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

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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.

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34 Meyerhoff’s 2000 literature review for Danila Dilba Health Service (see footnote …) refers to illicit drug use 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’.\(^\text{35}\)) 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)\(^\text{35}\). 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\(^\text{36}\) 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 Youthslink 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 QuIHN 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 OATSIH
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
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.

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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\textsuperscript{40}. 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.

\textsuperscript{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.
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

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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

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’.
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’.) NSP 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\(^{45}\).

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 Streetwize 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.
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.