significant dangers if circumstances change.

- Relatively few Indigenous-specific health services currently provide NSP services. The reasons for this include the ‘crowded Indigenous health agenda’, on which a disease such as hepatitis C
does not at this stage rank very high, and the fact that the NSP’s harm reduction approach is seen as running counter to the abstention philosophies which are common in Indigenous communities. By the same token, Indigenous IDUs may feel that their privacy is better protected if they do not use Indigenous-specific services.

- At present Indigenous IDUs are therefore largely dependent on mainstream services for the supply of clean needles and syringes, and in various ways they encounter barriers and enablers similar to those experienced by other IDUs. Thus, like others, they stand to benefit from improvements such as longer hours of operation of NSP outlets and increased geographical coverage, and from siting and design of outlets which afford privacy.

- As a doubly marginalised group, however, Indigenous IDUs may be especially hesitant to approach an NSP outlet, and it appears to be common for them to try to get friends or acquaintances to obtain equipment on their behalf. If Indigenous use of NSP services is to increase, IDUs need to know that they will be treated helpfully and courteously and that their circumstances will be understood. Access is thus likely to be improved by NSPs taking steps to ensure that they are, and appear to be, inclusive and ‘Indigenous-friendly’.

- Because Indigenous communities, both urban and rural, are often small and close-knit, Indigenous IDUs are likely to be particularly concerned about privacy and anonymity. Indigenous IDUs who live in country areas, however, are generally likely to have limited access to services and little choice as to where they seek injecting equipment.

- There is no one type of NSP outlet which best meets the needs of Indigenous clients. However the study indicates that Indigenous IDUs are sometimes reluctant to use pharmacy and hospital outlets, and that they value mobile and outreach services where these are available. Vending machines (which are few in number except in New South Wales) facilitate access, both in city and country areas, because of their availability at any hour and because they avoid the need for IDUs to interact with a possibly unsympathetic worker.

- Partly because there has in the past been relatively little advocacy from the Indigenous health sector on behalf of IDUs, mainstream outlets may find it difficult to know how well or badly they are meeting the needs of Indigenous clients, and how they could reduce barriers for those whom they are not effectively reaching. Therefore it is to be welcomed that NACCHO and its affiliates have in recent years been more actively engaged in this area.

- This study did not specifically examine issues relating to drug injecting in prison or ways of reducing the harms associated with this. However, particularly given the high rates of incarceration among Indigenous Australians, both male and female, this is an important matter that demands attention.

- The suggestions for improving access which emerged from this study were of several different kinds. Some focussed on fostering effective links or partnerships between NSP planners and providers and the community controlled health sector, so as to ensure that provision of NSP services is more consistently informed by Indigenous perspectives and insights. Some related to NSP improvements or developments of a general kind, while others aimed to address barriers perceived as affecting Indigenous IDUs in particular. Some related to initiatives within Indigenous health services or Indigenous communities.

Key recommendations

1. In consultation with communities, the Australian, State and Territory Governments should give high priority to identifying effective ways of reducing rates of HCV infection among young Indigenous Australians, and implement policies, projects and practices designed to achieve this.

2. The Australian, State and Territory Health Departments should promote and support active cooperation between the Indigenous health sector and those responsible for planning and delivering NSP services, and in particular ongoing involvement by NACCHO and its affiliates in relevant research and policy development.
3. At this stage improving access to mainstream NSP services represents the most effective way of facilitating access for Indigenous IDUs. This needs to be pursued both through general service improvements (eg continuing improvement in the number and location of NSP outlets, longer hours of operation including evenings and weekends, wider use of vending machines, offering IDUs some choice of services wherever possible, flexibility in amount and types of equipment offered), and also through initiatives designed to address the needs of Indigenous IDUs in particular. Policies and practices specifically addressing Indigenous access should include:

- training in cultural competence and safety for mainstream NSP workers
- consultation by NSP planners and service providers with relevant Indigenous organisations, Indigenous communities and Indigenous IDUs themselves
- employment of Indigenous staff where this is considered appropriate
- expansion and improvement of NSP services in regional and rural areas in particular, including ongoing training for people providing services through secondary outlets and pharmacies
- increased use of mobile and outreach services
- use of posters, sign, brochures and the like which indicate that service providers are Indigenous-aware and Indigenous-friendly
- more secure funding for innovations, projects and pilot programs designed to address Indigenous needs.

4. Where Indigenous organisations are willing to deliver NSP services there should be continuing support and encouragement for them to do so; the possibility of offering some funding assistance for this purpose should be considered. Indigenous health services which do not wish to offer NSP services directly should be encouraged (for example through assistance with staff training) to play an ancillary role through liaison with NSP outlets in their area, providing information to clients and referring people to NSP services where appropriate.

5. DoHA and the State and Territory Health Departments should give high priority to research and policy initiatives designed to address the issue of unsafe drug injecting in adult and juvenile prisons.

6. DoHA and the State and Territory Health Departments should make use of this report in undertaking consultation and information-sharing with Indigenous communities around the issues of blood-borne viruses, injecting drug use, and ways of reducing hepatitis C infection among Indigenous Australians.
1 Introduction

1.1 This report

This is a report on a national study commissioned by the Department of Health and Ageing (DoHA) in co-operation with the Health Departments of the States and Territories.

Australia has been a world leader in minimising the spread of HIV, hepatitis C and other blood-borne infections through the provision of Needle and Syringe Program (NSP) services that are designed to reduce unsafe injecting practice among drug users. Among other things the Australian approach has involved many successful partnerships between government and non-government bodies – the latter including drug user support and advocacy groups. However there is concern about increasing rates of hepatitis C infection among Indigenous Australians, which suggest that Indigenous injecting drug users (IDUs) may not be benefiting as much as they could from NSP policies and services.

In 2005 DoHA commissioned a National Needs Assessment designed to facilitate ‘a more strategic approach to the expenditure of national funds’ supporting Needle and Syringe Programs. One of the priority initiatives identified by that Needs Assessment was a study to examine enablers and barriers relating to Indigenous access to NSPs. The objectives of the present study were as follows:

- to consider current strategies across jurisdictions for supporting or increasing access to NSP services by Indigenous people who inject drugs
- to identify relevant enablers and barriers in diverse geographical areas (metropolitan, regional, rural/remote)
- to identify any particular types of NSP outlet or service that Indigenous IDUs are more likely to use
- to identify effective practices that could be more widely adopted as best practice models for increasing Indigenous access
- to describe characteristics of the ‘drug culture’ of Indigenous IDUs.

Research undertaken

A number of previous Australian studies have examined various aspects of drug use, BBV infection and use of services among Indigenous IDUs; the main research method relied on has been survey interviews with small samples of Indigenous IDUs. Such studies have generated valuable information, although there are major difficulties in obtaining appropriate samples of respondents and in assessing the extent to which these are representative of the Indigenous IDU population.

Given the policy-related objectives of the present research, a more wide-ranging approach was desirable. Key elements of this study included the following:
Fieldwork visits to a range of cities and towns across Australia, involving consultation with substantial numbers of relevant individuals and organisations such as Aboriginal community controlled health services, drug and alcohol workers, sexual health workers and NSP service providers, as well as small numbers of Indigenous IDUs. The locations visited by the study team are listed in section 1.3 below.

These research visits were conducted by two-person teams which included an Indigenous and a non-Indigenous researcher.

- Consultation with relevant Health Department personnel in the States and Territories.
- Consultation with a range of other organisations or individuals identified as key stakeholders, including the Australian Injecting and Illicit Drug Users League (AIVL), the National Aboriginal Community Controlled Health Organisation (NACCHO) and its State/Territory affiliates.
- A review of relevant literature.

The Reference Group

DoHA invited a range of key organisations and agencies to nominate representatives to form a Reference Group which could provide advice and guidance on conduct of the study. Members of the Reference Group are listed at the front of this report.

Urbis initially provided information about the study to the Reference Group, and sought their comments and suggestions, in a teleconference organised by DoHA in May 2007. Subsequently individual members of the Reference Group provided Urbis and DoHA with further advice or information on particular issues. A second teleconference with the Reference Group took place in November 2007, providing an opportunity for Reference Group members to comment on progress reports prepared by Urbis. Members of the Reference Group also offered comments on the draft version of the final report.

State and Territory Representatives

Urbis also received substantial expert assistance from State and Territory Health Department representatives on the COAG Multilateral Group on Needle and Syringe Programs – also listed at the beginning of this report.

Scope and limitations of the study

This was a qualitative research study focussing on practical policy questions around improving Indigenous client access to NSP services, and this was clearly reflected in the research methods adopted. The project was not designed to generate statistical information on Indigenous IDUs, on their use of drugs or on levels of BBV infection in this population – though the report contains references to data of this kind derived from other sources.
There is a range of different strategies that can be considered relevant to reducing the levels and impacts of BBV infection among Indigenous Australians – including, for example, more systematic screening and testing, community education initiatives, improved treatment and follow-up services, and suitable prison and post-release programs. (The National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008 accordingly reflects a range of different approaches and initiatives.) While this report makes some reference to broader issues of this kind, its focus is specifically on the harm minimisation strategy of improving access to NSP services.

Several important limitations of the study need to be noted. For example, this project involved consultation only with relatively small numbers of Indigenous drug users; further, these are not generally likely to have included people in the most marginalised or ‘hidden’ groups of IDUs. Since no research was undertaken in the Torres Strait, specific issues that may arise for Torres Strait Islander communities and individuals are not considered in this report\(^1\). Nor was research undertaken in Tasmania\(^2\). Although the particular towns and cities visited by the study team were chosen to reflect a broad range of geographical and social characteristics, the coverage was by definition selective. For instance, no specific information on Brisbane is included in the body of the report.

Another important limitation is that the study did not involve a specific examination of matters associated with drug injecting in prison – acknowledged by many as a significant issue in relation to the spread of hepatitis C (prison has sometimes been described as an ‘incubator’ of hepatitis C). More detailed and specific research is required on prison-related issues and on the ways in which these might be addressed.

It should also be noted that the study did not involve any broad program of consultation with Indigenous leaders or communities. The study team suggests that DoHA and the State and Territory Health Departments should consider ways of using the findings of this project as a basis for broader community consultations.

Needle and Syringe Programs were originally introduced in Australia to limited the spread of HIV, and this of course remains a key objective. Given the origins of this report, however, it focuses more consistently on issues relating to hepatitis C.

### 1.2 Background to the study

The research brief prepared by DoHA for this study (p B9) describes the background context in the following words:

---

1 A Queensland Health worker consulted in Cairns believed that there was in fact very little drug injecting in the Torres Strait – reflecting, among other things, the small size and remoteness of these communities.

2 The original brief called for research in six jurisdictions – New South Wales, Queensland, Northern Territory, Western Australia, South Australia and Victoria. Fieldwork in the ACT was added at the suggestion of members of the Reference Group, specifically because useful links with local IDUs could be accessed through The Connection in Canberra.
Studies have indicated that Indigenous people who inject drugs in both urban and regional areas have a higher prevalence of hepatitis C than non-Indigenous drug injectors. The Australian NSP Survey, National Data Report 2000-2004, commissioned by the National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, reports the prevalence of hepatitis C among Indigenous IDU has risen from 52% (compared to 54% non-Indigenous) in 2000 to 68% (compared to 59%) in 2004. This indicates that hepatitis C prevalence in Indigenous IDU is 9% higher than in non-Indigenous populations.\(^3\)

Given that reliable figures on the extent of Indigenous drug injecting are not available, and that NSP data do not give a clear or straightforward picture of the representation of Indigenous IDUs among NSP clientele, it is not possible to say with certainty that Indigenous use of NSP services is disproportionately low. It should be noted, for example, that around 10% of the respondents to the Australian NSP Survey over recent years have been Indigenous. Nevertheless the high and increasing rates of hepatitis C infection among Indigenous Australians are clear cause for concern. Among other things DoHA has noted that the long-term health impact of HCV infection among Indigenous Australians may be particularly severe given high Indigenous morbidity and mortality rates and Indigenous disadvantage in terms of access to health services, housing, education and the like.\(^4\)

A fact sheet issued by Hepatitis Australia in mid-2007 further highlights some of the key concerns that underlie the commissioning of this study. For example the fact sheet states that:

- In Australia some 264,000 people had been exposed to the hepatitis C virus, including a disproportionately large percentage of Aboriginal and Torres Strait Islander people.

- While Aboriginal and Torres Strait Islander people make up 2.4% of the total Australian population, it is estimated that they constitute 8.3% of the Australian population living with hepatitis C. This indicates that (by contrast with the HIV epidemic, where Aboriginal and Torres Strait Islander people have had much the same exposure rates per capita as the general population) Aboriginal and Torres Strait Islander people are considerably more likely to be exposed to the hepatitis C virus than are non-Indigenous Australians.

- Given that some two-thirds of hepatitis C notifications are reported without Indigenous status being recorded, it is possible the true rate of hepatitis C among Indigenous Australians is even higher; accurate data from Western Australia and the Northern Territory indicate that Aboriginal and Torres Strait Islander people account for around 10% of all new hepatitis C notifications.\(^5\)

---

\(^3\) The national NSP survey has subsequently shown a further rise in Hepatitis C infection to 71% of Indigenous NSP clients.


\(^5\) National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008
Currently it is estimated that some 22,000 Aboriginal and Torres Strait Islanders people are living with hepatitis C antibodies, among whom 16,000 are living with chronic hepatitis C. Although rates of hepatitis C infection in the non-Indigenous population have improved, rates of infection within the Aboriginal and Torres Strait Islander population continue to rise.

Other points made by Hepatitis Australia include the following:

- *The National Hepatitis C Strategy 2005-2008* identifies three main priority populations for which action is urgently needed – Aboriginal and Torres Strait Islander people who engage in risk behaviour, people in custodial settings, and people who inject drugs. In addition to being identified as a priority population in their own right, Aboriginal and Torres Strait Islander people are also significantly represented within these two other at risk populations. In particular Aboriginal and Torres Strait Islander people are several times more likely to be imprisoned than non-Indigenous Australians, and they make up some 27% of the total prison population. Additionally, since Aboriginal and Torres Strait Islander inmates often serve shorter sentences than non-Indigenous Australians, the rate of hepatitis C in custodial settings has greater potential to translate into increased infection rates within the general Aboriginal and Torres Strait Islander population.

- It is estimated that some 90% of all new hepatitis C transmissions are attributable to sharing of injecting equipment. Regular NSP surveys suggest an increase in participation in injecting drug use by Aboriginal and Torres Strait Islander people (who currently represent some 10% of the survey respondents) and also reveal an increasing prevalence of hepatitis C among Aboriginal and Torres Strait Islander participants.

- *The National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008* recognises the need for a whole of primary health care sector approach to addressing blood borne viruses in Aboriginal and Torres Strait Islander communities. A key priority of this strategy is access to Needle and Syringe Programs and the increased capacity of the health and community workforce to address all aspects of Aboriginal and Torres Strait Islander HIV/AIDS, sexually transmitted infections and blood borne viruses.

In 2006 the WA Department of Health issued a report on *The Epidemiology of Notifiable Sexually Transmitted Infections and Blood-Borne Viruses in Western Australia 1995–2004*. This presents statistical data for 2004 and data trends over the period from 1995. Among other things it contains an analysis of hepatitis C by Aboriginality, noting (p103) that ‘Aboriginal people were much more likely to be notified with … hepatitis C than non-Aboriginal people, and … this trend has increased over the last ten years’. Strikingly, ‘Aboriginal people of both sexes were 4 to 5 times more likely to be notified with unspecified hepatitis C than non-Aboriginal people, and 10 to 12 times more likely to be notified with

---

7 Quoting Australian Bureau of Statistics; 1301.0 – Year Book Australia, 2004
8 Australian NSP Survey; National Data Report 2001-2005, National Centre in HIV Epidemiology and Clinical Research
newly acquired hepatitis C infections’ (p107). The highest rates of hepatitis C notifications among Aboriginal people were in metropolitan Perth.9

Although the overall rates of HIV diagnosis are similar for Indigenous and non-Indigenous Australians, the patterns of HIV transmission are somewhat different; with transmission related to injecting drug use having become considerably more significant in the Indigenous population:

Among Aboriginal and Torres Strait Islander people, the percentage of HIV infections attributed to injecting drug use increased from 5% in 1992-1998 to 18% in 2002-2006. In the non-Indigenous population, the percentage of HIV infections attributable to injecting drug use has remained constant at 3% during these periods.10

A research project carried out in 2003-04 by the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC), in conjunction with Mandala Consulting, found – in the words of the present study brief (p B9) – that:

- among Indigenous Australians diagnosed with HIV, there is a higher proportion of IDUs diagnosed with HIV than non-Indigenous people;
- in NSW there is a greater proportion of Indigenous people with hepatitis C, attributable to injecting drug use;
- Indigenous people are diagnosed with hepatitis C at a younger age compared to non-Indigenous people; and
- there needs to be a fuller understanding of the risk of blood borne infections to Indigenous communities, which includes better understanding and support for the harm minimisation role of NSPs.

The Needs Assessment commissioned by DoHA in 2005 concluded that among Indigenous IDUs there was limited knowledge about blood borne viruses, high rates of risky behaviour, and limited or irregular use of NSPs.

The brief for the present study suggests that some of the factors adversely affecting Indigenous communities and Indigenous IDUs include:

- limited knowledge about the risks of contracting blood borne viruses such as hepatitis C from unsafe injecting;
- reluctance among some community leaders to acknowledge the fact of drug injecting among members of their communities;

---

INTRODUCTION

- tension between abstention and harm reduction models for addressing drug use problems.

A 2007 article in *The Hepatitis C Review* suggests several possible reasons why Aboriginal people are over-represented in the estimates of hepatitis C cases. These include the following:

- a higher proportion of young people in the Indigenous compared with the broader population
- significantly higher levels of incarceration compared with the non Aboriginal population
- the mobility of Aboriginal populations
- inadequate access to health services in general
- a low level of knowledge of hepatitis C within the Aboriginal community
- an increase in injecting drug use and its associated risks and harms.

The authors – James Ward and Sallie Cairnduff – go on to say that:

*Given the higher rates of hep C, a key issue for Aboriginal communities in addressing the condition is access to services such as harm reduction and other prevention, care, treatment and support services and an adequately prepared workforce.*

Ward and Cairnduff have also argued that Indigenous Australians are at increased risk of exposure to hepatitis C because of their marginalised status, and possibly higher rates of sharing of injecting equipment. Echoing DoHA observations referred to above, they note that hepatitis C infection is also potentially *more serious* for people in the Indigenous community because of other health risks such as high rates of smoking, obesity and Type II diabetes. As noted above, within the prison population Indigenous Australians are at particular risk because of their young average age and the fact that they are more likely than other groups to be serving relatively short sentences, relatively frequently, for relatively minor offences. Young Indigenous Australians (especially young women) are again heavily over-represented in juvenile justice institutions.

At a conference on hepatitis C held in Melbourne in June, 2007, the CEO of Hepatitis Australia stated that although there are an estimated 22,000 Indigenous Australians infected with hepatitis C, it remains difficult to get this issue onto the Indigenous health agenda. Changing this situation, she argued, will require sustained leadership both from governments and from Indigenous communities.

Some further statistical information relating to Indigenous drug injecting and BBV infection is set out in Appendix C to this report.

---


12 Presentation to the National Hepatitis C and Aboriginal and Torres Strait Islander Communities Workshop: Engaging Communities, Melbourne, 7 June 2007.
1.3 NSP services and policies in the States and Territories

Although largely funded by the Australian Government, the NSP is administered by the State and Territory Governments. Both government and community-based agencies – including in some cases drug user support and advocacy groups – are involved in delivering NSP services in various locations. There are some differences from one part of Australia to another in the ways in which NSP services are managed and delivered, and in the ways that issues relating to Indigenous access have been approached. Appendix B to this report provides some background information on services, issues and strategies in various jurisdictions.

The broad pattern is that in each State or Territory there are some primary NSP services, which have been established specifically to provide harm reduction services to IDUs and are staffed by specialist workers. Apart from making available clean injecting equipment, primary NSP outlets are designed to provide information and education, client advice and support and appropriate referrals. They also represent an important ongoing source of information on patterns of drug injecting behaviour, and may play a significant role in developing partnerships with and offering information and workforce training for other services. In most cases primary outlets provide clean needles and syringes to clients free of charge, though there may be a charge for other injecting items such as sterile water, filters, non-standard barrels and the like.

*The range of equipment provided at NSP outlets … varies across and within jurisdictions, partly in response to the types of drug being injected. As a minimum, NSP services provide needles and syringes, alcohol swabs and sharps containers for the safe disposal of used needles and syringes. NSP outlets may also provide condoms and lubricant and further injecting equipment, including sterile water, spoons, filters, winged infusion sets and tourniquets, sometimes on a cost-recovery basis.*

Typically, NSP outlets also accept and provide for appropriate disposal of used injecting equipment.\(^{13}\)

Primary NSP services are limited in number, and are complemented by secondary services that operate in a variety of settings – in particular, hospitals and community health centres. These are outlets where NSP activity is incidental to the service provider’s other responsibilities; the staff involved in distributing injecting equipment (usually at no charge) will generally have received some degree of information or training relating to this role. At community health centres, sexual health services and the like, the staff-member responsible is often the receptionist. Hospitals generally provide their NSP service through their Accident/Emergency departments, and play an important role in distribution because they are open at all hours (in many cases hospital-based NSP service are available only after hours).

Primary NSP outlets mostly operate at a fixed site, but some offer (in addition or instead) a *mobile* service by vehicle or occasionally by foot, which follows an established route and timetable to provide greater geographical coverage and to reach people who may be unable or unwilling to access a fixed site. *Outreach* services also involve distribution beyond the confines of a fixed site; these may involve workers travelling to various locations where they can expect to find groups of IDUs, and/or delivering equipment to particular groups of people or particular locations – possibly including some people’s homes\(^\text{14}\).

Many NSP outlets provide a return/disposal facility, without necessarily requiring that there be an exchange of equipment. Some set limits on the distribution of new equipment if used fits are not returned. In some cases clients of secondary NSP outlets can collect pre-packaged equipment from a cupboard or shelf without needing to have any contact with staff.

In some jurisdictions there are small numbers of Aboriginal health services or other Indigenous-specific agencies which act as secondary NSP services; historically there have been more of these in New South Wales than elsewhere. In general, as later sections of this report emphasise, Aboriginal medical services have not to date been particularly keen to take on this role, and in any event Indigenous IDUs have not necessarily been enthusiastic about using Indigenous-specific services.

In all jurisdictions *community pharmacies* play a significant role in the distribution of sterile injecting equipment – though that role is generally less central than it was in past years when primary and secondary services were less developed. Participating pharmacies are authorised to sell clean injecting equipment – which typically comes pre-packaged as a set of three or five needles and syringes, possibly with other equipment such as swabs, brief printed information on safe injecting and possibly a container for safe disposal (*Fitpacks*\(^\text{®}\) are designed in such a way that the plastic container holding the needles and syringes also provides a built-in disposal facility). The current charge for five needles is typically around $6 or $7. In New South Wales pharmacies a client can obtain a replacement *Fitpack* free on return of a used pack.

Vending or dispensing machines are available in several jurisdictions – but only in any significant numbers in New South Wales. From the consumer’s perspective these machines offer the advantage of anonymity and unlimited hours of availability, although a small cost is usually involved. From a service provider’s perspective, maintaining the machines and keeping them stocked can be something of a challenge, and there are also some complexities in determining what sorts of sites (eg in terms of visibility to passers by, ensuring safety for users and the like) are most suitable for this purpose.

In general the availability of NSP services is not widely advertised, with the result that word-of-mouth information is particularly important. Typical means of informing people about NSPs include brochures

\(^{14}\) The terms ‘mobile’ and ‘outreach’ are used in slightly different ways in different locations. For SAVIVE in Adelaide, for example, a *mobile* service involves responding to phone calls requesting equipment, while an *outreach* service is proactive, ‘going out to where people are’. In this report a ‘mobile’ service is generally one which follows a consistent path and timetable.
that may be displayed at health centres or other community services. Websites are used in some cases. In Mildura the study team heard that these sorts of methods are supplemented by community service announcements or late night television.

There are hepatitis C policies relating to Indigenous Australians at Commonwealth and at State level. Access to NSPs is identified as a strategic priority in the National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy. Several of the States and Territories have from time to time undertaken specific projects or initiatives with the aim of more effectively reaching and providing services for Indigenous IDUs. However, the point was made by stakeholders consulted during the present study that the funding for such initiatives has typically been short-term, and that realistic timeframes and ongoing funding are required if these issues are to be tackled more systematically.

At national level, Hepatitis Australia in 2006-07 conducted a project designed to map and scope hepatitis C education and prevention activities targeting Indigenous communities, and to identify priorities for future action. Among other things that work involved surveys of Aboriginal Community Controlled Health Services (ACCHSs) and of other relevant mainstream and community organisations. It identified a need for parallel streams of activity within the Indigenous health sector and in mainstream health, including expanded hepatitis C training for those working in community controlled health services and relevant cultural awareness training in the mainstream. It recommended collaboration on production of a ‘culturally appropriate consumer information resource targeting Aboriginal and Torres Strait Islander people’, collaboration in establishing hepatitis C workshops for the Indigenous health workforce, promotion of the benefits of NSPs ‘in all hepatitis C and BBV education programs for ATSI community health workers, clinical staff and community leaders’, and workshops to facilitate ‘the sharing of information and experiences of successful NSP provision by ACCHOs’.

1.4 Research methods

*Ethics approval*

Ethics approval for this study was sought in January 2007 from DoHA’s Departmental Ethics Committee (DEC), which includes specialist Indigenous advisors. The DEC requested DoHA and Urbis to provide certain additional information and clarification of a number of issues relating to the methods and approaches proposed; after receipt of this supplementary material the DEC gave its approval in March 2007 for the study to proceed.

---

15 Troy Combo, ‘Mapping and scoping of hepatitis C education and prevention activities targeting Aboriginal and Torres Strait Islander Communities’ - presentation at the Melbourne workshop on hepatitis C, June 2007.
Research undertaken

As previously explained, the methodology for this study reflected its focus on practice and policy issues related to facilitating NSP access for Indigenous clients. Main elements of the research included the following:

- **Fieldwork visits to 14 cities and towns** (located in all jurisdictions except Tasmania)\(^{16}\) involving consultation with people such as NSP managers and workers, management or staff of Aboriginal health services, people working in drug and alcohol services, drug user support groups, other relevant organisations and service providers, and a total of 40 Indigenous IDUs (both male and female) in seven different cities and towns. The locations visited by the study team were as follows:

  - **Northern Territory**  Darwin and Alice Springs
  - **Western Australia**  Perth and Carnarvon
  - **South Australia**  Adelaide and Port Augusta
  - **Victoria**  Melbourne and Mildura
  - **New South Wales**  Sydney, Dubbo/Wellington and Taree
  - **Queensland**  Cairns and Mt Isa
  - **Australian Capital Territory**  Canberra

The research visits were conducted by two-person teams including an Indigenous and a non-Indigenous researcher. In planning and carrying out these visits Urbis sought the guidance and advice of relevant organisations and service providers in each location, including for example local NSP services, drug user support groups and Aboriginal health services. The study team also requested the advice and assistance of such organisations in making contact with some IDUs in the local area, so that clients and potential clients of NSPs could have some direct input to the study. As noted above, 40 IDUs took part in interviews, in seven metropolitan and regional locations (Sydney, Darwin, Canberra, Taree, Dubbo, Cairns and Alice Springs). IDUs were interviewed either individually or in small groups, as they preferred; approximately two-thirds were male and one-third female. Appendix A lists the people consulted in each location (IDUs are of course not named).

Appendices D and E set out the discussion guides which the study team used in conducting semi-structured interviews with service providers and IDUs respectively. Background information on the study, its objectives and methods was provided to the various agencies and experts approached.

\(^{16}\) See footnote 2
by the study team. A Plain English information sheet (see Appendix F) was given to each IDU who expressed interest in participating in the research, and the researchers went through this at the start of each IDU interview to ensure that it was understood. Each participant signed an appropriate consent form, and a payment of $50 was made to each. The IDUs who were interviewed were recruited in approximately equal numbers through drug user groups and other community-based organisations, and through NSP outlets.

Obviously the material gathered from these interviews was qualitative in nature. The study team’s notes on each discussion were analysed in detail to identify common themes and observations, to clarify areas of similarity and difference from respondent to respondent and from place to place, and to highlight implications for facilitating access to services.

- **Consultation with relevant Health Department personnel in the States and Territories.**

  Interviews with Health Department personnel were recorded and analysed in similar fashion to the consultations conducted during the field visits.

- **Consultation with a number of other organisations or individuals identified as key stakeholders,** including the Australian Injecting and Illicit Drug Users League (AIVL) and State/Territory drug user organisations, National Aboriginal Community Controlled Health Organisation (NACCHO) and its State/Territory affiliates, the Australian Drug and Alcohol Council (ADAC), and the National Drug Research Institute (NDRI) in Perth.

- **A review of relevant literature.**

  The literature review focused primarily on Australian material that was of direct, practical relevance to the objectives of the study. Several key reports dealing with Indigenous drug use and the characteristics, needs and preferences of Indigenous IDUs in various parts of Australia were considered – for example:

  - Gray and others, *The Harm Reduction Needs of Aboriginal People who Inject Drugs*, 2001 (based on research in Perth and four regional centres in WA)

  - ADAC (SA) Inc, *Responding to the Needs of Indigenous People who Inject Drugs*, 2003 (based on research in Adelaide)

  - Aboriginal Health and Medical Research Council and Mandala Consulting, *Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or who Have Blood Borne Infections*, 2004

17 Since searches revealed only limited overseas literature directly relevant to the study, a systematic review of overseas material was not undertaken. However, various references to overseas literature appear where relevant in later sections of this report.
The findings of the literature review are set out in Appendix C, and are summarised at the beginning of section 2 of the report.
2 Injecting Drug Use among Indigenous Australians

2.1 Information from previous research

This part of the report begins by summarising findings from previous Australian research (discussed in greater detail in Appendix C) which may shed light on issues of interest in the present study.

