Appendix A People and organisations consulted

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

Alice Springs	
Dr Rosalie Schultz	Medical Officer, Clinic 34
Michael Cody	Clinical Nurse Manager, Community Drug and Alcohol Services
Tony Hand	Clinical Nurse, Community Drug and Alcohol Services
VJ Thorpe	Clinical Nurse, Community Drug and Alcohol Services
Susie	Retail Manager, Priceline Pharmacy
Jill Meade	NSP Coordinator, NTAHC
Craig Scolari	NSP Worker, NTAHC
Louise Gilbey	Education Officer, NTAHC
Dr John Boffa	Central Australian Aboriginal Congress
John Kiddle	Central Australian Aboriginal Congress
IDUs	3 males, 2 females, age range late 20s to mid 40s

Perth	
Jude Bevan	Senior Policy and Planning Officer, Sexual Health and BBV Program, WA Department of Health
Lisa Bastian	Manager, Sexual Health and BBV Program, WA Department of Health
Vanessa Hunt	Senior Program Officer, Sexual Health and BBV Program, WA Department of Health
Trish Langdon	Executive Director, WA AIDS Council
Leigh Cleary	NSP Manager, WA AIDS Council
Gail Jones	Aboriginal and Torres Strait Islander Community Development Officer, WA AIDS Council
Clyde Dubois	NSP Worker, WA AIDS Council
Sandra Fox	Manager, WASUA
Paul Dessauer	Outreach Coordinator, WASUA
Lenette Mullen	President, Pharmaceutical Council of Western Australia
Cliff Collard	Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office
Jennifer Keen	Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office
Norma Morrison	Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office
Angela Hanslip	Aboriginal Alcohol and Other Drug Program Team, Drug and Alcohol Office
Danny Kiely	Prisoner Addiction Services Manager, Department of Corrective Services
Holly Beasley	BBV Consultant, Health Services, Department of Corrective Services
Denise Cail	Workforce Development, Drug and Alcohol Office
Celia Wilkinson	Workforce Development, Drug and Alcohol Office
Dr Susan Carruthers	National Drug Research Institute
Michael Doyle	Project Officer, Aboriginal Health Council of WA
Francine Eades	NSP Coordinator, Derbarl Yerrigan Health Service

Carnarvon	
Quentin Richards	Case Manager, Gascoyne Population Health Unit, WA Department of Health
Luke Wilkinson	Gascoyne Primary Health Manager, Midwest Region, WA Country Health Service
Stephen Farrington	General Manager, Carnarvon Medical Service Aboriginal Corporation
Taryn Duncan	Community Drugs Service Team, Mid West Health Service
Vicki Chudziak	Community Drugs Service Team, Mid West Health Service
Nursing staff	Carnarvon Hospital
Robin Fahl	Pharmacist, Amcal Pharmacy

Sydney	
Owen Westcott	Senior Policy Analyst, AIDS/Infectious Diseases, NSW Health
Felicity Sheaves	Acting Harm Minimisation Coordinator, Sydney West Area Health Service
Julie Page	Clinical Nurse, Specialist, South Court Primary Care, Kingswood
Ian Bridges-Webb	Social Worker, South Court Primary Care, Kingswood
Julie Anne Downey	Enrolled Nurse, South Court Primary Care, Kingswood
Jane Shakeshaft	Acting Team Leader, Blacktown NSP
Dr Penny Abbott	GP, Aboriginal Medical Service Western Sydney Co-op
Leanne Schuster	Psychiatric Nurse, Aboriginal Medical Service Western Sydney Co-op
Tim Stern	Harm Minimisation Manger, Sydney South West Area Health Service
Troy Combo	Formerly Aboriginal and Torres Strait Policy and Projects Officer, Australian Hepatitis Council
Sallie Cairnduff	Project Officer, Aboriginal Health and Medical Research Council
IDUs	2 males, 2 females, age range 20s to mid 40s

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

Dubbo	
Margaret Crowley	Manager, Dubbo Sexual Health Service
Bedelia Skinner	NSP Coordinator, Dubbo Sexual Health Service
Bev Tyson	Aboriginal Health Education Officer
Kylie Vaughn	Secretary, Dubbo Sexual Health Service
Gai Honeyset	Front Desk Worker, Dubbo Community Health Service
Rex Wintle	Pharmacist, O'Donnells Pharmacy
IDUs	5 males, age range 20s to 40s

Wellington	
Darren Ah See	CEO Wellington Aboriginal Corp Health Service
Billy Stanley	Sexual Health Worker, Wellington Aboriginal Corp Health Service
Jason Carr	Alcohol and Other Drugs Worker, Wellington Aboriginal Corp Health Service
Tyrone Kiernan	Registered Nurse, Wellington Hospital

