

Injecting drug use and associated harms among Aboriginal Australians



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A joint research project by Anex and
National Aboriginal Community Controlled
Health Organisation (NACCHO) Inc.

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List of acronyms

Terminology

ACCHS	Aboriginal community-controlled health services
AIDS	Acquired Immune Deficiency Syndrome
ANSPS	Australian Needle and Syringe Program Survey
AOD	alcohol and other drugs
ATSI	Aboriginal and Torres Strait Islander
BBV	blood-borne virus
CURF	Confidentialised Uniform Record File
DUCO	Drug Using Careers of Offenders Project
DUMA	Drug Use Monitoring in Australia Program
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IDU	injecting drug use(r)
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCIS	National Coroners Information System
NDSHS	National Drug Strategy Household Survey
NDSS	National Diabetes Service Scheme
NMDS	Alcohol and Other Drug Treatment Services National Minimum Dataset
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSP	needle and syringe program
OMT	opioid maintenance treatment
OST	opioid substitution treatment
STI	sexually transmitted infection
SVM	syringe vending machine

Organisations

ABS	Australian Bureau of Statistics
ADAN	NSW Aboriginal Drug and Alcohol Network
ADAC	Aboriginal Drug and Alcohol Council (SA) Inc.
AFAO	Australian Federation of AIDS Organisations
AH&MRC	Aboriginal Health and Medical Research Council of New South Wales
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users League
ANCD	Australian National Council on Drugs
COAG	Council of Australian Governments
DoHA	Australian Government Department of Health and Ageing
HREOC	Australian Human Rights and Equal Opportunity Commission
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aboriginal and Islander Day Observance Committee
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCHSR	National Centre in HIV Social Research
NCOTSA	National Clients of Treatment Services Agencies
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
OATSIH	Office for Aboriginal and Torres Strait Islander Health

Glossary

Aboriginal – For the purposes of this report, the term ‘Aboriginal’ has been used to refer to people who identify as either Aboriginal and/or Torres Strait Islander people, except where directly citing a study or report that refers to ‘Indigenous Australians’. In 2009, the National Aboriginal Community Controlled Health Organisation (NACCHO) and its members and affiliates voted unanimously for ‘Indigenous’ to be used in an international context and ‘Aboriginal’ in the domestic context. The use of the term ‘Indigenous’ is not intended to offend or to mean we do not recognise the diversity within the Aboriginal and Torres Strait Islander populations.

Aboriginal health – refers not only to the physical wellbeing of an individual but also to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life–death–life.¹

Aboriginal health service – the term encapsulates both Aboriginal health services provided for Aboriginal people and Aboriginal community-controlled health organisations, managed by boards comprised of Aboriginal community members and specifically designed to meet the needs of Aboriginal people. An Aboriginal health service may not necessarily be an Aboriginal community-controlled health organisation.

Acquired immune deficiency syndrome (AIDS) – AIDS is a syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immunosuppression.

Amphetamines – a group of drugs that stimulate the central nervous system. Produced in various forms, amphetamines are commonly known as: speed, ice and crystal meth.

Blood-borne virus (BBV) – a virus that can be transmitted from a person with infection to another person by blood-to-blood contact, such as by sharing injecting equipment.

Convenience sampling – a type of non-probability sampling that involves a sample population selected because it is available and convenient. The researcher using such a sample cannot scientifically make generalisations about the total population from this sample because it would not be sufficiently representative.

Harm reduction strategies – strategies designed to reduce the impacts of drug-related harm on individuals and communities. Harm reduction does not condone illegal risk behaviours such as injecting drug use; rather, it acknowledges that these behaviours occur and therefore there is a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.

¹ As defined in NACCHO’s Memorandum and Articles of Association as amended 9 March 2006; also by the National Aboriginal Health Strategy, 1989.

Hepatitis – inflammation of the liver caused by viruses, alcohol, drugs and other toxins or, less commonly, by a breakdown in a person's immune system. There are five viruses that specifically cause hepatitis: hepatitis A, B, C, D and E. Each may produce similar symptoms, the main difference between them being the mode of transmission and the effects on a person's health. Hepatitis viruses that develop into a chronic infection may, over time, cause fibrosis (liver cells are damaged and destroyed and scar tissue takes their place).

Human immunodeficiency virus (HIV) – HIV is a human retrovirus that leads to AIDS. Infection with HIV occurs when the virus present in the bodily fluids of a person with HIV is transmitted to another person by blood-to-blood contact. Bodily fluids include blood, semen, vaginal fluid, pre-ejaculate or breast milk. The major routes of transmission are unprotected anal or vaginal sex, re-using injecting equipment when injecting drugs, and vertical transmission (from mother to child before, during and after birth).

Illicit drug – a drug whose production, sale or possession is legally prohibited.

Injecting drug use – the administration of drugs to the body via a needle and syringe, including intramuscular and subcutaneous as well as intravenous injecting.

People who inject drugs – a person who is actively injecting licit or illicit drugs. People may inject one or more drugs of choice frequently or infrequently. The method by which someone administers drugs distinguishes them as a person who injects drugs, not the type of drug they use, nor the frequency of use. On occasion, the term 'injecting drug user' has been used within this report, when directly referencing other sources using this term.

Key informants – refers to individuals with expertise in various areas who were interviewed for the project.

National Drug Strategy Household Survey – one of the data collections used to monitor trends and progress under the National Drug Strategy. Conducted by the Australian Institute of Health and Welfare on behalf of the Australian Government Department of Health and Ageing, the survey was conducted nationally in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004 and 2007, providing data on behaviour, knowledge and attitudes relating to drug use among people aged 14 years and over.

Needle and syringe program (NSP) – a public health harm reduction initiative, formally established in Australia in 1987 within the harm minimisation framework of the National Drug Strategy to prevent the transmission of HIV among people who inject drugs and, subsequently, to the broader community. NSP services are provided through a range of models and modalities including fixed site, outreach and syringe vending machines.

Outreach – a service that is delivered by workers outside fixed-site service locations, to those in need of support. It may be delivered via a vehicle or on foot, and people who inject drugs may attend at set locations at scheduled times, or respond to requests to attend at locations identified by service users.

Opioids – the group of drugs similar in their effects on the body to those derived from the opium poppy and can be naturally derived, semi-synthetic or fully synthetic. The term 'opiates' refers to the natural and semi-synthetic drugs, whereas the term 'opioid' describes the entire class of drugs.

Opioid maintenance treatment – a pharmacological intervention using medication to assist in the treatment (withdrawal/maintenance) of dependence on opioids.

Peer education – members providing education and information to other members of the same group in both formal and informal ways. This model of education is based on social learning and health behaviour theories and is designed to impart information, skills and knowledge to others (peers). Peer education also recognises the influence that peer pressure and the behaviours of a peer group have on the decisions an individual makes.

Peer researcher – in this context refers to people who inject drugs, Aboriginal people working with people who inject drugs, and Aboriginal people.

Primary needle and syringe program – an outlet specifically funded to employ staff to deliver NSP services including education, referral and support as well as injecting equipment. Primary NSP outlets typically operate in areas with high levels of injecting drug use. They may be co-located with other health services, operate as stand-alone facilities, or deliver services through outreach.

Referral – the provision of a referral to another service which may occur through providing information in writing or verbally about the other service or through a staff member initiating contact with the other service on the service user's behalf. Referral to other NSPs, such as primary sites, is included in this definition.

Secondary needle and syringe program – an outlet located within an agency that is not specifically funded to employ staff to deliver NSP services. NSP provision may be only one among a range of services provided by the agency. Secondary NSP staff deliver NSP services alongside other duties, such as reception, nursing or counselling.

Syringe vending machine – dispenses needles, syringes and other injecting equipment, usually in exchange for a fee. Also known as needle dispensing machines.

Tertiary distribution – the act of distribution of injecting equipment by people who inject drugs and who access NSPs to collect injecting equipment for themselves and also collect and distribute injecting equipment among their social networks. These people who inject drugs are not registered to distribute injecting equipment but collect equipment on behalf of people who inject drugs who may be unwilling or unable to access distribution services.

Executive summary

A brief compiled in May 2008 by the Australian National Council on Drugs (ANCD) noted that alcohol continued to be the primary drug of concern for Aboriginal Australians. However, Aboriginal people who inject drugs were a small, but significant, subpopulation that was particularly vulnerable for a range of largely unidentified and poorly documented reasons. The harms associated with injecting drug use for Aboriginal Australians were not reliably reported, in part due to weaknesses in data collection. Unsafe injecting practices were of concern because of the increased risk in transmitting and acquiring blood-borne viruses such as human immunodeficiency virus (HIV), hepatitis C and bacterial infections.

The brief also noted that the ANCD was specifically interested in a project to obtain 'an understanding of the dimensions and characteristics of Indigenous injecting drug use and its associated harms, including gaps in knowledge, and whether there are specific issues that exist for Indigenous people'.

The ANCD commissioned Anex and the National Aboriginal Community Controlled Health Organisation (NACCHO) Inc. to conduct a project entitled *Injecting Drug Use and Associated Harms among Aboriginal Australians*. The project is based on recommendations made by the National Indigenous Drug and Alcohol Committee (NIDAC), which reports to the ANCD on drug and alcohol problems and associated harms in Aboriginal communities nationally.

Providing choice and improving options for individuals must be the ultimate goals in a functioning health system. Barriers to choice and options for access to health services can increase dependence on a person's level of disadvantage and vulnerability. The findings of this project support this premise and outline a range of issues that impact on the ability of Aboriginal people who inject drugs to access quality and timely prevention, treatment and harm reduction services, when and where they need them. These issues are in part structural, through policy and funding mechanisms, but are also embedded in practice. This in turn affects the ability of services to effectively meet the needs of their communities.

This report highlights the need for greater investment in the prevention, treatment and harm reduction sector so that those most disadvantaged in our community are not further disadvantaged by an ineffective system. The findings from this project tell a similar story to many other research projects undertaken in this area. The next steps must be to move from analysis and consideration to action – that is, a structured and detailed approach to planning and delivering services that encompasses the complexity inherent among Aboriginal people who inject drugs, but is practical enough to make a difference.

Contextualising Aboriginal people and injecting drug use

While it is acknowledged that there are major gaps in accurate data collection for Aboriginal injecting populations, it appears from previous surveys that injecting drug use is over-represented in Aboriginal communities. The 2008 Australian needle and syringe program (NSP) survey found that 11 per cent of the 2007 sample of over 1900 NSP service users identified as Aboriginal or Torres Strait Islander (Iversen et al., 2008). This proportion increased from 10 per cent in 2005, 8 per cent in 2003 (Iversen et al., 2008), 8 per cent in 2001, and 5 per cent in 1995 (Buddle et al., 2003).

Aboriginal Australians, and in particular those who inject drugs, are vulnerable to poor health, including general health problems, blood-borne viruses (BBVs) and mental health issues. Poor health, employment, education and housing are interrelated in their impact on each other and therefore can compound any difficulties associated with one or all of these dimensions. In regard to the harms associated with injecting drug use, it is clear that there are significant disparities between the health of Aboriginal Australians and that of their non-Aboriginal counterparts.

Harms associated with injecting drug use can be considered to fall into three broad categories (van der Sterren et al., 2006):

- harms to the individual – such as problems related to health, finances, relationships, employment or studies, and criminal behaviour
- harms to the family – such as personal safety, financial security and the long-term welfare of the family
- harms to the community – such as inter-generational impacts and community breakdown.

Injecting drug use has implications not just for the individual and family, but also for the broader community. Individual harms are experienced in relation to health and wellbeing, interpersonal relations, criminal behaviour, and employment and study opportunities. Harms to families and communities have the potential to threaten the social fabric and cultural health of communities. It is therefore important that approaches to minimising the harms associated with Aboriginal injecting drug use must take these broader harms into consideration.

Key findings

An extensive literature review was undertaken focusing on Australian and international research, as well as on unpublished literature from Australian organisations and services. This review examined and analysed literature on prevalence of Aboriginal injecting drug use, types of drugs injected, associated harms, barriers to access, and harm reduction services currently available.

Forty-five key informant interviews were conducted across Australia with key experts working in Aboriginal community-controlled organisations and Aboriginal health services, drug user advocacy organisations, frontline NSP services, health services, key researchers, and treatment services. These interviews contributed to the key findings of this project.