2.1.1 Levels of injecting drug use

Statistical information currently available is not adequate to provide reliable information on the incidence or prevalence of drug injecting among Aboriginal and Torres Strait Islander Australians. However, survey research and analysis undertaken in several previous studies suggest that overall levels of injecting drug use among Indigenous Australians are relatively high (reportedly somewhat higher than in the non-Indigenous population) and that they have tended to increase over time.

2.1.2 Characteristics of Indigenous IDUs

**Gender**

Information presented in previous studies suggests that between about half and two-thirds of Indigenous IDUs are male. Thus, while female injectors may be in the minority, their numbers are significant.

**Age**

The research indicates that the age range of Indigenous IDUs is wide, and that many young people (teenagers and even children) are included. In both an early Queensland study conducted in 1996, and a 2003 South Australian study, the mean age of first injecting was around 18 years. The findings of other studies are generally consistent with this, recording that injecting commonly begins in the teenage years, and below the age of 12 in some cases. There is some evidence of a trend towards increasingly young initiation of drug injecting.

Available Australian data on age and gender among IDUs in general indicate little difference between Indigenous and non-Indigenous IDUs.

**Education**

The research indicates typically low levels of educational achievement among Indigenous IDUs.

**Imprisonment**

Previous studies report that many Indigenous IDUs, both male and female, have been in juvenile and/or adult detention, and that incarceration is more common among Indigenous than non-Indigenous IDUs.
2.1.3 Patterns of drug use

Earlier studies report that the drugs used by Indigenous IDUs may vary from time to time and place to place depending on availability, cost and the like. While injecting of amphetamines is common, heroin is often the drug preferred. People living in urban areas are generally more likely to report using heroin, while amphetamine use is more commonly reported in non-urban areas. It is quite common for amphetamines to have been used in other ways (eg smoked or ingested) before they are first injected. As is reported for IDUs in general, polydrug use is common.

Some of the previous research indicates that first-time Indigenous injectors typically have assistance from others more experienced, and that this most often comes from another Aboriginal person(s) who may be a relative, friend or partner. The existence of drug injecting among friends or family members can increase the likelihood of an individual beginning to inject.

According to a Western Australian study reported in 2001, relatively few Indigenous IDUs inject alone. Most tend to inject in company with some combination of friends, family members and partner. In the WA study, these companions were mostly Indigenous.

2.1.4 Obtaining clean equipment

Some earlier studies have reported community pharmacies as the main source of clean injecting equipment among Indigenous IDUs, but this is likely to reflect the fact that NSP services were less available in past years than they are today. Other sources include NSP outlets, secondary NSP services such as hospitals, Aboriginal medical services, and friends or drug dealers. The early Queensland study noted that younger people, in particular, were more likely to rely on friends than to visit a pharmacy or NSP. The South Australian study reported that it was common for Indigenous NSP clients to collect ‘bulk’ supplies of needles and syringes that they could then pass on to others who needed them.

Factors identified as inhibiting access to clean equipment include cost, limited hours of availability and, in particular, unfriendly or judgemental staff attitudes. Numbers of the Indigenous IDUs who participated in earlier studies have reported being reluctant to seek injecting equipment from an Aboriginal-specific service (eg an AMS) because of concerns about privacy, confidentiality, expertise and/or staff attitudes. Because of the anonymity they offer and the fact that they function without time limits, vending machines are seen as offering an important service.

2.1.5 Safe and unsafe injecting

Previous studies report that sharing of needles is quite common among Indigenous IDUs – and among young IDUs in particular. Using a needle before or after someone else is frequently said to involve cleaning the needle between users, but it is by no means clear that the methods used for this are consistently effective. (Some of the information resources available to IDUs describe cleaning methods
that may be used when there is no alternative, but current best practice in the NSP sector is to urge ‘a new fit for every hit’.) Past research with IDUs in general shows that they offer a range of reasons for sharing injecting equipment\textsuperscript{18}. In the earlier Australian studies the reasons given by Indigenous IDUs for sharing needles or other equipment include lack of access to sterile equipment, being part of a group that regularly injects together, confusion or mistake, and lack of concern (sometimes of a fatalistic kind) about the possible consequences of sharing.

### 2.1.6 Suggested improvements

Indigenous IDUs consulted in previous studies have advocated:

- better access to clean injecting equipment
- additional counselling and treatment services – either Indigenous-specific or mainstream, so long as they demonstrate awareness of both drug-using and Indigenous issues
- increased education and information in various forms – for IDUs themselves, in schools, in prisons, for the wider Indigenous community
- greater use, in particular, of peer education and support among Indigenous IDUs
- printed or graphic resources designed to communicate effectively with various groups of Indigenous IDUs and to demonstrate that services are Indigenous-aware
- use of other, non-print means of communication such as music, radio and social events or gatherings
- promoting a more realistic and open awareness within Indigenous communities of issues around drug use and drug injecting.

### 2.2 Findings from the present study

The qualitative findings of the present study are broadly consistent with earlier findings discussed in Appendix C and summarised above. However, in a number of instances they shed additional or somewhat different light on aspects of drug use behaviour and Indigenous IDUs’ accessing of services.

#### 2.2.1 Levels of injecting drug use

This research confirms the lack of reliable data both on the extent of drug injecting among Indigenous Australians, and on Indigenous IDUs’ use of NSP services. Client contact data collected through NSP

\textsuperscript{18} Reasons recorded as early as 1994 included difficulty in obtaining sterile equipment, the dangers not seeming so important when in withdrawal, and injecting occurring with friends or lovers – see Ross M, Wodak A, Stone A, Gold J (1994) ‘Explanations for sharing injection equipment in injecting drug users’, \textit{Addiction} 89:4 pp 473-79.
services, for example, are of limited value in this context because of variability in information recorded on Aboriginality. While some NSP services report keeping records on Indigenous status, many do not. In South Australia, for example, only services which are specifically funded to address the needs of Indigenous IDUs are required to collect information on the Indigenous status of NSP contacts. Where information on Indigenous status is recorded by NSPs, it is evidently common for workers not to ask clients whether or not they are Indigenous, but rather to record their own impression on this (as is often the case for age, also). Information on numbers or proportions of Indigenous client contacts at NSPs is therefore uneven and in part a matter of guesswork. It is also important to note that since NSP data normally refer to client contacts rather than numbers of individual clients; there is no reliable way of relating these data to numbers of IDUs or frequency of injecting.

The annual Australian NSP Survey is not designed to provide an accurate estimate of the proportion of NSP clients who are Indigenous (nor, of course, to estimate numbers of Indigenous IDUs overall). Nevertheless it is of interest that around 10% of the NSP clients who participated in annual surveys between 2003 and 2007 were Indigenous. Appendix G sets out Indigenous population percentages for each state and Territory (based on the 2006 Census), together with the corresponding percentages of respondents to the 2007 NSP Survey who were Indigenous. Everywhere except in the ACT, Indigenous representation in the survey was higher than Indigenous representation in the total population, and in the ACT (where the NSP sample is small) this was true in the previous year’s survey. It is not completely clear what conclusions can be drawn from these figures, but we can reasonably say that:

- they are consistent with the proposition that the incidence of injecting drug use is relatively high in the Indigenous population; and
- they show that Indigenous IDUs’ current use of the NSP is far from negligible overall.

NSP outlets consulted during this study reported varying levels of Indigenous client contact. Staff at one metropolitan location noted that when they had for a time collected information on Aboriginality on a sample basis, they were surprised that the percentage of Indigenous client contacts was as high as it was (some 15%–30% at various outlets). Close to a third of client contacts at the Blacktown (Sydney) NSP were identified as Indigenous during a period when this information was collected. The REPIDU service at Redfern in Sydney believes that it has the highest level of Indigenous IDU contact of any service across Australia; Indigenous IDUs account for a high level of client contacts at its fixed site service, and for most of the contacts at its outreach service located at ‘The Block’ in Redfern.

At most of the locations visited by the study team, people whom they consulted believed that there were significant levels of local Indigenous drug injecting. Some IDUs interviewed in Western Sydney, for example, described Indigenous drug injecting as quite common: ‘Everybody knows someone who’s

---

19 Workers at numbers of NSPs referred to the importance of not ‘hassling’ clients with too many questions. AN IDU in Cairns commented favourably on the speed and simplicity of using a particular NSP outlet – ‘You’re straight in and out’.

involved'. In some locations the view was that there were certainly Indigenous IDUs, although it was difficult to say with any confidence what the numbers might be. Several of those who were interviewed in Alice Springs, however, believed that there was at present relatively little drug injecting among Aboriginal people in Central Australia; Indigenous hepatitis C rates in Central Australia – for example as recorded through prison screening – were described by one professional as ‘incredibly low’. ‘All the hepatitis C patients’ at Alice Springs Hospital, it was said, were non-Indigenous. In Mt Isa the general opinion among those consulted was that there was little Indigenous drug injecting in that area.

Stakeholders consulted in several locations described injecting use among Indigenous Australians as having increased over recent years. In Port Augusta, for example, a number of those consulted believed that there had been more injecting by Aboriginal people over the past year or so; possibly this reflected the fact that there was more money in the town as a result of nearby mining activity, attracting increased supplies of drugs and increased drug injecting generally. An IDU interviewed in Alice Springs similarly believed (perhaps contrary to the view reported above) that injecting had become more common among Indigenous people in that area in recent years – ‘getting pretty bad, eh’. WASUA staff consulted in Perth believed that where there had once been only a ‘small hard core’ of Indigenous IDUs, drug injecting has become considerably more common. ‘More traditional’ Aboriginal people, said an IDU in Cairns, are often reluctant to use a needle; in this population there were consequently ‘more sniffers’. In her view, however, injecting (and unsafe injecting) was increasing.

A number of stakeholders indicated that they would like to see national discussion and agreement on whether and how Aboriginal or Torres Strait Islander identity should be recorded by NSPs – even if only on a sample basis. They made the point that funding is needed to support the gathering of more reliable data on such matters as the level and patterns of Indigenous drug injecting, and risk behaviour among Indigenous young people.

Although there was general acknowledgement of the existence of drug injecting among Indigenous Australians, it was frequently observed that alcohol, tobacco, marijuana, and in some locations petrol sniffing, continue to represent the most common drug issues within Indigenous communities. Port Augusta, for example, was described by one worker as ‘pretty much an alcohol and cannabis town’; nevertheless, as noted above, injecting drug use was thought to be increasing there – possibly influenced by the money generated by mining operations in the region.

---

21 ‘Everyone’s related to bloody everyone’ in the long-established Aboriginal community in Mt Isa, so that it is ‘pretty hard to keep anything secret’. One Mt Isa worker said that the Aboriginal IDUs whom she did see tended to be from out of town, newcomers. They were generally occasional rather than dependent drug users, she believed.

22 An information sheet on the NSP in Western Australia, issued in May 2007 by the Communicable Disease Control Directorate of the WA Health Department, states that ‘Nationally, it had been noted that there is an increase in injecting drug use in Indigenous youth ....’
2.2.2 Characteristics of Indigenous IDUs

Both IDUs and others consulted were asked about their impressions of gender and age group among local Indigenous injectors. As for gender, the typical responses were either that IDUs were about 50/50 male/female, or else that males accounted for a majority – perhaps two-thirds – of Indigenous IDUs. (It will be noted that these estimates echo the information and impressions reported in earlier research – see section 2.1.2 above.) As with the wider IDU population, couples who both inject are reportedly quite common; it was said that a male might well introduce his female partner to drug injecting. Thus, while females may be in the minority, they represent a significant part of the Indigenous IDU population. In Cairns it was reported that hepatitis C rates among female IDUs were higher than for males in the 16-24 age group – possibly reflecting unsafe injecting among female IDUs with an older partner.

As for age group, it was reported by numbers of NSP outlets that the most typical age range for Indigenous NSP clients was between about 25 and 45, with relatively few younger people using the service. In Darwin, for example, NTAHC representatives noted that despite the young average age of the Northern Territory population, their NSP saw relatively few clients in their teens or early 20s (this was true for both Indigenous and non-Indigenous clientele). A group of Indigenous IDUs who were consulted in Darwin, however, reported that there were significant numbers of young Indigenous injectors in an area like Palmerston. A number of NSP workers commented that it was difficult for them to judge whether there were significant numbers of younger injectors whom they were not seeing.

Numbers of IDUs and workers who were interviewed during the study referred to young Aboriginal people first injecting in their mid teens – including young women influenced by older partners or family members. Whether Indigenous or non-Indigenous, ‘kids are hitting the party scene from Year 8’, said a Canberra worker. A Melbourne stakeholder stated that in his experience Aboriginal people may tend to start injecting drugs at a young age – possibly reflecting ‘low horizons’ or life expectations and the fact that friends or older siblings may be injecting. (A health worker consulted in Carnarvon spoke of Aboriginal people often having little reason to be optimistic about their long-term prospects, and of encountering ‘that horrible fatalism’ among those he met in his work.) In Taree it was suggested that injecting often began around the age of 16, with the peak IDU age group being up to about 30. One woman in Cairns described herself as a ‘late starter’ who did not inject until she was 27.

In this context it is interesting to note that the Implementation Plan for Aboriginal People under the NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies notes that in the period 2000-2005, 20% of newly acquired HCV notifications among Aboriginal people were among those aged between 15 and 19 years; this was almost double the corresponding rate (11%) for non-Aboriginal people.

The view in Alice Springs seemed to be that Aboriginal IDUs were pretty much a cross-section of the local Aboriginal population. For example, it was said, there were Aboriginal IDUs who depended on pensions or benefits, but others who were employed in either the public or the private sector.
One other point that deserves mention here is that Indigenous IDUs may be transient or without a permanent home. This is to some extent a characteristic shared with other Indigenous Australians, but possibly exacerbated in the case of IDUs by poverty, dysfunction and alienation from family.

2.2.3 Drug choice and availability

This study did not point to significant differences in the drugs used by Indigenous and non-Indigenous IDUs. However there are differences from place to place, and from time to time, in the injectable drugs most readily available and most commonly used. In various areas of Sydney, for example, the most commonly injected drug might be heroin, or speed, or methadone; heroin, for example, was reportedly much easier to obtain in some parts of town than others. ‘Party drugs’ were described as a significant part of the current Sydney scene. Amphetamines had traditionally been ‘big’ in Adelaide, and were thought to account for perhaps 75% of local injecting. In Melbourne the use of heroin and amphetamines was thought to be about equal at present. The drugs injected in Canberra were said to vary depending on what was available from time to time – eg ice, heroin, and pharmacotherapy drugs such as buprenorphine. Numbers of stakeholders described polydrug use as common.

Stakeholders consulted in the Top End reported relatively little use of heroin. Morphine (in some cases diverted from prescription use) and to a lesser extent amphetamines were identified as the drugs most commonly injected there – both by Indigenous and by non-Indigenous IDUs. Morphine was estimated to account for perhaps 50% of drug injecting in Darwin, and was said to be more popular with older, established drug users; amphetamines (possibly accounting for 40%) were more likely to be used by young people. In contrast to the southern capital cities, there was said to be ‘no street-based drug culture’ in Darwin, with injecting mostly occurring in people’s homes and often involving a small group of friends or acquaintances.

In general, it was reported that illicit drugs – and heroin in particular – are more consistently available in the major cities than in smaller or more isolated population centres. The point was made that drug injecting in a town such as Alice Springs, for example, tends to be sporadic or ‘up and down’ as drugs are more or less available. As one worker saw it, ‘There’s no regular drug scene here in Alice’. Given the irregularity of supply, drugs tended to be used very quickly when they were available: ‘It goes pretty quick’, said one IDU. Consistent with this, some said that Indigenous drug injecting was ‘very ad hoc’ and as a result more likely to be unsafe: ‘They’re not prepared for it’ in the way that more consistent users might be. In Carnarvon – another isolated location - it was said that ‘people party for a few days’ when a drug shipment comes into town.

Some stakeholders consulted in the Northern Territory commented that drug injecting was ‘hard to sustain’ in the Territory because of the unreliability of drug supply and also because of the difficulty of

23 In Carnarvon, for example, any heroin that was available was said to be costly and of poor quality (‘We get the dregs’). Speed was easier to get and more cost-effective to use.
keeping one’s activities private in small communities – and within close-knit Aboriginal populations in particular. ‘Sometimes it’s more of a chore than anything else’, said one worker.

2.2.4 Drug user culture

IDUs interviewed during the present study often described a drug ‘scene’ in which both Indigenous and non-Indigenous users participate. It appeared that the drug-using friends or acquaintances of many Indigenous injectors include both Indigenous and non-Indigenous people, and those who were consulted identified few obvious or consistent differences in the drug-using behaviour of Indigenous IDUs and their non-Indigenous peers. ‘It’s blackfellas and whitefellas, all together’ (IDU, Western Sydney); ‘It’s definitely black and white together’ (IDU Cairns); the injecting scene is ‘colourblind’ (IDU Cairns). ‘It’s all the same scene’ (health worker, Port Augusta).

Some of those interviewed in Mildura referred to an active and ‘very obvious’ drug scene in a particular area of the town; this was described as ‘quite multicultural’, involving for example Caucasians, Pacific Islanders and Aboriginal people. Drug and alcohol workers in Mildura observed that it was common for one person to come into the NSP from a car which might have a combination of Indigenous and non-Indigenous passengers, and a similar comment was made in Cairns. It was suggested in Cairns that non-Indigenous peers were an important source of injecting equipment for young Indigenous IDUs in particular. An Aboriginal worker in Perth emphasised that the local drug scene was ‘very mixed’ in terms of Indigenous and non-Indigenous involvement. In Dubbo and Taree in regional NSW, on the other hand, there were varying comments on the extent of mixing between Indigenous and non-Indigenous IDUs (one IDU said, for example, that non-Indigenous people were sometimes suspected of being undercover Police). In the small community of Carnarvon, in Western Australia, it was suggested that there might well be largely separate groups of Indigenous and non-Indigenous drug users.

One implication of extensive contact between Indigenous and non-Indigenous IDUs is that mainstream NSP initiatives, information campaigns and the like can be expected to reach significant numbers of Indigenous IDUs. Given that young Indigenous IDUs, for example, tend to have numbers of non-Indigenous friends and acquaintances, ‘It can be argued that campaigns that are effective in reducing drug use among non-Indigenous young people may also deter drug use by Indigenous youth’24.

Nevertheless, for a range of historical, social and economic reasons, Indigenous IDUs were thought to be clustered towards the most disadvantaged end of the drug using spectrum. A Perth stakeholder spoke of the appeal of drug injecting (specifically injecting amphetamines) for marginalised and disempowered people. Injecting was ‘tailor-made’, he believed, for Aboriginal people with low self-esteem and few hopes or personal resources; for a time, it can make you ‘feel like God’. The point was also made that substance misuse of one kind or another (particularly involving alcohol, tobacco and

---

marihuana) has been a common element of dysfunctionality in Aboriginal communities, with the result that many disadvantaged Aboriginal children and young people are from an early age familiar with relatives and neighbours using alcohol and other drugs.

Numbers of those consulted, in various locations, argued that Indigenous drug injecting is commonly an outcome or reflection of marginalisation and multiple disadvantage. The ‘middle class experimentation’ that accounts for some non-Indigenous injecting was not seen as characteristic of Indigenous injecting. It was much more likely to be a means of coping with unpleasant life realities and/or a symptom of having little to lose. Aboriginal people are rarely ‘successful drug users’, thought one Adelaide worker.25

Another important, and possibly distinctive, aspect of Indigenous drug injecting was that it frequently occurred within a group of friends and/or family members, and that Indigenous young people were often introduced to injecting by older relatives or friends. According to one interviewee, there were ‘whole households of Noongar injectors’ in Adelaide. Another Adelaide stakeholder spoke of groups of family members and friends acquiring and using drugs together (‘Who has the cash today?’). Trust and familiarity within such groups (a ‘caring and sharing’ context) could easily mean risky behaviour; ‘Sharing within the family doesn’t count’; said another observer. Further, easy access to drugs in this kind of situation could be reflected in people starting to use and to inject drugs at a young age. A Carnarvon health worker made the point that, given factors such as crowded living conditions and the tendency to use drugs in a group situation, Indigenous Australians’ drug using and drug injecting may well be more ‘in your face’ than among non-Indigenous people.

Stakeholders noted that low income or dependence on social security was not necessarily a barrier to using illegal drugs. Numbers of those consulted said that acquisition of drugs might be financed by low-income people in various ways – for example by sharing or pooling of welfare benefits, by theft (sometimes from friends or family), sex work or exchanging sexual favours for drugs. Some IDUs were said to use small-scale dealing (eg in home-grown marihuana) to enable them to purchase injectable drugs. Some observers also made the point that, especially in the larger cities, injectable drugs were not necessarily very costly relative to alcohol or even tobacco – particularly if the drugs were used in relatively small quantities. According to one Melbourne stakeholder, ‘a hit can be cheaper than a packet of smokes’ if you’re only using lightly. In Carnarvon it was said that ‘speed is cheaper then grog, usually’.

Some observers commented, however, that while the low incomes common among Indigenous Australians need not prevent people from injecting, they could affect the frequency with which they do so. In Port Augusta, for example, Aboriginal injecting was described as ‘sporadic’ – affected both by the availability of drugs and the capacity to pay for them. A Northern Territory health worker likewise drew a

25 Meyerhoff’s research for Danila Dilba Medical Service in 2000 quotes earlier researchers as stating that within Indigenous populations ‘drugs are taken as a way of dealing with pain both emotional and physical’ (p10), and that other relevant factors include low educational/employment status, limited leisure activities and family breakdown. ‘Like other Australians, however, some young people use a variety of drugs in order to alter their mood and have fun’ (quoting Brady 1992).
connection between low Indigenous incomes and relatively limited access to illicit drugs. Some of those consulted by the study team said that the high cost of a drug like heroin tended to limit its use among young people; drugs such as cannabis were cheaper and more easily obtained. One worker in Cairns had concluded that, for the most part, local Indigenous IDUs tended to be recreational or occasional, rather than regular, injectors.

2.2.5 Obtaining clean equipment

Sources of clean injecting equipment referred to by IDUs who participated in this study included the following:

- primary NSP outlets
- secondary outlets such as those operating at community health services or hospitals
- mobile or outreach NSP services
- community pharmacies
- vending or dispensing machines
- friends, fellow-injectors and/or drug dealers.

There were frequent references, in particular, to obtaining needles and syringes from friends or peers – consistent with the proposition that some Indigenous IDUs are reluctant themselves to visit NSP outlets and prefer to rely on others to collect equipment on their behalf.\(^\text{26}\) As previously noted, this was thought to be especially true of young injectors. In Carnarvon and some other locations it was noted that the person who was asked to obtain equipment from the NSP might not personally be an IDU. Outreach or mobile NSP services are of course designed to overcome some of the access barriers experienced by particularly marginalised groups (eg homeless people) or those who are reluctant to visit fixed services, and several stakeholders saw these as an important mechanism for reaching Indigenous IDUs in particular.

At a CNP (Clean Needle Program) outlet in Adelaide it was reported that Aboriginal women often pick up equipment for male partners. In Dubbo there was again reference to couples injecting, with either the male or the female partner accessing an NSP service on behalf of both. People consulted in Dubbo suggested that the female partners of male IDUs tended themselves to take up injecting in the context of developing or maintaining the relationship.

\(^\text{26}\) In Western Sydney the comment was made that a similar pattern applies to buying drugs: one person will go to the dealer ‘to get on’ on behalf of a group of acquaintances.

The fact of intermediaries accessing needle and syringe services on behalf of others is recognised in the international literature, and in the USA has been described as ‘secondary syringe exchange’: see, for example, Snead J, Downing M, Lorvick J, Garcia B, Thawley R, Kegeles S and Edlin B, ‘Secondary Syringe exchange among injection drug users’, *Journal of Urban Health* 80:2, June 2003.
Consultations indicated that, reasonably enough, Indigenous IDUs generally prefer outlets where injecting equipment is free, and where they can expect to be treated in a courteous and non-judgemental fashion (which in very broad terms may point to primary rather than secondary outlets).

In several locations, including Cairns and Perth for example, workers expressed the view that Indigenous clients who do use NSP services tend to visit more often and to take smaller amounts of equipment for personal use.

2.2.6 Safe and unsafe injecting

Those consulted in various locations typically believed that many Indigenous IDUs were currently fairly well informed about issues relating to safe injecting and the risks of sharing equipment. The most likely exceptions to this generalisation, it was thought, was young, inexperienced injectors.

IDUs consulted in Alice Springs, for example, believed that knowledge about the importance of safe injecting was widespread (‘A lot of people think about things like that now’; ‘Everybody’s on the ball now, hygiene and that’). Some specifically related this change to the increased availability of NSP services and sterile equipment. An AMS health worker in Sydney commented that when she speaks with IDUs about safe injecting, ‘They all say they know about it’. Clients may often say that they would never share a needle – except ‘with my partner’, or ‘if I was off my face’. In Taree, Carnarvon and Canberra there were references to people known to be uninfected ‘going first’ with a shared fit. In Darwin both Indigenous and non-Indigenous IDUs were thought to be generally quite well informed about safe injecting – though of course this did not mean that injecting was always safe.

Having the relevant ‘head knowledge’ was no guarantee of consistently safe injecting behaviour, among either Indigenous or non-Indigenous IDUs. It was often said that if you were ‘hanging out’ and a clean needle was not readily available, you might well share (possibly making some attempt to clean the equipment, such as rinsing a couple of times with water). ‘At the time they don’t care’, said a health worker consulted in Canberra. ‘Come crunch time, when they’re hanging out’. ‘It doesn’t matter – all they want is that hit’ (worker, Taree). ‘The understanding is there, but – ‘(Carnarvon); ‘There’s a helluva lot of risk behaviour’ (Perth).

Nights and weekends were obvious times when obtaining sterile equipment could be difficult. ‘Sunday’s the hard day’, said a drug user in Canberra; you have to try to ‘keep a stash’ for the weekend. There was reference to reuse of one’s own needles – possibly many times – perhaps giving the syringe a ‘quick little rinse’ with water or mouthwash before re-use.

The fact that a group of friends or acquaintances might pool funds in order to purchase drugs – reportedly a common practice among Indigenous IDUs – tended to give a communal or collective flavour to the drug using, which could be conducive to sharing of injecting equipment. In western Sydney, for example, it was said that some Indigenous IDUs routinely share needles. A drug and alcohol worker consulted in Mildura stated that in the past she had had Indigenous IDU clients who had
shared and re-used needles and had made little if any use of the local NSP; her view was that there was a good deal of unsafe injecting by Aboriginal people. Failure to use NSP services was attributed partly to apathy and partly to a fear of being identified as an injector. A Dubbo IDU said that he was associated with a group of about 30 drug users – both Indigenous and non-Indigenous – among whom a minority would share equipment.

In one location it was said that the situation where a dealer offers a drug free (eg to potential new customers – ‘first shot free’ and a ‘bonus’ for the person introducing the new client) could encourage sharing of a needle. In Canberra it was suggested that NSPs distributing one-shot containers of sterile water were far preferable to issuing ‘one big water’, which could encourage sharing behaviour.

While some of the IDUs who took part in the study said that they would never share a needle, other people believed that sharing was relatively common – especially by couples or among close friends or family members. In Canberra, for example, a group of IDUs who knew each other well took part in a round-table discussion; they indicated that they had certainly shared needles with each other (rinsing with water between users, or with bleach if it happened to be available). ‘Everybody shares’ with their mates or their family, it was said.

In Alice Springs the point was made that there was ‘a very strong sharing culture’ in Aboriginal communities. It was agreed that this had relevance for injecting drug use, with pressure on individuals to share both their drugs and their needles (‘Share the gear and share the equipment’). Some IDUs (eg in Taree) commented that the larger the group you injected with, the more pressure there could be to share your drugs. Elsewhere IDUs said that ‘Everything belongs to everyone’; ‘There’s no such thing as ‘mine’ – ‘Come on, bro’. Thus, while it is no doubt simplistic to say that Indigenous IDUs share injecting equipment because they come from a culture where sharing is the norm, this research suggests that a combination of factors such as using drugs with groups of relatives and friends, pooling funds to buy drugs, and peer pressure against ‘selfish’ or individualistic behaviour, do tend to increase the possibility of unsafe injecting.

A Cairns IDU spoke about his injecting practice with his partner. Both of them had hepatitis C, he said, but ‘different strains’. He said that he normally shared a needle and syringe with the partner: ‘I do her first, then wash it out’ – first with cold water, then boiling water. A Cairns worker thought that people sometimes took the view that sharing a needle added no extra risk on top of unprotected sex.

It was clear that there remained gaps in knowledge. In Cairns, for instance, a male IDU said that originally he had been very ignorant about hepatitis C; he had thought it was ‘something that you get overseas’ – ‘a bad flu sort of thing’. QuIHN in Cairns, said another IDU, ‘still sees people who’ve got no idea’, while a Cairns NSP worker said that if she asked a few questions of clients she often found ignorance or confusion about hepatitis C infection. For instance it was still easy for people to be confused between hepatitis A, B and C.
Sharing of equipment can also arise through confusion or mistake. When people are injecting together and re-using their needles, said a Cairns IDU, ‘after a while you don’t know whose was whose’. ‘Their minds are so scattered’ (Canberra worker). Another IDU interviewed in Cairns said that some people are ‘too far gone to care’ whether or not they are injecting safely – or else ‘just lazy’. Users may also assume that ‘you haven’t got anything I haven’t got’. The bottom line for some IDUs was that lack of a clean needle ‘wouldn’t stop them shooting up’; ‘there’s one needle and five of us want a shot’, it was highly likely that the needle would be shared – with or without an effort to clean it between users.