Melbourne	
Roland Jauernig	Manager, Health Protection Services, Department of Human Services
David Wright	Project Coordinator, Health Protection Services, Department of Human Services
Kelly Gallagher	Koori Program Coordinator, Drugs Policy and Services Branch, Department of Human Services
Danny Jeffcote	NSP Team Leader, Drug Safety Services, North Yarra Community Health
Majida Ritter	Team Leader Community Development, Turning Point Alcohol and Drug Centre
Peter Waples-Crowe and other staff members	VACCHO
'Bootsie' Thorpe and Alan Thorpe	Koori Withdrawal Access Program, Ngwala Willumbong Co-Op Ltd
Damon Brogan	Executive Officer, VIVAIDS

Mildura	
Kayleen Tulloch	Drug and Alcohol Worker, Mildura Aboriginal Corporation
Paul Sloane	Social and Emotional Wellbeing Worker, Mildura Aboriginal Corporation
Mary Bassi	Drug and Alcohol Team Manager, Community Health Centre
Melissa Lonsdale	Drug and Alcohol Team Coordinator, Community Health Centre
Linton Gray	Manager, Coomealla Health, Dareton
Eric Oguzkaya	Albert and Braithwaites Pharmacy

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

Adelaide	
Stephen Lymb	Manager, Harm Reduction, Drug and Alcohol Service of South Australia
Danielle Bament	Manager Clean Needle Program, Drug and Alcohol Service of South Australia
Don Hayward	Manager, Aboriginal Program, Drug and Alcohol Service of South Australia
Scott Wilson	Director, Aboriginal Drug and Alcohol Council
Janine Englehart and other staff	Aboriginal Health Council of South Australia
Michael McCabe	NSP Coordinator, Nunkuwarrin Yunti
Bradley Lawton	NUHIT Worker, Nunkuwarrin Yunti
Dominic Guerrera	Project Officer, Nunkuwarrin Yunti
George Carvajal	Drug Treatment Worker, Nunkuwarrin Yunti
Mandy Brown	Gambling Educator, Nunkuwarrin Yunti
Carol Holly	Manager, SAVIVE (South Australian Voice for Intravenous Education)
NSP Workers and other staff members	SAVIVE

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

Mount Isa	
Jenny Darr	Injilinji Medical Service
Rachel Gregory	Sexual Health Worker, Mt Isa Hospital
Sandra Kennedy	ATODS
Ian Williamson	ATODS
Pharmacist	Angelo Bertoni Pharmacy
Jess Burrie	Pharmacy First

Cairns	
Amanda Kvassay	NSP Coordinator, Northern Area Health Service
David Rowley	NSW Worker, Northern Area Health Service
Nancy Long	Executive Officer Primary Health, WuChopperen Health Service
Joanne de Vries	Sexual Health Worker, WuChopperen Health Service
Ian Twist	Drug and Alcohol Workers, WuChopperen Health Service
Tamara McDougall	Coordinator, Youthlink NSP
Dan	Manager, Youthlink
Joanne Leamy	Clinical Nurse Consultant, Sexual Health Service
Anita Plesko	QuIHN
'Kerry'	Volunteer, QuIHN
Miguel	NSP Worker, 'Dolls House', Cairns Base Hospital
Brendan Cashman	Queensland AIDS Council
IDUs	2 males, 2 females, age range late 20s/30s

Appendix B Services and policies in the States and Territories

B1. New South Wales

B1.1 NSP services

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

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

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

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

[1] NSW Health Department, 'COAG Supporting, Measures for the Needle and syringe Program 19989/90 – 2002/03'.

Primary outlets

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

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

Secondary outlets

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

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

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

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

Service modality

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

- Mobile outreach

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

- Pedestrian outreach

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

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

Automatic dispensing machines

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

Pharmacy outlets

Pharmacists across NSW may participate in the Pharmacy NSP Scheme, managed by the NSW Branch of The Pharmacy Guild of Australia. Under this scheme, in which 375 city and country pharmacies were participating at the end of 2007, pharmacies sell needles and syringes, or exchange

used needles and syringes for new ones at no charge. (A small number of pharmacies sell needles and syringes independently of the Pharmacy NSP Scheme.)

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

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

B1.2 Serving Indigenous clients

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

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

Within some Area Health Services there has been a long history of co-operation with Aboriginal Medical Services around the provision of NSP services, and across the state around eight AMSs are currently actively involved as secondary NSP outlets [2]. In some locations, however, the provision of NSP services remains a controversial issue from the perspective of the Indigenous health sector.

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

[2] The study team visited AMSs at Taree and at Wellington which provide NSP services.

The AH&MRC seeks to enhance capacity in the mainstream health workforce as well – including community pharmacies. There has also been work in innovative resource development – for example an interactive BBV resource designed for young people.