Key findings of this project fall into four broad categories:

1. Gaps in knowledge

There is a clear gap in knowledge in relation to Aboriginal people who inject drugs. In particular, there is a lack of accurate and representative data on patterns and prevalence of Aboriginal injecting drug use that can be compared nationally. This project found that there are significant knowledge gaps and issues in: the methods used to collect Aboriginal recreational and injecting drug use data; data sources; the focal point of data collection; and the purpose of data collection. Despite significant investment in research, Australia does not have a comprehensive system to determine the level of injecting drug use in Aboriginal communities. More work needs to be undertaken to build on existing data collection systems to ensure a comprehensive understanding of

injecting drug use. Furthermore, an inclusive approach to posing research questions and their intended outcomes, by enabling participation of Aboriginal communities in research design, is critical to determining relevance and meaning when dealing with data and its use.

2. Opportunities available to improve quality and access of services

There are a number of issues and challenges inherent in delivering services to Aboriginal people who inject drugs. These issues fall into three distinct categories: workforce capacity; access to services; and Aboriginal input into service planning and evaluation. Further support is needed in the area of workforce capacity through funding for training and development of Aboriginal health workers and of mainstream health service staff working with Aboriginal people who inject drugs. Development of a range of strategies to increase the reach of NSP services, particularly in rural and remote areas, is also considered important to improving service response. The quality of service as determined by members of the community needs to be part of any improvement framework. What constitutes culturally sensitive service delivery and its impact on access to, and the effectiveness of, services received is another key component of improvement. The ability of services to engage meaningfully with members of the community in the planning and evaluation of services has long been considered important in order to achieve relevant and targeted outcomes. Community collaboration has again been reinforced throughout this project as critical to successfully meeting the needs of Aboriginal people who inject drugs.

3. Improving service models

There is a need to strengthen service models that recognise the Aboriginal definition of health and subsequently to offer services that address the multifaceted needs of Aboriginal people. Aboriginal community-controlled health services (ACCHS) currently work across three different social dimensions: the individual; the family; and the community. It is believed that this model of service delivery is best suited to address the health needs of Aboriginal Australians by taking into account the social, cultural and emotional wellbeing of Aboriginal clients while also recognising the competing influences and potential support roles the family and community can play. While this model may currently be in place in ACCHS, it requires both structural and financial reinforcement across the service system to ensure consistency in outcomes. Better referral pathways and collaboration in general between mainstream and the Aboriginal community-controlled health sector are required.

4. Specific Aboriginal populations

There are a number of specific issues associated with populations within the Aboriginal community that require particular attention. These include: issues related to Aboriginal Australians living in urban, rural and remote areas; prisoners; people with comorbidity problems; young people transitioning into drug use and injecting; men who have sex with men; sex workers; and homeless and displaced people.

Recommendations

The following recommendations are designed and targeted at providing more resources and attention to improve service responses aimed at reducing the harms associated with injecting drug use among Aboriginal Australians.

To avoid duplication in service delivery and achieve the best health return on investment, additional funding must be made available. However, in the first instance, financial and other resource investments required to implement these recommendations should be drawn from a review of the current funding frameworks to determine if they are being targeted appropriately. In addition, it is crucial that any planned action in response to these recommendations involves meaningful consultation with key stakeholders operating at the service delivery level. This dialogue must include Aboriginal communities and commence from the initial planning stage through to implementation to ensure maximum benefit is achieved throughout each community. As Aboriginal communities are most affected by any proposed recommendations or consequent changes, failure to properly consult within a holistic framework of health as defined by the Aboriginal community will limit the intended outcomes.

The recommendations are listed under the following categories:

Policy development and funding

- Provide incentive grants to cover initial implementation costs for Aboriginal community-controlled health services seeking to establish needle and syringe programs.

- Review existing performance measures and reporting requirements for those services that provide needle and syringe programs to Aboriginal communities.
- Target an increase in the availability of sterile injecting equipment, particularly in regional areas of Australia. Strategies to achieve this goal may vary between communities and may include: the placement of syringe vending machines; enhancements to Aboriginal community-controlled health service funding; additional outreach mobile services; and additional support for pharmacy and hospital-based needle and syringe programs.
- In consultation with the Aboriginal community, design and implement a new policy structure for Aboriginal community-controlled health service delivery which focuses on the harm reduction framework used within the drug treatment sector and which encompasses the interrelated social dimensions of the individual, the family and the community.
- Fund a site trial of Aboriginal-specific detoxification services within (or in partnership with) the community-controlled health sector.
- Establish a trial needle and syringe program in an Australian prison to enable access to harm reduction services already provided in the general community.
- Increase funding for the community-controlled health sector, in particular Aboriginal medical services, to enable greater education and training for, and provision of, needle and syringe programs.

Data collection

- Consistent with the National Drug Strategy Household Survey, hold the National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement triennially and expand it to include inner and outer regional areas of Australia.
- Expand the National Aboriginal and Torres Strait Islander Health Survey and the National Aboriginal and Torres Strait Islander Social Survey to include questions specifically relating to injecting drug use, including separate reporting on each injecting practice, and to include rural and remote communities in survey sampling.
- Develop a minimum data set for drug and alcohol services and Aboriginal community-controlled health services regarding Aboriginal injecting drug use to ensure consistency and to enable comparability of data collected.
- Implement improvements across data sets in the recording of Aboriginal status from all mainstream health service clients.
- Collect data in accordance with national Aboriginal health information guidelines, with particular emphasis on: consultation with Aboriginal communities on the design of relevant questions; and custodianship of data in relation to control, access, ownership and usage.
- Collect data that are outcome-focused and not used solely for the purposes of meeting funding requirements.

Service responses

- Promote a harm reduction framework within Aboriginal community-controlled health services supported by a workforce development strategy that builds capacity and capability in this area.
- Provide intensive support to Aboriginal community-controlled health services in the start-up phase of establishing a needle and syringe program including: assistance with operational planning in line with current risk and accreditation processes; policy development; workforce education and training; and financial resources.
- Implement organisational policy in mainstream health services (including detox and residential rehabilitation) which covers: cultural sensitivity training for all staff; support for Aboriginal staff; and ongoing monitoring and evaluation processes. This step must involve a high degree of consultation with the Aboriginal community to allow input into planning and evaluation.

Workforce development

- Build the capacity of the Aboriginal workforce through establishment of a national network of Aboriginal workers in alcohol and other drugs services.
- Ensure consistency in approaches to investment in the Aboriginal sexual health workforce across all jurisdictions. This may include the provision of education, training and support for Aboriginal health workers primarily engaged in the delivery of services in sexual and blood-borne virus health as an interim measure while a national strategy for alcohol and other drug services is in development.
- Provide training in the harm reduction sector in the form of a nationally accredited and standardised program.
- Support the National Aboriginal Health Worker competencies training package to enable inclusion of drugs and alcohol as an elective subject to enhance the workforce within Aboriginal community-controlled health services.
- Develop and deliver additional educational resources, greater support and cultural sensitivity training for all staff to assist Aboriginal staff retention and hence skills enhancement.
- Provide cultural competency training to all health care workers in mainstream health services.

1. Introduction

The Australian National Council on Drugs (ANCD) commissioned Anex and the National Aboriginal Community Controlled Health Organisation (NACCHO) Inc. to conduct a project entitled *Injecting Drug Use and Associated Harms among Aboriginal Australians*. The project is based on recommendations made by the National Indigenous Drug and Alcohol Committee (NIDAC), which reports to the ANCD on drug and alcohol problems and associated harms in Aboriginal communities nationally.

1.1 Background

A brief compiled in May 2008 by the ANCD noted that alcohol continued to be the primary drug of concern for Aboriginal Australians. However, Aboriginal people who inject drugs were a small but significant group that was particularly vulnerable for a range of largely unidentified and poorly documented reasons.

The harms associated with injecting drug use for Aboriginal Australians were not reliably reported. Unsafe injecting practices were of concern because of the increased risk in transmitting and acquiring blood-borne viruses such as human immunodeficiency virus (HIV), hepatitis C and bacterial infections.

The brief specified that the ANCD was particularly interested to obtain ‘an understanding of the dimensions and characteristics of Indigenous injecting drug use and its associated harms, including gaps in knowledge, and whether there are specific issues that exist for Indigenous people’.

The brief noted that the report from the project needed to identify key issues associated with Aboriginal injecting drug use. Also, the report should describe current knowledge about injecting drug use among Aboriginal Australians and discuss the implications of this information, including consideration of:

- gaps in knowledge and responses
- opportunities available to improve services
- priority areas to target.

1.2 Approach to the project

Anex partnered with the National Aboriginal Community Controlled Health Organisation (NACCHO), merging the expertise of two national bodies in harm reduction and Aboriginal health, respectively. This partnership represents an important linkage between the two sectors and has ensured a comprehensive, consultative and culturally sensitive approach to the project.

1.2.1 Project aim and methodology

The primary aim of the project was to record a national picture of injecting drug use among Aboriginal Australians in order to compile the necessary evidence to inform future work. This task included identifying gaps in the available evidence.

The project comprised three major phases. These were:

- Phase 1: Literature review
- Phase 2: Consultations with key informants across Australia
- Phase 3: Consolidation of this information into a final report.

A Project Reference Group was convened to provide direction and guidance to the project team and to provide input into the design of project tools, consultation processes, and deliverables including development and analysis of the project findings and report.

A project plan was developed, coupled with standard project management tools such as risk and issues registers, communication protocols and Participant Information Statements. Further, advice was sought from

NACCHO and members of the Project Reference Group regarding ethical and consultative practices when undertaking research in Aboriginal communities.

Given the project's primary aim, some of the outcomes of this project were directly affected by the quality of the available data. As this project was not established to provide empirical data collection on injecting drug use among Aboriginal Australians in various communities across Australia, this report does not provide an authoritative review of the number of people who inject drugs or of the types of drugs being used and a comparison to non-Aboriginal drug use. The barriers and difficulties associated with the project methodology are further outlined in the method section. However, every attempt was made in reviewing the available literature to capture current and relevant research in this field.

1.2.2 Literature review

A comprehensive literature review was conducted as Phase 1 of the project. The literature review focused on Australian research, as well as the literature obtained from Australian organisations and services working in the field, such as internal and external reports both published and unpublished, information obtained from the community consultations undertaken by NIDAC throughout Australia and other relevant research. This review examined and analysed literature regarding the prevalence of injecting drug use in Aboriginal communities, types of drugs injected, associated harms, barriers to access, and harm reduction services currently available. The review considers literature from 1995² to mid-2009.

² One article from 1994 was included in this review because it was referred to in numerous articles and reports, and may be considered one of the seminal articles attempting to document the prevalence of injecting drug use among Aboriginal Australians.

International literature from Canada and New Zealand was also included where relevant and with consideration of the transferability of the information to the Australian Aboriginal context. The full literature review can be viewed in Chapter 3.

1.2.3 Key informant consultations

The second phase of the project involved consultation with key informants across Australia. The project partners recognise that there is a high degree of accumulated wisdom and expertise among individuals and organisations that are often not documented. In this context, we included oral tradition, anecdotal evidence and discussions for follow-up and aligned these with existing literature where particularly relevant. The purpose of service provider consultations was to identify and document this knowledge in relation to injecting drug use among Aboriginal Australians.

The consultation plan was developed in conjunction with the Project Reference Group and was informed by the findings of the literature review. Face-to-face interviews were conducted with key informants in each Australian capital city and in some regional areas. Other interviews were conducted by telephone. Interviews were semi-structured, open-ended and conducted with both individuals and groups. The consultations aimed to explore more deeply the themes, issues, opportunities and gaps in knowledge identified in the literature.

A broad range of key stakeholders, groups and organisations was consulted from across Australia including:

- Aboriginal community-controlled health services and other Aboriginal health services
- drug user advocacy organisations
- NSP services
- mainstream health services
- research organisations, and
- drug and alcohol treatment services.

Forty-five key informants were consulted during this phase of the project.

Aboriginal people who inject drugs were not interviewed, as it was not within the scope of this project. The intent of the project was to record service provision to Aboriginal people who inject drugs and identify related issues for service providers that may impact on their capacity or capability to effectively meet the needs of Aboriginal people who inject drugs.

1.2.4 Analysis

Notes and transcripts from the key informant interviews were analysed for common themes and issues. The outcomes of this process are presented in Chapter 4. The data from key informant interviews were combined and a qualitative analysis was undertaken using the data package Nvivo 8.

A number of themes emerged during the key informant interviews, which were categorised according to the key areas on which we were required to report:

Gaps in knowledge and responses

- data – including data collection, sample sizes, national data sets, purpose of data and quality of data
- policy – frameworks and structures
- Aboriginal drug use – including issues of stigmatisation, denial and shame, drug types used, rates of use
- research – including barriers to undertaking research, ethics approval, funding, health economics research, Aboriginal researchers.