In Canberra injecting was reported as often unsafe in various ways. It was said that people may use in the open (eg in a park or laneway) or in public toilets, in very unhygienic circumstances. Further, ‘I’ve seen people so desperate they’ll pick up a needle from the street’ (Canberra IDU). IDUs thus needed to be taught as fully as possible about clean practices in all situations. A Darwin IDU commented that, while there was not a big local ‘street scene’ injecting did take place in locations – eg at the beach or in public toilets – where hygienic practice was difficult. Workers in Cairns likewise referred to young Aboriginal IDUs injecting in parks or in the street.

2.2.7 Remote communities

In the Northern Territory, most of those consulted believed that drug injecting was not currently a significant issue in remote communities. Given movement in and out of communities, however (eg by tradespeople), increased injecting was certainly a future possibility. The health risks of this could be extremely serious and therefore the situation needed to be carefully watched.

So far as they were aware, said some Alice Springs IDUs, there was currently ‘nothing in the homelands’ in Central Australia. However, it was again emphasised that social and environmental conditions in outlying communities (eg inadequate water supply) were such that, if drug injecting did spread further, injecting in communities was highly likely to be unhygienic and unsafe. One worker noted that if cleaning needles for re-use was ‘dicey’ anywhere, it was especially likely to be a problem in remote communities.

Some of those interviewed in Cairns believed that the use of speed was increasing on Cape York and in the Torres Strait, but that the drugs were not necessarily being injected. A local IDU, on the other hand, believed there were ‘lots of kids injecting speed on the Cape’. There were several references to ‘denial’ within the communities and among AHWs on the Cape.

Obtaining clean injecting equipment on Cape York was described as difficult. Hospitals at places such as Weipa, Lockhart River and Cooktown do offer NSP services – but they are largely used by tourists, it was said. Cairns was regarded as the best source of injecting equipment for IDUs living on the Cape, which meant that people visiting Cairns could be asked to bring back sterile equipment for others: clients would on occasion come to an NSP outlet with ‘a great long shopping list’ for people back home. Even when visiting Cairns, however, Indigenous IDUs from the Cape might well be reluctant to ‘front up’
to an NSP, and might ask others to collect equipment for them – or possibly request needles and syringes from a drug dealer.

Education programs and NSP services were said by one IDU in Cairns to be ‘dead set needed’ on Cape York; such services needed to be delivered in people’s own terms – not by some ‘authority figure’. It was ‘a very hard job to reach those kids’ on Cape York, and it was argued that peer-based approaches had the best prospect of success.

Several possible routes were suggested for the spread of drug use and drug injecting into remote or isolated Indigenous populations – trucking in of goods, visiting tradespeople, young people returning to communities from urban areas and/or from prison, mining operations (eg in the Top End) and commercial fishing (‘It’s rife on the trawlers’ that work in the Gulf of Carpentaria, and use of drugs on fishing boats was also mentioned in Carnarvon). ‘Transients’ such as long distance truck drivers and fishermen were described as a significant source of drug supply in rural and regional Australia generally. As previously noted, it was argued that irregular supply of drugs in more isolated locations meant sporadic drug injecting, which might well be associated with unsafe injecting practice.

2.2.8 Role of Aboriginal Medical Services

Consultations in various locations indicated that there is often little direct contact or co-operation between NSP services and local Aboriginal Medical Services or other Indigenous-specific services. Workers at a secondary NSP in one town noted that although their organisation had a good working relationship with the local AMS, there was never any comment or input from the latter relating to NSP services. Building closer relationships or partnerships around BBV infection and drug use was thus seen as having the potential to improve access to services for Indigenous IDUs. A non-Indigenous stakeholder in Melbourne commented that service providers found themselves ‘in a bit of a quandary’ as to how best to meet the needs of Indigenous IDUs; in part this was because there was little if any pressure or advocacy on this subject from Indigenous organisations.

A number of stakeholders believed that Aboriginal Health Workers generally have insufficient training in issues around hepatitis C. People consulted in Cairns, for example, emphasised that need for increased training relating to hepatitis C for both mainstream and Indigenous health personnel. It was also apparent in discussions at some Aboriginal Medical Services that staff did not know much about local NSP services. Some specifically made this point themselves; in other instances AMS workers were unable to offer information about NSP services or else gave inaccurate information.

Staff consulted at one or two AMSs commented that they did come across clients who were injecting drugs, when they visited the service for other reasons. Some medical services (eg at Mt Druitt in western Sydney) had pamphlets on safe injecting available. Staff members consulted at WuChopperen Health Service in Cairns were familiar with the local NSP outlets, and stated that they made reference to safe injecting in their health education work – including work in schools. At another medical service,
senior staff reported that AHWs and nurses were happy to distribute clean equipment to clients who requested it; conversation with frontline staff members, however, suggested that some were in fact quite reluctant to do this.

At WuChopperen in Cairns it was said that Board members were open-minded and realistic on issues such as services for IDUs – ‘They don’t bury their head in the sand’. The possibility of operating an NSP had been considered, but the judgement was that the existing mainstream services were currently adequate. Similarly, Congress in Alice Springs was reported to be clearly committed to harm minimisation principles and to have considered the possibility of offering NSP services; however it had concluded that the existing local services were currently adequate for Aboriginal people. In Darwin it was said that there were small numbers of referrals to the NTAHC NSP from the Danila Dilba Health Service, but that drug injecting was ‘a pretty taboo subject’ in the community. When asked whether their medical service might consider introducing an NSP, staff at one AMS replied ‘You’d be pushing the friendship there’.

There are some medical services – eg the Aboriginal Medical Service Western Sydney Co-op – which operate a methadone program. It was suggested here that the methadone clients were probably ‘the tip of the iceberg’ in relation to injecting drug use. Establishing the methadone program at western Sydney had reportedly been controversial within the Service, and ‘took a long time’. However, its operation was said to have helped inform and change some staff and Board attitudes around drug injecting.

The range of reasons why Aboriginal Medical Services may be reluctant to provide NSP services is further discussed in section 3.2.3 of this report. Some people emphasised, however, that an Aboriginal health service did not need to be an NSP provider in order to play a constructive role in reducing the spread of BBV infections among IDUs. For example, a health service could demonstrate support for NSP services by providing information pamphlets and the like, offer hepatitis C testing, provide advice on meeting Indigenous IDUs’ needs, raise awareness among its staff, and make referrals.

2.2.9 Imprisonment

Both IDUs and others consulted during this study frequently referred to unsafe injecting within the prison system, and saw prisons as offering fertile ground for the spread of hepatitis C in particular. In detention needles are ‘definitely shared, out of necessity’, said a worker in Cairns. It is a lot easier to get drugs into prison than a clean needle, commented a Perth stakeholder. As a Canberra interviewee described the situation, ‘one fit may be used for three months in a prison wing’ – with 30 or 40 people using it over time. Then, ‘those prisoners go to other gaols’. In prison, said another stakeholder, ‘No fit’s clean after the first half hour’. In prison ‘the needle gets used till it’s falling apart’ (Carnarvon worker).

On the other hand, prison was also said to be the most likely place for Indigenous Australians, whether male or female, to receive HCV treatment, and it also offers significant opportunities for BBV education (this is one aspect of the Hoops for Health project in Darwin, for example – see Appendix B 2.2).
The point was made in Melbourne that Aboriginal people tend to be gaoling for offences such as theft and assault (including family violence), rather than for drug offences; imprisonment, however, can lead to the take-up of drugs and drug injecting. ‘A lot of our clients have gone into gaol clean and come out with hepatitis C’ (because of either injecting or tattooing), said health workers consulted in Canberra. ‘Gaols really need to wake up’. A Perth stakeholder made the important observation that prison health tends generally to be a low priority for governments, and that this has particularly negative consequences for the Indigenous population.

2.2.10 Summary

The findings both of earlier research and of the present study show that Indigenous IDUs, as would be expected, have much in common with non-Indigenous IDUs. For instance the available evidence indicates that average age of first injecting is similar for both groups, and that in both cases a significant minority of injectors are female. The present study suggests a high level of interaction between Indigenous and non-Indigenous IDUs, especially in urban areas (‘It’s all the same scene’), and gives no reason to believe that the drugs most often injected by Indigenous IDUs are significantly different from those commonly used by non-Indigenous injectors. Sharing of injecting equipment is an issue for both groups.

Nevertheless the available evidence, both quantitative and qualitative, also suggests some differences. Particularly striking is the fact that - reflecting high rates of incarceration among Indigenous Australians overall - Indigenous IDUs are much more likely than non-Indigenous IDUs to have spent time in prison. Although comprehensive data are not available, there is also evidence to suggest that the proportion of people who have experience of injecting drugs is somewhat higher in the Indigenous than the non-Indigenous population.

Other trends or patterns suggested by this and/or earlier research include the following:

- Reflecting the circumstances of Indigenous Australians generally, levels of social and economic disadvantage are likely to be particularly high among Indigenous IDUs; for example in terms of income, housing conditions, general health and access to health services. Various implications for safe/unsafe injecting may follow – from the low expectations of life that are reflected in the belief that ‘something is going to get us’ (if not hepatitis C, then something else), to the fact that overcrowded or impermanent housing can make it more difficult for IDUs to ensure that they have clean injecting equipment available when needed.

- For a range of reasons, including the fact that drugs may often be purchased by or for a group of IDUs, the frequency of injecting with a group of friends or relatives, and the common expectation in Indigenous communities that money or goods will be shared with others, injecting among Indigenous IDUs may often have a communal flavour that can encourage sharing of injecting equipment.
While individual experience no doubt varies considerably, there are suggestions that drug injecting among Indigenous IDUs may in general be more sporadic than among non-Indigenous IDUs – at least outside the major cities. Possible reasons for this are low Indigenous incomes and the unreliability of drug availability in non-urban areas with relatively high Indigenous population. Some observers believe that sporadic or opportunistic injecting carries greater risks of unsafe behaviour.

Given the fact that Indigenous communities, even in urban areas, tend to be small and close-knit, maintaining anonymity is a very high priority for many Indigenous IDUs.

Numbers of those consulted during this study identified young Indigenous IDUs as a particularly vulnerable group that may fail to use NSPs and other health services.
3 Access to NSP services

3.1 NSP access in general

Indigenous Australians’ access to NSP services clearly depends to a large extent on the nature and quality of those services overall. Whether IDUs are Indigenous or not, their effective access to NSP services depends on basic issues such as the number and location of services, their hours of operation, and worker attitudes and skills.

This section of the report discusses what might be called generic enablers and barriers that are potentially relevant to all IDUs; section 3.2 then focuses on issues that are likely to be particularly relevant or significant from an Indigenous perspective.

3.1.1 Hours of operation

The hours during which clean injecting equipment can be obtained vary from place to place and from one type of outlet to another. Hours of operation among primary NSP outlets vary to some extent, but 9-to-5 Monday-to-Friday operation is common. This is also true of many secondary outlets other than hospitals. Mobile services, by their nature, are available in particular locations at particular times of the day or week, while other types of outreach service may operate very flexibly in this regard.

Stakeholders interviewed during this study frequently made the point that since a lot of drug use occurs at night and over the weekend, the limited availability of NSP services after hours is a major problem. 'At night in Palmy', said a Darwin IDU, 'it’s easy to get drugs’ – but not a clean needle.

Where hospital Emergency Departments provide NSP services, these are in some cases accessible 24 hours a day, seven days a week; mostly, however, hospital services are available after hours only. Dispensing machines – available only in some States, and few in number outside New South Wales – offer 24/7 access, so long as they are in working order and are regularly restocked. Certain other fixed outlets are open long hours (for example the NSP service based at the Port Augusta Sobering Up Unit, which operates 24 hours six days a week, or the Health Information Exchange in St Kilda, Melbourne, which is open until 11pm seven days a week). Opening hours of community pharmacies vary, but in numbers of areas pharmacies offer the only after-hours or weekend source of clean injecting equipment.

27 The ‘generic’ barriers discussed here are broadly similar to those described in numbers of other studies and reviews on NSP services, both Australian and overseas; see for example Canadian HIV/AIDS Legal Network, Sticking Point: Barriers to Access to Needle and Syringe Programs in Canada, April 2007.

28 Exceptions include the REPIDU fixed site in inner Sydney which operates every day, and the WAAC and WASUA outlets in Perth which are open Saturday mornings.

29 That is, other than friends, dealers or other or acquaintances who may offer clean needles.
In Mildura the NSP service at the Community Health Centre is open 9-5 Monday to Friday. Outside these hours injecting equipment can be bought from a pharmacy (open until 9pm weekday evenings and 5pm at the weekend). The local hospital does not provide any NSP service. In this situation, it was said, the NSP must try to encourage its clients to ‘plan ahead’ – which they may well find it difficult to do.

3.1.2 Location

Location and geographical accessibility of services likewise have obvious implications for all IDUs. Broadly speaking, inner-city areas tend to offer easier access to services than suburban or outer suburban locations. In country towns ease of access can vary considerably; there are generally few primary NSP services. Within a metropolitan area, clients may for reasons of anonymity prefer to go to an NSP outlet some distance from where they live; this is one reason why accessibility of the NSP site by train, tram or bus is important.

The current location and distribution of NSP services may reflect a range of historical factors, such as the identification of drug-using ‘hotspots’ at a particular time, the location of agencies which have been willing and able to act as secondary outlets, and the granting or withholding of Local Government planning approvals. Location of outlets may, or may not, make obvious sense in terms of the places where IDUs in general are currently most likely to be found (eg where they live or where drugs of various kinds are purchased). What is convenient for IDUs in general may often coincide with what suits Indigenous IDUs, but this is not necessarily the case. For example, at the time of this study there was no general-purpose NSP in western Sydney’s Mt Druitt area, which is home to a significant Aboriginal population. (More generally, said one health worker, there was ‘a massive shortfall’ in NSP services in western Sydney, and especially in the Campbelltown area.) There is no after hours access to clean needles and syringes in Palmerston, a large satellite suburb of Darwin which has a high proportion of Indigenous residents. In Taree it was noted that the Aboriginal population is concentrated on the edge of town, a long way from local NSP outlets. Both in Dubbo and Taree people commented that secondary NSPs had been relocated to sites that some Indigenous IDUs now find much less accessible.

Even if some good quality services are available in a given city or town, geographical access to these may be very uneven. In Darwin, for example, both the NTAHC primary outlet and the Clinic 34 secondary service are located in the city centre, with pharmacies providing the only NSP services in the suburban areas to the north and west.

Mobile or outreach services represent efforts to minimise locational barriers to access. However, these may be relatively costly to operate (and in some cases may be regarded as politically sensitive), and

30 The only existing service in Mt Druitt is for people aged under 25.
are not widespread. Nunkuwarrin Yunti in Adelaide is the only example the study team encountered of an Indigenous-specific outreach service, although at Redfern in inner Sydney REPIDU operates an outreach service that serves a largely Aboriginal clientele. The WAAC mobile service in Perth has two Aboriginal workers and in some locations serves a significant number of Indigenous clients.

The specific location or address of an NSP may pose difficulties in various ways – including visibility to passers by. Video camera surveillance may also be a cause of concern to potential clients. While the ‘Dolls House’ NSP outlet in Cairns was reported to offer good services, some criticised its location at the entrance to the Base Hospital as ‘very exposed’. It was readily observed by hospital staff who stood outside the hospital to smoke, and it was also common for Police vehicles, as well as ambulances, to be seen in the adjacent parking area. ‘It’s a bit in your face’. The possibility that your car might be unregistered or that you might not have a current driving licence were other reasons for not wanting to attract Police attention. Concern about being seen using the service was said to be even greater issue among Indigenous IDUs because the Indigenous community was relatively small and close-knit.

Whether for these reasons or otherwise, it was reported that Indigenous use of the Dolls House was low compared to other NSP services in Cairns – and that there were very few female Indigenous clients.

Some stakeholders discussed issues relating to the location of NSP outlets relative to other services. In particular, the point was made that IDUs may not feel comfortable accessing an NSP that is physically (or possibly administratively) close to a methadone program or other drug and alcohol service that they may be using. In Taree, for example, there was comment on methadone and NSW services being located close to each other. In another town visited by the study team the NSP had been moved out of the premises occupied by the Drug and Alcohol service and its methadone program, on the basis that these were not compatible services. The NSP at Blacktown in Sydney’s western suburbs was described as located close to the methadone clinic where there is a uniformed security guard. This was said to be something of ‘a turnoff’ for new clients – especially young people for whom making a first visit to an NSP is intimidating enough in any event.31

3.1.3 Design and layout

Privacy and anonymity are relevant issues within an NSP site as well as outside. Potential clients may be reluctant to use a secondary outlet where the NSP service is set up in such a way that ‘everybody knows what you’re there for’. Some service providers have accordingly organised their premises so that NSP clients are able to access the service without going through the main entrance used by other clients or visitors. The Nunkuwarrin Yunti health service fixed site in Adelaide, for example, has a separate room for NSP use; so too does the ATODs service in Cairns. In Mildura the secondary NSP operates from a ‘Privacy Alcove’ opening off the Reception area of the Community Health Centre – the

31 NSP Policy Guidelines in NSW specifically provide that offering pharmacotherapy services should not be a barrier to providing NSP services also.
best arrangement that could be achieved in an existing building; injecting equipment is provided ‘discreetly’ in a black plastic bag.

As noted above, the use of security cameras, for instance at hospitals, can also raise issues for IDUs. It was pointed out in Taree that a sign at the Community Health Centre notifies people that they are being filmed.

3.1.4 Staff attitudes

Discussions both with workers and with IDUs made it very clear that staff attitudes and behaviour can either enhance or undermine access to NSP services. In a word, clients are likely to be ‘turned off’ by what they see as unfriendly, judgemental or – for Indigenous clients – racist treatment. Some users, for example, cite unfriendly staff attitudes as a reason they are reluctant to purchase needles and syringes from community pharmacies, or to access after-hours services at hospital Emergency Departments.

In some locations the point was made that the quality of a secondary service depends to a significant extent on the attitudes and motivation of the individual responsible for coordinating the service, and on the extent to which he or she is supported by others ‘higher up’. It was also noted – for example in Wellington – that awareness and attitudes among hospital nursing or clerical staff can vary greatly from person to person.

The use of trained peer workers or educators was referred to by a number of stakeholders as a way of facilitating good communication and rapport with clients.

3.1.5 Range of services offered

Some NSP outlets offer, or are associated with, various additional facilities or services which can make them more attractive or useful to clients. These can include relevant health or counselling services available on-site or close by, or ‘drop-in’ facilities such as somewhere to sit and talk, have a cup of coffee or something to eat, make phone calls or take a shower.

COAG funding for enhanced services has been used at South Court Primary Care in Kingswood (western Sydney) to establish a multidisciplinary team offering a range of services. The clinic is under the supervision of Sexual Health. Apart from NSP services, it offers wound care, blood tests, hepatitis vaccinations, dispensing of basic medications, referrals, counselling, a visiting sexual health worker, facilities to make ‘a cuppa’ and toast, use of a telephone and photocopier, and also a supply of second-hand clothing which is said to be very popular with clients. An Aboriginal IDU described this centre as offering her welcome ‘time out’ and some friendly company. As one staff member saw it, the nature of the service provided at South Court Primary Care considerably increases clients’ access to other health services. This breadth of service was seen as particularly valuable for more marginalised or disadvantaged people, including many Indigenous clients. Existing clients commonly bring friends or acquaintances in as new clients, it was said. Having professionally qualified staff in-house – for
example a nurse and a social worker – was also said to give an NSP like this some ‘weight’ within the broader health system. (It was frequently observed that NSPs tend to be marginalised or undervalued by other health professionals or agencies: ‘NSPs are certainly stigmatised by other people in the health system’.)

The MINE service in inner-suburban Melbourne provides another example of an enhanced service, which itself offers drop-in facilities and adjoins a specialist health centre addressing IDU needs.

A Cairns stakeholder argued that a drop-in centre which provides the opportunity for a yarn, coffee or a snack gives valuable opportunities for establishing better rapport with clients and is a good service model in terms of reaching and retaining Indigenous clients. It is clear, however, that this approach (as well, of course, as being relatively costly) will not appeal to everybody: numbers of IDUs indicate that what they want is speedy access to clean equipment with minimal exposure to or interaction with anybody else.

*The Connection* in Canberra is not an NSP outlet, but it provides a useful example of a drop-in service provided by young Indigenous workers to offer peer support, practical assistance and information to IDUs (see Appendix B, section B6).

### 3.1.6 Supplies and cost

Injecting equipment provided by primary and secondary outlets across Australia is normally free to the client (services operated by the WA AIDS Council and WASUA are a partial exception to this). IDUs who obtain equipment from community pharmacies or vending machines, however, generally need to pay for it. Vending machines in some jurisdictions dispense one or two needles at a cost of, say, $1-$2; machines in NSW typically dispense a pack of five needles at a cost of $2-$3. While the details vary from place to place, pharmacies typically sell a pack of 3 or 5 needles and syringes (often with additions such as swabs or sterile water) at a cost of around $5-$7. The pharmacy scheme in NSW provides for a new Fitpack to be issued free of charge when a used pack is returned.

Some of the IDUs and others consulted in this study made the point that the cost of buying sterile equipment is trivial in relation to the cost of drugs, or in the context of looking after your health. Others saw cost as a barrier to access – especially for low-income drug users such as those dependent on a pension or benefit. After buying drugs, said one IDU (Cairns), you may have ‘not a cent over to buy a syringe’.

Consultation suggested that cost is not the only barrier or disincentive to use either of pharmacies or of vending machines. Other issues raised in relation to pharmacies included lack of privacy, possibly negative staff attitudes, and limited pharmacy coverage in terms of hours and locations. As for vending

---

32 As previously noted, it was often suggested that groups of low-income IDUs may share their welfare benefits to purchase drugs.
machines, the risk of the machine being empty or malfunctioning seemed if anything to cause more concern than the need to pay as such.

In western Sydney the availability to NSP clients of injecting equipment other than needles and syringes – for example swabs, sterile water, filters, disposal containers – was reported as a positive. In various other locations, also, it was argued that offering ‘a good range’ of injecting equipment was for some IDUs an incentive to use NSP outlets. The services provided by WAAC and WASUA in Perth, for example, offer a wide range of equipment for sale at cost recovery price.

The consultations showed that NSP outlets may vary in their attitudes to the amount of injecting equipment they issue. There were some NSP staff who said that their concern was not with clients taking too much equipment but taking too little; they were normally willing to supply relatively large numbers of needles and syringes if this was requested. The basis for supplying substantial amounts of equipment (particularly to regular clients and/or to people who had travelled from out of town) was that some people accessing the NSP were known to be doing so on behalf of friends or acquaintances who were reluctant or unable to collect for themselves. It appeared that this pattern was particularly important among Indigenous IDUs. On the other hand members of the study team met some workers (eg some of those working in community health services) who appeared to take a more restrictive approach, fearing that providing ‘too much’ equipment to a client might lead to some form of ‘abuse’, such as the client seeking to sell needles and syringes to others. Some NSP staff were not comfortable issuing injecting equipment to clients whom they knew or suspected to be dealing in drugs. However, as noted elsewhere, some IDUs report obtaining sterile equipment from dealers.

3.1.7 Legal and policing issues

Several of those consulted by the study team referred to various legal issues which continued to have negative implications for safe injecting and/or effective NSP services. For example s36 of the Northern Territory’s Misuse of Drugs Act was said to discourage people from keeping a supply of clean needles available.

Across Australia there have generally been agreements negotiated to the effect that Police will not operate in a way that discourages drug users from accessing NSP services. However it is still sometimes reported that, for whatever reason, there is a greater or more obvious Police presence near NSP outlets or outreach activity that compromises their capacity to function effectively. During the present study this point was raised in particular in relation to the Nunkuwarrin Yunti Indigenous outreach service in Adelaide.

33 A Californian study reported in 2007 makes the point that less restrictive policies on dispensation of needles and syringes is associated with ‘increased prevalence of adequate syringe coverage among clients’: Bluthenthal RN, Ridgeway G, Schell T, Anderson R, Flynn NM, Kral AH, ‘Examination of the association between syringe exchange program (SEP) dispensation policy and SEP client-level syringe coverage among injection drug users’, Addiction 102:4, April 2007.
3.1.8 Politics

Since their introduction in Australia, Needle and Syringe Programs have generally been supported as an effective health measure by both major political parties. However, sensationalist media stories and opposition from some religious groups and individual politicians were described by participants in this study as ongoing threats to the provision of appropriate NSP services – both in general and at local level. Pressures of this nature can result in NSP services, and the public servants responsible for them, keeping a low profile and hesitating to seek desirable service extensions and improvements. ‘We’re the most vulnerable program around’ and we have to be very cautious, said one NSP staff member in Sydney. As noted above, NSP services tend to see themselves as occupying a marginal or insecure position within the health system. ‘The wider health system doesn’t recognise the value of NSPs’ (Carnarvon).

A Melbourne stakeholder made the point that some local communities and Local Government Authorities, especially in country areas, may be opposed to the establishment or maintenance of NSP services. In Taree it was claimed that proposed improvements to NSP services had been thwarted by local politics, and observations about local Councils being ‘far from comfortable’ with NSP services were made in some other towns.

In general, as a matter of policy, NSP services are not widely advertised or publicised. Information on where to find NSP outlets is thus spread largely by word-of-mouth. Some people have commented, for example, that out-of-town IDUs seeking clean needles may well visit places such as hospital Emergency Departments, since they do not know where to find more specialised local outlets.

3.2 Factors relating to Indigenous access in particular

This research generally suggested that in most locations Indigenous and non-Indigenous IDUs tend to mix freely and that there are many similarities between them. However, the particular circumstances of Indigenous IDUs need to be understood in the context of broader patterns of social and economic disadvantage among Indigenous Australians.

Some of the NSP staff members consulted in Perth, for example, believed that while there were considerable numbers of white middle-class IDUs who were comfortably off and had ‘plenty of social support’, Indigenous IDUs were likely to be more marginalised and disadvantaged, living in less stable circumstances, less well-informed, and at greater health risk. They had fewer resources at their disposal, and were less likely to be in a position to take a long-term perspective on their own health and welfare. Overcrowded housing conditions meant that Indigenous IDUs might have little privacy and therefore find it more difficult, for example, to keep clean needles on hand. An experienced Adelaide worker reported that Indigenous IDUs tended to present with ‘more complex needs and issues’, including possibly homelessness and ‘dislocation from family, community and culture’. Some
stakeholders made the point that disadvantage and marginalisation could be both a trigger for drug use in the first place, and also a factor in unsafe injecting behaviour.

The fieldwork pointed to a number of issues - discussed in the following subsections - that are particularly common or significant for Indigenous IDUs.

3.2.1 Stigma, shame, anonymity

Time and again the researchers heard that drug injecting is a ‘shame job’ for Indigenous Australians, and that for many Indigenous IDUs secrecy and anonymity are crucial issues in relation to injecting behaviour and use of services. (Similar points are frequently made in the earlier studies discussed in Appendix C.)

Shame and the need for secrecy have several implications. For example, some Indigenous IDUs may be extremely reluctant to visit any NSP outlet, and will try to find friends or acquaintances – possibly including people who do not themselves use drugs – who will collect clean equipment for them. Time after time, in diverse locations, those consulted by the study team spoke of Indigenous IDUs wanting friends or acquaintances to collect injecting equipment on their behalf, so that they themselves did not have to ‘front’ the NSP. In Mildura, for instance, it was said that some Indigenous IDUs’ shame and embarrassment make it ‘really difficult for them’ to go to the NSP at the Community Health Centre. (One advantage of a secondary service, on the other hand, was that you were not ‘labelling yourself’ as a drug injector by walking in the door.)

It was said by people consulted in a number of different locations that young Indigenous injectors were likely to be especially hesitant about using NSP services. ‘We have young kids crouching down in cars to avoid being seen’, said an NSP worker in Cairns. Among other things this has clear implications for the desirability of a flexible approach to the amounts of injecting equipment that NSPs issue.

Second, Indigenous IDUs may particularly seek to avoid services (eg an outlet located in a main street, near a fast food outlet or near a busy agency such as Centrelink), where they believe they may be readily seen or identified. Thus the NSP outlet should preferably present a nondescript or understated appearance – there should be ‘no flashing lights’. In western Sydney it was noted that the existing, youth-oriented NSP in Mt Druitt is located quite close to the Police Station – not a very desirable situation, especially from an Indigenous perspective given that ‘most of our fellas have got warrants out for them’.

Privacy is a particularly difficult issue in small population centres. Truly confidential access was described by one observer as ‘pretty much a nonsense’ in a town the size of Alice Springs, for example. Outreach or mobile services were one possible response to this issue, but even with these it was likely to be quite difficult to offer a genuinely discreet service. A worker described the WAAC mobile service in Perth as ‘anonymous, but not particularly private’ – that is, it was hard for clients to ensure they were not observed by others. ‘The van does a great job’, said another stakeholder, but ‘it’s almost too visible’.
Third, Indigenous IDUs may avoid Indigenous-specific services (in particular, Aboriginal health services) on the basis that these involve greater risks of their being seen and identified as drug users by family members or others in the Indigenous community. As a result, some existing NSP services based at Aboriginal health services attract mostly non-Indigenous IDUs. Thus it is not easy for NSP program managers to know what priority should be given to encouraging Indigenous-specific health services to offer NSP services.

Some of those consulted drew a comparison between the issues that could arise for IDUs and for lesbians or gay men in making use of AMSs. A health worker in Cairns, who commented that ‘gay guys and sistagirls’ may tend to avoid going to the local AMS on sexual health matters, also believed that this group included relatively high numbers of IDUs (more so, for example, than non-Indigenous gay men), and that this reflected ‘double’ marginalisation (being part of a minority within a minority), low self-esteem, and possibly separation from home or family. The reference to injectors who are homosexual is a reminder that among Indigenous IDUs there is a range of subgroups who may each have their own particular characteristics and needs.

In Mt Isa, health workers made the point that in a small population centre with a significant Indigenous population, the chances of an Indigenous client encountering a family member or friend were almost as great at mainstream health services as at an Indigenous-specific service. In this kind of situation, therefore, mainstream services did not in practice afford anonymity. Somewhat similar comments were made in Taree, where it was said that an IDU could encounter relatives, neighbours or acquaintances in any busy waiting room or reception area – not just at the AMS.