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

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

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

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

B2 Northern Territory

B2.1 NSP Services

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

Primary outlets

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

Secondary outlets

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

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

Pharmacies

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

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

User organisation

NAP in Darwin provides an informal NSP to its own members and contacts ('a niche market'). Availability of injecting equipment through NAP was described as particularly important after hours.

The Northern Territory currently has no needle and syringe vending machines, and no NSP outreach services.

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

B2.2 Serving Indigenous clients

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

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

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

The stated objectives of this project are:

- *to engage and establish effective relationships with Aboriginal and Torres Strait Islander Injecting Drug Users;*
- *to raise awareness and increase understanding of the concept of hepatitis C amongst Aboriginal and Torres Strait service providers and services serving Indigenous Australians;*
- *to increase the number of Aboriginal and Torres Strait islander people presenting for HCV screening, especially Injecting Drug Users;*

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

B3 Western Australia

B3.1 NSP Services

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

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

Primary outlets

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

Both WASUA and WAAC supply clean needles and syringes at no cost to the client, conditional on the return of used items, ie exchange; if no exchange takes place a cost recovery price is charged. WAAC reports that swabs are provided free, and sterile water at cost price. A range of other items of injecting equipment is available for purchase from both WASUA and WAAC. WAAC's exchange policy was described as 'strict, but with some flexibility' in appropriate circumstances; staff aimed to work within 'clear boundaries' which are said to be generally respected by clients. It was reported that Indigenous clients, in particular, tend to ask for only small numbers of fits, suggesting to NSP workers that they cannot afford to inject frequently/consistently[3]. Although legislation relating to possession of used equipment remains 'on the books' in Western Australia, the Police policy was said to be not to interfere with people carrying equipment for return to an NSEP.

[3] A perceived advantage of this WA exchange-based model is that it minimises inappropriate disposal and thus reduces the time that might otherwise need to be invested in community relations around this issue. (WASUA reports a return rate of 97%.)

In Perth WASUA operates a fixed primary outlet in the inner city, backed up by some outreach work; its operation in the south-western region of the State is a mobile service[4]. These are peer-based services. The fixed outlet in the city operates six days a week (to 8pm on Thursday and Friday). It also offers free BBV and STI testing, with pre and post test counselling, and free hepatitis A and B vaccinations (these BBV/STI services are supported by DoHA Hepatitis C Education and Prevention funding). It also offers information and supported referral to alcohol and drug treatment, housing, social and legal services; support and advocacy for people on pharmacotherapy programs; and peer support, information, referral and advocacy for people with hepatitis C or at risk of infection. Outreach work in the Perth metropolitan area focuses on providing equipment to people likely to have difficulty accessing a fixed outlet (eg those with a physical disability), or on reaching locations where there are known to be high concentrations of users. This outreach service averages some 15-30 client contacts a week – far fewer than the fixed outlet (which had around 5,000 client contacts in a recent 6-month period). About 5% of client contacts overall are recorded as Indigenous.

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

WASUA and WAAC coordinate their buying of supplies from wholesalers.

Secondary outlets

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

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

Pharmacies

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

[4] The term 'mobile' service in Western Australia refers to a service which follows a regular timetable of visits to specific locations.

obtained a 'blanket' approval for pharmacies to sell a small number of standard products such as packs of 3 or 5 needles and syringes. Some pharmacies also sell 'singles', but require an individual approval to do so.

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

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

Vending machines

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

Aboriginal Medical Services

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

B3.2 Serving Indigenous clients

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

Aboriginal BBV prevention scoping project

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

The objectives were to:

- identify barriers and enablers to ACCHOs providing NSP and other harm reduction services for Aboriginal people who inject drugs
- identify barriers and enablers in other sectors for providing blood borne virus harm reduction services for Aboriginal people who inject drugs
- make recommendations as to strategies to address barriers and capitalise on enablers
- inform the development of a sustainable model for providing targeted best practice training to support ACCHOs to implement needle and syringe programs (in accordance with the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008 Implementation Plan* and *Strong Spirit Strong Mind: Western Australian Aboriginal Alcohol and Other Drugs Plan 2005 – 2009)*.

B4 South Australia

B4.1 CNP Services

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

Primary outlet

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

Secondary outlets

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

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

Secondary enhanced outlets

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

Outreach services

There are three Outreach CNPs currently operating in SA; Outreach services target more marginalised groups of injecting drug users. Evidence quoted by DASSA suggests that providing CNP services through an outreach mode of service delivery is the best way to reach injecting drug users who engage in risky injecting practices and are at increased risk of blood borne virus transmission – for example Aboriginal, homeless, young and sex worker IDUs[5]. The three outreach services include one which targets Aboriginal and homeless people in inner city Adelaide; another targeting street-based sex workers in Adelaide's western and northern suburbs; and a third targeting Vietnamese drug users in the western suburbs.