Opportunities available to improve services

- service delivery – including accessing sterile injecting equipment, confidentiality issues, Medicare rebates, service models and workforce.

Priority settings/populations

- geographical location, prisoners, dual-diagnosis and comorbidity, men who have sex with men, sex workers, and homeless and displaced people.

Names of those interviewed as well as other identifying details have been changed or removed to ensure anonymity.

1.2.5 Methodological limitations

Limitations inherent in the methodology employed include the following.

- A limited number of key informants were interviewed due to budget constraints. As a result, the project was restricted to consulting 45 key informants, the majority of whom work in Australian capital cities rather than in rural or remote settings. It should be noted, however, that some of these informants had previous experience in rural and remote settings. Therefore, analysis of the findings has been undertaken at a thematic level due to the sample size.
- Aboriginal people who inject drugs were not interviewed as part of this project. Although research undertaken with Aboriginal people who inject drugs was included in the literature review, consulting with Aboriginal people who inject drugs was not within the scope of this project.
- Only qualitative data were collected. While the literature reviewed did include quantitative data, the review found limited accurate quantitative data on this topic. As noted above and discussed further in the report, an empirical data collection exercise was not within the scope of this project. The lack of good quantitative data makes the triangulation of data difficult.

2. Context

This section highlights the major factors that contribute to poor health outcomes for Aboriginal Australians. The Aboriginal population lags behind the rest of the Australian population in all major socioeconomic indicators while also faring poorly in morbidity and mortality rates when compared to non-Aboriginal Australians. Aboriginal Australians who inject drugs are particularly vulnerable to poor health, including general health problems, vulnerability to blood-borne viruses, and mental health issues. These health outcomes impact on employment, education and housing. A range of social and structural influences affecting the health and wellbeing of Aboriginal Australians is discussed below (Mitchell, 2007; Siggers & Gray, 2007).

2.1 Aboriginal population profile

According to the latest available data from the Australian Bureau of Statistics (2008), *Population Characteristics: Aboriginal and Torres Strait Islander Australians*, in 2006, there were 517 200 Aboriginal people living in Australia, making up 2.5 per cent of the total Australian population. Thirty-one per cent of Aboriginal Australians lived in major cities, 45 per cent lived in regional areas, and 24 per cent lived in remote and very remote areas (Australian Bureau of Statistics, 2008a).

The Aboriginal population is significantly younger compared to the non-Aboriginal population. The 2006 Australian census revealed that 38 per cent of the Aboriginal

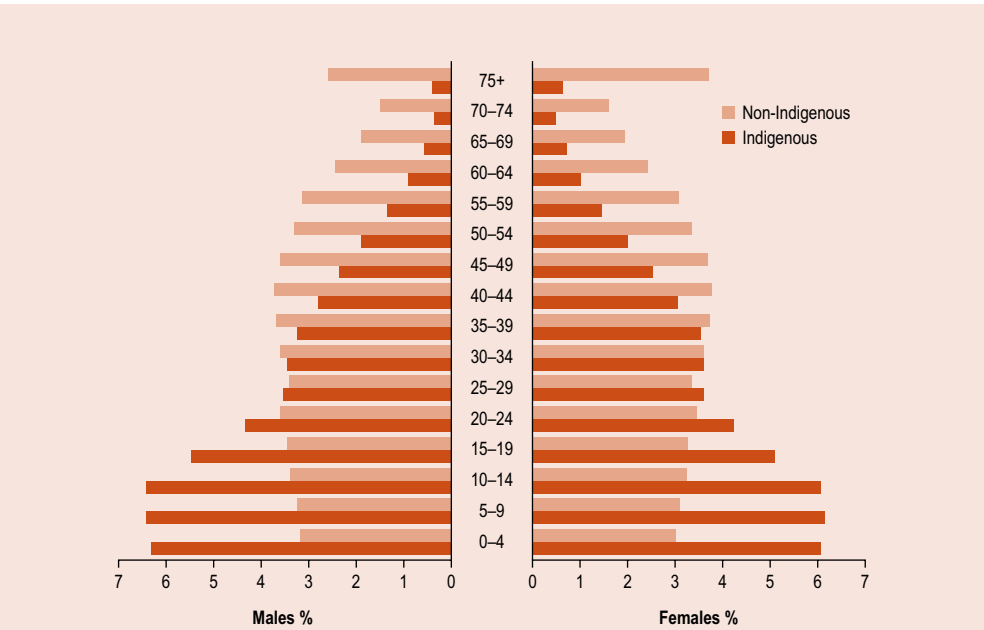


Figure 1: Estimated resident population by age group and Indigenous status, 2006
Source: Australian Bureau of Statistics, *Experimental Estimates of Aboriginal and Torres Strait Islander Australians, June 2006* (Australian Bureau of Statistics, 2008a)

population were aged less than 15 years (compared with 19 per cent of the non-Aboriginal population); 19 per cent were aged 15–24 years (compared with 14 per cent) and 3 per cent were aged 65 years and over (compared with 13 per cent). The different age profiles between Aboriginal and non-Aboriginal Australians highlight the higher rates of fertility and shorter life expectancy among the Aboriginal population (Australian Bureau of Statistics, 2008a).

A comparison of the age of Aboriginal and non-Aboriginal Australians is provided in Figure 1.

Aboriginal people have a significantly lower life expectancy than non-Aboriginal Australians. The Australian Bureau of Statistics estimates that Aboriginal males born in the period 2005–07 are expected to live approximately 66.9 years (compared to 78.7 years for non-Aboriginal males). In the same period, it is estimated that Aboriginal females will live to approximately 72.6 years (compared to 82.6 years for non-Aboriginal females) (Australian Bureau of Statistics, 2008b; 2008c).

2.2 Social determinants of health

I have come to realise health is not dependent on the physical wellbeing of individuals. It is also dependent on key indicators such as education, financial status, adequate housing, sanitation, diet, and access to a range of goods and services. When considering health, you need a model that has a focus on structural inequalities, not just a focus on personal stories of misfortune. Also you need a model that acknowledges a history of oppression and dispossession, and a history of systematic racism. (Lowitja O'Donoghue, 2007, p. xxii).

The social determinants of health are the circumstances, including the health system, in which people are born, live, age and work. These situations are dependent on the allocation of wealth, resources and power at local, national and global levels (World Health Organization, n.d.). Socioeconomic positioning, most often calculated through a comparison of income, employment and education levels, is often cited as the main social determinant of health. However, other factors include housing, food, social supports, gender and ethnicity (Saggers & Gray, 2007) as well as social and emotional wellbeing, and cultural differences and disempowerment. These social determinants of health contribute towards health inequalities present within and among countries (World Health Organization, n.d.).

According to Walter and Saggers, Aboriginal Australians 'experience one of the highest levels of health inequality suffered by any group in contemporary, developed society' (Walter & Saggers, 2007, p. 87). Traditionally the explanation given for the poor health status of Aboriginal Australians has focused mainly on individual behaviours such as diet

and the use of addictive substances (Baum, 2007). However, it is becoming increasingly apparent that a variety of structural factors influences the lives of Aboriginal people, and ill-health is rooted in historical, cultural and political circumstances (Mitchell, 2007).

For Aboriginal Australians, poor health is understood and situated in the context of macro-social influences including: the effects of colonialism; poverty; institutional racism; and dispossession from country (Saggers & Gray, 2007). For Aboriginal Aus-

tralians, socioeconomic circumstances, coupled with other macro-social factors, reinforce the divide between Aboriginal and non-Aboriginal Australians where Aboriginal people lag behind in all major socioeconomic indicators (Walter & Saggers, 2007). Table 1 highlights the significant socioeconomic disparity that exists between Aboriginal and non-Aboriginal Australians.

Table 1: Australian Aboriginal and non-Aboriginal socioeconomic comparison 2003, 2005

Socioeconomic indicator	Aboriginal ^a %	Non- Aboriginal %
Male unemployment rate	22	8
Female unemployment rate	18	7
Proportion employed in manager/administrator or professional/associated professional occupations	23	39
Apparent Year 12 retention rate	36	75
Holds Bachelor degree	2	13
Holds post-school qualifications	29	50
Attending post-school institution aged 18–24 years	21	45
Lives in rental accommodation	70	24
Proportion living in households that require an additional bedroom	16	3
Unable to raise \$2000 within a week for something important	54	14
Proportion of prison inmates	20 ^b	80

^a Comparative percentages may vary slightly by year.

^b Imprisonment rate is 16 times higher for the Aboriginal population when compared with the non-Aboriginal population.

Source: Walter and Saggers (2007), p.95.

2.3 Policy context

Within the context of current policy frameworks for Aboriginal and Torres Strait Islander health, the Australian Government has identified a number of priorities related to the issues discussed in this report. The *National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003–2013* outlines several key areas that are specifically designed to address issues related to: data and information; research and knowledge translation; substance use; and harm reduction programs, e.g. needle and syringe programs. Each of these target areas emphasises strategies that encourage a coordinated approach between government agencies, non-government organisations and Aboriginal and Torres Strait Islander communities for investment, resourcing, planning, implementation and monitoring.

Particularly relevant to the findings within this report are the strategies around data, research and evidence. The objectives are:

- improved quality of information and information management processes about the health of Aboriginal peoples
- improved information collection and use of information on successful models of health-care provision for Aboriginal peoples
- greater range and quality of research about the health of Aboriginal peoples with a focus on interventions to improve health outcomes.

Agencies responsible for these strategies are the Australian Government Department of Health and Ageing (DoHA), the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the National Health and Medical Research Council. Salient points include strategies aimed at ensuring Aboriginal community input into strategy development and implementation along with increased participation and control of research and research-funding processes.

Additionally, workforce and sector development issues are identified as priorities within the framework, with strategies aimed at community and organisational capacity building and improvement of infrastructure for health professionals working in Aboriginal health. Multiple federal government agencies are identified as responsible for development and implementation of these strategies, including DoHA, the Department of Families and Community Services, the Department of Education, Science and Training, and the Department of Employment and Workplace Relations (the last two now merged in the Department of Education, Employment and Workplace Relations).

There are also service plans and frameworks within each jurisdiction (e.g. Victoria Department of Human Services, *Aboriginal Services Plan 2008–2010*), which outline similar strategies to address these issues. Given the level of investment already made at both a federal and state level in identifying and planning for improvement in these areas, coupled with the findings of this report which indicate little if any progress has been made in relation to injecting drug use within Aboriginal communities, it is worth asking what actual outcomes have been achieved and how we can improve the addressing of these issues.

In reviewing the literature for this project, we note that the same issues continue to be identified and the same recommendations continue to be made regarding actions by government health and community services departments and also by health services. These themes mirror those drawn from the consultations conducted for this project. They include:

- greater collaboration between mainstream services and ACCHS
- development of skills and knowledge in the areas of substance use, harm reduction and cultural sensitivity
- investigation into better ways to collect and analyse health data for service planning, delivery and evaluation
- greater participation of the Aboriginal community, including consumers, service providers and peak bodies, in research and service planning for Aboriginal health
- exploration of good practice service models and methods to better meet health outcomes in the area of substance use and harm reduction.

The Council of Australian Governments (COAG) more recently acknowledged that, despite concerted efforts by successive federal, state and territory governments to address Indigenous disadvantage, only modest improvements have been made in outcomes such as education and health, while other health indicators have remained static or even worsened (Council of Australian Governments, 2008). Even in those areas where there have been improvements, the outcomes for Aboriginal Australians remain far short of the outcomes for non-

Aboriginal Australians. To close the gap in Aboriginal disadvantage, COAG has committed to making significant reforms in order to address six specific targets:

1. Closing the life expectancy gap within a generation
2. Halving the gap in mortality rates for Indigenous children under five years old within a decade
3. Ensuring all Indigenous four-year-olds in remote communities have access to early childhood education within five years
4. Halving the gap for Indigenous students in reading, writing and numeracy within a decade
5. Halving the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020
6. Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

As part of the Closing the Gap initiative, a National Partnership Agreement has been established to address targets set by COAG for closing the gap in health outcomes between Aboriginal and non-Aboriginal Australians. The agreement is centred on five priority areas: tackling smoking; providing a healthy transition to adulthood; making Aboriginal health everyone's business; delivering effective primary health-care services; and better coordinating the patient journey through the health system.

COAG states that this identified package of health reforms is consistent with the evidence, which acknowledges that, to overcome Aboriginal health disadvantage, a holistic life-stage approach is required that builds sustainable social change and embeds system reform. Further, this proposal's effectiveness will be influenced and supported by the successful implementation of other Aboriginal initiatives including early childhood reforms, broader health system changes and measures to address the underlying social determinants of poor health. In addition, this initiative will support life-style changes by individuals, families and communities (Council of Australian Governments, 2009, p. 4).