Certain groups were mentioned as having special concerns with regard to secrecy. In Darwin, for example, the comment was made that Aboriginal women with child care responsibilities may attach great importance to keeping their drug use secret from their children or other family members, and that this tends to discourage them from actively using NSPs or similar services. Fear of intervention by the welfare department is a related concern.

Consultations made it clear that the importance attached to keeping one’s drug-using to oneself is more than simply a matter of self-protection. The other side of this coin is a respect for family and community which does not want them to be exposed to things they would find embarrassing or distressing (‘We don’t want to give our family a bad name’, said a young Sydney woman). Staff at a metropolitan AMS similarly commented that part of the reason that injecting drug use in the community is ‘behind closed doors’ or ‘hush hush’ is a matter of showing ‘a bit of respect’ for family and elders. It was suggested that this was also a reason for Indigenous IDUs taking care to safely dispose of used needles.

---

34 Meyerhoff’s 2000 literature review for Danila Dilba Health Service (see footnote ...) refers to illicit drug us among gay/bisexual/transgender Aboriginal people.
3.2.2 Indigenous-friendly services

Those consulted during this study often observed that for any drug injector there may well be an initial barrier of fear or uncertainty to overcome before accessing an NSP service, and therefore that new/young/experimental IDUs tend to avoid using such services. This research suggests that for an Indigenous IDU approaching a mainstream service such hesitation and concerns are generally likely to be all the greater.

Accordingly it has sometimes been suggested that services for Indigenous IDUs need to be ‘culturally appropriate’. A stakeholder interviewed in Alice Springs argued, however, that this makes little sense, because drug injecting effectively involves an abandonment of Indigenous cultural tradition. (‘You take on another persona’; ‘Culture goes out the window.’) Much the same view was put in Cairns (‘the drug scene carries its own culture’) and in Perth (‘the drugs overtake’ racial traditions or divisions)\(^{35}\). Further, as noted above, the importance of keeping one’s drug use private from relatives or other community members can militate against using an Indigenous-specific agency that offers NSP services. Nevertheless it was clear that mainstream services could be intimidating or off-putting for some Indigenous IDUs, and IDUs who were interviewed by the study team tended to say that they would value at least having some access to Indigenous NSP workers. ‘We can talk freely’ to other Aboriginal people – especially people who have personal experience of drug injecting; with an Aboriginal peer it is ‘easier to talk openly’ (Alice Springs). Aboriginal IDUs interviewed in Western Sydney similarly said that they would like to have an Aboriginal worker at the NSP (‘We’d open up just that bit more’). However, the present, non-Aboriginal workers were well regarded (‘They’re pretty cool’), and these clients felt welcome and well cared for.

The researchers encountered some NSP outlets (eg REPIDU in Sydney and WAAC in Perth) which employed, or had at some time employed, Indigenous workers\(^ {36}\) but this did not seem common. In some cases (for example at the outlets operated in Darwin and in Alice Springs by the NT AIDS and Hepatitis Council) there were Indigenous staff-members who were employed in other roles in the organisation but who performed NSP duties as required. The NTAHC primary NSP in Darwin reports having had Aboriginal volunteer workers from time to time, and there is currently an Aboriginal staff member who works part-time in the NSP. Carnarvon has in the past has an Indigenous NSP Coordinator – from outside the town – who reported useful progress in networking with Indigenous IDUs.

Some non-Indigenous staff-members at NSPs indicated that they themselves felt very comfortable working with Indigenous clients, and believed the clients were likewise comfortable with them. However,

\(^{35}\) The 2004 ACT report ‘I want to be heard’ refers (p 30) to Aboriginal community concern at drug injectors being ‘immersed … in a totally alien way of life’.

\(^{36}\) The clearest example of Indigenous staffing was provided by the outreach service based at Nunkuwarrin Yunti in Adelaide, which involves a small team of Aboriginal workers and targets homeless Aboriginal drug users.
especially in secondary outlets such as community health centres, where NSP services are often provided ‘over-the-counter’ by a receptionist, this may not always be the case.

While having Indigenous staff-members could be a positive for some clients, others – particularly in regional or rural areas, whose population numbers are smaller – may see it as a threat to privacy. For instance ‘one young bloke’ was described as having been very nervous when he encountered an Aboriginal worker at the NTAHC NSP outlet in Alice Springs. Thus it was sometimes said that it was generally more straightforward to employ Indigenous workers in city services, or that it was desirable to find a worker who came ‘from somewhere else’. NSP staff consulted in western Sydney suggested that Indigenous outreach workers could certainly play a valuable role in extending the reach of services.

In Alice Springs, Clinic 34 was said to have a good general reputation among local Aboriginal people, which meant that in terms of Indigenous IDU access it provided an appropriate secondary site. Similarly, the Youlthlink service in Cairns was thought likely to be seen as an Indigenous-friendly NSP outlet, since most of the clients of the youth service itself are Indigenous. In Cairns the local QuHIN office was described as offering a friendly and supportive atmosphere that helped to attract Indigenous IDUs. Indigenous clients tend to like a service that has an ‘easy-going’ style, it was said.

Port Augusta provided an example of a service that was reported to work well for Indigenous IDUs. The local NSP is located at the Sobering Up Unit, which is generally regarded as an Aboriginal service and is largely staffed by Aboriginal workers. Given the nature of their usual role in working with intoxicated people, however, these workers could be seen as experienced and realistic in relation to drug issues, and less likely to be shocked or judgemental than, say, some health workers at an Aboriginal medical service might be. Other advantages of this particular service were that it is discreetly located (in a quiet street near the hospital, on the outskirts of town), and that it is open 24 hours a day, six days a week – with injecting equipment always available from the nearby hospital Emergency Department as a back-up. (On the other side of the ledger, the Sobering Up service may perhaps be perceived as a largely male service, and some 75% of client contacts were said to be with males.)

In several locations it was noted that NSP staff had received no cultural awareness training to assist them in working with Indigenous clients. In Melbourne, however, the drug and alcohol agency Turning Point (which offers an NSP service among other things) was in mid-2007 undertaking an Indigenous cultural awareness training program for its staff; the Victorian NACCHO affiliate, VACCHO, was working with them on this. At Taree an Aboriginal Liaison Officer has been appointed to the Community Health Centre, and this was seen as a positive step in promoting Aboriginal access to NSP services available there.

Other simple actions taken by some outlets to project an Indigenous-friendly message include display of appropriate posters, pamphlets and the like. (It appears that overall there is not a great deal of Indigenous-specific material readily available on issues such as safe injecting. However, such material has certainly been developed and produced in the past. Relevant initiatives have included OATS...
funding to AIVL to design and produce a number of Indigenous-specific brochures – see also section 3.2.7 In Sydney a mainstream western suburbs NSP reported flying the Aboriginal flag, which had become ‘a bit of a landmark’.

There were some mixed views expressed in Darwin and Alice Springs on the appropriateness and accessibility of the NTAHC primary outlets for Indigenous IDUs. One observer, for example, was of the view that NTAHC tended to be perceived in the Aboriginal community as a white people’s place, a gay men’s place and an HIV place – none of which was especially likely to encourage usage by Aboriginal IDUs, or by women in particular. On the other hand an NTAHC representative in Alice Springs stated that ‘We have very good relationships with our Indigenous clients’, and it was apparent that some Aboriginal IDUs in Alice Springs, both male and female, regarded the NTAHC outlet as their preferred service; its advantages were described by one client as including knowledgeable staff, ‘someone to talk to’, good availability of equipment (including, for example, filters), and the availability of relevant information, magazines and the like. An NTAHC client in Alice Springs commented that there were certainly initial barriers of fear and uncertainty for people to overcome, but that ‘once they get there they think it’s good’. In Carnarvon it was reported that the NSP outlet operated by Population Health at its Communicable Disease Centre was commonly referred to as ‘the AIDS House’, and that this was not helpful in promoting its use by a full cross-section of IDUs.

In Darwin it was suggested that ‘urban’ Aboriginal IDUs would far more readily access a mainstream NSP than would people from more isolated or traditional backgrounds. Workers at one NSP made the point that language could be a barrier or an embarrassment for some potential clients, and that people who were not fluent in English were not generally likely to approach a mainstream NSP outlet.

It was notable that some NSP services, while having Indigenous clients, seemed not to have given any particular consideration to their needs or characteristics. ‘I didn’t think much about Indigenous till you rang’, said one service manager to a member of the study team. The point was also made that it could be very difficult for a mainstream service to know how well it was doing in terms of Indigenous access. As noted elsewhere, in the past NSP services have tended not to get much input or feedback from, say, the Indigenous health sector. The situation is improving in this regard, however, with bodies such as VACCHO and the AH&MRC in New South Wales taking a more active role issues relating to hepatitis C.

A number of the issues considered in this subsection and in 3.2.1 above are reflected in a checklist for the location and presentation of sexual health and related services that comes from the 2004 AH&MRC/Mandala Consulting report on Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or who Have Blood Borne Infections. That report suggests that relevant services should:

- be close to reliable and regular public transport
- be in a discreet location, away from high traffic/visibility gathering points or services
not be in obvious proximity to security or law enforcement services

have minimal reception barriers to be crossed

be signposted in an appropriate way that de-stigmatises the main role of the service

offer multiple access points (eg shopfront, vehicle, foot)

display visible indications that the service is Koori-friendly – eg naming, posters, use of colours and symbols.

3.2.3 Views within communities and in the Indigenous health sector

The researchers heard frequently that many people within Indigenous communities have some difficulty with the harm reduction approach embodied in Needle and Syringe Programs; this point has been frequently made in earlier research (see Appendix C). It was reported that, for various reasons, abstention philosophies tend to be particularly strong across Indigenous organisations and communities, and that the notion of offering an NSP service thus tends to be controversial. Indigenous community embrace of an abstinence approach was attributed to a number of different factors, including a continuing legacy of Christian mission influence and the fact that alcohol has had such disastrous impacts in many Indigenous communities.

A Western Australian stakeholder described ACCHS commitment to an abstinence philosophy and resistance to NSP services as ‘fairly pervasive’. The Drug and Alcohol Service of South Australia (DASSA) has had relatively little success with a program, pursued over the past four years, aiming to increase the number of organisations in the community – particularly Aboriginal medical services – willing to act as NSP outlets. Staff interviewed at one ACCHS thought that their patients and the local community would be responsive to harm reduction messages and approaches, but that the Board would find provision of an NSP service hard to accept.

Across the country, the number of community controlled health services which participate in a Needle and Syringe Program is relatively small. In Victoria, for example, it was reported that only three of the State’s 26 Aboriginal medical services offer any NSP service; the position was similar in Western Australia and South Australia. In NSW the number of ACCHSs involved in providing NSP services has gone up and down over time, but the numbers are currently small.

37 Quoted in Implementation Plan for Aboriginal People (NSW HIV/AIDS, STIs and Hepatitis C Strategies), p16.

38 Strong adherence to an abstinence philosophy is also reported among Indigenous communities in Canada – see eg Dell C and Lyons T, Harm Reduction policies and programs for persons of Aboriginal descent, Canadian Centre on Substance Abuse, June 2007.

In the present study it was reported that conflict between abstinence and harm reduction principles was an issue that regularly arose within the national training program for Indigenous drug and alcohol workers. For some Aboriginal workers engaged in harm reduction activities, it was said, the first task is to ‘convince yourself’ of the appropriateness of this approach. An Aboriginal NSP worker in a country town commented that he found it quite difficult when he had to give out injecting equipment to young people whom he knew.
Apart from possible adherence (by elders, Board members, staff) to an abstinence approach to drug and alcohol issues, reservations about NSP services as such are compounded by ‘the crowded Indigenous health agenda’. That is, those working in Indigenous health face such a range of serious and widespread health problems that it is not surprising if an issue like hepatitis C prevention comes a long way down the priority list. Other reasons cited as underlying AMS/ACCHS reluctance to provide NSP services included the following:

- lack of funding for such organisations to offer NSP services
- lack of relevant training among staff members
- limited access to drug and alcohol staff or expertise in general
- difficulties in incorporating services for IDUs into what are seen as core health service responsibilities – including, for example, ensuring a positive environment for families or ‘mums and bubs’
- belief that IDUs can be a challenging and time-consuming client group
- concerns about negative impacts on reputation if the wider community came to associate Indigenous health services with drug injecting issues
- concerns in particular about negative impacts on relationships with neighbouring households or services in particular
- concern about possible legal implications – for example of making injecting equipment available to minors or to people for whom this might involve a breach of bail or parole conditions.

This situation plays out in various ways. Aboriginal Health Workers, for example, may not be well-informed about issues relating to BBVs, about drug injecting itself, or about NSP services. As a result they may be reluctant, or simply unlikely, to refer clients to NSP outlets. A doctor at one AMS commented that ‘some of the older staff would struggle’ if required to provide NSP information. As previously noted, several of those consulted by the study team also commented that mainstream services’ capacity to identify and respond to the needs of Indigenous IDUs has suffered in the past from a lack of clear advocacy on behalf of this group.

Given concerns within some Indigenous communities about NSPs being seen as ‘encouraging our people to use drugs’, it is clearly important to focus on effective ways of building community awareness and understanding of the value, for the whole community, of a harm reduction approach. People consulted by the study team suggested that this requires a holistic approach that places NSPs clearly in a broader health context. While Indigenous community members might be reluctant to engage in

---

39 As previously indicated, there were several instances where ACCHS personnel gave the study team what turned out to be inaccurate information about needle and syringe availability, or simply did not appear to know much about the services available.
discussion of health issues among drug injectors, they were thought much more likely to respond to messages about ‘preventable chronic disease’. Possibly community acceptance of NSP services may more readily be forthcoming for services which clearly do more than simply issue clean equipment – for example, ‘enhanced’ services such as are referred to in section 3.1.5 above.

3.2.4 Young drug users

People consulted by the study team often made the point that young people injecting drugs were particularly vulnerable to associated health risks, as a result of possibly limited knowledge and relative inexperience coupled with fear or uncertainty about approaching services. A worker in Cairns, for example, suggested that it possibly took a typical IDU a year or two to ‘start to interface’ with an NSP – ample time to suffer the consequences of not using clean equipment. According to NSP staff consulted in western Sydney, after two years of injecting around 50% of IDUs have become infected with hepatitis C; it was suggested that this situation was likely to be exacerbated among young Indigenous IDUs by additional cultural barriers to accessing mainstream services. ‘Eighty per cent of the young injectors we see turn out to have hep C’, said an Indigenous youth worker in Canberra. ‘By the time they get here’, said a Melbourne NSP worker, ‘a lot already have hep C’ – and ‘bad habits’. Since there is such a large Indigenous youth population and since people tend to pick up hepatitis C very early in their using life, said a Carnarvon worker, reaching young people is crucial; a Perth stakeholder used virtually the same words.

Various aspects of the ‘image’ of NSPs were mentioned by some observers in this context – for example a perception that NSP clients tended to be older, more established drug injectors. One reason why some younger IDUs might be reluctant to use NSP outlets, therefore, was a wish to avoid being identified with ‘those old junkies’.

Accordingly many of those consulted were concerned to find ways of reaching Indigenous young people with relevant information and support. Numbers of stakeholders, for example, referred to the lack of education on such issues at high school, and believed that appropriate education at junior secondary school level was likely to be the most effective way of doing this – though others argued that getting such an approach accepted in schools was likely to be a slow and difficult task. Another suggested option was to ensure that a wide range of youth workers and organisations have the necessary skills and resources to make young people – and Indigenous youth in particular – aware of key issues around injecting drug use, including the need to protect themselves against blood-borne infection if they should become involved. Publications in the style of Streetwize comics were seen by a number of stakeholders as valuable in this context.

---

40 The importance of including safe injecting information in school drug education programs was identified in numbers of the centres visited, including Adelaide, Sydney and Cairns.
ACCESS TO NSP SERVICES

A current NSW Health strategy document dealing with sexually transmitted infections and blood borne viruses notes the young age profile of the Aboriginal population and suggests that ‘key settings for reaching young Aboriginal people at greatest risk’ include:

(s)ettings which are primarily populated by young people, including places where young people ‘hang out’ or other settings such as Juvenile Justice Centres, school homework centres, youth centres, and other settings where activities such as sex work (including ‘sex for favours’) may take place ....

3.2.5 Supporting access by women

Some earlier research makes the point that harm reduction policies and services need to give specific attention to the characteristics and needs of female IDUs – including female Indigenous IDUs. One Australian source, for example, argues that ‘(S)trategies to reduce sharing of equipment might target women in particular, who demonstrate higher rates of sharing than their male counterparts’.

This report has noted that there are significant numbers of female Indigenous IDUs, and also that some women take responsibility for obtaining clean injecting equipment on behalf of partners or others. However, there are some NSP outlets which are largely or solely staffed by non-Indigenous male workers, and which may give the impression of being pretty much a male domain. It is essential that Indigenous women can feel comfortable accessing whatever NSP outlets are available in their area. The most obvious way of addressing this is by ensuring an appropriate gender mix in staffing of services. In Adelaide, for example, the comment was made that the female member of the Nunkuwarrin Yunti outreach team is often approached separately by female clients. SAVIVE in Adelaide has numbers of women NSP workers, and the mobile service operated by the WA AIDS Council has a two-person team of Indigenous workers, one male and one female.

3.2.6 Different types of service

Primary fixed outlets

IDU feedback received about primary fixed outlets (eg in western Sydney, Darwin, Alice Springs, Canberra and Cairns) was broadly positive, with key advantages of these services being that workers were well-informed and treated clients well. In Cairns, for example, an IDU (contacted through the user group QuIHN) described ‘the Dolls House’ there as a good NSP because it was in a convenient


location, was confidential, offered additional services such as counselling and STI testing, plus a vending machine (‘If it’s working’). In Alice Springs several IDUs said that NTAHC offered a good service – once clients got over their initial nervousness and uncertainty. A major limitation of primary outlets, of course, is that there are relatively few in number, and in particular that there are relatively few located outside the capital cities. For the most part primary outlets also have limited hours of availability, generally operating during standard business hours.

**Enhanced services**

Consultations suggested that enhanced NSP operations which offer ancillary health services and/or ‘drop-in’ facilities – for example MINE in inner suburban Melbourne – may offer benefits in terms of Indigenous access. On the one hand this is because the additional support available may be valuable for IDUs who are heavily disadvantaged and have very limited resources; enhanced services also tend to create more time to establish worker-client rapport and for workers to understand the client’s situation. Further, it may be easier for Indigenous communities and families to accept the value of something that provides a range of health and related services rather than an outlet that ‘just hands over fits’ (Darwin worker). As previously noted, there was positive client comment about the quality of service provided by the enhanced NSP at South Court Primary Care in western Sydney.

However, enhanced services are of course relatively costly to provide, and within a limited NSP budget there may be a trade-off between offering enhanced services in a particular location and providing more numerous if more basic NSP outlets. Given this tension, one possibility could be for governments to allocate some funding outside the NSP budget to enhance services in areas where there are significant numbers of Indigenous drug users. It also needs to be remembered that some clients may in fact prefer a service which simply gives them easy access to clean equipment. Workers consulted at South Court Primary Care saw ‘a fine balance’ between meeting IDUs’ immediate needs (eg for clean fits) and offering a broader service; being too treatment-focussed could ‘put people off’.

**Outreach and mobile services**

Mobile or outreach teams with both male and female workers were widely seen as a very good option in terms of Indigenous IDU access. DASSA representatives in Adelaide, for example, emphasised the value of such services for particularly marginalised or hard-to-reach groups, including Indigenous IDUs. A Melbourne stakeholder similarly commented that in his experience outreach services were highly valued by Aboriginal IDUS. A mobile service provided by the WA AIDS Council in Perth reportedly reaches numbers of Indigenous clients at some locations.

---

44 For an international review of the value of both mobile vans and dispensing machines in meeting needs among hard-to-reach IDUs, see Islam MM and Conigrave KM, ‘Assessing the role of syringe dispensing machines and mobile van outlets in reaching hard-to-reach and high-risk groups of injecting drug users (IDUs): a review’, Harm Reduction Journal 4:14, 2007. Among other things this review concludes that ‘dispensing machines and mobile vans are preferred modalities for hidden and high-risk IDUs’.
ACCESS TO NSP SERVICES

Nunkuwarrin Yunti in Adelaide has for some years operated a well regarded outreach service targeting homeless Aboriginal people in particular. The outreach service operated by REPIDU at The Block in Redfern has a large Aboriginal client group. Other examples include MINE in Melbourne which will deliver equipment requested by phone, 365 days a year, and the WASUA outreach service in Perth.

On top of the ‘wish list’ for some NSP workers consulted in Darwin was a mobile service which could provide HIV and HCV education, condoms and clean injecting equipment. It was said that a van providing such a service could effectively reach ‘hotspots’, and could also be used to provide some services in remote areas such as Maningrida.

Emergency Departments

Hospital Emergency Departments across the country represent a key source of secondary NSP services, being particularly important because of their accessibility after hours. However, some hospitals decline to play this role (for example because of the pressure of other work, or because of reluctance to attract IDUs to the hospital). In any event, some people commented that if a country hospital has a generally negative reputation in the local Indigenous community, it is not likely to be an attractive source of injecting equipment for Indigenous IDUs. One WA observer commented that Aboriginal people ‘don’t like hospitals in the first place’. ‘Clients hate them’, said a worker in Perth. Some of the nursing staff consulted at the Emergency Department at Port Augusta Hospital said that they had ‘never seen an Aboriginal client’ requesting needles and syringes.

Other stakeholders consulted in Perth noted that for Emergency Departments themselves NSPs are ‘not core business’, and in Carnarvon it was said that they see themselves as having ‘far more important things to do’; all hospitals departments are ‘understaffed, under the pump’. Not all hospital staff have received training relating to provision of NSP services; needle and syringe distribution policy may not be clear, or may be applied differently by different staff members.

Many of those consulted during the study made the point that staff attitudes at hospital outlets are variable and may in some cases be quite negative. An IDU in one town, for example, described staff responsible for issuing needles and syringes at the local Emergency Department as being ‘narky’ about this; ‘they want to make you feel like a junkie’; staff attitudes at the local NSP, he said, were ‘way better’. In another town the Emergency Department was described by IDUs as ‘a bit of a turnoff’; staff ‘treat you like a junkie’; ‘I’d rather not go there’. Hospital attitudes are ‘still a major obstacle in terms of prejudices (health worker Carnarvon). An Aboriginal worker in one country town thought that Aboriginal IDUs would go to an Emergency Department only ‘if they were half dead’, reflecting a perception that they were likely to be badly treated both as ‘blacks’ and as ‘junkies’. Indigenous IDUs in another town reported staff at the local hospital seeking to embarrass them by asking them to repeat their request for needles in a louder and louder voice.
**Other secondary outlets**

As previously noted, one advantage sometimes attributed to secondary NSP outlets is that you are not ‘labelling yourself’ by going there. On the other hand, it was observed that levels of staff training and the way IDUs are treated can vary substantially from service to service. Consultation suggested the value of providing NSP services through agencies which have a good general reputation within Indigenous communities, which are in accessible locations (eg by public transport) and where the service can be provided in a discreet fashion.

**Pharmacies**

In a number of locations it was noted that pharmacies are playing a smaller role in the supply of clean injecting equipment than they have done in the past when the alternatives were more limited.

Numbers of those consulted during the present study (eg in Canberra, Alice Springs, Carnarvon) were of the view that pharmacies tend to be used mostly by ‘middle class’, employed and/or recreational drug users (‘Mr Average’ or Mr Next Door’), while government or community-run NSP outlets are more likely to be used by disadvantaged, marginalised or dependent IDUs. ‘Functional’ injectors are generally inclined to use pharmacies, said a Melbourne worker, while it tends to be low-income and long-established drug users who are happy to use NSP services – people with ‘nothing left to lose’. In Mildura it was said that the NSP sees no ‘white collar clients’; these IDUs were assumed to purchase equipment from a pharmacy, or possibly acquire both drugs and injecting equipment from Melbourne or Adelaide.

Most of the community pharmacy representatives who were consulted in various locations indicated that those who purchase injecting equipment from them do tend to be ‘middle class’ customers, and that Aboriginal people purchasing needles and syringes is not common. A Mildura pharmacy, by contrast, reported significant numbers of Aboriginal people among its customers for injecting equipment. This pharmacy, which sells injecting equipment (3-packs and 5-packs), is also the pharmacy which dispenses most of the prescriptions written at the Aboriginal Co-operative. It reported that something like 30% of its needles and syringe customers were Aboriginal. Most of the sales were made after hours, with the typical age group being late twenties/thirties. In Port Augusta and Mt Isa, also, there are pharmacies with active links with the local AMS, which sell injecting equipment and reported having some Aboriginal customers.

IDUs who were interviewed during this study tended to be generally unenthusiastic about community pharmacies as a source of injecting equipment. For an IDU interviewed in Alice Springs, for example, pharmacies were the last resort: he tried ‘not to go there at all’. Service at a pharmacy was described as impersonal, and ‘some of the ladies screw their face up at you’. Particularly in small towns, it was said, the pharmacy may offer little privacy to IDUs. Indigenous IDUs may face the additional barrier of being seen by staff as ‘undesirables’ on the basis of race as well as drug use. Because of embarrassment...
and lack of privacy, people who go into a pharmacy intending to buy needles may get nervous, ‘buy some lollies and walk out’ (Carnarvon).

**Vending machines**

Given Indigenous IDU concerns with privacy and anonymity, it was widely thought that vending or dispensing machines were one useful way of improving their access to clean injecting equipment. Despite the need to have the correct change available, a number of the IDUs consulted said they would prefer to use a machine rather than go to a hospital Emergency Department; using the machine was discreet, quick, and did not require interaction with unsympathetic people. A vending machine can definitely be ‘a good supplement to back up a primary NSP after hours’ (Alice Springs).

On the other hand, a machine is obviously useful only if it is well maintained and regularly restocked. (One IDU in Cairns claimed that a local vending machine was ‘always empty’.) NSW staff consulted in Canberra commented that ensuring that the local machines were stocked and in working order was ‘the bane of our life’. In Mount Isa there was reference to the difficulty of finding the right location for a vending machine – for example one that was safe and convenient for users while not being easily observed by others.

**Aboriginal Medical Services**

Community controlled and government run Aboriginal medical services play a crucial role in the delivery of health services for Indigenous Australians across the country. However, their role in the provision of NSP services has been modest to date. Relatively few community controlled services, for example, have been willing to operate as secondary NSP outlets. There is a range of reasons for this, as summarised in section 3.2.3 above.

Both previous research and the present study also indicate that Indigenous IDUs themselves may have significant reservations about using AMSs as a source of clean injecting equipment. Some of the IDUs interviewed by the study team in various locations were quite dismissive of the possibility of obtaining services at their Aboriginal Medical Service: ‘They wouldn’t have a clue’; ‘They’re not interested; ‘No one in their right mind would go to [the AMS] to ask for a fit’. It was also clear that the ‘shame’ of revealing oneself as a drug injector was likely to be much greater if the person you were dealing with was also Indigenous.

As explained in earlier sections of this report, IDU reservations about using Indigenous-specific services reflected concern that they would be embarrassed or compromised by being seen by other community members or relatives, that appropriate standards of confidentiality might not be observed, and that health workers would lack expertise and/or empathy. Some nursing staff or AHWs were said to see NSP services as inappropriate or distasteful; of one country AMS that is authorised as an NSP outlet it was said that ‘the staff aren’t amenable’ to offering the service.
While AMSs were useful for many other purposes, a Western Sydney IDU did not see them as an attractive provider of NSP services: ‘I don’t want them looking down on me’; ‘I’d feel so embarrassed, ashamed’. Another IDU commented that while he attended a men’s group at the local AMS, he ‘kept quiet’ about his drug use. In Taree, although there is an NSP service available at the Biripi AMS, numbers of Aboriginal IDUs evidently prefer to obtain injecting equipment from the mainstream service based at the local Community Health Centre. In another location a male IDU said that although he used the AMS for his general health needs, he tried to ensure that he would not be recognised by staff as an IDU by injecting in places on the body which were not likely to be detected by health workers or doctors.

One result of Indigenous IDUs’ reservation about using an Indigenous-specific outlet is that, where an AMS does provide such a service, it may be used largely by non-Indigenous clients. For example Nunkuwarrin Yunti’s fixed site serves mostly non-Indigenous clients, as does the NSP outlet at Winnunga Nimmityjah Aboriginal Health Service in Canberra. Coomealla Aboriginal Health at Dareton, near Mildura, offered an NSP service a few years ago, but no longer does so. During its period of operation it reportedly placed great emphasis on attempting to ensure clients’ anonymity – for example by making deliveries of injecting equipment so that people did not have to come to the health service.

Within Aboriginal medical services the attitudes and approaches of CEOs evidently vary. At Nunkuwarrin Yunti in Adelaide, for example, it was said that clear and strong leadership had been important in enabling the service to play an active role in harm minimisation for IDUs. At an AMS in another State, by contrast, the CEO was said to be unenthusiastic about providing the NSP service, choosing to ‘turn a blind eye’ to it.

At one AMS the point was made that the service’s capacity to work effectively with any drug users was severely limited by the difficulty of employing a drug and alcohol worker. Two reasons for this were offered: a severe shortage of qualified D&A workers (especially Indigenous workers), and a lack of ongoing funding for such positions. The outcome was that the AMS lacked expertise in drug-related matters and was unlikely to be proactive in addressing them. In Port Augusta and in the Gascoyne region of Western Australia, also, it was emphasised that there was a severe shortage of drug and alcohol workers.

