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. Nor was research undertaken in Tasmania. 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.

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.

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.

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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
newly acquired hepatitis C infections’ (p107). The highest rates of hepatitis C notifications among Aboriginal people were in metropolitan Perth\textsuperscript{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\textsuperscript{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;

\textsuperscript{9} For information about BBV epidemiology in WA see \url{http://www.population.health.wa.gov.au/Communicable/STIs_BBVs.cfm}.

\textsuperscript{10} Australian NSP Survey; National Data Report 2003-2007, National Centre in HIV Epidemiology and Clinical Research
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.

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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.\(^{14}\)

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\(^{\circledR}\) 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

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\(^{14}\) 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.

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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) 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.

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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\textsuperscript{17}. 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, \textit{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, \textit{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, \textit{Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or who Have Blood Borne Infections}, 2004

\textsuperscript{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.
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− National Centre for Epidemiology and Population health, ANU, ‘I want to be Heard’ – An Analysis of Needs of Aboriginal and Torres Strait Islander Illegal Drug Users in the ACT and Region for Treatment and Other Services, 2004

− Coupland and others (Australian Federation of AIDS Organisations), ‘Something is Going to Get Us’ – a Consultation and Development Project for a National Campaign Addressing Injecting Drug Use in Indigenous Communities, draft, 2005 (based on national consultation).

The findings of the literature review are set out in Appendix C, and are summarised at the beginning of section 2 of the report.