In this agreement, initiatives are outlined under the following five priority areas:

- Preventive health: to reduce the factors that contribute to chronic disease through effective anti-smoking campaigns and integrated alcohol, drug and mental health services
- Primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services
- Hospital and hospital-related care: to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management
- Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and coordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Aboriginal health needs, in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Aboriginal people into mainstream and targeted health services
- Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce; to reform and improve the supply of the health workforce generally, including the adoption of complementary workplace reforms; to create sustainable program and funding models; to measure performance and ensure that services are responsive both to national targets and local community needs (Council of Australian Governments, 2009, pp. 5–6).

3. Literature review

3.1 Introduction

The literature review involved searching both peer-reviewed and non-peer-reviewed literature from 1995³ to mid-2009. Peer-reviewed literature was sourced from the following databases: Medline, CINAHL, Meditext, Psyc-Info, ATSIhealth and the Cochrane Library using combinations of the following search terms:

Table 2: Search terms used

Search term	Boolean	Search term
Substance use	AND	Aboriginal
Substance abuse		Indigenous
Substance-related disorder		Maori
Injecting drug use		Native Indian
Intravenous drug use		First Nations
Street drugs		

The non-peer-reviewed literature search formed an integral part of this review because many community groups and organisations have conducted a considerable amount of research in attempting to identify and address Aboriginal substance use issues. Non-peer-reviewed literature was sourced by accessing the websites of the following

organisations and research centres, several of which have compiled comprehensive reference lists pertaining to Aboriginal substance use and Aboriginal injecting drug use:

- Australian Indigenous Health InfoNet
- National Centre in HIV Social Research (NCHSR)
- National Centre in HIV Epidemiology and Clinical Research (NCHECR)
- National Drug Research Institute (NDRI)
- Australian Government Department of Health and Ageing (DoHA)
- Office for Aboriginal and Torres Strait Islander Health (OATSIH)
- Australian Institute of Health and Welfare (AIHW)
- Australian National Council on Drugs (ANCD)
- National Indigenous Drug and Alcohol Committee (NIDAC), and
- State health and human services departments.

To further ensure the comprehensiveness of the literature search, the reference lists of key articles and reports were cross-referenced to identify additional relevant articles that may have been missed through other search strategies. By combing both search strategies, no additional articles were identified in the reference lists.

³ One article from 1994 was included in this review because it was referred to in numerous articles and reports, and may be considered one of the seminal articles attempting to document the prevalence of injecting drug use among Aboriginal Australians.

Articles and reports were identified that were not relevant and were therefore excluded from the review. Several criteria were used to inform the decision to include or exclude an article. Articles were excluded if they:

- focused specifically on the use of one substance, which was not being administered via injection or which did not discuss illicit substance use in general
- addressed specific harms, risk factors or determinants that are associated with injecting drug use, but did not discuss injecting drug use; for example, articles regarding only blood-borne viruses and articles discussing suicide or self-harm which did not discuss the association with injecting drug use
- did not answer at least one of the questions posed in this literature review
- related to injecting drug use among Indigenous peoples in Canada or New Zealand but addressed prevalence only or did not discuss responses to the associated harms
- used the term ‘indigenous’ as a way of describing peer education, rather than ethnicity (i.e. indigenous to the street drug scene or to a cluster or network of users).

Based on this search strategy, over 2000 articles and reports were identified. Using the exclusion criteria above, 151 were included in this review (including 14 from Canada and six from New Zealand). The literature was reviewed from the following perspectives:

- prevalence of injecting drug use
- patterns of drug use
- injecting drug use in different settings
- gender and age differences
- associated harms, and
- service responses.

3.1.1 Overview of key studies on Aboriginal injecting drug use

Through the literature search, several key studies were identified that examined injecting drug use, and other illicit drug use in some cases, among Aboriginal Australians. These studies are considered seminal studies for the purposes of this report; they address all or most of the key issues covered within this literature review and include a variety of data sources or methods of data collection. Table 3 provides a brief overview of each of the studies, as they will be referred to continually throughout the remainder of this document.

Table 3: Summary of key research identified

Study (Author)	Year	Methods	Sample	Sample size
NDSHS: Urban Aboriginal and Torres Strait Islander Peoples Supplement – national (AIHW, 1995)	1994	Cross-sectional random selection of Aboriginal households in cities over 1000	Random sample of Aboriginal household residents, general Aboriginal population	2993
NATSISS/ NATSIHS – national (ABS, 2004a; 2006; 2009)	2002 2005 2008 Triennial	Cross-sectional random sample of Aboriginal households based on census	Self-selected individuals in non-remote areas who agree to complete substance use form, general Aboriginal population	10 000+ (total) 80% response rate to substance use form for those in non-remote areas
IDRS – national (Black et al., 2008)	2007 Annual	Cross-sectional interviews with regular IDUs	Convenience sample of regular IDUs recruited from a variety of locations, primarily urban, general IDU population	909 15% (137) identify as Aboriginal or Torres Strait Islander
ANSPS (Buddle et al., 2003; Iversen et al., 2008; 2010)	Annual	Cross-sectional interviews with IDUs at NSPs	Convenience sample of IDUs recruited at NSPs, primarily urban, general IDU population	1912 11% (210) identify as Aboriginal or Torres Strait Islander
Numerous locations (Coupland et al., 2005)	2004–05	Semi-structured interviews and focus groups with Aboriginal IDUs in six urban and non-urban sites around Australia	Convenience sample recruited through the member organisations of two national peak bodies – AIVL and AFAO, Aboriginal IDU population	70

Study (Author)	Year	Methods	Sample	Sample size
New South Wales (Perkins et al., 1994)	1994	Cross-sectional interviews with members of Aboriginal households	Random sample of Aboriginal households in two NSW communities, based on census of Aboriginal households in NSW, general Indigenous population	531
Western Australia (Gray et al., 2001)	2000–01	Examination of prevalence indicators, semi-structured interviews with Aboriginal IDUs and others	Convenience sample of IDUs recruited at a variety of locations and snowballing in 5 different cities/towns, Aboriginal IDU population	Perth: 42 Broome: 0 Geraldton: 15 Kalgoorlie: 2 Bunbury: 15 = 74
Australian Capital Territory (Dance et al., 2004)	2002–04	Semi-structured interviews with Aboriginal or Torres Strait Islander illicit drug users	Convenience sample of illicit drug users recruited through various agencies and word of mouth, Aboriginal IDU population	95 Total 54 IDU
Victoria, Melbourne mainly (Edwards et al., 1998)	1995–99	Semi-structured interviews and focus groups with community members, including those who inject	Recruited through networks, word of mouth, Aboriginal IDU population	About 30 IDUs About 30 others
South Australia, Adelaide (Holly & Shoobridge, 2004)	2001	Rapid assessment procedures involving semi-structured interviews with key consultants and Aboriginal IDUs	Convenience sample recruited through peer interviewers and word of mouth, Aboriginal IDU population	307

Study (Author)	Year	Methods	Sample	Sample size
South Australia, Lower Murray (Shoobridge et al., 2000)	1997	Rapid assessment procedures involving semi-structured interviews with key consultants and Aboriginal IDUs	Convenience sample recruited through various locations, Indigenous IDU population	25
Northern Territory, Darwin only (Roberts & Crofts, 2000)	1998	Repeat cross-sectional study involving survey and interview of IDUs	Convenience sample of NSP service users, general IDU population	July: 129 Oct: 121 14% identify as ATSI =18/17
Queensland, Brisbane only (Larson et al., 1999)	1996	Cross-sectional interviews with Aboriginal IDUs	Convenience sample recruited by peer interviewers, Aboriginal IDU population	77
Tasmania	—	—	—	—

3.2 Prevalence of injecting drug use

There are very few studies that have explicitly attempted to assess the prevalence of injecting drug use among Aboriginal Australians at a national level. A review of existing data sources on drug use among Aboriginal Australians revealed that there are over 44 different national and regional data sources (Australian Institute of Health and Welfare, 2006). However, in spite of the number of data sources, the data do not provide a meaningful picture regarding substance use among Aboriginal Australians (Australian Institute of Health and Welfare, 2006).

A study undertaken to estimate the prevalence of drug use among Aboriginal Australians was conducted by AIHW in 1994 as a supplement to the National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 1995). The National Drug Strategy Household Survey is conducted every three years, using a random sample of Australian households, to monitor substance use among Australians aged 14 years and older. The supplemental survey, Urban Aboriginal and Torres Strait Islander Peoples Supplement, was conducted because the sampling strategy used for the larger survey does not yield sufficient data on Aboriginal households to allow for separate analysis of the findings (Australian Institute of Health and Welfare, 1995). While this survey is one of the most comprehensive studies

undertaken to estimate the prevalence of licit and illicit substance use, including injecting drug use, the supplemental survey in Aboriginal Australians has never been repeated.

This supplement, now out of date, found that 3 per cent of the respondents had injected drugs in their lifetime and 2 per cent reported current use (Australian Institute of Health and Welfare, 1995). By comparison, in the same year, 2 per cent of the general population reported ever injecting drugs and 0.5 per cent reported current use (Australian Institute of Health and Welfare, 1995). This finding suggests a higher prevalence of injecting drug use in Aboriginal communities compared to that in the general population at that time.

More recent iterations of the NDSHS do not report separately on Aboriginal substance use. However, Putt and Delahunty (2006), in a review of the literature on the extent of illicit drug use among Aboriginal Australians, report that the 2004 NDSHS revealed much higher rates of lifetime and recent use of illicit substances among Aboriginal respondents. They do not report on injecting drug use specifically, but, excluding cannabis, nearly 12 per cent of Aboriginal respondents had used illicit substances in the previous 12 months, compared with 8 per cent of the general population (Putt & Delahunty, 2006). The most commonly used substances after cannabis were ecstasy, amphetamines and analgesics for non-medical purposes (Australian Institute of Health and Welfare, 2005).

The first National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) was conducted in 2005 and provides more recent data. The substance use form, which is completed separately from the health survey, is implemented only in non-remote areas, and is voluntary (Australian Bureau of Statistics,

2006). Eighty per cent of the NATSIHS respondents who were eligible to complete the substance use form (i.e. those in non-remote areas) answered the substance use questions (Australian Bureau of Statistics, 2006). The data show that 28 per cent reported illicit substance use in the past 12 months (Australian Bureau of Statistics, 2006). The most commonly reported illicit substances were cannabis (23%), amphetamines (7%) and analgesics and sedatives for non-medical use (6%) (Australian Bureau of Statistics, 2006). Respondents were not asked specifically about injecting drug use, nor about the method of administration of the substances for which use was reported (Australian Bureau of Statistics, 2004).

The National Aboriginal and Torres Strait Islander Social Survey (NATSISS) is also conducted every six years and alternates with each of the NATSIHSs. The results from the NATSISS conducted in 2002 show somewhat lower rates of overall illicit substance use in the previous 12 months at 23.5 per cent. Cannabis was the most commonly reported illicit drug, followed by amphetamine use at 4.7 per cent. In this survey, a greater proportion of NATSISS respondents who were eligible to complete the substance use form did so, with 93 per cent of those in non-remote areas completing the questions (Australian Bureau of Statistics, 2004a).

The most recent NATSISS was conducted in 2008 and covered remote and non-remote areas. The most commonly reported drugs ever used (32.5%) and used in the previous 12 months (15.5%) were categorised as 'marijuana, hashish, cannabis'. In terms of drugs that are commonly injected throughout Australia, as evidenced by the annual NSP surveys, the 2008 NATSISS found that 'amphetamines/speed' were 'ever used' by 9.9 per cent of respondents and 'used' by 3.6 per cent of respondents in the previous 12

months. Painkillers/analgesics, which figure prominently as an injectable illicit drug, particularly in the Northern Territory and Tasmania, were 'ever used' by 6.7 per cent and were 'used' by 4.1 per cent of respondents in the previous 12 months. This extensive survey did not produce data on the most commonly injected illicit drug in Australia, heroin.

It should be noted that the prevalence of the use of other drugs that may be injected is not reported separately in either NATSISS or NATSIHS. The rates were thought to be too low to be considered reliable and therefore the use of the data and the ability to draw generalisations from them are questionable (Australian Bureau of Statistics, 2006; 2004a).