**Peer services**

Among those consulted by the study team there was frequent reference to the value of peer-based services in reaching Indigenous IDUs. Essentially this meant services provided by current or former IDUs, though in some cases there was an emphasis on the peer also being Indigenous. Among the IDUs interviewed in Alice Springs, for example, there was comment on the value of health services using peer educators (‘people like us’) to outreach to Aboriginal youth in particular. (It was interesting that some IDUs appeared to expect NSP workers themselves to have a history of injecting; in Canberra, for example, there was a complaint about one service to the effect that ‘some of them up there aren’t even users’.) It appeared that, at least within an Indigenous context, the ‘peer’ did not necessarily have
to be someone in the same age group; it was said in several locations that older people might be the most effective workers with young Indigenous IDUs. Some of the stakeholders consulted emphasised that, across the NSP, there is a place for both peer and non-peer services. Merely being a former user does not make you a good worker, while ‘there are some fantastic NSP workers who’ve never been near drugs themselves’ (Melbourne). It was emphasised that peer services need to be well managed and supported (Melbourne).

SAVIVE workers consulted in Adelaide made the point that it could be very difficult to recruit Indigenous peer workers (ie with experience of drug injecting) because they were reluctant to label themselves as drug users: ‘You out yourself and you’re out of the community’.

Choice

While there is no one type of NSP service which can be described as best or most acceptable for Indigenous IDUs, the point was frequently made that access is facilitated by offering clients some options as to which service they use.

3.2.7 Resources

OATSIH and other agencies have from time to time provided funding for the development and dissemination of printed materials designed to communicate with Indigenous Australians about hepatitis C and other blood borne infections, safe injecting and NSP services. Recently staff at DASSA in Adelaide have been working on hepatitis C resources specifically for Indigenous youth, while a Creole resource for use in Far North Queensland and the Torres Strait has been developed through extensive consultation (it addresses HIV, viral hepatitis and common STIs). However, the study team’s visits to a range of locations and services suggested that overall there is relatively little information currently available on such issues as hepatitis C prevention and safe injecting that is designed to cater for Indigenous Australians in particular, or to meet the needs of groups with limited English literacy.

People working in the NSP field expressed a range of views on the importance of brochures, pamphlets, posters and the like in relation to the needs of Indigenous IDUs. While some were anxious that appropriate and specific material should be readily available, others were concerned that ‘producing more pamphlets’ could be a trite response and a substitute for wrestling more actively with the problem. (One public servant, for example, indicated that she would be horrified if the present study resulted in recommendations for investing substantial time and resources in more printed materials.)

Three main issues were raised in relation to information material such as pamphlets and posters. First was the proposition that there was a need for resources that were culturally appropriate for various groups of Indigenous Australians – for example in terms of the graphics and terminology used. As noted

45 The role of peer-based services is emphasised in some of the earlier Australian studies, for example Australian Federation of AIDS Organisations, Something is Going to Get Us, November 2005.
earlier, the Condoman safe sex poster was often mentioned as an example of something that was clearly designed for and had been well received by an Indigenous audience. It was suggested that suitable resources on drug injecting and hepatitis C might be in story form, using people’s ‘own lingo’ (eg the term ‘goey’ for speed). More remote or isolated communities were certainly said to need their own resources (Cairns IDU); some stakeholders (eg in Darwin) also saw a need for information presented in community languages.

The second point was that many Indigenous Australians may have a deprived educational background, limited cognitive skills and limited literacy. It was also noted that English might be a second or third language for Indigenous Australians – not only in remote areas but also in urban centres such as Darwin. Accordingly a need was seen for resources which effectively used pictorial information supported by very clear and simple language. Poor education, poor concentration and low literacy levels were said to demand ‘a different approach’, with less reliance on the written word. (The point was made that such materials could of course have value also for other clients who might have low English literacy.) In Far North Queensland a need was seen for appropriate and localised information materials. Some of the material produced in the south, said one worker, was ‘just shocking’ in that it was ‘trendy’, obscure and difficult to read, and thus unsuitable for many local clients. The Condoman poster was again cited as an example of a strong Indigenous resource, and Streetwise comics were mentioned as effective in communicating with young and/or less well educated groups.

A third point was that the availability and display of Indigenous-specific materials sent an important signal that the service was aware of Indigenous issues and that Indigenous clients were expected and welcome.

One other issue that emerged from this research was that there may be certain educational messages that are especially relevant or important for Indigenous IDUs, and that can be communicated most effectively through purpose-designed resources. Given the points previously made about the pressure that Indigenous injectors may find themselves under to share their needles and other equipment, one clear example would be the message that sharing is not caring (a message that already appears in a pack of playing cards that has been developed as an Indigenous-specific drug and alcohol resource). Another matter that may deserve special attention in the context of Indigenous drug injecting is the issue of cleaning fits and the effectiveness or otherwise of this. It was clear from many of the discussions that took place during the study that there is a common belief that sharing needles is acceptable if there is some effort to clean them between users. If good practice requires ‘every hit a new fit’, Indigenous injectors in particular may need clear and consistent messages to this effect.

3.2.8 Urban, regional and rural locations

- There were many similarities in the issues raised by those consulted over the course of the study, whether they lived in metropolitan areas or in large or small towns. However there are of course some obvious differences in the situations which people face in city and country locations.
ACCESS TO NSP SERVICES

- Given that relatively more Indigenous than non-Indigenous Australians live outside the major cities, adequacy of NSP coverage and service quality in regional and rural areas represents one important element in providing appropriate access for Indigenous IDUs. Barriers to access, however, are in general most obvious in country areas, where there are likely to be relatively few options available and where small population numbers make privacy both particularly important, and quite problematic. We have noted the comment of one observer in Alice Springs, for example, to the effect that confidential access is very difficult to achieve in a town of that kind. In smaller centres the most likely source of clean injecting equipment - apart from friends - is either the Hospital Emergency Department or the community pharmacy, so that quality of access very much depends on how effectively these perform and on their reputation among clients and potential clients. In this context appropriately trained staff who treat clients well, and who understand the importance of privacy and discretion, are probably the most effective enabler.

- Access to NSP services is generally even more limited in rural or remote areas than in country towns. In Cairns it was reported that although hospitals in Cape York communities such as Lockhart River do offer clean injecting equipment, local Indigenous clients are unlikely to be comfortable using these, generally preferring to rely on obtaining equipment when they - or others - visit Cairns. The evidence of this study was that primary outlets in places such as Cairns, Alice Springs and Darwin are generally well aware of the needs of clients who come into town only at limited intervals, and who may be taking responsibility for distributing equipment to others at home.

- Indigenous IDUs living in the cities are in general likely to have more options available to them, and to find it easier to avoid NSP outlets in places where they may be known or recognised. However, clients in metropolitan areas may choose to travel some distance in order to ensure greater privacy, and accessibility of services by public transport was therefore identified as an important issue.

- Both in the city and in country locations, vending machines were seen as having the potential to significantly improve access, with the chief benefits being anonymity and unrestricted hours of availability. Not having coins, or the correct coins, was a possible barrier to vending machine access: there were some suggestions for introducing tokens of some kind or possibly a ‘swipe card’.

- Another practical issue raised by those consulted was that the availability of drugs can vary significantly between country and city areas. By and large, heroin was more difficult to obtain - and more costly - outside the large cities, so that amphetamines and other options such as morphine were more typical of injecting in regional and rural areas. Further, given the cost and the unreliability of drug supply in more distant or isolated areas, injecting was likely to be sporadic or opportunistic rather than regular. A number of stakeholders suggested that this was likely to increase the chances of unsafe behaviour.
3.2.9 Good practice

Particularly given their uncertainties about the role of Indigenous-specific services or Indigenous NSP workers, a number of those consulted during this study found it difficult to know what best practice in facilitating Indigenous access would be. ‘I’m a bit flummoxed, really’, said one experienced worker in the Northern Territory. The privacy and anonymity issues relating to employment of Indigenous NSP workers were described by another Northern Territory informant as ‘a bit of a double bind’. Therefore the point was often made that it was essential to offer options or choices that would enable people to make use of whatever type of service they found best suited their needs. As one person saw it, licensing a wide range of health workers to offer NSP services could be one possible way of achieving this.

While there may be no one approach that is clearly best or of general application, numbers of the services and activities which the study team heard about demonstrate aspects of good practice in facilitating NSP access for Indigenous clients. Specific examples are noted in Appendix H, covering such matters as the following:

- partnerships between the Indigenous health sector and those responsible for NSP policies and the management and delivery of NSP services
- an active role for drug user support groups
- approaches to making NSP services more inclusive or ‘Indigenous-friendly’
- cultural safety and awareness training for mainstream agencies
- extended NSP hours
- use of mobile/outreach services
- use of ‘enhanced’ NSP services
- use of dispensing machines
- peer services
- reaching young Indigenous IDUs
- offering choices or options for indigenous IDUs.
4 Conclusions and recommendations

4.1 NSP access in general

In many ways the access barriers and enablers affecting Indigenous use of NSP services are naturally similar to those affecting all IDUs. Some of these broad generic issues are summarised below:

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Limited hours of NSP operation</td>
<td>• Increased hours of operation, especially at night and at weekends</td>
</tr>
<tr>
<td></td>
<td>• Increased trialling/use of vending or dispensing machines</td>
</tr>
<tr>
<td>• Limited geographical coverage/need for</td>
<td>• Ongoing improvement in number/location of NSP outlets</td>
</tr>
<tr>
<td>clients to travel</td>
<td>• Ongoing improvement in training and support for people providing NSP</td>
</tr>
<tr>
<td></td>
<td>services</td>
</tr>
<tr>
<td>• Negative staff attitudes (especially in</td>
<td>• Location and layout of premises that offer privacy</td>
</tr>
<tr>
<td>some secondary outlets and pharmacies)</td>
<td>• Minimising charges</td>
</tr>
<tr>
<td>• Visibility when using NSP services</td>
<td></td>
</tr>
<tr>
<td>• Charges for equipment in some cases</td>
<td></td>
</tr>
</tbody>
</table>

Longer hours of NSP operation, increased availability of vending machines in suitable locations, improvements in the geographical coverage of NSP outlets, improvements in layout and design that protect clients’ privacy, minimisation of charges for injecting equipment, and ongoing training and support for people who deliver NSP services – all of these can be expected to improve access to NSP services for both Indigenous and non-Indigenous IDUs.

4.2 Indigenous access

Beyond this there are specific issues which arise more often or more significantly for Indigenous IDUs. These reflect a range of background factors, such as the following:

• Indigenous Australians tend to live in relatively small and close-knit communities – both in country and in city areas. This tends to make issues of privacy and anonymity especially significant for Indigenous IDUs.

• This and earlier studies suggest that in Indigenous communities there is often a lack of awareness/acknowledgement of the reality of drug injecting.
CONCLUSIONS AND RECOMMENDATIONS

- Relatively large numbers of Indigenous Australians live in regional and rural areas where health and community services may be limited and where there may be few options for IDUs to obtain injecting equipment. Quality of service from pharmacies and secondary outlets in non-metropolitan areas is therefore one important element in effective access for indigenous IDUs.

- Indigenous IDUs may perceive mainstream services – even specialist NSP outlets – as intimidating, racist, unwelcoming or simply unfamiliar.

- Indigenous disadvantage, marginalisation, lack of resources and pessimism about the future may on the one hand be factors underlying the misuse of drugs, and on the other can be reflected in risky behaviour and disinclination to use NSP services.

- The Indigenous population includes relatively high numbers of young and of mobile, transient or homeless people, among whom there is again the possibility of more risk-taking and less likelihood of accessing services.

While barriers of ignorance, fear and embarrassment may stand in the way of many IDUs accessing NSP outlets or other sources of clean injecting equipment, such barriers are likely to be especially significant for Indigenous IDUs because of their doubly marginalised status, their doubts about how mainstream services will receive them, and concerns about their drug use becoming public knowledge. In this situation many people may prefer to rely on obtaining equipment through friends or acquaintances.

One possible response to some of these issues is to locate more NSP services within appropriate Indigenous agencies or organisations – in particular in community controlled health services. However, there have in the past been difficulties with this approach both at the ‘supply’ and at the ‘demand’ end. As for supply, relatively few Aboriginal or Islander health services have to date been willing to offer NSP services. Various possible reasons for this have been discussed in earlier sections of the report (eg section 3.2.3), and can be summarised as follows:

- injecting issues and hepatitis C tend to rank low on the crowded Indigenous health agenda and must compete for resources with many other concerns

- the NSP harm reduction approach runs counter to the abstinence philosophies which are fairly common among Indigenous community leaders, including for example some ACCHS Board members

- there has to date been little funding to support ACCHS provision of NSP services, and staff are not sufficiently trained in issues relating to drug injecting and hepatitis C

- services for IDUs may be seen as difficult to offer in the ‘family atmosphere’ of an ACCHS

- it may be thought that offering NSP services could have adverse impacts on medical services in terms of their relationships with neighbours, other community organisations etc
some medical services are concerned about what they see as possible legal implications of offering an NSP service.

By the same token, this (and earlier) research suggests there is reluctance among some Indigenous IDUs to access Indigenous-specific NSP services (eg at an ACCHS) because:

- given the ‘shame’ or stigma associated with injecting drug use, they fear being recognised as injectors by staff or other clients who know them or their family (there may well be a cousin or auntie in the waiting room or behind the counter)

- they are not confident that medical service staff will be knowledgeable about injecting issues, and fear that they may well be judgemental.

One result has been that the clients of NSPs based in Indigenous health services have typically included many – perhaps mostly – non-Indigenous clients.

Clearly there needs to be ongoing support for Indigenous-specific health services which are willing to provide an NSP service. However, attempting to persuade reluctant ACCHSs to participate directly in the NSP may not represent the best use of resources at this point. While there is broad agreement among stakeholders that workers in the Indigenous health sector should receive more information and education about hepatitis C issues and risks, such information and education should possibly focus on enabling them to play a positive role in providing accurate information and guidance for IDUs and making appropriate referrals to mainstream NSP services.

Given the complexities involved, promoting effective approaches within the Indigenous health sector to preventing and treating hepatitis C – including NSP services – is perhaps best seen as a medium-term goal. Also needed in the short term is a concerted effort to make sure that all mainstream services operate in an inclusive manner and are supported in facilitating access by diverse groups of Indigenous IDUs. This could mean a range of approaches involving, for example, closer liaison between the NSP and Indigenous health sectors at national, State and local level, training for mainstream NSP workers in cultural competence and safety, recruitment of Aboriginal staff in appropriate situations, seeking input on quality and appropriateness of services from Indigenous IDUs and other community members, display of ‘Indigenous-friendly’ posters, signs and the like, and further development of Indigenous-specific resources.

### 4.3 Types of NSP service

This research indicates that Indigenous IDUs currently make use, to varying extents in different places, of the full range of NSP services and outlets available. However, it was frequently reported that they tend to be somewhat reluctant users of Emergency Departments and community pharmacies – essentially because they fear being treated poorly, made to feel embarrassed, or looked down upon. As
noted above, there are also particular issues surrounding people’s willingness to use NSPs located within Indigenous-specific services.

Broadly speaking the most acceptable kind of service is one which offers as much privacy as possible, where Indigenous clients can be confident of being treated in a courteous and helpful way, and where equipment is available free. Across the country there are numbers of primary and secondary services which meet these criteria to a reasonable degree. Ease of physical access is also important; mobile and outreach services of various kinds are valued both as facilitating access and as possibly offering greater privacy. Evening and weekend access are also regarded as highly desirable – but there are only limited numbers of high quality services which operate on this basis. Since they can offer both anonymity and extended hours of availability, vending or dispensing machines are another desirable element in a comprehensive range of services. Ensuring that IDUs have some choices or options open to them is a significant enabler.

4.4 Other issues

- A key conclusion from this research is that high priority needs to be given to delivering more effective access to services for young Indigenous IDUs, who are widely regarded as an especially vulnerable and hard-to-reach group. Those consulted during the study frequently made the point that young people are generally unlikely to seek out services early in their injecting life, that their behaviour is often ill-informed and unsafe, and that by the time they are sufficiently well informed and confident to approach an NSP they may well be HCV positive already. There do not appear to be any simple ways of turning this situation around, but it is important that there be concerted efforts to inform and educate young people on issues relating to BBVs, the health risks associated with injecting and how to reduce these.

- A range of youth strategies needs to be considered - for example development and dissemination of targeted resources (Streetwize comics could be one good precedent); information programs for high school students; work through both mainstream and Indigenous-specific youth services and organisations; and targeted youth projects such as the Hoops 4 Health project in Darwin. It appears that a peer-based service such as The Connection in Canberra can play an important role in engaging young IDUs and supporting safer behaviour and appropriate use of services. Given that young people may be initiated into drug injecting by older friends or relatives, and may rely on other people to obtain injecting equipment for them, there is also a need to consider how such peers or intermediaries can be encouraged more consistently to support safer behaviour among young and less experienced drug users.

- Although community pharmacies are an important element in NSP coverage across Australia, this research suggests that some Indigenous IDUs are reluctant to use them. Pharmacies which already have links with Indigenous communities (eg as the usual prescriber for the local AMS) and which
have significant numbers of indigenous customers should be encouraged to sell injecting equipment if they do not already do so.

- People consulted during this study made the point that an agency or service provider which does not enjoy the confidence of Aboriginal people generally is not likely to represent a particularly useful service for Aboriginal IDUs. It was suggested that this is one reason why some Indigenous IDUs may be reluctant to seek injecting equipment from hospital Emergency Departments. In establishing new secondary NSP outlets, particular attention should be given to agencies/organisations which are already familiar to and well-regarded in the Indigenous community.

- Past initiatives to facilitate Indigenous access have sometimes been limited by the short-term nature of their funding. These are long-term problems and finding solutions is likely to require adequate funding over a reasonable period of time.

- There is a need for collection of more adequate and reliable information about Indigenous Australians’ drug use and drug injecting – including, for example, surveillance of risk that may arise in remote locations.

- This study points to a pressing need to address unsafe injecting in prisons and for implementation of relevant pre-release and post-release programs for Indigenous prisoners.

### 4.5 Range of possible responses

The suggestions for improving access which emerged from this study were of several different kinds. Some focussed on fostering effective links or partnerships between NSP planners and providers and the community controlled health sector, so as to ensure that NSP services are more consistently informed by Indigenous perspectives and insights. Some related to NSP improvements or developments of a general kind, while others aimed to address barriers perceived as affecting Indigenous IDUs in particular. Some related to initiatives within Indigenous communities or Indigenous health services. Suggestions and proposals are summarised below.

**Partnerships, strategy and advocacy**

- further development of linkages between the Indigenous health sector (including NACCHO and its affiliates) and those responsible for planning and managing NSP services – in particular, State and Territory health departments

- more active advocacy for Indigenous community/IDU needs relating to blood borne viruses, and funding support for positions which will have this focus
stronger links between the Indigenous health sector and non-government organisations such as AIDS and Hepatitis Councils and with drug user support organisations, together with support of drug user organisations’ work in responding to the needs of Indigenous IDUs

- NSP service providers building relationships with and seeking input and advice from local Indigenous groups and organisations, and also seeking ongoing feedback from Indigenous IDUs

- research and education projects undertaken by bodies such as NACCHO involving Indigenous IDUs and the broader Indigenous community – for example, research on the needs of particular groups of Indigenous IDUs (eg women) or on improving services in regional and rural areas

**Role of Indigenous health services**

- training and awareness raising for people in the Indigenous health workforce on BBVs in general and hepatitis C in particular

- funding and support for community controlled health services which choose to offer NSP services

**Community information and education**

- ongoing information/education for Indigenous communities on issues such as drug injecting, HIV, hepatitis C, harm reduction and NSP services, taking account of varying community attitudes and expectations

- use of Indigenous radio programs to disseminate health messages on BBV issues and risk factors.

- use of this report in consultations on BBV and NSP issues with Indigenous communities

**Data and research**

- continuing and improved surveillance of hepatitis C infection, including monitoring of the situation in remote communities

- ongoing funding for research and data collection on the extent and nature of drug injecting among various Indigenous populations

**NSP service improvements**

- ongoing review of the location/distribution of NSP services, with the aim of increasing client options and with needs of Indigenous IDUs specifically taken into account

- improved after-hours access to clean injecting equipment – including wider use or at least trialling of vending machines

- increased use of appropriately staffed mobile or outreach services, with particular attention to the needs of Indigenous IDUs

- ensuring flexibility in policy on the amount and type of equipment that NSPs can supply
• training for mainstream NSP staff in cultural competence and safety, with Indigenous services or organisations being proactive in promoting or supporting such training

• recruiting Indigenous workers and volunteers wherever appropriate, and exploring the possibility of making Indigenous-specific appointments designed to extend the reach of NSP services

• increased emphasis on peer-based education for Indigenous IDUs, including support of existing NSP clients in playing a more consistent role in helping prevent HCV infection

• supporting the development of more ‘holistic’ NSP services which may offer drop in facilities, primary health care or referrals etc

• funding provision for enhanced NSP services in areas which are judged to have significant unmet need among Indigenous IDUs in particular

• display of appropriate Indigenous symbols and materials (purpose-designed posters and notices, the Aboriginal and Torres Strait Islander flags, etc)

• facilitating access to NSP services by female clients – eg by ensuring that both male and female workers are employed

• information and resources designed, in a consultative fashion, to communicate effectively with diverse groups of Indigenous IDUs, and to communicate messages that may be especially relevant for them.

Young people

• education on drug injecting, BBVs and harm reduction for secondary school students

• enabling/resourcing youth services, and especially indigenous-specific youth services, to offer information and support around drug injecting, hepatitis C and harm reduction

• information materials specifically designed to communicate with Indigenous youth, made available in a variety of ways including through print and other media targeting Indigenous young people

• outreach projects, activities and events targeting Indigenous young people in particular.

The prison system

• co-ordinated efforts to develop and implement education, treatment and harm reduction programs within adult and juvenile detention facilities.

The prison system

• co-ordinated efforts to develop and implement education, treatment and harm reduction programs within adult and juvenile detention facilities.
4.6 Key recommendations

1. Both previous research and the present study (see eg sections 2.2.1, 2.2.2 and 3.2.4) indicate that there are significant numbers of young Indigenous IDUs, that this group may be particularly hesitant to access NSP and related services, and that they represent a group at high risk of BBV infection. Therefore:

   *In consultation with communities, the Australian, State and Territory Governments should give high priority to identifying effective ways of reducing rates of HCV infection among young Indigenous Australians, and implement policies, projects and practices designed to achieve this.*

2. There has in the past been only limited liaison and co-operation between the NSP sector and key agencies and organisations in Indigenous health. This has been reflected in limited Indigenous input in the development of NSP policies and services, and insufficient articulation of and advocacy for the needs of Indigenous IDUs (see eg section 2.2.8). In recent years, however, NACCHO and its State and Territory affiliates have been more actively involved in identifying and addressing HCV and drug injecting issues and challenges in Indigenous communities. Therefore:

   *The Australian, State and Territory Health Departments should promote and support active co-operation between the Indigenous health sector and those responsible for planning and delivering NSP services, and in particular ongoing involvement by NACCHO and its affiliates in relevant research and policy development.*

3. Given that relatively few Indigenous-specific health services have to date been ready to offer NSP services, plus the fact that many Indigenous IDUs may have reservations about using such services to obtain clean injecting equipment (see eg sections 2.2.8 and 3.2.3), mainstream services will for the foreseeable future remain the main source of supply for Indigenous IDUs. Therefore:

   *At this stage improving access to mainstream NSP services represents the most effective way of facilitating access for Indigenous IDUs. This needs to be pursued both through general service improvements (eg continuing improvement in the number and location of NSP outlets, longer hours of operation including evenings and weekends, wider use of vending machines, offering IDUs some choice of services wherever possible, flexibility in amount and types of equipment offered), and also through initiatives designed to address the needs of Indigenous IDUs in particular. Policies and practices specifically addressing Indigenous access should include:*

   - training in cultural competence and safety for mainstream NSP workers
   - consultation by NSP planners and service providers with relevant Indigenous organisations, Indigenous communities and Indigenous IDUs themselves
   - employment of Indigenous staff where this is considered appropriate
CONCLUSIONS AND RECOMMENDATIONS

- in planning and designing of NSP services, identification and consideration of factors relevant to Indigenous access in particular – for instance significant concentrations of Indigenous population
- specific attention to minimising access barriers for Indigenous women
- consideration of options for ‘enhanced’ NSP services in areas potentially serving significant numbers of Indigenous clients
- expansion and improvement of NSP services in regional and rural areas in particular, including ongoing training for people providing services through secondary outlets and pharmacies
- increased use of mobile and outreach services
- increased use of peer-based approaches
- continuing development and distribution of information and resources targeting various groups of Indigenous IDUs
- use of posters, signs and the like which indicate that service providers are Indigenous-aware and Indigenous-friendly
- making use of secondary NSP outlet sites and pharmacies which are already familiar to or well regarded in the indigenous community
- use of Indigenous media, eg radio and print, to disseminate information about BBVs and NSP services
- more secure funding for innovations, projects and pilot programs designed to address Indigenous needs.

4 There are some community controlled health services which have played and continue to play a valuable role in delivering NSP services, and such work needs to be encouraged and supported. Indigenous-specific health services which may not wish to be directly involved in the providing NSP services can still contribute actively to addressing BBV issues among IDUs by providing relevant information, building closer relationships with mainstream NSP service providers, making referrals and the like. Therefore:

Where Indigenous organisations are willing to deliver NSP services there should be continuing support and encouragement for them to do so; the possibility of offering some funding assistance for this purpose should be considered. Indigenous health services which do not wish to offer NSP services directly should be encouraged (for example through assistance with staff training) to play an ancillary role through liaison with NSP outlets in their area, providing information to clients and referring people to NSP services where appropriate.

5. Indigenous IDUs, both male and female, are much more likely than non-Indigenous IDUs to be, or to have been, in prison; further, it is widely believed that unsafe injecting in prison is a significant factor in the spread of HCV (see eg sections 2.1.2 and 2.2.9). Therefore:

DoHA and the State and Territory Health Departments should give high priority to research and policy initiatives designed to address the issue of unsafe drug injecting in adult and juvenile prisons .
6. Effective long-term strategies for combating HCV infection among Indigenous Australians require engagement with and support from Indigenous communities themselves. Therefore:

DoHA and the State and Territory Health Departments should make use of this report in undertaking consultation and information-sharing with Indigenous communities around the issues of blood-borne viruses, injecting drug use, and ways of reducing hepatitis C infection among Indigenous Australians.
Appendix A  People and organisations consulted
### Darwin

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barry Horwood</td>
<td>Executive Director, NTAHC (NT AIDS and Hepatitis Council)</td>
</tr>
<tr>
<td>Craig Scott</td>
<td>NSP Coordinator, NTAHC</td>
</tr>
<tr>
<td>Timmy Duggan</td>
<td>Hepatitis C Project Officer, NTAHC</td>
</tr>
<tr>
<td>Damien Murray</td>
<td>Indigenous Sexual Health Worker, NTAHC</td>
</tr>
<tr>
<td>Shane</td>
<td>NSP Worker, NTAHC, Darwin City</td>
</tr>
<tr>
<td>Tom</td>
<td>NSP Worker, NTAHC, Palmerston</td>
</tr>
<tr>
<td>Cat</td>
<td>NSP Worker, NTAHC, Palmerston</td>
</tr>
<tr>
<td>Jan Holt</td>
<td>Sexual Health Unit, Territory Health Department</td>
</tr>
<tr>
<td>Jamie Broadfoot</td>
<td>Hep C/IDU/NSP Policy Officer, Department of Health and Community Services</td>
</tr>
<tr>
<td>Des McKenzie</td>
<td>AMSANT</td>
</tr>
<tr>
<td>Lexy Marshall</td>
<td>Community Pharmacist, Casuarina</td>
</tr>
<tr>
<td>Fiona</td>
<td>Peer Educator and NAP Harm Reduction Coordinator</td>
</tr>
<tr>
<td>IDUs</td>
<td>4 males, age range 20s – 30s</td>
</tr>
</tbody>
</table>

### Alice Springs

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Rosalie Schultz</td>
<td>Medical Officer, Clinic 34</td>
</tr>
<tr>
<td>Michael Cody</td>
<td>Clinical Nurse Manager, Community Drug and Alcohol Services</td>
</tr>
<tr>
<td>Tony Hand</td>
<td>Clinical Nurse, Community Drug and Alcohol Services</td>
</tr>
<tr>
<td>VJ Thorpe</td>
<td>Clinical Nurse, Community Drug and Alcohol Services</td>
</tr>
<tr>
<td>Susie</td>
<td>Retail Manager, Priceline Pharmacy</td>
</tr>
<tr>
<td>Jill Meade</td>
<td>NSP Coordinator, NTAHC</td>
</tr>
<tr>
<td>Craig Scolari</td>
<td>NSP Worker, NTAHC</td>
</tr>
<tr>
<td>Louise Gilbey</td>
<td>Education Officer, NTAHC</td>
</tr>
<tr>
<td>Dr John Boffa</td>
<td>Central Australian Aboriginal Congress</td>
</tr>
<tr>
<td>John Kiddle</td>
<td>Central Australian Aboriginal Congress</td>
</tr>
<tr>
<td>IDUs</td>
<td>3 males, 2 females, age range late 20s to mid 40s</td>
</tr>
<tr>
<td>Perth</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Jude Bevan</td>
<td>Senior Policy and Planning Officer, Sexual Health and BBV Program, WA Department of Health</td>
</tr>
<tr>
<td>Lisa Bastian</td>
<td>Manager, Sexual Health and BBV Program, WA Department of Health</td>
</tr>
<tr>
<td>Vanessa Hunt</td>
<td>Senior Program Officer, Sexual Health and BBV Program, WA Department of Health</td>
</tr>
<tr>
<td>Trish Langdon</td>
<td>Executive Director, WA AIDS Council</td>
</tr>
<tr>
<td>Leigh Cleary</td>
<td>NSP Manager, WA AIDS Council</td>
</tr>
<tr>
<td>Gail Jones</td>
<td>Aboriginal and Torres Strait Islander Community Development Officer, WA AIDS Council</td>
</tr>
<tr>
<td>Clyde Dubois</td>
<td>NSP Worker, WA AIDS Council</td>
</tr>
<tr>
<td>Sandra Fox</td>
<td>Manager, WASUA</td>
</tr>
<tr>
<td>Paul Dessauer</td>
<td>Outreach Coordinator, WASUA</td>
</tr>
<tr>
<td>Lenette Mullen</td>
<td>President, Pharmaceutical Council of Western Australia</td>
</tr>
<tr>
<td>Cliff Collard</td>
<td>Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Jennifer Keen</td>
<td>Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Norma Morrison</td>
<td>Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Angela Hanslip</td>
<td>Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Danny Kiely</td>
<td>Prisoner Addiction Services Manager, Department of Corrective Services</td>
</tr>
<tr>
<td>Holly Beasley</td>
<td>BBV Consultant, Health Services, Department of Corrective Services</td>
</tr>
<tr>
<td>Denise Cail</td>
<td>Workforce Development, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Celia Wilkinson</td>
<td>Workforce Development, Drug and Alcohol Office</td>
</tr>
<tr>
<td>Dr Susan Carruthers</td>
<td>National Drug Research Institute</td>
</tr>
<tr>
<td>Michael Doyle</td>
<td>Project Officer, Aboriginal Health Council of WA</td>
</tr>
<tr>
<td>Francine Eades</td>
<td>NSP Coordinator, Derbarl Yerrigan Health Service</td>
</tr>
</tbody>
</table>
## APPENDIX A – PEOPLE CONSULTED IN THE FIELD

