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 (e.g., 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 (e.g., 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. 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

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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’, *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

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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

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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. ‘Its 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’.

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

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marijuana) 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.

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 marijuana) 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 than 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

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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\(^26\). 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.

\(^{26}\) 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, Sneed 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, were 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’. QuIHIN 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’; ‘If 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 gaoled 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.