Although not national in scope and dated, a study was conducted in two communities in New South Wales to estimate the prevalence of substance use based on a random sample of Aboriginal households (Perkins et al., 1994). The study examined the use of alcohol, tobacco, marijuana, cocaine, heroin and petrol sniffing. The authors found that the prevalence of alcohol use was lower than that in the general population, although a larger proportion of those who did use alcohol did so at a more harmful level. They also found that the prevalence of smoking tobacco and cannabis was much higher than within the general population. With respect to heroin use, they found a prevalence of lifetime use of 6 per cent.

Interestingly, this study also found significant differences in the prevalence of drug use across the two communities that were included. For example, in Community A, lifetime use of heroin was 12 per cent compared to 1 per cent in Community B, and lifetime use of cocaine was 9 per cent compared to 2 per cent, respectively. The authors conclude

that while the prevalence of heroin use is significantly higher than that in the general population, there may also be significant differences across communities and settings. As such, generalisations from community level samples of Aboriginal people to the broader Australian setting are not appropriate (Perkins et al., 1994).

It is clear from these studies that there are several challenges in attempting to assess the prevalence of injecting drug use among Aboriginal Australians. The relatively small population of Aboriginal people in Australia means that it is difficult to obtain a large enough sample to allow for a separate analysis of the data related to Aboriginal respondents (Putt & Delahunty, 2006).

The illegal nature of injecting drug use also presents a challenge to reliable assessment of its prevalence, due to a reliance on self-identification as a person who injects drugs. This is true in the general population, but may be further confounded in the Aboriginal population, who may experience distrust of government and research bodies due to historical precedents (VicHealth, 2000). Furthermore, the shame and stigma that may be associated with injecting drug use present challenges to accessing people who inject drugs. As a result, people who inject drugs may not self-identify, and responses to questions pertaining to injecting drug use practices may not be wholly reliable (Edwards et al., 1998; Meyerhoff, 2000). Within Aboriginal communities, people who inject drugs may hide their use from family or community, or may become isolated from the community (Edwards et al., 1998), and therefore may be even more difficult to access.

3.2.1 Indicators of Aboriginal injecting drug use

Other than prevalence estimates based on self-reported injecting drug use in national surveys (as discussed above), there are several other data sources referred to in the literature which provide information about injecting drug use in Aboriginal Australians. Information from these sources includes:

- demographic characteristics of those surveyed about substance use monitoring and surveillance studies (e.g. National Drug Strategy Household Survey; Australian Needle and Syringe Program Survey)
- hospital admissions for drug-related conditions (other than alcohol or tobacco)
- hepatitis C and other blood-borne virus notifications
- treatment participation
- community perceptions
- police arrests for drug-related crime and prison-based surveys.

Several studies explore the likelihood that injecting drug use is more prevalent among Aboriginal Australians than in the general Australian population.

One study in Western Australia, which focused on Aboriginal people in five communities (Perth, Bunbury, Kalgoorlie, Geraldton and Broome), examined hospital admissions, hepatitis C notifications and police arrest data (Gray et al., 2001). Changes in these three indicators, between approximately 1994 and 2000 (depending on the availability of data), were examined in order to estimate the change in prevalence of injecting drug use among Aboriginal people in Western Australia since the 1994 Urban Aboriginal and Torres

Strait Islander Peoples Supplement of the National Drug Strategy Household Survey was conducted. The study found a 122 per cent increase in drug-related hospital admissions between 1996 and 2000, including opioid-related admissions and drug-related psychoses. It also found a substantial increase in hepatitis C notifications among Aboriginal people between 1993 and 1999, as well as increases in the number of Aboriginal people charged with drug-related offences and the proportion of drug-related offences attributed to Aboriginal people. Based on the study's analysis, the authors estimate that injecting drug use among Aboriginal people in Western Australia may have doubled since 1994. They report that 4.5–6 per cent of Aboriginal people in Western Australia over the age of 14 have ever injected and that 3–4 per cent have injected within the past year. Based on regional differences in the increases in the indicators, the authors estimate that the majority (60%) of Aboriginal people who inject drugs reside in Perth (Gray et al., 2001).

3.2.1.1 Substance use monitoring and surveillance

There are several ongoing studies that monitor trends and patterns in substance use in Australia. The National Drug Strategy Household Survey is used to monitor substance use in the population as a whole. Two other studies of note include the Illicit Drug Reporting System (IDRS) and the Australian Needle and Syringe Program Survey (ANSPS). These studies, conducted annually, attempt to monitor trends more closely within the population of people who inject drugs and, for ANSPS, those people who inject drugs who access needle and syringe programs (NSPs). The IDRS focuses specifically on heroin, methamphetamine, cocaine and cannabis use in Australia

(Black et al., 2008). The ANSPS monitors the risks and harms associated with injecting drug use (IDU) specifically (Iversen et al., 2008). Both studies may provide an indication of issues related to Aboriginal IDU. However, it is important to note that both studies make use of convenience samples and therefore may not be considered representative of all people who inject drugs.

In the most recent iteration of the IDRS, 15 per cent of the total sample of 909 self-identified people who inject drugs regularly also identified as Aboriginal or Torres Strait Islander (Black et al., 2008). The number in each state and territory was: 24 per cent in New South Wales; 24 per cent in Queensland; 21 per cent in the Northern Territory; 14 per cent in Tasmania; 11 per cent in the Australian Capital Territory; 9 per cent in South Australia; 7 per cent in Western Australia; and 5 per cent in Victoria (Black et al., 2008). This may be an indication of a higher prevalence of injecting drug use among Aboriginal Australians in some areas, or it may simply represent more effective engagement and recruitment of Aboriginal people who inject drugs in areas of higher prevalence. It is interesting to note the relatively high proportion of Aboriginal people who inject drugs in Tasmania, where there is otherwise a lack of research on injecting drug use within this community (see Table 3).

In the 2007 ANSPS, 11 per cent of more than 1900 NSP service users identified as Aboriginal or Torres Strait Islander (Iversen et al., 2008). This was up from 8 per cent in 2003 (Iversen et al., 2008), 8 per cent in 2001, and 5 per cent in 1995 (Buddle et al., 2003). The ratio had risen to 12 per cent

by 2009 (Iversen et al., 2010). Once again, the increase in the proportion of Aboriginal injecting drug users who were surveyed may be indicative of an increase in the prevalence of injecting drug use among Aboriginal Australians, or it may be related to increased engagement and recruitment of Aboriginal people who inject drugs through NSPs.

Interestingly, an examination of the Aboriginal status of respondents in each state and territory shows the proportion of Aboriginal and Torres Strait Islander respondents ranged from none in the Australian Capital Territory to 97 per cent in the Northern Territory in 2007 (Buddle et al., 2003). However, these proportions represent an anomaly compared with the other states, and likely require further investigation. Data collected by the Northern Territory AIDS and Hepatitis C Council, which provides NSP services in Alice Springs and Darwin, suggest that 10 per cent of the clients of the Northern Territory AIDS and Hepatitis C Council identify as Aboriginal.⁴ Table 4 presents the number and proportion of Aboriginal respondents and examines changes over a six-year period. It is worth noting that in many cases the number of people represented is small.

⁴ Personal communication, the Northern Territory AIDS and Hepatitis C Council nurse educator, 21 November 2008.

Table 4: Number and proportion of Aboriginal or Torres Strait Islander respondents in the Australian Needle and Syringe Program Survey, by state and territory, 2003–07, 2009

Year	ACT n (%)	NSW n (%)	NT n (%)	Qld n (%)	SA n (%)	Tas. n (%)	Vic. n (%)	WA n (%)	National n (%)
2009	5 (8)	122 (15)	10 (13)	105 (13)	31 (13)	15 (12)	23 (7)	12 (5)	323 (12)
2007	0	105 (15)	30 (97)	38 (10)	16 (7)	25 (15)	14 (6)	5 (5)	233 (11)
2006	3 (6)	87 (13)	3 (15)	49 (10)	18 (9)	25 (17)	14 (7)	4 (3)	203 (10)
2005	7 (18)	115 (16)	1 (3)	14 (5)	17 (8)	12 (9)	9 (5)	10 (6)	185 (10)
2004	3 (11)	81 (13)	1 (4)	33 (6)	21 (8)	8 (7)	9 (4)	9 (5)	165 (8)
2003	4 (7)	91 (12)	6 (10)	51 (7)	25 (7)	13 (11)	6 (3)	7 (5)	203 (8)

3.2.1.2 Hospital admissions

A study examining data in Western Australia on first-time hospital admissions for drug-related problems from 1980 to 1995 found an increase of substance use in general among Aboriginal people (Patterson et al., 1999). This analysis revealed a rapid increase in first-time admissions, beginning in 1991, and a cross-over in the rates of Aboriginal and non-Aboriginal first-time admissions. In 1980, non-Aboriginal people were admitted to hospital at a rate of 16.4 per 100 000 compared to 9.2 per 100 000 for Aboriginal people. While rates had increased in both populations by 1995, the difference was 95.5 per 100 000 compared to 180.7 per 100 000, respectively (Patterson et al., 1999).

3.2.1.3 Hepatitis C and other blood-borne viruses

The prevalence and incidence of blood-borne viruses where injecting drug use is a risk behaviour may also provide an indication of injecting drug use among Aboriginal Australians. In particular, injecting drug use is the main risk behaviour for acquiring hepatitis C. Topp (2007) indicates that most infections in Australia (89% of 9700) in 2005 were attributed to injecting drug use. National hepatitis C notifications data reveal that, while Aboriginal people make up only 2.4 per cent of the Australian population, they account for 8.3 per cent of people living with hepatitis C (Hepatitis Australia, 2007). It is estimated that 16 000 Aboriginal people are living with chronic hepatitis C (McNally & Latham, 2009). In South Australia, Western Australia and the Northern

Territory, Aboriginal Australians account for 10 per cent of all new notifications (Hepatitis Australia, 2007). However, Hepatitis Australia also notes that up to two-thirds of new notifications fail to record Aboriginal status (Hepatitis Australia, 2007).

The rate of newly diagnosed cases of hepatitis C among Aboriginal Australians increased by 34 per cent between 2002 and 2006 (Ward, 2007). This increase may indicate increases in injecting drug use, but may also reflect improvements in testing in this population. Nonetheless, in the same time period, the rate of newly diagnosed cases in the general Australian population remained stable (Ward, 2007).

The National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–13 and the National Hepatitis C Strategy 2010–13 identify Aboriginal people who engage in risk behaviours as one of the three main priority populations for action. Aboriginal people are also disproportionately represented within the other two priority populations: people in custodial settings; and people who inject drugs (McNally & Latham, 2009).

The incidence of hepatitis B virus has remained relatively low in non-Aboriginal Australians (Ward, 2007). However, since 2002, there has been an increase in the number of newly diagnosed cases in Aboriginal Australians, despite vaccination programs (Ward, 2007). Although injecting drug use is a risk behaviour for hepatitis B, the route of transmission and injecting status are not recorded in this surveillance report.

Injecting drug use is only one risk behaviour for human immunodeficiency virus (HIV). Owing largely to the comprehensive introduction of NSPs across Australia, the rate of HIV among people who inject drugs in

general has remained low (Health Outcomes International, 2002). While the incidence of HIV in Aboriginal Australians has remained stable or even declined slightly over recent years, an unsettling trend has been witnessed in the pattern of transmission (Ward, 2007). While transmission has primarily been through sexual contact between men who have sex with men in the general population, a higher proportion of transmission in Aboriginal Australians occurs through injecting drug use (Ward, 2007). In non-Aboriginal cases of HIV, only 3 per cent of new cases are in people who inject drugs, and 4 per cent are in men who have sex with men who also inject drugs (Ward, 2007). In Aboriginal cases the proportions are 18 per cent and 8 per cent, respectively (Ward, 2007). The proportion of cases transmitted via heterosexual contact is also much higher in Aboriginal Australians at 34 per cent, compared to 19 per cent in non-Aboriginal people.

The incidence of HIV transmission in Australia reflects trends in other countries, where harm reduction services for people who inject drugs were not introduced as early and are not as accessible as in Australia. In Canada, for instance, the proportion of HIV cases attributable to injecting drug use in Indigenous peoples is 53 per cent, while the proportion attributable to injecting drug use in the general Canadian population has seen a decline in recent years to 14 per cent (Public Health Agency of Canada, 2006).

3.2.1.4 Treatment for substance use

The latest annual report (2007–08) of the Alcohol and Other Drug Treatment Services National Minimum Dataset (NMDS) includes information about:

- age group by Indigenous status and gender
- care provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services
- Indigenous status and principal drug of concern
- trends in principal drug of concern by Indigenous status
- Indigenous status and treatment programs; and
- Indigenous status by geographical location (Australian Institute of Health and Welfare, 2009).