<table>
<thead>
<tr>
<th>Carnarvon</th>
<th>Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quentin Richards: Case Manager, Gascoyne Population Health Unit, WA Department of Health</td>
<td>Owen Westcott: Senior Policy Analyst, AIDS/Infectious Diseases, NSW Health</td>
</tr>
<tr>
<td>Luke Wilkinson: Gascoyne Primary Health Manager, Midwest Region, WA Country Health Service</td>
<td>Felicity Sheaves: Acting Harm Minimisation Coordinator, Sydney West Area Health Service</td>
</tr>
<tr>
<td>Stephen Farrington: General Manager, Carnarvon Medical Service Aboriginal Corporation</td>
<td>Julie Page: Clinical Nurse, Specialist, South Court Primary Care, Kingswood</td>
</tr>
<tr>
<td>Taryn Duncan: Community Drugs Service Team, Mid West Health Service</td>
<td>Ian Bridges-Webb: Social Worker, South Court Primary Care, Kingswood</td>
</tr>
<tr>
<td>Vicki Chudziak: Community Drugs Service Team, Mid West Health Service</td>
<td>Julie Anne Downey: Enrolled Nurse, South Court Primary Care, Kingswood</td>
</tr>
<tr>
<td>Nursing staff: Carnarvon Hospital</td>
<td>Jane Shakeshaft: Acting Team Leader, Blacktown NSP</td>
</tr>
<tr>
<td>Robin Fahl: Pharmacist, Amcal Pharmacy</td>
<td>Dr Penny Abbott: GP, Aboriginal Medical Service Western Sydney Co-op</td>
</tr>
<tr>
<td></td>
<td>Leanne Schuster: Psychiatric Nurse, Aboriginal Medical Service Western Sydney Co-op</td>
</tr>
<tr>
<td></td>
<td>Tim Stern: Harm Minimisation Manager, Sydney South West Area Health Service</td>
</tr>
<tr>
<td></td>
<td>Troy Combo: Formerly Aboriginal and Torres Strait Policy and Projects Officer, Australian Hepatitis Council</td>
</tr>
<tr>
<td></td>
<td>Sallie Cairnduff: Project Officer, Aboriginal Health and Medical Research Council</td>
</tr>
<tr>
<td></td>
<td>IDUs: 2 males, 2 females, age range 20s to mid 40s</td>
</tr>
</tbody>
</table>
## APPENDIX A – PEOPLE CONSULTED IN THE FIELD

<table>
<thead>
<tr>
<th>Taree</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Reece</td>
<td>NSP Worker, Taree Community Health Service</td>
</tr>
<tr>
<td>Michelle Wilkes</td>
<td>Aboriginal Liaison Officer, Taree Community Health Service</td>
</tr>
<tr>
<td>Julie Elms</td>
<td>Hepatitis C Nurse, Taree Community Health Service</td>
</tr>
<tr>
<td>Greg Stewart</td>
<td>Sexual Health Nurse, Taree Community Health Service</td>
</tr>
<tr>
<td>Stacy Donovan</td>
<td>Sexual Health Worker, Biripi</td>
</tr>
<tr>
<td>Qew Druett</td>
<td>Manning River Pharmacy</td>
</tr>
<tr>
<td>Melinda Round</td>
<td>Office Manager, Accident and Emergency Department, Manning Rural Referral Hospital</td>
</tr>
<tr>
<td>IDUs</td>
<td>4 males, 6 females; age range 20s to mid 40s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dubbo</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret Crowley</td>
<td>Manager, Dubbo Sexual Health Service</td>
</tr>
<tr>
<td>Bedelia Skinner</td>
<td>NSP Coordinator, Dubbo Sexual Health Service</td>
</tr>
<tr>
<td>Bev Tyson</td>
<td>Aboriginal Health Education Officer</td>
</tr>
<tr>
<td>Kylie Vaughn</td>
<td>Secretary, Dubbo Sexual Health Service</td>
</tr>
<tr>
<td>Gai Honeyset</td>
<td>Front Desk Worker, Dubbo Community Health Service</td>
</tr>
<tr>
<td>Rex Wintle</td>
<td>Pharmacist, O’Donnells Pharmacy</td>
</tr>
<tr>
<td>IDUs</td>
<td>5 males, age range 20s to 40s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wellington</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Darren Ah See</td>
<td>CEO Wellington Aboriginal Corp Health Service</td>
</tr>
<tr>
<td>Billy Stanley</td>
<td>Sexual Health Worker, Wellington Aboriginal Corp Health Service</td>
</tr>
<tr>
<td>Jason Carr</td>
<td>Alcohol and Other Drugs Worker, Wellington Aboriginal Corp Health Service</td>
</tr>
<tr>
<td>Tyrone Kiernan</td>
<td>Registered Nurse, Wellington Hospital</td>
</tr>
</tbody>
</table>
### Melbourne

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roland Jauernig</td>
<td>Manager, Health Protection Services, Department of Human Services</td>
</tr>
<tr>
<td>David Wright</td>
<td>Project Coordinator, Health Protection Services, Department of Human Services</td>
</tr>
<tr>
<td>Kelly Gallagher</td>
<td>Koori Program Coordinator, Drugs Policy and Services Branch, Department of Human Services</td>
</tr>
<tr>
<td>Danny Jeffcote</td>
<td>NSP Team Leader, Drug Safety Services, North Yarra Community Health</td>
</tr>
<tr>
<td>Majida Ritter</td>
<td>Team Leader Community Development, Turning Point Alcohol and Drug Centre</td>
</tr>
<tr>
<td>Peter Waples-Crowe and other staff members</td>
<td>VACCHO</td>
</tr>
<tr>
<td>‘Bootsie’ Thorpe and Alan Thorpe</td>
<td>Koori Withdrawal Access Program, Ngwala Willumbong Co-Op Ltd</td>
</tr>
<tr>
<td>Damon Brogan</td>
<td>Executive Officer, VIVAIDS</td>
</tr>
</tbody>
</table>

### Mildura

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kayleen Tulloch</td>
<td>Drug and Alcohol Worker, Mildura Aboriginal Corporation</td>
</tr>
<tr>
<td>Paul Sloane</td>
<td>Social and Emotional Wellbeing Worker, Mildura Aboriginal Corporation</td>
</tr>
<tr>
<td>Mary Bassi</td>
<td>Drug and Alcohol Team Manager, Community Health Centre</td>
</tr>
<tr>
<td>Melissa Lonsdale</td>
<td>Drug and Alcohol Team Coordinator, Community Health Centre</td>
</tr>
<tr>
<td>Linton Gray</td>
<td>Manager, Coomealla Health, Dareton</td>
</tr>
<tr>
<td>Eric Oguzkaya</td>
<td>Albert and Braithwaites Pharmacy</td>
</tr>
</tbody>
</table>
## Canberra

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Van Den Dungen</td>
<td>Coordinator/Peer Support Worker, The Connection</td>
</tr>
<tr>
<td>Kim Davidson</td>
<td>CEO, Gugan Gulwan Youth Aboriginal Corporation</td>
</tr>
<tr>
<td>Selena Walker</td>
<td>Drug and Alcohol Worker, Gugan Gulwan Youth Aboriginal Corporation</td>
</tr>
<tr>
<td>Harold Chatfield</td>
<td>Coordinator Men's Program, Winnunga Nimmitjyah Aboriginal Health Service</td>
</tr>
<tr>
<td>Tracey Dobie</td>
<td>NSP/Pharmacy Program Manager, DIRECTIONS ACT</td>
</tr>
<tr>
<td>Teri Brandy</td>
<td>DIRECTIONS ACT</td>
</tr>
<tr>
<td>Tamara Speed</td>
<td>Australian Injecting and Illicit Drug Users League (AIVL)</td>
</tr>
<tr>
<td>Annie Madden</td>
<td>Australian Injecting and Illicit Drug users League (AIVL)</td>
</tr>
<tr>
<td>IDUs</td>
<td>7 males, 2 females, age range 20s to early 30s</td>
</tr>
</tbody>
</table>

## Adelaide

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Lymb</td>
<td>Manager, Harm Reduction, Drug and Alcohol Service of South Australia</td>
</tr>
<tr>
<td>Danielle Bament</td>
<td>Manager Clean Needle Program, Drug and Alcohol Service of South Australia</td>
</tr>
<tr>
<td>Don Hayward</td>
<td>Manager, Aboriginal Program, Drug and Alcohol Service of South Australia</td>
</tr>
<tr>
<td>Scott Wilson</td>
<td>Director, Aboriginal Drug and Alcohol Council</td>
</tr>
<tr>
<td>Janine Englehart</td>
<td>Aboriginal Health Council of South Australia</td>
</tr>
<tr>
<td>Michael McCabe</td>
<td>NSP Coordinator, Nunkuwarrin Yunti</td>
</tr>
<tr>
<td>Bradley Lawton</td>
<td>NUHIT Worker, Nunkuwarrin Yunti</td>
</tr>
<tr>
<td>Dominic Guerrera</td>
<td>Project Officer, Nunkuwarrin Yunti</td>
</tr>
<tr>
<td>George Carvajal</td>
<td>Drug Treatment Worker, Nunkuwarrin Yunti</td>
</tr>
<tr>
<td>Mandy Brown</td>
<td>Gambling Educator, Nunkuwarrin Yunti</td>
</tr>
<tr>
<td>Carol Holly</td>
<td>Manager, SAVIVE (South Australian Voice for Intravenous Education)</td>
</tr>
<tr>
<td>NSP Workers and other</td>
<td>SAVIVE</td>
</tr>
<tr>
<td>staff members</td>
<td></td>
</tr>
</tbody>
</table>
### Port Augusta

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Cooper</td>
<td>Sobering Up Centre</td>
</tr>
<tr>
<td>Gregory</td>
<td>Sobering Up Centre</td>
</tr>
<tr>
<td>Tamara Filmer</td>
<td>Pharmacist, Sparrows Pharmacy</td>
</tr>
<tr>
<td>Valery Oakey</td>
<td>DASSA Councillor</td>
</tr>
<tr>
<td>Marie Williams</td>
<td>Manager, Community Harmony, Port Augusta City Council</td>
</tr>
<tr>
<td>Cephas Stanley</td>
<td>CEO, Pika Wiya Health Service</td>
</tr>
<tr>
<td>Dr Carolyn Dearlove</td>
<td>GP, Pika Wiya Health Service</td>
</tr>
<tr>
<td>Carol Browne</td>
<td>Clinical Nurse Consultant, Emergency Department, Port Augusta Hospital</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>Emergency Department, Port Augusta Hospital</td>
</tr>
</tbody>
</table>

### Mount Isa

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny Darr</td>
<td>Injilinji Medical Service</td>
</tr>
<tr>
<td>Rachel Gregory</td>
<td>Sexual Health Worker, Mt Isa Hospital</td>
</tr>
<tr>
<td>Sandra Kennedy</td>
<td>ATODS</td>
</tr>
<tr>
<td>Ian Williamson</td>
<td>ATODS</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Angelo Bertoni Pharmacy</td>
</tr>
<tr>
<td>Jess Burrie</td>
<td>Pharmacy First</td>
</tr>
</tbody>
</table>
### Cairns

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda Kvassay</td>
<td>NSP Coordinator, Northern Area Health Service</td>
</tr>
<tr>
<td>David Rowley</td>
<td>NSW Worker, Northern Area Health Service</td>
</tr>
<tr>
<td>Nancy Long</td>
<td>Executive Officer Primary Health, WuChopperen Health Service</td>
</tr>
<tr>
<td>Joanne de Vries</td>
<td>Sexual Health Worker, WuChopperen Health Service</td>
</tr>
<tr>
<td>Ian Twist</td>
<td>Drug and Alcohol Workers, WuChopperen Health Service</td>
</tr>
<tr>
<td>Tamara McDougall</td>
<td>Coordinator, Youthlink NSP</td>
</tr>
<tr>
<td>Dan</td>
<td>Manager, Youthlink</td>
</tr>
<tr>
<td>Joanne Leamy</td>
<td>Clinical Nurse Consultant, Sexual Health Service</td>
</tr>
<tr>
<td>Anita Plesko</td>
<td>QuIHN</td>
</tr>
<tr>
<td>‘Kerry’</td>
<td>Volunteer, QuIHN</td>
</tr>
<tr>
<td>Miguel</td>
<td>NSP Worker, ‘Dolls House’, Cairns Base Hospital</td>
</tr>
<tr>
<td>Brendan Cashman</td>
<td>Queensland AIDS Council</td>
</tr>
<tr>
<td>IDUs</td>
<td>2 males, 2 females, age range late 20s/30s</td>
</tr>
</tbody>
</table>
Appendix B  Services and policies in the States and Territories
B1. New South Wales

B1.1 NSP services

New South Wales, the largest State, is also the jurisdiction with the largest Indigenous population – some 135,000 people. It also accounts for around 40% of national Hepatitis C notifications.

Within New South Wales’ ‘highly devolved’ health service structure, NSP services are managed on a regional basis, in both metropolitan and non-metropolitan locations, by the eight Area Health Services (AHSs). The Central Office of the Health Department, however, sets ‘the broad parameters in matters of policy, planning and finance’\(^1\).

In New South Wales the NSP is delivered primarily within the public sector, through the AHSs, complemented in the private sector through a government-subsidised community pharmacy scheme. Some non-government organisations are authorised to operate as secondary NSP outlets. A number of community-based organisations such as the NSW Users and AIDS Association (NUAA), the AIDS Council of NSW (ACON) and the Hepatitis C Council of NSW are funded to carry out a range of peer education and community development functions.

Overall NSW has the country’s largest network of NSP services. At the end of 2007 there were in total nearly 400 public sector NSP outlets across the State.

\(^1\) NSW Health Department, ‘COAG Supporting, Measures for the Needle and syringe Program 1998/90 – 2002/03’. 
Primary outlets

There are primary NSP outlets in various locations within all Area Health Services. These are outlets where provision of needles and syringes to prevent blood borne viruses is the prime purpose of the service. A primary outlet employs staff in positions where their primary role relates to the provision of NSP services. Primary outlets are required to:

- provide a range of needle gauges, 1, 3 and 5 ml syringes, and condoms and lubricant
- provide fixed site disposal services
- provide education, health promotion and brief interventions
- provide referral to a wide range of health and community services
- collect relevant data
- provide support to secondary outlets as required – eg in staff training and education, provision of injecting equipment and resources, and data collection.

Secondary outlets

Secondary NSP services are provided through a range of government and non-government agencies where the provision of needles and syringes is not a prime purpose of the service but occurs as one of a range of other health or community functions. Staff at secondary outlets are primarily employed to perform duties other than to provide NSP services. Secondary outlets are required, at a minimum, to:

- provide 1ml needles and syringes
- provide fixed site disposal services
- be able to refer people to the Alcohol and Drug Information Service and/or to a primary NSP
- record data on needle and syringe distribution in an appropriate way.

Typical secondary outlets include Community Health Centres, Sexual Health services, Alcohol and Other Drug (AOD) Services, Youth Services, Aboriginal Community Controlled Health Services (see below) and Hospital Emergency Departments.

Some secondary outlets are involved in both drug treatment services and the distribution of sterile needles and syringes.
Service modality

‘Service modality’ is the method by which an NSP service is provided. NSP services can be delivered from fixed sites (buildings), via outreach (pedestrian or vehicle) or via automatic dispensing machines. Often a primary or secondary NSP outlet will operate more than one service modality. The following strategies may be employed.

- **Mobile outreach**

  Mobile NSP services operate through use of a vehicle, and are typically delivered from a specified location at a specified time. Mobile outreach services can be classified as primary or secondary depending on their prime purpose. Primary mobile outreach services provide a full range of injecting equipment and aim to provide education, briefing intervention and referral services at levels similar to those offered at a fixed outlet. All mobile outreach services are required to provide disposal services.

- **Pedestrian outreach**

  Pedestrian outreach services are provided by staff who move around from place to place or group to group in an effort to promote and extend the reach of the service. Distribution of needles and syringes takes place as part of this broader promotional and education activity. Pedestrian outreach aims to increase access to IDUs who may not come into contact with NSP services in other ways. An important goal of outreach work is to develop rapport and credibility with clients, and refer them to other mobile or fixed site NSPs. The outreach worker’s task includes developing an understanding of the social structures and characteristics of an area so that professional relationships are established leading to better access and use of sterile needles and syringes. Generally, pedestrian outreach provides basic injecting equipment and a limited range of education resources. Outreach workers use brief interventions with clients and seek to make referrals as required.

  Where appropriate, outreach may also be provided at selected community events.

**Automatic dispensing machines**

There are over 100 automating dispensing machines in operation across NSW. These are devices used for the purpose of dispensing needles and syringes without the personal attention of staff. Automatic dispensing machines may or may not charge a fee.

**Pharmacy outlets**

Pharmacists across NSW may participate in the Pharmacy NSP Scheme, managed by the NSW Branch of The Pharmacy Guild of Australia. Under this scheme, in which 375 city and country pharmacies were participating at the end of 2007, pharmacies sell needles and syringes, or exchange...
used needles and syringes for new ones at no charge. (A small number of pharmacies sell needles and syringes independently of the Pharmacy NSP Scheme.)

Some retail pharmacies are involved both in methadone dispensing and in the distribution of sterile needles and syringes.

Over the four years to June 2008 NSW Health received some $2.5 million in COAG funding for diversification of NSP outlets and services and for increased counselling, education and referral.

B1.2 Serving Indigenous clients

Provision of NSP services in NSW comes within the broad terms of the NSW Health Aboriginal Partnership, signed off some years ago by the Health Department and the Aboriginal Health and Medical Research Council (AH&MRC – the NACCHO affiliate in NSW). The partnership agreement sets out guiding principles of consultation, support and shared understanding.

New South Wales also has an HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009. Among other things this sets out principles such as community ownership and participation, a holistic approach, workforce development and active outreach.

Within some Area Health Services there has been a long history of co-operation with Aboriginal Medical Services around the provision of NSP services, and across the state around eight AMSs are currently actively involved as secondary NSP outlets. In some locations, however, the provision of NSP services remains a controversial issue from the perspective of the Indigenous health sector.

During 2003, with financial support from OATSIH, the AH&MRC conducted a substantial research project on Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or who have Blood Borne Infections. Among other things the report on that study led to the establishment of two new positions within the AH&MRC – a Harm Minimisation Officer and a Workforce Development Officer. The AH&MRC continues to be actively involved in work designed to improve service quality and access to services for people at risk of hepatitis C. It has pursued a range of strategies, including training and awareness-raising for ‘the Aboriginal hepatitis C workforce’, which is largely identified with the sexual health workforce. NSW has a network of 40 Aboriginal Sexual Health Workers across the State, working in approximately equal numbers in the public and in the community controlled sector; they have specific responsibilities relating to blood borne infections and harm minimisation – including supporting access to NSPs – as well as sexual health.

---

2 The study team visited AMSs at Taree and at Wellington which provide NSP services.
The AH&MRC seeks to enhance capacity in the mainstream health workforce as well – including community pharmacies. There has also been work in innovative resource development – for example an interactive BBV resource designed for young people.

The aim is to increase awareness among Aboriginal service providers of Harm Reduction approaches and strategies (including NSP services), while also assisting mainstream services to become more Indigenous-aware and to offer more culturally appropriate services.

Relevant advocacy work by the AH&MRC includes work with appropriate Ministerial Advisory Committees and IASHC, the NSP Workers’ Forum, the Hepatitis C Council and NSW Health.

Another interesting initiative, evidently at an early stage, is a joint project in the Hunter/New England Area involving Aboriginal medical services, NUAA and ACON in efforts to enhance NSP access for Indigenous IDUs in the Newcastle region.

The Health Department has committed itself to increased collection of data on Indigenous use of NSPs.
B2 Northern Territory

B2.1 NSP Services

NSP services in the Northern Territory are overseen by the Sexual Health and Blood Borne Virus Program of the Territory Department of Health.

Primary outlets

There are two primary NSP services operating in the Territory – one in Darwin and one in Alice Springs. Both are managed by the NT AIDS and Hepatitis Council (NTAHC). The Darwin service has one fixed outlet at NTAHC in the city centre, and another at the rear of a shopping centre in the satellite town of Palmerston. The Alice Springs outlet is located at NTAHC’s premises in the town centre. These services operate during business hours, Monday to Friday, and on Saturday morning; they supply equipment free of charge. They receive both Australian and Territory Government funding support. Paid and volunteer staff include a small number of Aboriginal workers.

Secondary outlets

Clean needles and syringes are available at night and at weekends from Accident and Emergency Services at the hospitals in four Territory towns – Katherine, Gove, Tennant Creek and Alice Springs; there is currently, however, no NSP service available through the Royal Darwin Hospital. Sexual Health clinics (Clinic 34) in Darwin and these other four towns serve as fixed secondary outlets during the day.

NSP services are also available through the Royal Flying Doctor Service at Uluru, but there is reportedly only sporadic demand, and little if any Indigenous use of the service.

Pharmacies

About half of the Territory’s 24 community pharmacies currently sell injecting equipment. Of eight Darwin pharmacies listed as selling injecting equipment, there are reportedly two which sell substantial amounts (of the order of 200 packs a month). NTAHC has recently received funding with the aim of increasing the number of pharmacies acting as secondary NSPs. One stakeholder described pharmacies as ‘a weak spot’ in the Territory’s NSP coverage.

Some NT pharmacies purchase Fitkits that are made up for them by NTAHC at a cost price of $3 each; others purchase their own supplies from wholesalers.

User organisation

NAP in Darwin provides an informal NSP to its own members and contacts (‘a niche market’). Availability of injecting equipment through NAP was described as particularly important after hours.
The Northern Territory currently has no needle and syringe vending machines, and no NSP outreach services.

Mandatory prison screening for hepatitis C provides a form of surveillance in the Territory. Such screening reportedly shows infection rates of around 12%, with the overwhelming majority of those testing positive being non-Indigenous. Given a large Indigenous prison population, some stakeholders comment that this suggests currently low rates of HCV infection in the Territory’s Indigenous community.

B2.2 Serving Indigenous clients

Around one-third of the Northern Territory population is Indigenous. The percentage of client contacts identified as Indigenous by NTAHC in Darwin has increased from around 5% to around 10% over recent years.

The Northern Territory currently has no specific policies or strategies relating to Indigenous access to NSP services, but there have been two recent projects (both funded by the Commonwealth and both managed by NTAHC) which have aimed to improve levels of engagement with Indigenous IDUs.

One of these - the Aboriginal and Torres Strait Islander Hepatitis C Awareness Raising Project - is an initiative based in Darwin, and began in mid-2006. It involves the employment by NTAHC of an Aboriginal hepatitis C project worker, and aims to raise awareness and enhance knowledge of the disease in Aboriginal and Torres Strait Islander communities, and with service providers interacting with Indigenous communities, in the Darwin urban region. Target populations include HCV-positive Aboriginal and Torres Strait Islanders, Indigenous injecting drug users, influential members of Indigenous communities, Top End urban transient and town camp populations, service providers interacting with Indigenous people such as youth workers, sporting organisations and alcohol and drug workers. The key focus is on getting messages on hepatitis C out to young people, and the project includes work in both juvenile and adult correction facilities. Building on an earlier, mainstream health promotion program, it uses a ‘Hoops for Health’ approach that involves an annual basketball challenge.

The stated objectives of this project are:

- to engage and establish effective relationships with Aboriginal and Torres Strait Islander Injecting Drug Users;
- to raise awareness and increase understanding of the concept of hepatitis C amongst Aboriginal and Torres Strait service providers and services serving Indigenous Australians;
- to increase the number of Aboriginal and Torres Strait Islander people presenting for HCV screening, especially Injecting Drug Users;
APPENDIX B – SERVICES AND POLICIES IN THE STATES AND TERRITORIES

- to increase knowledge of HCV issues in the target groups, particularly groups in correctional settings;
- to support Aboriginal and Torres Strait Islander clients who are HCV positive and provide referral to appropriate services for support and treatment;
- to raise awareness about the potential harms of injecting drug use and the impact of HIV and Hepatitis C on the individual and the community;
- to raise awareness of needle and syringe programs and safe injecting practices; and
- to promote networking and referral opportunities.
B3 Western Australia

B3.1 NSP Services

Both government and non-government agencies provide NSP services in Western Australia. The program is co-ordinated and managed by the Sexual Health and Blood-borne Virus Program (SHBBVP) of the Communicable Disease Control Directorate, Department of Health. In 2006, 4.2 million needles and syringes were distributed in WA.

The WA Poisons Amendment Act (1994) allows approved organisations to provide sterile injecting equipment to people who inject drugs. WA has three main types of service: needle and syringe exchange programs (NSEP); NSPs based within health services (eg hospitals, community health centres); and pharmacy-based services. Regional coordinator positions are located in the Great Southern, Kimberley, Southwest, Midwest and Wheatbelt regions; these positions are supported by COAG funding to offer increased education, counselling and referral through community based organisations and support diversification of existing needle and syringe programs.

Primary outlets

Currently around 50% of WA’s needle and syringe distribution is provided through NSEPs which are operated by non-government organisations, funded through the SHBBVP. In Perth the WA Substance Users’ Association (WASUA) has a fixed primary outlet, while the WA AIDS Council (WAAC) provides a fixed outlet as well as a mobile service. WASUA also operates a mobile service in the south-west of the State.

Both WASUA and WAAC supply clean needles and syringes at no cost to the client, conditional on the return of used items, i.e. exchange; if no exchange takes place a cost recovery price is charged. WAAC reports that swabs are provided free, and sterile water at cost price. A range of other items of injecting equipment is available for purchase from both WASUA and WAAC. WAAC’s exchange policy was described as ‘strict, but with some flexibility’ in appropriate circumstances; staff aimed to work within ‘clear boundaries’ which are said to be generally respected by clients. It was reported that Indigenous clients, in particular, tend to ask for only small numbers of fits, suggesting to NSP workers that they cannot afford to inject frequently/consistently. Although legislation relating to possession of used equipment remains ‘on the books’ in Western Australia, the Police policy was said to be not to interfere with people carrying equipment for return to an NSEP.

---

3 A perceived advantage of this WA exchange-based model is that it minimises inappropriate disposal and thus reduces the time that might otherwise need to be invested in community relations around this issue. (WASUA reports a return rate of 97%.)
In Perth WASUA operates a fixed primary outlet in the inner city, backed up by some outreach work; its operation in the south-western region of the State is a mobile service. These are peer-based services. The fixed outlet in the city operates six days a week (to 8pm on Thursday and Friday). It also offers free BBV and STI testing, with pre and post test counselling, and free hepatitis A and B vaccinations (these BBV/STI services are supported by DoHA Hepatitis C Education and Prevention funding). It also offers information and supported referral to alcohol and drug treatment, housing, social and legal services; support and advocacy for people on pharmacotherapy programs; and peer support, information, referral and advocacy for people with hepatitis C or at risk of infection. Outreach work in the Perth metropolitan area focuses on providing equipment to people likely to have difficulty accessing a fixed outlet (eg those with a physical disability), or on reaching locations where there are known to be high concentrations of users. This outreach service averages some 15-30 client contacts a week – far fewer than the fixed outlet (which had around 5,000 client contacts in a recent 6-month period). About 5% of client contacts overall are recorded as Indigenous.

WAAC provides both a mobile service and a fixed outlet in Perth. Staffing of the mobile service currently includes two Aboriginal workers; it visits ten sites across metropolitan Perth each week (Monday to Saturday), spending at least two hours at each site in the afternoon or early evening. Operations at each site need to be approved by the local Council, and the locations are publicised through use of flyers and the like. The program is partly financed through COAG funds, which have enabled expansion to several outer suburban sites.

WASUA and WAAC coordinate their buying of supplies from wholesalers.

**Secondary outlets**

NSPs based in government health services distribute free sterile equipment in the form of Fitsticks® (five sterile NS with approved disposal device packaged in a plastic bag), which are provided at no cost to the service by the SHBBVP.

Under an Operational Directive issued by the Director General of the Department of Health, all regional and rural hospitals in Western Australia that provide emergency after-hours services are required to provide after-hours access to needles and syringes (free of charge) for people who inject drugs. Some hospital Emergency Departments offer a 24-hour service. NSP services are also available from some community health centres, population health clinics and the like.

**Pharmacies**

Pharmacy based services operate on a commercial basis through the sale of Fitpack® and Sterafit®. It was reported that the majority of community pharmacies in Western Australia sell needles and syringes. To do so, pharmacies require an approval from WA Health, but the Pharmaceutical Council has

---

4 The term ‘mobile’ service in Western Australia refers to a service which follows a regular timetable of visits to specific locations.
obtained a ‘blanket’ approval for pharmacies to sell a small number of standard products such as packs of 3 or 5 needles and syringes. Some pharmacies also sell ‘singles’, but require an individual approval to do so.