[5] Conroy et al 2003; Miller et al 2002; Riley et al 2000

Pharmacies

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

B4.2 Serving Indigenous clients

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

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

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

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

B5 Victoria

B5.1 NSP services

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

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

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

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

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

Primary, Secondary and Enhanced Secondary NSP Services

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

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

and other agencies, such as schools, pharmacies, local government, and health, drug treatment and welfare agencies.

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

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

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

Secondary outlets across Victoria include:

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

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

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

All Primary, Secondary and Enhanced Secondary NSP outlets receive indirect support by way of the provision of consumables for distribution to clients (needles and syringes, alcohol swabs, sharps disposal containers, condoms and lubricant), a range of information and education resources, clinical waste disposal services and, crucially, orientation and further training for NSP workers.

Free hepatitis B vaccination is available to IDU clients of any NSP agency where a registered nurse is available to administer that vaccine, and there are facilities to store it.

Community Pharmacies

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

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

B5.2 Serving Indigenous clients

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

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

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

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

DHS sees injecting drug users as a marginalised and hard-to-reach, at-risk population for whom NSPs may be the first point of contact within the health and welfare sectors. This puts NSPs in a unique position, with each service contact representing a potential opportunity to engage the client and encourage safer behaviours, from lower-risk injecting and appropriate disposal practices to accessing drug treatment. These issues are particularly relevant for Indigenous drug users. Stigma, shame and concerns regarding confidentiality and anonymity remain important issues for Indigenous IDUs and often affect their use of NSP services.

A specific project is due to commence in 2008 to raise awareness of the Victorian NSP among Aboriginal Community Controlled Organisations. This will be carried out in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Koori AOD Network (Vic). An Access and Equity Project has recently commenced, managed by Anex and investigating culturally and linguistically diverse projects and Indigenous access to NSP services, with a desired outcome of a Memorandum of Understanding with the VACCHO.

B6 Australian Capital Territory

B6.1 NSP Services

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

Primary Outlets

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

Secondary Outlets

There are currently five secondary outlets in the ACT:

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

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

Silent Outlets

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

Pharmacies

A total of 34 pharmacies (approximately 60% of ACT pharmacies) sell injecting equipment, in the form of 4-syringe Fitpacks®, in a range of ACT locations. The recommended pharmacy price for a 4-pack, with sterile water and disposal container, is $2 (the equipment is provided to pharmacies at no cost).

It was suggested that pharmacies tend to cater for people who are in the workforce and recreational users.

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

Vending machines

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

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

Outreach

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

Hospitals

There is no NSP service through Canberra hospitals.

B6.2 Serving Indigenous Clients

- Winnunga Nimmityjah Aboriginal Health Service provides a holistic health service for Aboriginal and Torres Strait Islander people of the ACT and surrounding areas. It operates a secondary NSP outlet from its Narrabundah facility – a service accessed by Indigenous clients as well as other members of the community.
- An evaluation of the SVM trial has reported that 11% of SVM clients and 10% of NSP clients who were surveyed identified as being Aboriginal.
- Gugan Gulwan Youth Aboriginal Corporation, an Aboriginal youth service, operates an NSP outreach service with support from DIRECTIONS.
- The Connection, a peer-based drop-in centre at Civic, is not part of the NSP program, but is an innovative service providing peer education and support for IDUs in the ACT, and for Aboriginal IDUs in particular. It is promoted as 'Run for Indigenous users by Indigenous ex users', and as offering services also to IDUs' families and friends. The Connection is auspiced by AIVL, and receives funding support from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Foundation for Young Australians. It also acknowledges support from Gugan Gulwan, the

CDEP, the ACT Youth Coalition and the Sydney Peace Prize Foundation. Among other things The Connection uses a workshop educational kit that has been developed by young Aboriginal drug users.

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

B7. Queensland

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

- **Primary NSP**: The primary role of staff is the provision of NSP services to IDUs - sterile injecting equipment, health promotion through education and information on BBVs and IRIDs, transmission and risk behaviours associated with injecting drug use, safer drug use, injecting health, and referrals for drug treatment, medical, legal and social services. In addition, the program develops responses to community concerns such as inappropriate disposal of used injecting equipment.
- **Secondary NSP**: Staff provide limited NSP services as part of their general duties and the NSP is provided as an adjunct to other services.
- **Community Pharmacies**: Sterile injecting equipment is provided on a commercial basis.