Bearing in mind that 2.5 per cent of the Australian population identifies as being Indigenous, 11 per cent of treatment episodes nationally were for people who identified themselves as being Aboriginal and/or Torres Strait Islander. However, the ratio was 63 per cent in the Northern Territory where amphetamines accounted for only 2.4 per cent of treatment episodes and heroin accounted for 1.2 per cent of episodes. This compares with 11 per cent amphetamines and 11 per cent heroin in the national dataset (Australian Institute of Health and Welfare, 2009a).

Nationally, the NMDS reports that 66 per cent of amphetamine-related treatment involved injection, while 91 per cent of heroin-related episodes involved injection (Australian Institute of Health and Welfare, 2009). It is notable that, in the Northern Territory, morphine

accounted for 7.1 per cent of treatment episodes in 2007–08 (compared with 1 per cent nationally), with injection attributed to 89 per cent of those morphine-related episodes.

Treatment episodes were most common among those aged 20–29 years for both Indigenous and non-Indigenous clients. Similar to all episodes reported in the collection, some of the episodes involving Indigenous clients may have been provided to the same individuals. The current collection methodology does not allow analysis of this issue. Therefore, direct comparisons with the overall Indigenous/non-Indigenous composition of the Australian population are not appropriate.

Episodes were relatively more common among Indigenous clients aged 10–19 years (18%) than among non-Indigenous clients aged 10–19 years (11%). These differences may reflect the age structures of the two populations, as Indigenous peoples have a younger age profile than non-Indigenous Australians.

Most Australian Government-funded alcohol and other drug services for Indigenous people are beyond the scope of the NMDS for alcohol and other drug treatment services. The *Drug and Alcohol Service Report* (DASR) details the activity of Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services.

Within the 2007–08 DASR (Australian Government Department of Health and Ageing, 2008), ‘residential treatment and rehabilitation’ refers to residential programs where clients receive formal rehabilitation for substance use. In 2007–08, an estimated 3500 episodes of care were provided to clients in residential treatment/rehabilitation services. Of these episodes of care, 74 per cent were for male clients.

In 2007–08, an estimated 17 300 episodes of care were provided to clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation, whereas residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Approximately three in five (62%) episodes of such care were for male clients.

‘Other care’ refers to a diverse range of non-residential programs, including preventative care, after-care follow-up and mobile assistance/night patrol. In 2007–08, there were an estimated 72 000 episodes for other care, an increase from 57 900 episodes in 2006–07. The high number of episodes of other care, compared with residential or sobering-up episodes of care, is due to the short-term nature of other care, with some clients receiving multiple episodes of care over the course of the year (see DASR, Appendix 6). Three in five (60%) episodes for other care were for male clients.

There is currently no national minimum data set intended for use in needle and syringe programs.

The proportion of Aboriginal people in treatment specifically for opioid or amphetamine use may provide an indication of injecting drug use prevalence in this population. Comparing data from four iterations (1990, 1992, 1995 and 2001) of the National Clients of Treatment Services Agencies (NCOSTA) census, Shand and Mattick (2002) found that the number of Aboriginal people in treatment who report injecting drug use has increased over the 11 years. At the same time, the proportion of those being treated for alcohol problems has decreased and the number of those being treated for something other than alcohol has tripled (Shand & Mattick, 2002).

It should be noted that the absolute numbers being treated for alcohol-related problems did not decrease as the numbers being treated for illicit drug-related problems increased.

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) report from 2007 indicated that there were 38 568 Australians receiving opioid pharmacotherapy on the day of the survey (Australian Institute of Health and Welfare, 2008a). The Aboriginal status was available only for 24 256 clients on pharmacotherapy because these data are not available for Western Australia, Victoria, Tasmania or the Northern Territory. Of the total, 7.3 per cent of clients identified as Aboriginal or Torres Strait Islander. Clients identifying as Aboriginal or Torres Strait Islander accounted for 7.8 per cent of methadone clients, 5.5 per cent of buprenorphine clients, and 6.3 per cent of buprenorphine/naloxone clients. These proportions are lower than the proportion (11%) of Aboriginal injectors represented in the NSP survey in 2007.

3.2.1.5 Community perceptions

Community perceptions may be influenced by media reports or dominated by the opinions of a few or a non-representative group of community members. Nonetheless, community perceptions may provide some indication of the salience of an issue. Studies looking at Aboriginal substance use and injecting drug use across many jurisdictions in Australia have shown increasing community concerns related to injecting drug use or the use of commonly injected drugs, e.g. heroin, amphetamines, morphine (Aboriginal Drug and Alcohol Council, 1997; Dance et al., 2004; Western Australia Drug and Alcohol Office, 2007; Edwards et al., 1998; Holly & Shoobridge, 2004; Larson & Currie, 1995; Lehmann & Frances, 1998; Shoobridge et al., 2000).

In Adelaide, community perceptions indicate that injecting drug use has replaced alcohol as the substance use issue of most concern (Holly & Shoobridge, 2004). In Melbourne, it is estimated that due to the higher proportion of Aboriginal people who inject relative to the general population, and the smaller size of the Aboriginal community, every Aboriginal family has been affected by injecting drug use (Edwards et al., 1998; Lehmann & Frances, 1998).

In Western Australia, consultations in rural and remote communities revealed perceptions related to amphetamine use ranging from 'not here yet' to 'causing a lot of concern but not as much as alcohol or gunja [marijuana]' (Gray et al., 2001, p. 35).

A study in the Australian Capital Territory attempted to estimate the number of Aboriginal people who inject drugs based on data and estimates from Aboriginal health services, alcohol and other drugs (AOD) services and correctional services, as well as through talking to Aboriginal community Elders regarding illicit substance use within their families and communities (Dance et al., 2000). Based on the findings, it is estimated that there are 100–200 young Aboriginal people in the Australian Capital Territory using illicit substances, with many involved in injecting drug use. Some believe that, in the Australian Capital Territory, there could be as many as 500 people of all ages who inject drugs and who are Aboriginal, based on presentations to health services (Dance et al., 2000).

3.2.1.6 Police arrests and drug-related crime

The Drug Use Monitoring in Australia program (DUMA), introduced in 1999, is the only nationwide survey of drug use by alleged offenders conducted on a routine basis. It involves the quarterly collection of information from police detainees at various sites (police stations or watch-houses) across Australia. DUMA comprises two core components: a self-report survey of police detainees covering both drug use and drug market participation; and voluntary urinalysis (within 48 hours prior to arrest).

In 2008, a total of 4107 adult detainees were interviewed at nine sites: Brisbane and Southport (Queensland), Bankstown and Parramatta (New South Wales), Adelaide (South Australia), East Perth (Western Australia), Footscray (Victoria), Darwin and Alice Springs (Northern Territory).

Aggregated across all sites, 23 per cent of detainees self-identified as Indigenous, with detainees from Alice Springs (99%), Darwin (68%) and East Perth (32%) most likely to identify as Indigenous. Only 3 per cent of detainees at the Footscray site identified themselves as Indigenous (Gaffney et al., 2010). The DUMA report does not provide data pertaining to the percentage of respondents who have injected illicit drugs in the previous 12 months.

Regarding the most commonly injected illicit drug nationally, the 2008 DUMA analysis reported that urinalysis found that 11 per cent tested positive to heroin, compared with 27 per cent in 2000. Evidence of methamphetamine use was found in 21 per cent of the samples nationally. No traces of methamphetamines or heroin were found in Alice Springs samples. Among males in Darwin, where 68 per cent of detainees identified as Indigenous, only 5 per cent of samples contained traces of heroin and only 2 per cent contained methamphetamines.

No traces of either drug were found in the women detained in Darwin (n=37). In East Perth, where 32 per cent of detainees identified as Indigenous, the ratio was 30 per cent (methamphetamines) and 6 per cent (heroin) among males. Notably in East Perth, where women comprised 18 per cent of the detainees tested, 48 per cent of women tested positive to methamphetamines and 9 per cent to heroin.

The *Health of Australia's Prisoners 2009* report provides a week-long snapshot of prison entrants in Australia during 2009 and confirms that Aboriginal and Torres Strait Islander prisoners are over-represented within the prison system, with 26 per cent of prison entrants being Indigenous (Australian Institute of Health and Welfare, 2010).

Further information on prisoners is covered in section 3.4.2.

3.2.2 Limitations of existing prevalence data

There are several challenges to accessing reliable data on illicit drug use, as well as limitations to the existing data and hence our understanding of the prevalence of injecting drug use among Aboriginal Australians. National drug-use surveys such as the National Drug Strategy Household Survey are not based on a large enough sample size of Aboriginal households to allow for a disaggregated analysis (Australian Institute of Health and Welfare, 1995; 2006). While the National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement addressed this issue in 1994, it has never been replicated. This study is limited to urban areas and relies on self-identification.

National surveys focusing on the health and social wellbeing of Aboriginal Australians (i.e. the National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Islander Health Survey) are also limited in their capacity to assess illicit substance use among those living in rural and remote communities (Australian Institute of Health and Welfare, 2006). Furthermore, these surveys report only on the use of specific substances and do not specifically ask about injecting drug use history or practices (Australian Bureau of Statistics, 2004). As such, only assumptions can be made about the route of administration.

The Australian Needle and Syringe Program Survey provides some insight into the number of Aboriginal people accessing programs specifically targeting those who inject drugs. However, due to a variety of structural issues and barriers, Aboriginal people who inject drugs may be less likely to access NSPs, and those who do may be less likely to participate in surveys (Ministerial Council on Drug Strategy, 2006). The Australian Needle and Syringe Program surveys of people who inject drugs also rely on convenience samples and therefore cannot necessarily be considered representative of the entire population (Day et al., 2006).

A lack of accuracy and consistency in documenting Aboriginal status in service use records and surveys has also been noted (Australian Institute of Health and Welfare, 2006). The missing data may present limitations to the use of indicator data, such as rates of blood-borne viruses and hospital admissions. Teasdale et al. (2008) also argue that interview and survey designs may lack attention to the cultural appropriateness needed to elicit accurate self-report information.

3.2.3 Summary

Given the challenges and limitations in assessing the prevalence of injecting drug use generally and in the population of Aboriginal Australians, there is no clear understanding about the prevalence of Aboriginal injecting drug use from this literature. However, the available evidence suggests that the prevalence of injecting drug use is most likely higher among Aboriginal Australians than it is in the general population, and it has also most likely increased over the years (Gray, 2005; Gray & Morfitt, 1996). The evidence also suggests that prevalence may vary significantly between different Aboriginal communities (Perkins et al., 1994).

3.2.4 Gaps and ways forward

Based on this review of the literature, several gaps become apparent in the current understanding of the prevalence of injecting drug use among Aboriginal Australians. Most importantly, there appears to be a lack of quality data sources to adequately assess prevalence. While many data sources do exist, there are several limitations to their use and the ability to draw generalisations from them. There are also numerous challenges to accurately assess the prevalence of injecting drug use, which may be difficult to overcome.

Some researchers have examined different indicators and attempted to cross-check against several data sources in order to estimate prevalence (Gray et al., 2001). To date, however, there does not appear to be a consistently agreed-upon method for comparative data analysis, nor is there an agreed set of indicators for this population.

The increases in the numbers of Aboriginal people who inject drugs identified in convenience samples of people who inject drugs for the Illicit Drug Reporting System and the Australian Needle and Syringe Program Survey have also not been examined in detail. Further examination could help to shed light on whether these increases are related to increasing rates of injecting drug use among Aboriginal people, or improved engagement with those Aboriginal people who inject drugs. Furthermore, given that some of the state-based samples in these studies involve relatively high numbers of Aboriginal people who inject drugs (Table 4), some secondary analyses of these data sets may be warranted.

Another gap in the current understanding in relation to prevalence is the apparent difference in prevalence between Aboriginal communities. In addition to differences between remote, rural and urban communities, and different jurisdictions, there may also be differences between different communities in one urban area (Perkins et al., 1994). There does not appear to be any literature addressing the factors contributing to these differences. Such an analysis could, however, shed light on factors that may support resilience at a community level and support the identification and development of culturally appropriate demand reduction strategies.

3.3 Patterns of drug use

3.3.1 Overview of drug use in the broad Australian context

It is important to consider injecting drug use in Aboriginal communities in the broader context of drug use in Australia. The supply and availability of, as well as trends in, drug use have an impact on the way in which drugs are consumed. It is also important to recognise that drug use has existed in Australia and globally for centuries (Lang, 2004). For instance, the importation and smoking of opium were banned in Australia only in 1905 following pressure from the Chinese business community, as well as changes to the global response to opium (Lang, 2004).