Community pharmacies are currently responsible for about one-third of the distribution of needles and syringes across the State (until about 2000, before the establishment of new primary outlets, pharmacies distributed about two-thirds of the total). In many WA towns the pharmacy remains the only source of clean needles.

The Hepatitis C Council has offered some training for pharmacists and pharmacy assistants, and has also trained undergraduate pharmacy students. Some pharmacies may also provide their own in-store training. There was reference in WA to some pharmacies deterring potential customers by charging unusually high prices.

Vending machines

As of late 2007 Western Australia’s only vending machine was located in the grounds of Kalgoorlie Hospital. A number of additional vending machines were about to be introduced in other regional locations.

Aboriginal Medical Services

In Western Australia only three Aboriginal Medical Services (two of them community controlled) currently offer an NSP service.

B3.2 Serving Indigenous clients

The WA Action Plans for hepatitis C and for HIV both identify Aboriginal people as priority target groups.

Aboriginal BBV prevention scoping project

In 2007-08 the Practice Development Branch of the Drug and Alcohol Office undertook a scoping project to determine how workers and organisations in Western Australia could be better supported through workforce development to provide blood borne virus harm reduction services (in particular, needle and syringe programs) to Aboriginal IDUs. The decision to conduct this study came after the SHBBVP had experienced little success in earlier efforts to engage with a number of Aboriginal Medical Services. Workers and organisations consulted included the following: Aboriginal Community Controlled Health Organisations, Aboriginal Health Workers, the Aboriginal Alcohol and other Drug sector, the mainstream AOD sector, BBV and NSP sectors. The project focussed on two non-metropolitan locations.

The objectives were to:
- identify barriers and enablers to ACCHOs providing NSP and other harm reduction services for Aboriginal people who inject drugs

- identify barriers and enablers in other sectors for providing blood borne virus harm reduction services for Aboriginal people who inject drugs

- make recommendations as to strategies to address barriers and capitalise on enablers

- inform the development of a sustainable model for providing targeted best practice training to support ACCHOs to implement needle and syringe programs (in accordance with the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008 Implementation Plan* and *Strong Spirit Strong Mind: Western Australian Aboriginal Alcohol and Other Drugs Plan 2005 – 2009*).
B4 South Australia

B4.1 CNP Services

Clean Needle Program (CNP) services in South Australia are overseen by Drug and Alcohol Services South Australia (DASSA), a state-wide health service that sits within the Southern Adelaide Health Service.

Primary outlet

There is only one primary CNP outlet in South Australia, run by the South Australian Voice for Intravenous Education (SAVIVE) peer education program – an arm of the AIDS Council of South Australia. This service is located in the Adelaide suburb of Norwood.

Secondary outlets

There are 68 secondary CNP sites across the State. These are sites that are not specifically staffed by CNP workers, but are run by staff at health and community service agencies as an ancillary service to their main business. Sixteen of these 68 secondary sites are located in metropolitan Adelaide and 52 in regional and rural South Australia. SAVIVE employs workers who operate at a number of secondary outlets across Adelaide.

In rural and regional areas the large majority of secondary services are provided through hospital Accident and Emergency Departments.

Secondary enhanced outlets

There are currently eight secondary enhanced CNP outlets, in which there is a dedicated CNP worker located within a high volume site. All of these sites are in metropolitan Adelaide.

Outreach services

There are three Outreach CNPs currently operating in SA; Outreach services target more marginalised groups of injecting drug users. Evidence quoted by DASSA suggests that providing CNP services through an outreach mode of service delivery is the best way to reach injecting drug users who engage in risky injecting practices and are at increased risk of blood borne virus transmission – for example Aboriginal, homeless, young and sex worker IDUs. The three outreach services include one which targets Aboriginal and homeless people in inner city Adelaide; another targeting street-based sex workers in Adelaide’s western and northern suburbs; and a third targeting Vietnamese drug users in the western suburbs.

References:

5 Conroy et al 2003; Miller et al 2002; Riley et al 2000
**Pharmacies**

The CNP Pharmacy Scheme, developed in collaboration with the Pharmacy Guild (SA Branch), offers pre-packaged injecting equipment for purchase at over 180 pharmacies across the State. Many pharmacy outlets also provide a sharps waste disposal service for the return of injecting equipment. To be classified as a CNP, pharmacies must sell needles and syringes with a sharps disposal container with all transactions. Pharmacies sell a variety of packs of needles, syringes and disposal containers for between $5 and $10. Some pharmacies also provide sharps disposal facilities.

**B4.2 Serving Indigenous clients**

CNP sites are not required to collect data on Aboriginality as part of the mandatory statistics gathered for each CNP client transaction, unless they are specifically funded (like the Nunkuwarrin Yunti health service in Adelaide) to engage Aboriginal people who inject drugs. However, a Client Satisfaction Survey that is conducted annually at seven of the busiest CNP sites asks participants whether they are of Aboriginal or Torres Strait Islander origin. In 2007 approximately 6% of participants identified themselves as of Aboriginal or Torres Strait Islander origin.

DASSA conducted a 4-year project, finishing in 2007 (the Access and Expansion Project), that was designed to promote improved access to CNP services for three specific groups namely young IDUs, IDUs of CALD background, and Indigenous IDUs. One aim was to increase participation in the CNP by appropriate services, including Aboriginal Medical Services. Although a small number of new services were developed, there was little overall progress in increasing AMS participation in the CNP.

With regard to specific services for Aboriginal people, there are currently five CNPs that are located within Aboriginal-specific health services in South Australia. Two of such services are located in metropolitan Adelaide: one of these is in the northern suburbs and operates a secondary CNP, while the other is located in the CBD - at Nunkuwarrin Yunti – and provides both a fixed site and outreach CNP services. DASSA provides funding to support the outreach service that targets homeless Aboriginal people who inject drugs.

In regional South Australia there are CNPs located at Aboriginal-specific health services in the Riverland, Port Augusta and Ceduna. Port Augusta and Ceduna are fixed site services operating within a sobering up service; in the Riverland the CNP is part of an outreach health service.
B5 Victoria

B5.1 NSP services

The Victorian NSP began in 1987 with the aim of preventing the transmission of HIV (and later HCV) among injecting drug users through the provision of sterile injecting equipment; safe disposal options; information and education around injecting-related issues including vein care, overdose prevention, amphetamine use and appropriate disposal; and referrals to other health and welfare services, including drug treatment services. The Victorian NSP also supplies condoms and lubricants.

The NSP is administered by Health Protection Services (HPS), a unit within the Drugs Policy and Services Branch of the Department of Human Services (DHS). The Drugs Policy and Services Branch, part of the Mental Health and Drugs Division, has responsibility for strategic leadership in drug prevention and policy, service development, drug program funding, and in implementing, operating, monitoring and evaluating drug programs and initiatives.

Victoria’s alcohol and other drug (AOD) treatment system operates pursuant to the Victorian Drug Strategy 2006-2009, which underpins a harm minimisation framework with four key objectives: reducing supply; reducing demand; improving access to services; and reducing harm. The Victorian Strategy sits within and complements the national policy approach, including The National Drug Strategy Aboriginal and Torres Strait Islander People’s Complementary Action Plan 2003-2009.

Victoria’s NSP is governed by the Drugs, Poisons and Controlled Substances Act 1981. Health Protection Services has responsibility for Primary Health, Mobile Drug Safety and Mobile Overdose Response Services, as well as Municipal Drug Strategies. These all cater for injecting drug users and have been established since 2000 under the Victorian Government Drug Initiatives (VGDI) Saving Lives Strategy.

In 2006-2007, over 7.1 million syringes were distributed across Victoria.

Primary, Secondary and Enhanced Secondary NSP Services

Of Victoria’s more than 200 active NSP outlets, only 19 receive direct funding specifically to provide NSP services. More than 90% are classified as secondary outlets, where the provision of NSP services is ancillary to the main functions of the host agency and is not directly funded.

Primary NSPs have the greatest capacity to engage in community education activities to provide clients with health information and education and with referrals to other health and welfare services, including voluntary drug treatment. They also provide a forum to maintain collaborative relationships with Police
and other agencies, such as schools, pharmacies, local government, and health, drug treatment and welfare agencies.

In areas of Melbourne with historically high levels of street-based drug use, primary NSPs are co-located with Primary Health Services for IDUs established under the VGDI Local Drug Strategies.

Primary NSP outlets may offer daytime or after-hours mobile services. Mobile services include the ‘Foot Patrol’ which operates in the Melbourne CBD providing outreach NSP access until 11:15pm seven days a week. Other services supporting NSP agencies are seven Mobile Overdose Response Services supporting hotspot NSPs and nine Mobile Drug Safety Workers operating in association with key NSP outlets – four in Melbourne and one in each of Victoria’s five rural and regional DHS regions.

Most Primary NSPs provide needle and syringe retrieval services to the general public. Disposal initiatives include a 24-hour toll-free Disposal Help-line providing counselling, advice and assistance regarding the safe retrieval and disposal of inappropriately discarded injecting equipment. The Department also works in partnership with local government and other relevant agencies to reduce needle and syringe litter and also to improve access to retrieval and disposal facilities across Victoria.

Secondary outlets across Victoria include:

- community health centres
- hospital emergency departments
- local government offices
- drug treatment, accommodation, student, Indigenous, youth and family services
- other health and welfare agencies
- community pharmacies.

Workers delivering NSP services range from reception staff and pharmacy assistants, through youth, social and community development workers, to drug and alcohol counsellors and registered nurses.

An Enhanced Secondary NSP is one of a select number of busier Secondary NSP services, operating from a Community Health or AOD Treatment Service, that is partially funded (through COAG) for staffing to provide education and information to IDUs and the wider community, and referrals to other health and welfare services.

All Primary, Secondary and Enhanced Secondary NSP outlets receive indirect support by way of the provision of consumables for distribution to clients (needles and syringes, alcohol swabs, sharps disposal containers, condoms and lubricant), a range of information and education resources, clinical waste disposal services and, crucially, orientation and further training for NSP workers.
Free hepatitis B vaccination is available to IDU clients of any NSP agency where a registered nurse is available to administer that vaccine, and there are facilities to store it.

Community Pharmacies

In 2004, 666 Victorian pharmacies sold almost one million needle and syringes on a retail basis, at a time when over 6.7 million needle and syringes were being distributed through the NSP. Hence it was gauged that community pharmacies accounted for approximately 13% of all needles and syringes accessed by IDUs.

Out of 1,218 community pharmacies across Victoria, 35 are more actively involved with the NSP – 11 as full secondary outlets and 24 for provision of disposal facilities for used injecting equipment. (The latter generally also provide pharmacotherapy dispensing services and sell injecting equipment on a retail basis.)

B5.2 Serving Indigenous clients

Victoria’s Indigenous population totalled 30,141 at the time of the 2006 Census, being 0.6% of the total Victorian population. Licit and illicit drug use in Indigenous communities has been well documented and remains a priority for DHS. In 2004 DHA collated available data on STI and BBV infection among Aboriginal Victorians; recommendations were made on improving data collection, access to services, training for Koori workers and education initiatives in secondary schools.

A 2006 survey of four Victorian NSPs revealed that 7% of their clients were of Aboriginal or Torres Strait Islander origin. Anecdotal evidence from Victorian Koori AOD workers suggests that illicit drug users are generally aged 30 years or younger.

Three of Victoria’s 26 Aboriginal Community Controlled Health Services are currently authorised to offer an NSP service.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has taken a number of initiatives designed to improve the effectiveness of services for the State’s Indigenous IDUS – for example a report on relevant partnerships and a proposed Memorandum of Understanding with Anex, the umbrella body representing NSP service providers.

DHS sees injecting drug users as a marginalised and hard-to-reach, at-risk population for whom NSPs may be the first point of contact within the health and welfare sectors. This puts NSPs in a unique position, with each service contact representing a potential opportunity to engage the client and encourage safer behaviours, from lower-risk injecting and appropriate disposal practices to accessing drug treatment. These issues are particularly relevant for Indigenous drug users. Stigma, shame and concerns regarding confidentiality and anonymity remain important issues for Indigenous IDUs and often affect their use of NSP services.
A specific project is due to commence in 2008 to raise awareness of the Victorian NSP among Aboriginal Community Controlled Organisations. This will be carried out in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Koori AOD Network (Vic). An Access and Equity Project has recently commenced, managed by Anex and investigating culturally and linguistically diverse projects and Indigenous access to NSP services, with a desired outcome of a Memorandum of Understanding with the VACCHO.
B6 Australian Capital Territory

B6.1 NSP Services
In the ACT the non-government organisation DIRECTIONS ACT is responsible, with funding from the Territory Health Department, for managing the Needle and Syringe Program (NSP). NSP services include primary outlets, secondary outlets, silent outlets, an outreach service, pharmacy outlets, syringe vending machines, and training of NSP workers.

Primary Outlets
There are two primary outlets in the ACT. One is located in Civic (Canberra City) and the other at Woden (geographically central in Canberra). These primary outlets offer a comprehensive range of free needle and syringe equipment, information, education, counselling, primary health interventions, referrals, and waste disposal. DIRECTIONS is also progressing a proposal for a mobile NSP service to address priority gaps in access to services.

Secondary Outlets
There are currently five secondary outlets in the ACT:

- AIDS Action Council, Acton
- Alcohol and Drug Service, Civic
- Belconnen Health Centre, Belconnen
- Winnunga Nimmityjah Aboriginal Health Service, Narrabundah
- Tuggeranong Health Centre, Tuggeranong.

Secondary outlets supply, free of charge, a limited range of needle and syringe equipment.

Silent Outlets
There are four ‘silent’ outlets in the ACT. These operate as secondary outlets but without any publicity of the provision of injecting equipment by the host organisation. Essentially they serve the particular group catered for by the relevant organisation – for example university students.

Pharmacies
A total of 34 pharmacies (approximately 60% of ACT pharmacies) sell injecting equipment, in the form of 4-syringe Fitpacks®, in a range of ACT locations. The recommended pharmacy price for a 4-pack, with sterile water and disposal container, is $2 (the equipment is provided to pharmacies at no cost).
It was suggested that pharmacies tend to cater for people who are in the workforce and recreational users.

DIRECTIONS’ ongoing efforts to further increase the number of participating pharmacies have been largely unsuccessful.

**Vending machines**
Canberra has needle and syringe vending machines located at Community Health Centres in the town centres of Civic, Woden, Belconnen and Tuggeranong. Customers pay $2 for a pack of four, with swabs, water and spoon. Pharmacies are the main source of injecting equipment outside the main town centres.

Options to increase the number of SVMs are currently being explored.

**Outreach**
A mobile outreach service, the ‘Sex Worker Outreach Program’ (SWOP), distributes injecting equipment to sex workers in the Fyshwick and Mitchell areas. Recently, DIRECTIONS has provided the training necessary for SWOP staff to distribute the range of equipment equivalent to a primary outlet.

**Hospitals**
There is no NSP service through Canberra hospitals.

**B6.2 Serving Indigenous Clients**
- Winnunga Nimmityjah Aboriginal Health Service provides a holistic health service for Aboriginal and Torres Strait Islander people of the ACT and surrounding areas. It operates a secondary NSP outlet from its Narrabundah facility – a service accessed by Indigenous clients as well as other members of the community.

- An evaluation of the SVM trial has reported that 11% of SVM clients and 10% of NSP clients who were surveyed identified as being Aboriginal.

- Gugan Gulwan Youth Aboriginal Corporation, an Aboriginal youth service, operates an NSP outreach service with support from DIRECTIONS.

- The Connection, a peer-based drop-in centre at Civic, is not part of the NSP program, but is an innovative service providing peer education and support for IDUs in the ACT, and for Aboriginal IDUs in particular. It is promoted as ‘Run for Indigenous users by Indigenous ex users’, and as offering services also to IDUs’ families and friends. The Connection is auspiced by AIVL, and receives funding support from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Foundation for Young Australians. It also acknowledges support from Gugan Gulwan, the
CDEP, the ACT Youth Coalition and the Sydney Peace Prize Foundation. Among other things The Connection uses a workshop educational kit that has been developed by young Aboriginal drug users.

- In 2003-04 the Hepatitis C Council of the ACT supported an Indigenous needs analysis which produced the report *I want to be Heard*. One outcome was an Indigenous-specific brochure on treatment for hepatitis C – described as ‘an example of a non-Aboriginal organisation with a non-Aboriginal worker successfully engaging Aboriginal communities’. 
B7. Queensland

The Queensland Needle and Syringe Program operates a primary prevention model of service delivery which provides universal access and includes health promotion, illness prevention, care of the sick and community development. The three-tiered service model has three operational types:

- **Primary NSP**: The primary role of staff is the provision of NSP services to IDUs - sterile injecting equipment, health promotion through education and information on BBVs and IRIIDs, transmission and risk behaviours associated with injecting drug use, safer drug use, injecting health, and referrals for drug treatment, medical, legal and social services. In addition, the program develops responses to community concerns such as inappropriate disposal of used injecting equipment.

- **Secondary NSP**: Staff provide limited NSP services as part of their general duties and the NSP is provided as an adjunct to other services.

- **Community Pharmacies**: Sterile injecting equipment is provided on a commercial basis.

B7.1 Program delivery

Staff delivering primary and secondary services are supported regionally by QNSP through a Senior Project Officer based in Brisbane and responsible for NSPs within the Southern Area Health Service (SAHS) and the Central Area health Service (CAHS) and a Coordinator for the Northern Area Health Service (NAHS) as a QNSP satellite position based in Cairns. They are responsible for delivering:

- Training of staff involved in all NSP service delivery (primary, secondary and pharmacy)
- Liaison and support to community pharmacies involved in distributing sterile injecting equipment
- Links with local councils regarding sharps management and disposal
- Facilitation of research
- Communication networks among IDU populations across the regions

Primary and secondary NSP services are located within the QH Districts (District) in each of the QH Area Health Services (AHS). Staff delivering primary and secondary NSP services report through the District Health Services management line for day to day operations. Secondary NSPs draw on capacity of the staff from the generic and clinical personnel of the District. Districts deliver secondary NSP services on an ‘opt in’ basis.
B7.2 NSP Workforce

Current NSP service capacity

There are a total of 140 NSPs in Queensland. Of these, 97 are actively ordering NSPs, with 17 primary outlets and 80 secondary outlets. Eight needle dispensing machines (NDMs) have also been installed across Queensland (Caboolture, Cairns, Dalby, Warwick, Mackay, Rockhampton, Bundaberg and Toowoomba).

Primary sites are predominantly located in major regional and metropolitan town centres, where distribution is high. Approximately half of the NSP outlets (including vending machines) currently provide some after-hours service and/or service on weekends.

NSPs are delivered through ATODS and sexual health services within Queensland, as well as through community health centres, non-government organisations and hospitals. Approximately one-third of the NSP outlets are located in hospitals with another one-third located in community health centres. A large proportion of hospital-based NSPs are situated in regional, rural or remote centres.

Table 3: Distribution of NSPs in Queensland

<table>
<thead>
<tr>
<th>Health Service District</th>
<th>Area District</th>
<th>Primary outlets</th>
<th>Secondary outlets</th>
<th>Vending machine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Cairns &amp; Hinterland</td>
<td>2</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Cape York</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mackay</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mt Isa</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Townsville</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Central QLD</td>
<td>2</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Fraser Coast</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northside</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Southside</td>
<td>3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sunshine Coast &amp; Cooloola</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wide Bay</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Southern</td>
<td>Gold Coast</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>South West</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Toowoomba &amp; Darling Downs</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West Morton &amp; South Burnett</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The range of equipment available varies across NSP sites. Rural and remote sites issue fewer types of equipment (some distributing only one type of equipment item, eg 3ml pack) compared to large regional and metropolitan sites, where equipment such as filters and swabs can be distributed.
Distribution of injecting equipment

The number of needles and syringes distributed through NSPs in Queensland over time has more than doubled in the last 10 years. In the last five years alone, distribution has increased by over 25%. The top 20 distribution NSP sites account for approximately 60% of the needles and syringes distributed in Queensland.

![Graph showing the distribution of injecting equipment over financial years](image)

Figure 1: Number of needles and syringes distributed through primary and secondary NSPs in Queensland over the last 10 financial years

Pharmacy sales and disposal

In addition to primary and secondary NSP outlets, there are 561 pharmacies across Queensland that participate in the sale of sterile needle and syringes, with 141 pharmacies providing sharps disposal services.
COAG NSP funding supports the partnership between public and private sectors, which is a key element of the model as it provides the Program with broad coverage, the capacity to provide universal and targeted access to IDUs and to focus on populations at highest risk for transmission of blood-borne viral and non-viral infections. An evaluation of the Pharmacy Needle and Syringe Project undertaken by Siggins Miller in 2006 reinforced the importance of pharmacies in increasing the accessibility of sterile injecting equipment in Queensland, where geographic coverage is a key challenge. The partnership with pharmacies is facilitated in this way through 1FTE project officer and returns a 1.5m distribution level.

Figure 2: Outlets and distribution for 2006-07 across the three tiers of the service delivery model
Appendix C  Literature review
C.1 Introduction

As indicated in section 1.4 of this report, several research studies have been undertaken in Australia over the past ten years or so among Indigenous IDUs in various geographical contexts. Given the difficulties of accessing this target group, such studies have typically relied on small sample sizes and on research methods that have been pragmatic in nature. While none of them individually provides definitive or representative data on the patterns of injecting drug use in Indigenous populations, together they offer a useful set of findings of relevance to the present study.

In particular, the following research studies have been considered in this review:

- A 2005 study of 70 Indigenous IDUs in urban and non-urban settings in the ACT, NSW, Victoria, Western Australia and the Northern Territory. Conducted by the Australian Federation of AIDS Organisations (AFAO) and the Australian Injecting and Illicit Drug Users League (AIVL), the study recruited participants through AFAO and AIVL member organisations. A blend of quantitative and qualitative information was gathered from respondents.¹

- A 1996 study of 77 Indigenous IDUs in the Brisbane area. A structured questionnaire was administered by peer interviewers, specifically trained for the purpose.²

- A series of cross-sectional studies conducted in Sydney between 1997 and 2001. Indigenous people who either inject drugs or participate in a methadone program were selected for interview. A range of methods were used to recruit people through services and word of mouth. The quantitative data obtained were analysed as three separate data sets, with sample sizes of 68, 121 and 23.³

- A 2001 study amongst 74 Indigenous IDUs in urban and non-urban areas of Western Australia. The study used peers interviewers to both recruit participants and conduct interviews, seeking both qualitative and quantitative data.⁴

- A study among 307 Indigenous IDUs in metropolitan Adelaide, released in 2003. The study (based on fieldwork conducted in 2001) used peer interviewers to collect both qualitative and quantitative data from respondents recruited through a ‘snowballing’ process.⁵

¹ Coupland H, Ball K, Costello M, Harvey B and Maher L, Something is Going to Get Us: a consultation and development project for a national campaign addressing injecting drug use in Indigenous Communities, 2005. AFAO and AIVL.
³ Day C and Dolan K, Characteristics of Indigenous Injecting Drug Users in Sydney; gender, prison history and treatment experiences, National Drug and Alcohol Research Centre, University of New South Wales. *Paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference convened by the Australian Institute of Criminology and held in Sydney, 8-9 October 2001.*

---

KAJ14006 Final Draft Report October
A study conducted over two years and completed in 2004 in the ACT, based on qualitative and quantitative research with 95 Indigenous illegal drug users (IDUs and others). Participants were recruited via a variety of services and through word of mouth.6

C.2 Levels of Indigenous injecting drug use

Most of the studies that are discussed here note the lack of reliable data on the prevalence of injecting drug use amongst Aboriginal and Torres Strait Islander people. However, as early as 1994 the National Drug Strategy Household Survey (1994)7 found that 3% of Indigenous people in urban areas reported that they had injected drugs (with 2% having done so in the last 12 months). This compared to 2% of the wider Australian population who reported having ever injected drugs, and 0.5% who had done so in the previous 12 months. Thus there has for some years been evidence to suggest that Indigenous people are over-represented in the IDU population.8 Such evidence is supported by more recent research. For example, the NSW study released in 20019 found that Indigenous people were consistently over-represented in the IDU population across three separate data collections. The figures ranged from 15% at the lowest to 19% at the highest (much higher, obviously, than the approximately 2% of Australians identifying as Indigenous).

The National Centre in HIV Epidemiology and Clinical Research released data in 2005 that demonstrated that the percentage of blood-borne infections attributable to injecting drug use amongst Aboriginal and Torres Strait Islanders had risen between 1995-1999 and 2000-2004 from 7.5% to 20.6%. There was no comparable rise amongst non-Indigenous people.

The 2001 Western Australian study11 considered longitudinal hospital admissions data that in the researchers’ view provided a fairly clear indicator that injecting drug use among Indigenous people had been increasing. They reported that between 1996 and 2000 there was a 125% increase among Aboriginal females and a 119% increase among Aboriginal males in hospital admissions for conditions thought likely to be associated with injecting drug use. These increases were 6.6 and 2.4 times greater than increases among non-Aboriginal females and males respectively.

While most NSP services do not routinely collect data to identify clients as Indigenous, their feedback provided to researchers across a number of these studies has indicated that increasing numbers of

8 Commonwealth Department of Human Services and Health, 1994
9 Day et al, 2001
11 Gray et al, 2001
Indigenous people are being encountered. While this could of course reflect a pattern of increased use of services, it has generally been thought to indicate that Indigenous injecting drug use was on the rise.

A literature review conducted on behalf of Danila Dilba Medical Service in 2000\textsuperscript{12} notes that ‘a number of studies have found that injecting drug use is more prevalent in urban Indigenous communities than in rural Indigenous communities’\textsuperscript{13}, and notes that the proportion of the Indigenous population who live in urban areas is around two-thirds.

C.3 Characteristics of Indigenous IDUs
As noted above, the methodological limitations of past research studies mean that they cannot be expected to offer a reliable demographic profile of Indigenous IDUs; nor, of course, can they provide a reliable basis of comparison between Indigenous and non-Indigenous IDUs. Typically, research participants have been recruited through informal channels, although with efforts being made to ensure that a reasonable cross section of participants is included. The studies have engaged research participants via NSPs and other services and through informal networks of injecting drug users. It is clear that the ‘samples’ obtained in such ways are likely to be biased towards people who are accessing services. In any case, even if more rigorous recruitment methods could be adopted, there are of course no available data on the Indigenous IDU population that could be used to provide a basis for reliable sampling. While acknowledging these reservations, the following paragraphs summarise some of the results of earlier research involving Indigenous IDUs.

In terms of age, the past research indicates that a significant proportion of young people are represented in the Indigenous IDU population (a finding that is also widely reported for IDUs in general – see below). For example, the early Queensland study\textsuperscript{14} found that the mean age of first injecting was 17.8 years and that 39% of those included in the study had commenced injecting before age 16. Younger respondents tended to report a lower age of first injecting than did older respondents. The conclusion drawn here was that, at that time at least, there was a trend towards younger Indigenous people becoming increasingly involved in injected drug use.

The WA study\textsuperscript{15} found a similar pattern. The age at which the 74 respondents reported having first injected drugs ranged from eight to 42 years. Some 34% had first injected at the age of 14 years or less, and a further 40% between the ages of 15 and 19 years. The researchers also reported a trend for the age of first injecting to decrease over time – with only 13% of those now aged 30 or more years having started injecting before the age of 15 years, compared to 47% of those now aged 20 to 29 years.

\textsuperscript{13} ibid p7
\textsuperscript{14} Larson et al, 1999
\textsuperscript{15} Gray et al, 2001
The SA study\textsuperscript{16} found that the average age of first injecting was 18.3 years, while a small number of people reported being as young as 10 or 11 years when they first injected. Only 3\% were 30 years or older when they first injected.

In terms of age of first injecting, these various findings suggest little difference in Australia between Indigenous and non-Indigenous IDUs, with numbers of other studies and reports referring to a mean or median age of around 18 or 19 years. For example the NCHECR \textit{National Data Report} on the Australian NSP Survey 2003-2007 reports 18 years as the median age of first drug injection among the NSP clients surveyed\textsuperscript{17}.

In terms of gender, some conflicting anecdotal evidence and survey data emerge from the literature. The NSW study\textsuperscript{18} found that (in the largest of the samples it analysed) there were roughly equal numbers of male and female Indigenous IDUs, while in the non-Indigenous sample there were about two-thirds males to one-third females. Other studies generally recruited larger proportions of males than females (at about this same ratio of two-thirds to one-third). Additionally, service providers consulted as part of these studies were often of the view that more Indigenous males than females attended services\textsuperscript{19}, but that women certainly made up a significant proportion of Indigenous IDUs. One study\textsuperscript{20} included a number (7\%) of transgender people in its sample. Again the available information on gender suggests similarities between Indigenous and non-Indigenous IDUs; on the basis of the NCHECR Data Report referred to above it would appear that, overall, males account for approximately two-thirds of IDUs using NSP services\textsuperscript{21}.

In terms of level of education, it has fairly consistently been reported that educational attainment among Indigenous IDUs is low by mainstream standards (as is also true of Indigenous Australians overall). For example, the WA study\textsuperscript{22} found that 48\% of respondents had not completed Year 10 schooling, with a further 38\% saying that Year 10 was the highest level attained. The Queensland study\textsuperscript{23} found that the average age of leaving school was 15, and that about half the respondents reported having had no further education after leaving school. However, in both these studies, small proportions had gone on to further education at a VET institution or university, and a handful of respondents were currently enrolled in high school or at a VET institution or university.

In the Queensland study\textsuperscript{24}, 65\% of those interviewed were unemployed and 25\% had never had a job. A national study\textsuperscript{25} reported that 65\% of its urban sample and 59\% of its non-urban sample were employed – including those employed through the CDEP.