B7.1 Program delivery

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

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

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

B7.2 NSP Workforce

Current NSP service capacity

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

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

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

Table 3: Distribution of NSPs in Queensland

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

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

Distribution of injecting equipment

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

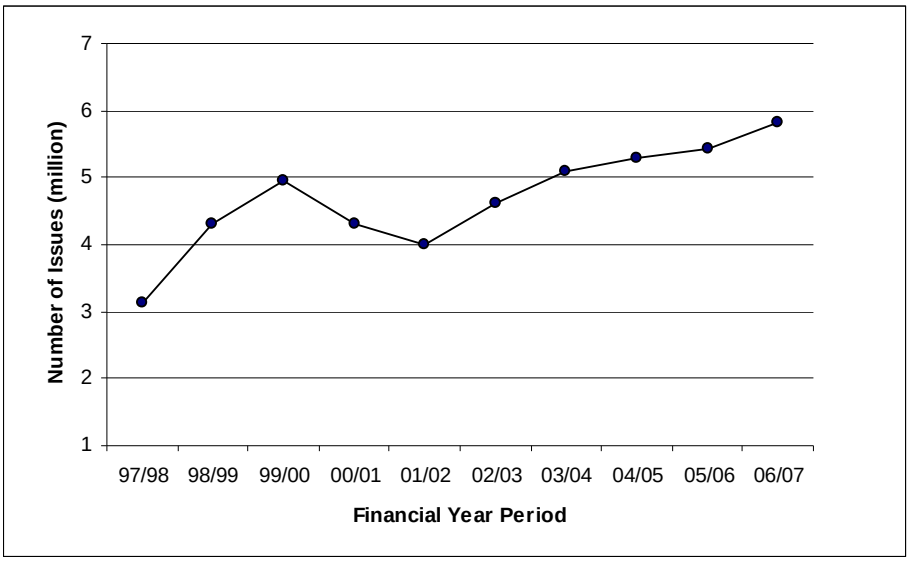

Figure 1: Number of needles and syringes distributed through primary and secondary NSPs in Queensland over the last 10 financial years

Pharmacy sales and disposal

In addition to primary and secondary NSP outlets, there are 561 pharmacies across Queensland that participate in the sale of sterile needle and syringes, with 141 pharmacies providing sharps disposal services.

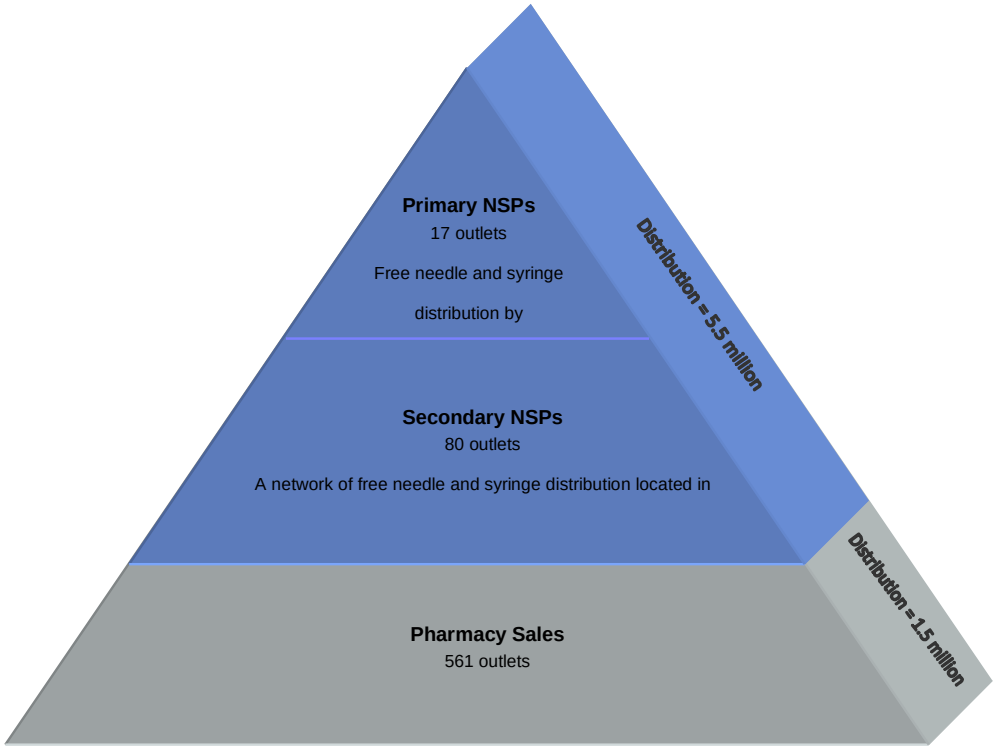

Figure 2: Outlets and distribution for 2006-07 across the three tiers of the service delivery model