The use of opium by Aboriginal Australians also predates any current concerns around substance use and injecting drug use, and has roots in Australia's colonial past. In northern parts of Australia, in particular, white employers often paid wages in opium to Aboriginal workers (Lang, 2004). Spanish colonialists in South America used similar practices with respect to coca leaves, although the use of coca by Indigenous South Americans predated colonisation (Streatfield, 2002). The sale and distribution of opium to Aboriginal Australians were first restricted through the *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* in Queensland, considered to be instrumental in effecting other ostensibly protectionist laws which ultimately formed the basis of the control and oppression of Aboriginal peoples for most of the next century (National Archives of Australia, n.d.).

3.3.1.1 General drug use patterns

Several national data sets document and monitor the use of licit and illicit substances in Australia today. These studies have consistently found that the use of alcohol and tobacco is more common than the use of illicit substances (Dietz et al., 2004). The evidence also indicates that the use of these licit substances results in a greater degree of harm to individuals and communities (Dietz et al., 2004). For example, the vast majority of drug-related deaths in Australia are attributable to tobacco and alcohol use, with deaths due to illicit drug use accounting for less than 5 per cent (Ridolfo & Stevenson, 2001).

The National Drug Strategy Household Survey indicates that over one-third of Australians over the age of 14 years have ever used an illicit substance (Australian Institute of Health and Welfare, 2008a). However, recent use (i.e. in the past 12 months) has shown a general decline since 1995, with roughly 17 per cent of those over 14 years of age reporting recent use in 1995 compared with 13.4 per cent in 2007 (Australian Institute of Health and Welfare, 2008a). Among the illicit substances, cannabis is the most commonly used drug in Australia (Australian Institute of Health and Welfare, 2008a). This same pattern of substance use is also reflected in the Aboriginal population of Australia. The use of alcohol and tobacco is much more prevalent than the use of illicit drugs, and the use of cannabis is much more common than other illicit drugs (Australian Bureau of Statistics, 2006).

However, in comparing the levels of use among Aboriginal versus non-Aboriginal Australians, some differences emerge. The data indicate that alcohol use is less prevalent among Aboriginal Australians, but a greater proportion of those who do use alcohol do so at harmful levels (Australian Bureau

of Statistics, 2006). It is important to note that the Australian Bureau of Statistics figures indicating a higher prevalence of abstinence from alcohol use among Aboriginal Australians hide a significant difference. The limited data from the 1994 Aboriginal supplement indicate that the percentages of lifetime abstainers in the Aboriginal and non-Aboriginal populations are about the same. The difference in the frequency of total abstinence is accounted for by the higher percentage in the Aboriginal population who used to drink but no longer do so – many have given up because of the harm to their health caused by alcohol. The rate of smoking in Aboriginal Australians is nearly double that in non-Aboriginal people (Australian Bureau of Statistics, 2006). The rate of cannabis use is higher in Aboriginal Australians as well (Putt & Delahunty, 2006).

In a South Australian study, nearly 60 per cent of adult Aboriginal people in non-remote areas of South Australia had ever used an illicit drug or taken a prescription drug for non-medical purposes. Approximately 31 per cent had recently used (in the last 12 months) an illicit drug or taken a prescription drug for non-medical purposes. The most common illicit drug recently used was cannabis (27.5%) followed by amphetamines (6.9%) (Richards, 2008).

Interestingly, this trend of a higher prevalence of cannabis use relative to the use of other illicit substances is also reflected in people who inject drugs in Australia. For example, in the 2007 Illicit Drug Reporting System, 81 per cent of those interviewed who inject drugs reported cannabis use in the last six months, compared to 74 per cent reporting amphetamine use and 54 per cent reporting heroin use (Black et al., 2008). In this study, the use of tobacco, alcohol and benzodiazepines was also very common (Black et al., 2008).

3.3.1.2 Injecting drug use

Injecting drug use is most closely associated with the use of heroin and other opioids, but may also involve the use of amphetamines, benzodiazepines, cocaine and even alcohol. The reported rate of recent and lifetime injecting drug use in Australia has remained low and the prevalence of heroin use is consistently among the lowest of all illicit drugs (Australian Institute of Health and Welfare, 2007). The prevalence of heroin use in Australia is roughly similar to that in other industrialised nations, including New Zealand, the United States of America and Canada, and slightly lower than that in the United Kingdom (Australian Institute of Health and Welfare, 2007).

The use of all types of amphetamines is comparatively high in Australia relative to other countries (Australian Institute of Health and Welfare, 2007). Amphetamines can be snorted, swallowed or smoked, as well as injected (Australian Institute of Health and Welfare, 2007). As the population prevalence of amphetamine use is higher than the population prevalence of injecting drug use, most amphetamine users are not people who inject drugs (Degenhardt et al., 2007). Indeed, while the use of amphetamines has increased among people who inject drugs, their use is also prevalent among young Australians and regular ecstasy users, who are more likely to swallow or smoke amphetamines (Degenhardt et al., 2008).

Evidence of the number of opioid-related deaths in Australia suggests that its use has increased since the 1970s, peaking in the late 1990s (Dietz et al., 2004). Although there is some debate whether Australia experienced a heroin glut or a drought, evidence suggests that the availability of heroin peaked in 1999 and had dropped dramatically by 2001 (Degenhardt et al., 2007). Evidence from the

drug use patterns of people who inject drugs and from overdose data suggests that the drop in heroin availability affected the rate of its use (Degenhardt et al., 2007) and the rate of heroin use among people who inject drugs in Australia has not completely returned to levels seen in the late 1990s (Degenhardt et al., 2007). However, injecting drug use has continued and use seems to have shifted to increased injection of amphetamines, benzodiazepines and, to a lesser extent (and primarily in Sydney), cocaine (Degenhardt et al., 2007).

As such, changes in the availability of heroin appear to have had generalised implications for the trends in injecting drug use in Australia, which is likely reflected in the trends among Aboriginal people who inject drugs, although this conclusion does not appear to have been comprehensively examined.

3.3.2 Patterns of injecting drug use among Aboriginal Australians

This section examines in more detail the patterns of drug use among Aboriginal people who inject drugs. To provide context, comparative data on the patterns of non-Aboriginal injecting drug use are provided followed by available data related to Aboriginal people who inject drugs. In general, this analysis, as well as others (Urbis, 2008), indicates that the patterns and types of drugs used by Aboriginal people who inject drugs are not dissimilar to those of non-Aboriginal drug users.

As for non-Aboriginal people who inject drugs, the literature seems to suggest that poly-drug use is the most common pattern of substance use among Aboriginal people who inject drugs (Correll et al., 2000; Dance et al., 2004; South Australia Department of State Aboriginal Affairs, 2002; Franks, 2006;

Gray et al., 2001; Holly, 2001; Holly & Shoo-bridge, 2003; 2004; Meyerhoff, 2000; Putt et al., 2005; Shoo-bridge et al., 2000; Teasdale et al., 2008; Urbis, 2008). In Aboriginal people who inject drugs, most studies vary between showing amphetamines and heroin as the drug of choice or most frequently injected drugs (Holly, 2001).

Based on interviews and focus groups conducted with Aboriginal people who inject drugs across Australia, commonly reported injected drugs included heroin, amphetamines, cocaine, methadone, benzodiazepines and morphine (Coupland et al., 2005). However, other substances injected included alcohol, 'tablets', ecstasy and buprenorphine (Coupland et al., 2005). The National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994 found that, of those reporting injecting drug use, 81 per cent were injecting amphetamines, 20 per cent heroin, 5 per cent cocaine and 11 per cent other drugs (Australian Institute of Health and Welfare, 1995). Among those who reported using amphetamines (6%), just under half (49%) reported injecting it, while among those reporting cocaine use (2%), 73 per cent reported injecting it (Australian Institute of Health and Welfare, 1995). These findings suggest that heroin and cocaine are commonly injected and not necessarily consumed via other routes of administration, while amphetamines are likely to be injected or administered in other ways.

The most recent annual Drug Use Monitoring in Australia report covers the 2008 survey conducted among people whose arrest was processed at the following police stations: Adelaide (South Australia), Alice Springs, Darwin (Northern Territory), Bankstown, Parramatta (New South Wales), Brisbane, Southport (Queensland), East Perth (Western Australia)

and Footscray (Victoria). Detainees are invited to complete a survey and provide a urine sample, which is tested for traces of drugs (Gaffney et al., 2010).

The analysis of individual sites does not disaggregate data by ethnicity or drug type. However, some insights can be gleaned to shed light on drug use among those tested in, for example, Darwin and Alice Springs. In Darwin, 290 detainees (37 females) provided a sample of urinalysis. Seventy per cent of males and 53 per cent of females tested positive to an illicit drug. The most common drug type was cannabis (males 65%; females 53%). Only 5 per cent of males and no women tested positive to the drug that would almost certainly be injected, heroin.

3.3.2.1 First drug injected

A series of semi-structured interviews and focus groups with Aboriginal people who inject drugs revealed several reasons or factors that lead to injecting drugs for the first time. These factors include the lack of availability or difficulties in obtaining the usual drug of choice (e.g. alcohol or cannabis); the perceived economic benefits of injecting versus other routes of administration in terms of the amount of a substance used relative to the resultant effects; exposure through social networks or family members; boredom; problems at home; and a coping mechanism to escape from trauma or reality (Coupland et al., 2005).

Among non-Aboriginal people who inject drugs, amphetamines are most commonly the first drug injected among the general population of people who inject drugs, with 47 per cent of Illicit Drug Reporting System participants reporting as such (Black et al., 2008). This is followed by heroin at 41 per cent of participants (Black et al., 2008). These figures are consistent across all jurisdictions,

except New South Wales where heroin is much more commonly the first drug injected (Black et al., 2008). In Tasmania, the Northern Territory, Western Australia and to a lesser extent Queensland, morphine is a more commonly reported drug at first injection (16%, 13%, 10% and 5%, respectively), compared to other jurisdictions where only 1 per cent of people who inject drugs report morphine use at first injection (Black et al., 2008). This likely reflects drug markets in these jurisdictions, where heroin in particular may be less available.

The first drug injected among Aboriginal people who inject drugs is not dissimilar to that among non-Aboriginal people who inject drugs. In an Australian Capital Territory study of Aboriginal people who inject drugs, heroin was the most common first drug injected, at 64 per cent of those who had ever injected (Dance et al., 2004). Amphetamines followed, at 35 per cent (Dance et al., 2004). By contrast, in a Brisbane study of Aboriginal people who inject drugs, the most common first drug injected was amphetamines, reported by over 80 per cent of respondents (Larson et al., 1999). In a Western Australian study of Aboriginal people who inject drugs, 91 per cent reported amphetamines as their first drug injected, with only 9 per cent reporting heroin (Gray et al., 2001).

In South Australia, there was a more even split between heroin and amphetamines as the first drug injected: in Adelaide, 48 per cent and 45 per cent of Aboriginal people who participated in the study first injected heroin and amphetamines, respectively (Holly & Shoobridge, 2004). It has been noted in this study and elsewhere that, while heroin was often the first drug injected, amphetamines are often administered by other routes of administration (e.g. inhaling) before progression to injecting (Holly & Shoobridge, 2004; Larson et al., 1999). In the lower Murray region of South Australia, amphetamines

were the first drug injected by 48 per cent of the participants, followed by heroin by 32 per cent of the participants (Shoobridge et al., 2000). This study also reported that morphine was the first drug injected by 12 per cent of participants, as well as cocaine (4%) and diazepam (Valium) (4%) (Shoobridge et al., 2000).

In summary, the literature suggests that amphetamines and heroin are most commonly the first drugs injected among Aboriginal people who inject drugs. Heroin appears to be more commonly the first drug injected in the Australian Capital Territory (Dance et al., 2004), while amphetamines are more commonly the first drug injected in Brisbane (Larson et al., 1999) and Western Australia (Gray et al., 2001). There is a more even split between Aboriginal people who inject drugs who report first injecting heroin and those who report first injecting amphetamines in rural and urban South Australia (Holly & Shoobridge, 2004; Shoobridge et al., 2000). Amphetamines are more likely to have been administered by some other method, prior to starting injecting.

3.3.2.2 Drug most injected

The drug most injected among the general population of people who inject drugs is reported in several sources. In the 2007 Illicit Drug Reporting System sample, the drugs most injected were heroin (36%), methamphetamine (26%), morphine (18%), methadone (8%), buprenorphine (4%) and cocaine (3%) (Black et al., 2008). Changes over time in the drugs most injected are most likely affected by the availability of certain drugs (Black et al., 2008). For instance, in the 2000 Illicit Drug Reporting System, 58 per cent reported heroin as the most frequently injected drug and this figure dropped to 36 per cent in 2001 following the reported heroin drought (Black et al., 2008). As previously

noted, cannabis use, although not injected, is also reported by a high proportion of the general injecting population.