\textsuperscript{16} Holly et al, 2003
\textsuperscript{17} See p2
\textsuperscript{18} Day et al, 2001
\textsuperscript{19} Holly et al, 2003
\textsuperscript{20} Coupland et al, 2005
\textsuperscript{22} Gray et al
\textsuperscript{23} Larson et al, 1999
\textsuperscript{24} ibid
A history of *incarceration* was common amongst Indigenous participants in all of these research studies. For example, the national study\(^26\) found that 44% of urban respondents and 27% of non-urban respondents had spent time either in gaol or in a juvenile detention centre; some 10% had been incarcerated in the previous 12 months. The Queensland study\(^27\) found that 39% had been in detention at one time or another; this was particularly common amongst the younger respondents, with 50% of those under 21 having a history of detention. The NSW study\(^28\) found that the likelihood of past incarceration was higher in the Indigenous population than the non-Indigenous population (68% vs 49%). Other available data tend to confirm that Indigenous IDUs experience disproportionately high rates of imprisonment; for example, over the period 2003-2007 the percentage of all IDU respondents to the Australian NSP Survey who had been in prison in the past year ranged between 13% and 18%\(^29\).

Some of the earlier research reports (eg *Something is Going to Get Us*, 2005) emphasise that Indigenous IDUs are by no means a homogeneous population, and that harm reduction measures thus need to target both urban and regional populations, diverse age groups and the like.

### C.4 Drug use and drug injecting

Earlier Australian studies indicate that drug preferences and drug use are reflective of local conditions (eg local drug culture, supply and cost issues) and may well change over time. In general, however, while a large number of illicit drugs figure in the list of drugs reportedly injected, there is a strong prevalence of amphetamine use although a preference for heroin.

The 2005 national study\(^30\) found that amphetamines were most often the last drug injected (44%), followed by heroin (39%). There was a clear difference here between urban and non-urban areas. Urban respondents (44%) were more likely than non-urban respondents (27%) to report having last injected *heroin*. In turn, urban respondents (35%) were *less* likely than non-urban respondents (64%) to report last injecting *amphetamines*.

The Queensland study\(^31\) found that all but one respondent had injected speed in the past, and 77% said this was the drug they had last injected. Some 66% had injected heroin, with 35% saying that this was the drug they last injected. A number said that they often used speed and heroin together in the same injecting session. Smaller numbers of people reported injecting other drugs including methadone, ‘homebake’, ecstasy, benzodiazepines, steroids, hallucinogens, cocaine and morphine.

---

25 Coupland et al, 2005  
26 ibid  
27 Larson et al, 1999  
28 Day et al, 2001  
30 Coupland et al, 2005  
31 Larson et al, 1999
The SA study\textsuperscript{32} found that 97% of respondents reported having used more than one drug in the past; the median number of drugs currently being used was four. Although non-injectable drugs such as cannabis figured prominently in the responses, 46% of respondents reported using both speed and heroin at least once per week. A high 82% said that they had injected heroin and 70% said they had injected speed. Heroin, however, tended to be the drug preferred – 56% preferred heroin as against 33% for speed.

The WA study\textsuperscript{33} found that 76% of those surveyed had injected more than one type of drug. By contrast with the studies conducted elsewhere in Australia, however, the WA study reported respondent ‘ambivalence’ towards heroin; only 19% had injected heroin on anything other than an experimental basis.

The SA study\textsuperscript{34} showed that among people who had injected heroin, only a minority had first tried it in some other form (eg smoking or ingesting it). Amphetamine injectors were much more likely to have first taken the drug via a method other than injecting; for example, 45% said they had snorted speed before they had tried injecting it.

The research presents a generally consistent picture of the circumstances in which people first injected drugs and continued to inject drugs. For example, the SA study\textsuperscript{35} found that 81% of first-time injectors received some assistance, 76% of these from another Aboriginal person – usually a relative (45%), friend (39%) or partner (14%). In the Queensland study\textsuperscript{36}, 84% stated that their first injecting experience was in the company of a relative or close friend. Some 65% of respondents identified these ‘helpers’ as Indigenous.

The national study\textsuperscript{37} found that among various factors contributing to the commencement of drug injecting, exposure through social networks was significant. Friends and ‘people I grew up with’ were commonly reported as the individuals providing the first exposure to injecting drugs. Exposure through family was also identified: siblings and cousins were the relatives most often reported, though parents and uncles were also commonly mentioned.

The WA research\textsuperscript{38} provides some detail about ongoing injecting drug use and the environments in which it occurs. Relatively small numbers of the WA respondents said that they usually injected either alone (12%) or with their partners (12%). The majority (69%) said that they usually used with some combination of friends, family members and partners. Seven per cent said that they injected with ‘anyone’. Two thirds (66%) of these WA respondents said that the groups with which they injected

\begin{thebibliography}{99}
  \item\textsuperscript{32} Holly et al, 2003
  \item\textsuperscript{33} Gray et al, 2001
  \item\textsuperscript{34} ibid
  \item\textsuperscript{35} ibid
  \item\textsuperscript{36} Larson et al, 1999
  \item\textsuperscript{37} Coupland et al, 2005
  \item\textsuperscript{38} Gray et al, 2001
\end{thebibliography}
consisted solely of Aboriginal people. Some 18% reported that their injecting groups sometimes included non-Aboriginal people, while 16% said that they injected only with non-Aboriginal people.

C.5 Sources of clean injecting equipment
The research provides a picture of accessing clean injecting equipment that reflects varying local circumstances and geographies as well as possible IDU preferences. For example the WA study\(^\text{39}\) reported that the majority of respondents (82%) obtained their needles and syringes from pharmacists; some 20% identified NSP services – which were at that time at a relatively early stage of development in WA - as their source of clean equipment. A number said that they also obtained equipment from friends or dealers. The WA study also sought to ascertain where people were not likely to go for clean injecting equipment. Some 32% identified one place or another, with pharmacies, hospitals and AMSs specified with equal frequency. No particular age differences were apparent in these results.

The early Queensland study\(^\text{40}\) found that at the time it was conducted pharmacies (69%) were the most common source of equipment. NSP services in various settings were used by just under half these respondents. Indigenous (35%) and non-Indigenous (14%) friends were also common sources for clean injecting equipment. Younger respondents were far more likely to rely on friends than to visit a pharmacy or NSP. The study found a strong reluctance to obtain clean injecting equipment from Aboriginal-specific services. As the report noted: ‘Overall, participants showed considerable scepticism about the expertise, confidentiality and sensitivity of Aboriginal health services towards the needs of injecting drug users.’ There was also a greater reluctance to visit pharmacies for clean equipment than was reported in the WA study.

The SA study\(^\text{41}\) reported that 36% of Indigenous IDUs were reluctant to obtain clean injecting equipment from pharmacies, while 15% said they did not like to use NSP services. That study also showed that it was common for people to obtain supplies in bulk (26% typically collected needles in boxes of 100 or more) and to obtain equipment on behalf of other people as well as themselves; 57% said that they usually collected equipment on behalf of at least one other person.

The 2005 national study\(^\text{42}\) expanded on the factors underlying Indigenous IDU preferences on where to obtain clean equipment. Cost was clearly one factor, with a number of participants in the research specifying said that they preferred to access free equipment where they could. Judgemental attitudes on the part of staff – whether at a hospital, pharmacy or NSP – also served as a barrier to accessing particular services. People reported that they avoided services where they had had a negative previous experience, regardless of the setting. Hours of operation were also a factor, leading to use of sources such as a late-opening pharmacy, mobile van or hospital as available. The national report also

\(^{39}\) ibid
\(^{40}\) Larson et al, 1999
\(^{41}\) Holly et al, 2003
\(^{42}\) Coupland et al, 2005
highlighted some people’s reluctance to access NSP services via an AMS or other Aboriginal-specific service; respondents spoke of a lack of awareness of the issues facing IDUs and an apparent lack of confidentiality that was sometimes exhibited. It was also noted – consistent with the research previously conducted in WA – that this reluctance was strongest in non-urban locations, where anonymity is a particularly difficult issue.

Virtually all of these earlier studies refer to the important role that ‘shame’ plays in Indigenous IDU interactions with services. Several instances were reported (for example in the national research) where IDUs had been ostracised in their communities for being known injecting drug users, and it was said that this persisted even if the injecting behaviour had stopped. The extent to which this directly leads to unsafe injecting practices (rather than accessing available services) is unclear. However, it is noteworthy that there is such consistent reporting that services or particular types of service are avoided because of shame.

According to various studies, vending machines were commonly used where there were available – and were called for in places where they were unavailable or difficult to access. Although respondents in the national study noted that vending machines involved a cost, having immediate late night access to clean injecting equipment was seen as an important means of deterring risky injecting practices. As one respondent said, ‘…there should be vending machines around for the days when there’s no fits around…on weekends and that…when I’ve caught Hep C would have been on a weekend …I’ve had no fits’.

The research also confirms that Indigenous IDUs may obtain clean injecting equipment from trusted friends or other members of the IDU community, and are comfortable with obtaining equipment in this way. A number of respondents spoke of how they themselves played a role in distributing equipment (obtained in bulk from an NSP) to their peers43.

In summary, the past research shows that Indigenous IDUs access clean injecting equipment through a variety of settings, tending to make greater use of services that offer after hours access and a non-judgemental, understanding and confidential environment.

C.6 Unsafe injecting and knowledge of risks
The previous research reports continuing risky injecting practices, with sharing of equipment reported as common. For example, 18% of the respondents to the Queensland study44 said that they had shared a needle in the past week, while a further 21% had shared in the past month (with sharing defined as using a needle before or after someone else). Sharing was much higher among young people - 63% of those aged under 20 reported sharing in the previous month. Virtually all of those who reported sharing

43 ibid
44 Larson et al, 1999
said that needles were cleaned between uses, but only about a half of these used the (then) recommended method of bleach and cold water 2X2X2.

The WA study went into some detail about the sharing behaviour of Indigenous IDUs. Some 43% of the sample acknowledged normally sharing needles when they injected. A larger 53% reported sharing bags, spoons, filters and other injecting equipment. Among these people, many said they were part of an ‘injecting group’ where needles and other equipment were always cleaned between uses. However, few if any of these people described cleaning practices that effectively minimised the risk of viral transmission. For example, most reported using boiling water rather than cold water to clean equipment, many without using bleach. Some reported using alcohol or detergent to clean equipment.

In the SA study\(^{45}\) 64% of those surveyed had at some time used a syringe either before or after another person, with 12% having used a syringe after another person in the previous 2-3 months. Among those who had shared a syringe or other equipment, only 22% described a cleaning process regarded as ideal. The SA study also explored the reasons for sharing injecting equipment. Lack of availability of clean equipment was put forward as a reason for sharing in 71% of cases, with 29% specifically saying that the NSP was closed and 15% saying that they had no transport to get to an NSP. Familiarity with members of the injecting group was also a common response, while 15% of those who reported sharing indicated a lack of concern for the implications of this. Only 4% referred to a lack of awareness of the risks of sharing.

The ACT study\(^{46}\) found broadly similar patterns, but also observed that ‘accidental’ sharing occurred at times, whereby someone else’s needle was used by mistake – even though it might have been labelled or marked in some way to signify ownership.

Among other things these results point to resignation among some IDUs to the prospect of contracting a blood-borne infection. This was a theme also explored through the AFAO/AIVL national research\(^ {47}\), leading to the report’s title of ‘Something is Going to Get Us’. That report states that hepatitis C in particular was considered by many in the sample to be ‘common’, or ‘nothing’, and it goes on to suggest that people had a perception that premature death from other causes was likely in any event. In the words of one respondent, ‘…gunna die anyway soon from all those other things like heart and liver’.

The study also suggested that a lack of awareness of the routes of hepatitis C transmission, or a belief that transmission could not be effectively prevented, were factors relevant to sharing behaviour.

Information presented in the NCHECR National Data Report on the Australian NSP Survey 2003-2007 (p1) shows that among NSP clients surveyed over that period ‘re-use of someone else’s needle in the last month ranged between 13%-18’%, while 71%-75% reported using sterile needles and syringes for

\(^{45}\) Holly et al, 2003
\(^{46}\) Dance et al, 2004
\(^{47}\) Coupland et al, 2005
all injections in the past month. Given that different researchers have asked somewhat different questions in this context, comparing survey data on sharing of equipment is not straightforward.

C.7 Education and other services
Several of these studies sought to explore what demand existed for additional services for Indigenous IDUs. When respondents in the WA study\textsuperscript{48} were asked what additional services were required, a high percentage said more counselling and/or treatment services. On the question of whether such services should be Aboriginal controlled or mainstream services, respondents were evenly divided. Perhaps the more important point was that services needed to be familiar with and understanding of both drug culture and Aboriginal culture. In the words of one respondent, the service should be ‘…for everyone and all drugs. Don’t care who runs it as long as staff are understanding of where we come from’. Thirty per cent called for enhanced education for IDUs about available services and harm minimisation practices, and some respondents specifically mentioned the need for education in schools about the harms of injecting drug use. Some 25% wanted to see some form of community-based family support for IDUs. Two-thirds called for greater access to clean injecting equipment, preferably free.

The AFAO/AIVL national research\textsuperscript{49} canvassed issues relating to the nature of any future education approaches for Indigenous IDUs. There was a fairly clear consensus that more education was needed, and a number of suggestions were made as to how this might be made more effective. Firstly, respondents stressed the value of peer education or, as one person put it, ‘us mob telling each other’. Past and present IDUs and people living with blood-borne viruses were thought to have the most credibility and ability to communicate with people in an informal and natural way. Older people were singled out as being particularly credible. A respondent to the AFAO/AIVL study claimed to be already playing this kind of role and actively distributing various educational pamphlets and the like to others in the community.

NSPs were seen as an obvious place to distribute information - whether to individual IDUs or to peers or intermediaries who might distribute it more widely. It was suggested that all packs of needles could include some written information or a sticker that provided a short message and/or helped to make Indigenous clients feel welcome at the service.

The research also suggested a role for written information with ‘a black face’. It drew attention to the importance of making written information available in a variety of formats, to suit people of different literacy levels, ages, economic circumstances and cultural backgrounds. The use of radio, and in particular music, was also suggested as an effective communication channel for some.

The research also found that some saw merit in organising social events or gatherings for Indigenous IDUs. Putting on a barbeque, for example, with the possibility of social interaction, was thought to

\textsuperscript{48} Gray et al, 2001
\textsuperscript{49} Coupland et al, 2005
provide a good basis for communicating an educational message. More educational activities in schools, gaols and legal centres were also advocated.

The national study also stressed the importance of using education and other approaches to encourage acknowledgement of the fact of drug injecting in Indigenous communities and to attempt to address the stigma associated with injecting drug use. IDUs involved in that study were of the view that Elders, AMSs and other community organisations had potential roles to play, but that this was not happening. There was a strong sense that the issue had been hidden or ‘swept under the carpet’ to avoid the shame that it might involve for the community. It seemed clear from this research that the development and refinement of services appropriate for Indigenous IDUs was, in part at least, being hampered by a lack of acknowledgement of the problem in the Indigenous communities.

The NSW report published in 2004 places particular emphasis on a need for a holistic approach to addressing blood-borne infections among Aboriginal people – placing hepatitis C issues, for example, in the broader context of other blood-borne infections, general health, and social, cultural and emotional factors.
Appendix D  Discussion guide for health services /NSP management and staff/other relevant community organisations
1. What services are available in this area for injecting drug users (IDUs) – eg Needle and Syringe Programs, fixed or outreach services, chemists who sell needles and syringes, etc? How suitable or adequate are those services for IDUs generally, and for Indigenous IDUs in particular? What do you think are the main sources of injecting equipment for IDUs – especially Indigenous IDUs?

2. Has the availability of services changed over time? In what ways? For better or for worse?

3(a). How much is known about injecting drug use in this area – especially among Indigenous people? eg any information about numbers, or how widespread the practice is? What is known about gender, age group etc of Indigenous IDUs? and about their frequency of injecting?

3(b) How easy or difficult is it to distinguish injecting drug use by Indigenous people? Are there any apparent differences between the practices or circumstances of Indigenous and non-Indigenous IDUs in this area?

3(c) Which drug(s) are most often injected in this area (generally, and by Indigenous IDUs in particular)? How readily/regularly are such drugs available?

3(d) Are there any particular groups/places/times/situations in which Indigenous people are more likely to inject?

3(e) Has the ‘drug scene’ changed in any significant ways over recent years?

4. How aware do you think IDUs in this area (and Indigenous IDUs in particular) are of issues like safe injecting and safe sex? Do you think there is a lot of unsafe behaviour – such as sharing needles? Are there particular sorts of (Indigenous) injectors who are more at risk than others? Are there particular places/times/situations where people are more likely to share needles?

5. What sorts of information (eg leaflets, posters etc) are available for Indigenous IDUs on health and safety issues?

6. How much use do Indigenous IDUs make of the health services, sources of clean injecting equipment etc which you referred to earlier (see Q1)? Are there some types of services that they use or prefer over others? Do you think that Indigenous IDUs use the available services more/less than non-Indigenous IDUs, or use services in different ways? Why is that? How do you know?

7. Are there particular things that you think encourage or deter access to services by Indigenous IDUs?

8. Are there particular groups or sorts of Indigenous IDUs who do/do not use NSP outlets, particular types of outlet, or other relevant services? Why do you think that is? Are there any other services or sources of help that Indigenous IDUs may use?

9. How much does the broader Aboriginal community know about drug injecting in this area? What attitudes do community members take? What implications, if any, do those community attitudes have on IDUs’ behaviour, willingness to use services etc?

10. Do you know of any particular strategies or approaches designed to encourage access to services by Indigenous IDUs – either locally or generally? What are they? What do you know/feel about the appropriateness or effectiveness of these?

11. Are there any services or approaches being used in this area that you think are particularly successful or effective, or could be described as ‘good practice’?

12. Can you suggest any ways in which Needle and Syringe services in this area could be improved, or made more accessible to Indigenous IDUs? What is currently working well, and what might work better?

13. Do you have any other comments on the matters we have been discussing?
Appendix E  Discussion guide for injecting drug users
NOTE: It may not be possible to cover all questions in each interview.

1. Do you think there are many Aboriginal or Torres Strait Islander people\(^1\) in this area who inject drugs? Do you have an idea of how common that is, or about how many people inject drugs?

2. Which drug(s) do you think Aboriginal\(^1\) people around here inject? How easy or hard is it for people to obtain those – eg is there a pretty regular supply? does the cost vary a lot? why is that?

3. What sorts of Aboriginal people in the community are injecting – eg which age groups? men or women? particular parts of the community? About how many people do you think would be regular/occasional injectors?

4. The Aboriginal people round here who inject – do you think most of them know each other, or are there separate groups, or people who keep to themselves? Do Indigenous injectors have a lot of contact with non-Indigenous injectors, or is it pretty much a separate ‘scene’?

5. Do you think there are any particular problems or risks for the people who inject? What are they? How are people who inject regarded by the wider Aboriginal community? How are they treated by the Police? by health services?

6. Do you think the Aboriginal people who inject drugs are well informed about ‘safe injecting’ – eg using clean needles, not sharing needles? Do they think that safe injecting is important? Who does/doesn’t think that? Do you have any ideas why?

7. How/where do people usually get their needles and syringes? How easy is it to get clean needles? What can make it difficult?

8. Do you think many Aboriginal people round here share needles? What sorts of people are most likely to share? Is it hard to say ‘No’ to sharing? Are there particular times/places/situations when people are more likely to share?

9. Is there anyone around here – for example health services – who can provide clean needles or give other help or information to people who inject? Are there different types of service available? Do you know much about those services? How did you hear about them?

10. What do people (Aboriginal IDUs) think about those services? Do they use some more than others? Why?

11. Are there any other people or places that IDUs might go to for information or help? Who?

12. What are the things that encourage some people to use the services that are available – or particular types of service? What are the reasons some people don’t use them? Have you heard any stories of people having good, or bad, experience with any services in the area?

13. Can you think of any changes that have occurred in the sorts of services available for IDUs in this area? What has changed? Have things got better or worse?

14. How could health services and information for injectors round here be improved, or reach more people? Are there any other things that might help (for example – education for the whole community about drugs and disease risks)?

15. Have you seen any information designed for people who inject – eg advice about safe sex or safe injecting? What sort of material was that? Where did it come from? Did you think it was clear/helpful?

16. Is there anything else you would like to say about the sorts of things we have been talking about?

Thanks very much for your help and for giving us your time.

\(^1\) These or other local terms to be used as appropriate.
Appendix F  Plain English Information Sheet
Research on Access to Needle and Syringe Services

What is this research about?
The Australian Department of Health and Ageing would like to find out whether or not Aboriginal and Torres Strait Islander people who inject drugs are finding it easy to use Needle and Syringe (or Clean Needle) services. These are services, available in many parts of Australia, to provide information and advice to people who inject, and to make sure they can get hold of clean needles. The Department is trying to find out why Indigenous people do or do not use these services, and how services could be improved.

Who is doing the research?
The research is being carried out by a team of people (some Indigenous, some not) from Urbis Keys Young, which is an experienced research company based in Sydney. They have done a lot of previous work on drug injecting, and a lot of work with Indigenous communities. The names of the individual researchers are at the bottom of this sheet.

Why are you talking to me?
The researchers are visiting 12 cities and towns in different parts of Australia, and in each place they want to hear directly from people in the community who may know something about drug injecting in that area. …………………..suggested that you might be able to help.

What about my privacy?
Within the limits of the law the researchers will treat all discussions like this as anonymous and completely confidential. They do not want to know your full name – first name or a nickname is fine. When they take notes, they will not write any name on them at all.

Why should I take part?
Because we can only find out how good or bad the services are by talking directly to people in the community, like yourself.

* Study Team Members
  John Schwartzkoff
  Ania Wilczynski
  Duncan Rintoul
  Samantha Ross
  Kerry Reed-Gilbert (Indigenous Consultant)
  Karen Milward (Indigenous Consultant)
Do I have to take part?
No, that is completely up to you. If you do agree to talk to the researchers, you can refuse to answer any question you don’t want to answer, and you can end the discussion when you want to.

Where and when would I talk to the researchers?
At a time and place that is convenient for you and them.

Do I get compensated for my time and trouble?
Everyone who takes part in the research will receive $50 in recognition of their time and trouble.

Will I find out the results of the research?
The main findings will go into a report that will be available to communities, and will be publicised in papers or magazines like the *Koori Mail* etc, and also in publications read by people who inject.

What if I’m not happy with the way the researchers treat me?
The researchers will make sure you have the name of a local organisation you can go to if you have any concerns, or if you want more information or assistance. Or you can contact Tess McLachlan at the Department of Health and Ageing, on (02 6289 4941, or email Tess.McLachlan@health.gov.au).
Appendix G  Indigenous populations in each State and Territory
## APPENDIX G – INDIGENOUS POPULATIONS IN EACH STATE AND TERRITORY

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Indigenous population, 2006 Census</th>
<th>Percentage of State/Territory population</th>
<th>Percentage of Australian NSP Survey respondents identifying as Indigenous (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>148,200</td>
<td>2.2 %</td>
<td>15%</td>
</tr>
<tr>
<td>Queensland</td>
<td>146,400</td>
<td>3.6 %</td>
<td>10%</td>
</tr>
<tr>
<td>Western Australia</td>
<td>77,900</td>
<td>3.8 %</td>
<td>5%</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>66,600</td>
<td>31.6 %</td>
<td>97% *</td>
</tr>
<tr>
<td>Victoria</td>
<td>30,800</td>
<td>0.6 %</td>
<td>6%</td>
</tr>
<tr>
<td>South Australia</td>
<td>26,000</td>
<td>1.7 %</td>
<td>7%</td>
</tr>
<tr>
<td>Tasmania</td>
<td>16,900</td>
<td>3.4 %</td>
<td>15%</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>4,000</td>
<td>1.2 %</td>
<td>Nil</td>
</tr>
<tr>
<td>Australia</td>
<td>517,200</td>
<td>2.5 %</td>
<td>11%</td>
</tr>
</tbody>
</table>


* Small sample. The relevant percentage in the 2006 survey was 15%.

** Small sample. The relevant percentage in the 2006 survey was 6%.
Appendix H  Examples of good practice
Some examples of good practice that were noted in the course of this study are set out below.

**Partnerships and advocacy**

Over the past five years or so the Aboriginal Health and Medical Research Council (AH&MRC) in New South Wales has been active in examining issues relating to hepatitis C infection and injecting drug use and in providing leadership in developing responses to BBV infection. The AH&MRC played a key role in conduct of the 2004 NSW research project on BBV needs and services (see Appendix C to this report), and was subsequently able to obtain funding for two new staff positions relating to workforce development and harm minimisation. It has established working relationships with organisations such as NUAA (NSW Users and AIDS Association) and has undertaken an advocacy role with national bodies such as Ministerial Councils and IASHC.

NACCHO affiliates in some other jurisdictions have taken on similar roles – for example in relation to partnerships with other relevant agencies and organisations, and hepatitis C training and awareness-raising for the Indigenous health workforce.

**Cultural awareness training in the mainstream**

In 2007 Turning Point, a Melbourne drug and alcohol agency and NSP outlet, undertook cultural awareness and safety training for its staff, working in partnership with VACCHO.

**Role of drug user support and advocacy groups**

AIVL, the national drug user advocacy body, has played a key role in the establishment and operation of The Connection, a peer-based drop-in and support service in Canberra for Indigenous IDUs.

In Cairns the Mix-Up peer education project conducted by the Queensland organisation QuIHN has been successful in reaching numbers of Indigenous IDUs. Drug user support groups in other places, such as NAP in Darwin, have effective links with both Indigenous and non-Indigenous IDUs, which they use to promote peer education activity and awareness of issues such as safe injecting.

**Outreach and mobile services**

It is widely accepted that mobile and outreach NSP services are an effective way of facilitating access by marginalised or hard-to-reach groups, and numbers of the stakeholders consulted during this study saw such methods as an important way of improving Indigenous IDUs’ use of services. In Adelaide the Nunkuwarrin Yunti medical service has for some years operated a daily outreach service targeting homeless and other disadvantaged Indigenous IDUs in the inner city, as well as a fixed site service. At Redfern in inner Sydney – which is unusual in being both a centre of Aboriginal population and an area known for high rates of illegal drug use – REPIDU similarly offers both a fixed site and an outreach service. The mobile NSP service operated by the WA AIDS Council reaches groups of Indigenous IDUs at some of the suburban locations it visits. In the Riverland in South Australia an NSP service has been incorporated into a mobile primary health service.
Indigenous friendly services

The report refers to various approaches that NSP services can take in an effort to ensure that they are perceived as friendly to and supportive of Indigenous clients. One is by display of relevant materials and symbols, use of appropriate colours, graphics and the like. The South Court Primary Care NSP in western Sydney, for example, flies the Aboriginal flag.

The study also pointed to the usefulness of offering NSP services at sites that are already identified in some way with the Indigenous community or regarded positively within that community. Examples quoted were the Youthlink service in Cairns, Clinic 34 in Alice Springs and the Sobering Up Centre in Port Augusta.

Enhanced NSP services

Some stakeholders argue that enhanced NSP services which offer IDUs additional health and referral services, and possibly ‘drop-in’ facilities, are useful in improving Indigenous access – both because of the direct benefits they offer to clients, and because more holistic services of this kind may help make the NSP more acceptable to the wider Indigenous community. MINE in inner Melbourne and South Court Primary Care in western Sydney are examples of NSPs offering access to broader health services. The range of health services provided by the Nunkuwarrin Yunti AMS in Adelaide (including a weekly liver clinic) means that in practice, although not funded as such, it too offers an ‘enhanced’ service.

Extended hours

Given that drug injecting frequently occurs at night or at the weekend, limited NSP hours were often mentioned as an access barrier by the Indigenous IDUs consulted during this research. Community pharmacies and in particular Emergency Departments are (apart from friends and acquaintances) the most common sources of clean equipment outside normal business hours. However, some primary or other secondary NSP outlets do offer evening or weekend services; examples encountered during this study included the Sobering Up Centre in Port Augusta, REPIDU in Redfern (Sydney), WAAC and WASUA in Perth and the Health Information Exchange in St Kilda (Melbourne).

Vending machines

Machines which automatically dispense packs of needles and syringes (usually for a small fee) provide a means of overcoming some of the barriers to Indigenous NSP access, including the fear and embarrassment which may deter people from approaching NSP workers. They can also, of course, provide considerably increased access out of hours. New South Wales has a substantial network of vending machines, and there are machines sited at Community Health Centres in the main town centres in the ACT. Queensland Health has set up dispensing machines in eight regional locations, and there are small numbers of machines currently in use in some other jurisdictions.
Peer services

The peer service most often referred to during this research was The Connection in Canberra. The Connection is not an NSP outlet, but it offers a supportive drop-in environment to IDUs (mostly but not exclusively Indigenous) and is widely seen as a valuable element in achieving harm reduction objectives in the ACT. The Nunkuwarrin Yunti NSP outreach operation in Adelaide, also, is a peer-based service in that it is staffed mostly by Indigenous workers.

It was often observed that some Indigenous IDUs act as intermediaries in collecting clean injecting equipment that they pass on to others. It would clearly be useful if this informal system of peer support and education could be reinforced; this is in fact one of the objectives of the ‘Mix Up’ project being undertaken in Queensland by the user support organisation QuHIN.

Reaching young people

One of the strongest themes to emerge from this research was the importance, and the difficulty, of ensuring that young and possibly inexperienced Indigenous IDUs have access to services that may help them avoid HCV infection. There do not appear to be many current initiatives that deal directly with this issue. In Darwin, however, Hoops 4 Health is a project that uses basketball activities as a way of engaging young people and conveying messages about hepatitis C issues and risks. The Gulwan Gugan youth service in Canberra provides an outreach NSP service and The Connection, also in Canberra, reaches a relatively young age group.

Choice

Ensuring that Indigenous IDUs have some choices or options about how to obtain sterile injecting equipment was identified as an important enabler. Even a small town like Carnarvon in Western Australia can offers IDUs a number of options; needles and syringes are available there from a service operated by Population Health, from the hospital Emergency Department and from a community pharmacy. The Aboriginal health service in Carnarvon is authorised to operate as an NSP outlet and the point was made that, although the volume of equipment that it dispenses is small, its participation in the NSP has a symbolic value in endorsing harm reduction principles.