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

Appendix C Literature review

C.1 Introduction

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

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

- A 2005 study of 70 Indigenous IDUs in urban and non-urban settings in the ACT, NSW, Victoria, Western Australia and the Northern Territory. Conducted by the Australian Federation of AIDS Organisations (AFAO) and the Australian Injecting and Illicit Drug Users League (AIVL), the study recruited participants through AFAO and AIVL member organisations. A blend of quantitative and qualitative information was gathered from respondents[1].
- A 1996 study of 77 Indigenous IDUs in the Brisbane area. A structured questionnaire was administered by peer interviewers, specifically trained for the purpose[2].
- A series of cross-sectional studies conducted in Sydney between 1997 and 2001. Indigenous people who either inject drugs or participate in a methadone program were selected for interview. A range of methods were used to recruit people through services and word of mouth. The quantitative data obtained were analysed as three separate data sets, with sample sizes of 68, 121 and 23[3].
- A 2001 study amongst 74 Indigenous IDUs in urban and non-urban areas of Western Australia. The study used peers interviewers to both recruit participants and conduct interviews, seeking both qualitative and quantitative data.[4]
- A study among 307 Indigenous IDUs in metropolitan Adelaide, released in 2003. The study (based on fieldwork conducted in 2001) used peer interviewers to collect both qualitative and quantitative data from respondents recruited through a 'snowballing' process[5].

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1 Coupland H, Ball K, Costello M, Harvey B and Maher L, Something is Going to Get Us: a consultation and development project for a national campaign addressing injecting drug use in Indigenous Communities, 2005. AFAO and AIVL.

2 Larson A, Shannon C and Eldridge C (1999) Indigenous Australians who inject drugs: results from a Brisbane study, *Australian Centre for International and Tropical Health and Nutrition, Graduate School of Medicine, University of Queensland, Australia*, *Drug and Alcohol Review* (1999) 18, 53.62

3 Day C and Dolan K, Characteristics of Indigenous Injecting Drug Users in Sydney: gender, prison history and treatment experiences, National Drug and Alcohol Research Centre, University of New South Wales. *Paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference convened by the Australian Institute of Criminology and held in Sydney, 8-9 October 2001.*

4 Gray D, Saggers S, Atkinson D, Carter M, Loxley W and Hayward D (2001) . The Harm Reduction Needs of Aboriginal People Who Inject Drugs , National Drug Research Institute, Curtin University of Technology, Perth

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

C.2 Levels of Indigenous injecting drug use

Most of the studies that are discussed here note the lack of reliable data on the prevalence of injecting drug use amongst Aboriginal and Torres Strait Islander people. However, as early as 1994 the National Drug Strategy Household Survey (1994)[7] found that 3% of Indigenous people in urban areas reported that they had injected drugs (with 2% having done so in the last 12 months). This compared to 2% of the wider Australian population who reported having ever injected drugs, and 0.5% who had done so in the previous 12 months. Thus there has for some years been evidence to suggest that Indigenous people are over-represented in the IDU population[8]. Such evidence is supported by more recent research. For example, the NSW study released in 2001[9] found that Indigenous people were consistently over-represented in the IDU population across three separate data collections. The figures ranged from 15% at the lowest to 19% at the highest (much higher, obviously, than the approximately 2% of Australians identifying as Indigenous).

The National Centre in HIV Epidemiology and Clinical Research[10] released data in 2005 that demonstrated that *the percentage of blood-borne infections attributable to injecting drug use* amongst Aboriginal and Torres Strait Islanders had risen between 1995-1999 and 2000-2004 from 7.5% to 20.6%. There was no comparable rise amongst non-Indigenous people.

The 2001 Western Australian study[11] considered longitudinal hospital admissions data that in the researchers' view provided a fairly clear indicator that injecting drug use among Indigenous people had been increasing. They reported that between 1996 and 2000 there was a 125% increase among Aboriginal females and a 119% increase among Aboriginal males in hospital admissions for conditions thought likely to be associated with injecting drug use. These increases were 6.6 and 2.4 times greater than increases among *non*-Aboriginal females and males respectively.

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

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5 Holly, C Shoobridge J (2003) Responding to the Needs of Indigenous People Who Inject Drugs: using rapid assessment procedures to investigate the impact of injecting drug use amongst Indigenous Australians in metropolitan Adelaide. Aboriginal Drug and Alcohol Council (SA) Inc. Adelaide.

6 Dance, P, Tongs J, Guthrie J, McDonal D, D'Souza R, Cubillo C, Bammer G (2004) "I want to be heard": An analysis of needs of Aboriginal and Torres Strait Islander illegal drug users in the ACT and region for treatment and other services. National Centre for Epidemiology and Population Health, The Australian National University. Canberra.

7 Commonwealth Department of Human Services and Health (1994) National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994. Canberra, Australian Government Publishing Services.

8 Commonwealth Department of Human Services and Health, 1994

9 Day et al, 2001

10 National Centre in HIV Epidemiology and Clinical Research (2005) HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia, Annual Surveillance Report. NCHECR and Australian Institute of Health and Welfare. Canberra.

11 Gray et al, 2001

Indigenous people are being encountered. While this could of course reflect a pattern of increased *use of* services, it has generally been thought to indicate that Indigenous injecting drug use was on the rise.

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

C.3 Characteristics of Indigenous IDUs

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

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

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

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12 Gary Meyerhoff 'Injecting Drug Use in Urban Indigenous Communities: a Literature Review with a Particular Focus on the Darwin Area', Danila Dilba Medical Service, 2000.

13 ibid p7

14 Larson et al, 1999

15 Gray et al, 2001

The SA study[16] found that the average age of first injecting was 18.3 years, while a small number of people reported being as young as 10 or 11 years when they first injected. Only 3% were 30 years or older when they first injected.

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

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

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

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

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16 Holly et al, 2003
17 See p2
18 Day et al, 2001
19 Holly et al, 2003
20 Coupland et al, 2005
21 *Australian NSP Survey: National Data Report 2003-2007*, National Centre in HIV Epidemiology and Clinical Research, p2
22 Gray et al
23 Larson et al, 1999
24 ibid

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

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

C.4 Drug use and drug injecting

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

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

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

25 Coupland et al, 2005
26 ibid
27 Larson et al, 1999
28 Day et al, 2001
29 *Australian NSP Survey: National Data Report 2003-2007*, National Centre in HIV Epidemiology and Clinical Research, p9
30 Coupland et al, 2005
31 Larson et al, 1999

The SA study[32] found that 97% of respondents reported having used more than one drug in the past; the median number of drugs currently being used was four. Although non-injectable drugs such as cannabis figured prominently in the responses, 46% of respondents reported using both speed and heroin at least once per week. A high 82% said that they had injected heroin and 70% said they had injected speed. Heroin, however, tended to be the drug preferred – 56% preferred heroin as against 33% for speed.

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

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

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

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

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

32 Holly et al, 2003
33 Gray et al, 2001
34 ibid
35 ibid
36 Larson et al, 1999
37 Coupland et al, 2005
38 Gray et al, 2001

consisted solely of Aboriginal people. Some 18% reported that their injecting groups sometimes included non-Aboriginal people, while 16% said that they injected *only* with non-Aboriginal people.

C.5 Sources of clean injecting equipment

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

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

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

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

[39] ibid
[40] Larson et al, 1999
[41] Holly et al, 2003
[42] Coupland et al, 2005

highlighted some people's reluctance to access NSP services via an AMS or other Aboriginal-specific service; respondents spoke of a lack of awareness of the issues facing IDUs and an apparent lack of confidentiality that was sometimes exhibited. It was also noted – consistent with the research previously conducted in WA – that this reluctance was strongest in *non-urban* locations, where anonymity is a particularly difficult issue.

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

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

The research also confirms that Indigenous IDUs may obtain clean injecting equipment from trusted friends or other members of the IDU community, and are comfortable with obtaining equipment in this way. A number of respondents spoke of how they themselves played a role in distributing equipment (obtained in bulk from an NSP) to their peers[43].

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

C.6 Unsafe injecting and knowledge of risks

The previous research reports continuing risky injecting practices, with sharing of equipment reported as common. For example, 18% of the respondents to the Queensland study[44] said that they had shared a needle in the past week, while a further 21% had shared in the past month (with sharing defined as using a needle before or after someone else). Sharing was *much higher among young people* - 63% of those aged under 20 reported sharing in the previous month. Virtually all of those who reported sharing

[43] ibid
[44] Larson et al, 1999

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

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

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

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

Among other things these results point to *resignation* among some IDUs to the prospect of contracting a blood-borne infection. This was a theme also explored through the AFAO/AIVL national research[47], leading to the report's title of 'Something is Going to Get Us'. That report states that hepatitis C in particular was considered by many in the sample to be 'common', or 'nothing', and it goes on to suggest that people had a perception that premature death from other causes was likely in any event. In the words of one respondent, '…gunna die anyway soon from all those other things like heart and liver'. The study also suggested that a lack of awareness of the routes of hepatitis C transmission, or a belief that transmission could not be effectively prevented, were factors relevant to sharing behaviour.

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

[45] Holly et al, 2003
[46] Dance et al, 2004
[47] Coupland et al, 2005

all injections in the past month. Given that different researchers have asked somewhat different questions in this context, comparing survey data on sharing of equipment is not straightforward.

C.7 Education and other services

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

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

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

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

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

[48] Gray et al, 2001
[49] Coupland et al, 2005

provide a good basis for communicating an educational message. More educational activities in schools, gaols and legal centres were also advocated.

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

The NSW report published in 2004 places particular emphasis on a need for a holistic approach to addressing blood-borne infections among Aboriginal people – placing hepatitis C issues, for example, in the broader context of other blood-borne infections, general health, and social, cultural and emotional factors.

Appendix D Discussion guide for health services /NSP management and staff/other relevant community organisations

1. What services are available in this area for injecting drug users (IDUs) – eg Needle and Syringe Programs, fixed or outreach services, chemists who sell needles and syringes, etc? How suitable or adequate are those services for IDUs generally, and for Indigenous IDUs in particular? What do you think are the main sources of injecting equipment for IDUs – especially Indigenous IDUs?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. Do you have any other comments on the matters we have been discussing?

Appendix E Discussion guide for injecting drug users

NOTE: It may not be possible to cover all questions in each interview.

1. Do you think there are many Aboriginal or Torres Strait Islander people[1] in this area who inject drugs? Do you have an idea of how common that is, or about how many people inject drugs?
2. Which drug(s) do you think Aboriginal[1] people around here inject? How easy or hard is it for people to obtain those – eg is there a pretty regular supply? does the cost vary a lot? why is that?
3. What sorts of Aboriginal people in the community are injecting – eg which age groups? men or women? particular parts of the community? About how many people do you think would be regular/occasional injectors?
4. The Aboriginal people round here who inject – do you think most of them know each other, or are there separate groups, or people who keep to themselves? Do Indigenous injectors have a lot of contact with *non*-Indigenous injectors, or is it pretty much a separate 'scene'?
5. Do you think there are any particular problems or risks for the people who inject? What are they? How are people who inject regarded by the wider Aboriginal community? How are they treated by the Police? by health services?
6. Do you think the Aboriginal people who inject drugs are well informed about 'safe injecting' – eg using clean needles, not sharing needles? Do they think that safe injecting is important? Who does/doesn't think that? Do you have any ideas why?
7. How/where do people usually get their needles and syringes? How easy is it to get clean needles? What can make it difficult?
8. Do you think many Aboriginal people round here *share* needles? What sorts of people are most likely to share? Is it hard to say 'No' to sharing? Are there particular times/places/situations when people are more likely to share?
9. Is there anyone around here – for example health services – who can provide clean needles or give other help or information to people who inject? Are there different types of service available? Do you know much about those services? How did you hear about them?
10. What do people (Aboriginal IDUs) think about those services? Do they use some more than others? Why?
11. Are there any *other* people or places that IDUs might go to for information or help? Who?
12. What are the things that *encourage* some people to use the services that are available – or particular types of service? What are the reasons some people *don't* use them? Have you heard any stories of people having good, or bad, experience with any services in the area?
13. Can you think of any *changes* that have occurred in the sorts of services available for IDUs in this area? What has changed? Have things got better or worse?
14. How could health services and information for injectors round here be improved, or reach more people? Are there any other things that might help (for example – education for the whole community about drugs and disease risks)?
15. Have you seen any information designed for people who inject – eg advice about safe sex or safe injecting? What sort of material was that? Where did it come from? Did you think it was clear/ helpful?
16. Is there anything else you would like to say about the sorts of things we have been talking about?

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

[1] These or other local terms to be used as appropriate.

Appendix F Plain English Information Sheet

Research on Access to Needle and Syringe Services

What is this research about?

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

Who is doing the research?

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

Why are you talking to me?

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

What about my privacy?

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

Why should I take part?

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

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* Study Team Members
  John Schwartzkoff
  Ania Wilczynski
  Duncan Rintoul
  Samantha Ross
  Kerry Reed-Gilbert (Indigenous Consultant)
  Karen Milward (Indigenous Consultant)

Do I have to take part?

No, that is completely up to you. If you do agree to talk to the researchers, you can refuse to answer any question you don't want to answer, and you can end the discussion when you want to.

Where and when would I talk to the researchers?

At a time and place that is convenient for you and them.

Do I get compensated for my time and trouble?

Everyone who takes part in the research will receive $50 in recognition of their time and trouble.

Will I find out the results of the research?

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

What if I'm not happy with the way the researchers treat me?

The researchers will make sure you have the name of a local organisation you can go to if you have any concerns, of if you want more information or assistance. Or you can contact Tess McLachlan at the Department of Health and Ageing, on (02 6289 4941, or email Tess.McLachlan@health.gov.au).

Appendix G Indigenous populations in each State and Territory

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

Sources: ABS Cat. No. 4705.0 – Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006; NCHECR, National Data Report, Australian NSP Survey 2003-2007.

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

** Small sample. The relevant percentage in the 2006 survey was 6%.

Appendix H Examples of good practice

Some examples of good practice that were noted in the course of this study are set out below.

Partnerships and advocacy

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

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

Cultural awareness training in the mainstream

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

Role of drug user support and advocacy groups

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

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

Outreach and mobile services

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

Indigenous friendly services

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

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

Enhanced NSP services

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

Extended hours

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

Vending machines

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

Peer services

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

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

Reaching young people

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

Choice

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