In contrast to the general injecting population, Aboriginal people who inject drugs seem to most commonly inject amphetamines, although there may be some regional variations. However, this trend could also be reflective of the time period when some of the studies in Aboriginal people who inject drugs were conducted, corresponding with the heroin drought in Australia. Furthermore, some studies of Aboriginal people who inject drugs have looked more broadly at the use of all illicit substances and have found, like the general injecting population, that the drug most used appears to be cannabis given its higher prevalence, recency and frequency of use, even among those who inject drugs (Dance et al., 2004; Gray et al., 2001; Holly & Shoobridge, 2004).

In Brisbane and in the Lower Murray region of South Australia, the drug most commonly injected by Aboriginal people who inject drugs was amphetamines, followed by heroin (Larson et al., 1999; Shoobridge et al., 2000). However, a variety of other drugs was also noted as the most commonly injected by some respondents, including cocaine, methadone, other opiates, benzodiazepines and hallucinogens (Shoobridge et al., 2000). In Western Australia, the most common drug injected was the amphetamine class, with regular heroin use reported by only a few participants (Gray et al., 2001). A study based in the Australian Capital Territory found that, while amphetamines were more commonly used, heroin was more commonly injected than amphetamines (Dance et al., 2004). Although amphetamines were commonly injected, they were not always administered via this means and over 17 per cent of amphetamine users reported oral and intranasal administration (Dance et al., 2004).

In contrast to the findings of these studies, an analysis of data from three New South Wales studies suggests that heroin is the main drug injected by Aboriginal people who inject drugs in Sydney (Day & Dolan, 2001). In the three studies, 87 per cent, 85 per cent and 77 per cent of Aboriginal respondents reported heroin as the most commonly used drug. This was higher than that reported by non-Aboriginal people who inject drugs in the same surveys, at 76, 78 and 69 per cent, respectively. However, only the first study showed a statistical difference that was significant (87% versus 76%) (Day & Dolan, 2001). Similarly, in Adelaide, the drug most injected was heroin as well as amphetamines, benzodiazepines and prescribed or diverted methadone (Holly & Shoobridge, 2004).

In summary, the drug most used appears to be cannabis, while the drug most injected appears to be an amphetamine. This appears to be the case in most jurisdictions where a specific analysis has been conducted of the drug-use histories of Aboriginal people who inject drugs, except in Sydney and Adelaide where heroin has been found to be the drug most injected. It should be noted that the data analysed for the Sydney study pre-dated the heroin drought. Data collected for the Adelaide study were collected after the heroin drought, but some authors have noted that the availability of heroin does not appear to have returned to levels witnessed prior to the drought (Degenhardt et al., 2007).

3.3.2.3 Drug of choice versus last drug or drug most injected

The most common drug of choice among the general population of people who inject drugs is heroin, at 52 per cent (Black et al., 2008). This first choice is followed by methamphetamine (21%), morphine (10%), cannabis (6%) and cocaine (3%) (Black et al., 2008). The preference appears to have changed since 2000, corresponding with the heroin drought, when 63 per cent of users nominated heroin as their drug of choice, followed by 16 per cent for amphetamines, 7 per cent for cannabis, 3 per cent for morphine, and 3 per cent for cocaine (Black et al., 2008).

The drug of choice may differ from the drug most injected and may be less influenced by availability than the drug most injected (Coupland et al., 2005). A study of NSP service users in Darwin, Northern Territory, found that heroin was the drug of choice, followed by amphetamines; this pattern was consistent across Aboriginal and non-Aboriginal service users (Roberts & Crofts, 2000). However, in this study, morphine was the last drug used by 75 per cent, which likely reflects the unavailability of heroin in the Darwin area at the time of the study (Roberts & Crofts, 2000).

In a rural South Australian Aboriginal community, the main drugs of choice were heroin and cannabis, reported by 36 per cent of the participants (Shoobridge et al., 2000). While amphetamines constituted the drug of choice for only 8 per cent of the participants, they were the most commonly injected substance (Shoobridge et al., 2000). An Adelaide study of Aboriginal people who inject drugs found that heroin was the most common drug of choice among those reporting one primary drug of choice, followed by amphetamines and cannabis, but amphetamines

were the most common drug reported as the last drug injected (Holly & Shoobridge, 2004). Among the participants in this study, 32 per cent reported more than one drug of choice, with some nominating up to five (Holly & Shoobridge, 2004). Among these participants, cannabis was most commonly reported (Holly & Shoobridge, 2004).

A Western Australian study found very few Aboriginal people who inject drugs reported heroin as their drug of choice (Gray et al., 2001). In fact, in this sample many who had injected heroin at some point reported ambivalence or distaste for the drug. However, by contrast, heroin was the most common drug of choice among non-Aboriginal people who inject drugs in Western Australia (Gray et al., 2001).

To summarise, the primary drug of choice among Aboriginal people who inject drugs appears to be heroin, which is consistent with non-Aboriginal people who inject drugs. The exception is in Western Australia, where the most common drug of choice appears to be an amphetamine. It should be noted that cannabis is also a common drug of choice, suggesting that some Aboriginal people who inject drugs may primarily be cannabis users before being injecting drug users. The primary drug of choice differs from the last drug injected or the most commonly injected drug in some cases, most likely due to availability and cost factors.

3.3.2.4 Frequency of injecting

In the 2007 Illicit Drug Reporting System and the Australian Needle and Syringe Program Survey, most participants (i.e. the general population of people who inject drugs) reported injecting daily (46% and 47%, respectively) (Black et al., 2008; Iversen et al., 2008). In the Australian Needle and Syringe Program Survey, 25 per cent reported injecting weekly but not daily, 18 per cent reported injecting less than weekly, and 8 per cent reported no injections in the last month (Iversen et al., 2008). In the Illicit Drug Reporting System, 36 per cent reported injecting more than weekly but less than daily, 17 per cent reported injecting weekly or less, and less than 1 per cent reported no injections in the last month (Black et al., 2008). This may vary by jurisdiction, given that in the Illicit Drug Reporting System study participants from Victoria and New South Wales had the highest proportions reporting injecting daily (Black et al., 2008). In most other jurisdictions, the majority reported injecting more than weekly but less than daily (Black et al., 2008). As the IDRS is a convenience sample, it is more likely to capture daily users than other surveys.

There is some evidence to suggest that Aboriginal people who inject drugs may inject more frequently. According to Correll, MacDonald and Dore (2000), Aboriginal respondents to the Australian Needle and Syringe Program Survey between 1995 and 1998 reported more frequent injecting. The authors found that 57 per cent of Aboriginal respondents reported daily use, which was significantly higher than the 49 per cent of non-Aboriginal respondents who did so. Aboriginal respondents were also significantly less likely to report injecting less than daily or to report not injecting in the last month (Correll et al., 2000).

An Adelaide-based study found that two-thirds (66%) of participants had injected the day of or the day before the interview (Holly & Shoobridge, 2004). In this study, 19 per cent had injected in the last week and 7 per cent in the last month (Holly & Shoobridge, 2004). There were still 5 per cent who reported no injections in the last month, but who had injected between the last one to three months (Holly & Shoobridge, 2004). The study also looked at the frequency of use based on different drugs and found that 85 per cent of heroin users reported daily use, while only 32 per cent of amphetamine users did so (Holly & Shoobridge, 2003). Of those reporting cannabis use, 90 per cent reported daily use (Holly & Shoobridge, 2003).

In the Northern Territory, researchers found no difference in the drug patterns between Aboriginal and non-Aboriginal NSP service users (Roberts & Crofts, 2000). In this study, two-thirds of respondents reported injecting daily, 22.5 per cent of whom reported injecting two to three times per day (Roberts & Crofts, 2000). This is in contrast to other data, which show less frequent injecting among Aboriginal people who inject drugs. A Brisbane study found that only 38 per cent reported current daily injecting, while 77 per cent reported injecting less than daily but at least once per week⁵ (Larson et al., 1999). In this study, 16 per cent reported that they had not injected in the past month.

A Western Australian study of Aboriginal injecting drug use found that only 24 per cent of the participants reported injecting daily (Gray et al., 2001). In this sample, most (43%) reported injecting less than daily but more than twice per week, and nearly one-third (32%) reported injecting no more than

once per week (Gray et al., 2001). Interestingly, in this sample where heroin was not very common, only one participant reported having injected heroin on one or two occasions in the one to four weeks prior to the interview (Gray et al., 2001). By contrast, 9 per cent of respondents reported daily amphetamine use, and 30 per cent reported more than twice a week but less than daily use in the previous week (Gray et al., 2001). Eight per cent reported using amphetamines once or twice in the one to four weeks prior to their interview (Gray et al., 2001). Cannabis was the most regularly used drug, with 54 per cent reporting daily use in the week prior to their interview (Gray et al., 2001).

One study of Aboriginal people from across Australia who inject drugs reported on periods of abstinence from injecting drug use (Coupland et al., 2005). Such occasions may be prompted by a variety of factors, including the lack of availability of the drug of choice and job searching (Coupland et al., 2005). Connecting with land or 'going bush' was also a factor in promoting or supporting a period of abstinence (Coupland et al., 2005; Dance et al., 2004).

Table 5 summarises information on the types and patterns of drugs injected, where this information is available for different jurisdictions.

This table demonstrates that there are many jurisdictions for which information is not available. It also demonstrates that, for those jurisdictions where information is available, there is no consistency in the type of information that is available, making it challenging to compare between jurisdictions and settings (i.e. rural versus urban).

⁵ Note that, based on the wording of the question, participants may have indicated more than one answer, and therefore the responses total more than 100 per cent.

Table 5: Summary of the patterns and types of drugs injected, by jurisdiction

Jurisdiction	First drug injected	Drug most injected	Drug of choice	Last drug injected
National 2007 IDRS (General IDU)	Speed 47% Heroin 41%	Heroin 36% Speed 26% Morphine 18% Methadone 8% Buprenorphine 4% Cocaine 3%	Heroin 53% Speed 21% Morphine 10% Cannabis 6% Cocaine 3%	Heroin 34% Speed 28% Morphine 19% Methadone 7% Buprenorphine 4% Cocaine 3% Bupe-Naloxone 1%
National 2007 ANSPS (General IDU)	—	—	—	Heroin 31% Speed 30% Morphine/other 14% Methadone 10% Subutex/Bupe 5% More than one 3% Other 3% Cocaine 2% Steroids 1%
Australian Capital Territory	Heroin 64% Speed 35%			
Brisbane	Speed 83%	Speed Heroin Others		Speed 56% Heroin 21%
Western Australia	Speed 91% Heroin 9%	Speed		

Jurisdiction	First drug injected	Drug most injected	Drug of choice	Last drug injected
Adelaide	Heroin 48% Speed 45% Morphine 2% Cocaine <2% Speed ball <1% Ecstasy <1% Methadone <1% Opium <1%	Heroin Speed Benzos Methadone	Heroin 56% Speed 33% Cannabis 11% Benzos 2% Methadone 1%	Speed
Lower Murray	Speed 48% Heroin 32%	Speed Heroin Cocaine Methadone Other opiates Benzos Hallucinogens	Heroin 36% Cannabis 36% Speed 8%	Speed
New South Wales	—	Heroin 77-87%		
Darwin	—		Heroin Speed	Morphine 75%

ANSPS: Australian Needle and Syringe Program Survey

IDRS: Illicit Drug Reporting System

IDU: injecting drug user

Table 6: Frequency of injecting, by jurisdiction

Jurisdiction	Frequency of injecting	Opioid (%)	Speed (%)
National 2007 IDRS (General IDU)	Daily	46	
	>Weekly, <daily	36	
	Weekly or less	17	
	Not in last month	1	
National 2007 ANSPS (General IDU)	Daily	47	
	Weekly, <daily	25	
	<Weekly	18	
	Not in last month	8	
National 1995–98 ANSPS	Daily Indigenous	57	
	Daily non-Indigenous	49	
Australian Capital Territory	Always daily	12	2
	Daily, or less, or none	57	21
	3–6 times/week	2	4
	2–4 times/week, or none	5	8
	Binges	—	2
	1–2 times/week	7	16
	>Occasionally, <weekly	12	6
	Occasionally/once only	5	33
	Stopped over 4 months ago	2	6
Brisbane	Daily	38	
	<Daily, >once/week	77	
	Not in past month	16	
Western Australia	Daily	24	
	<Daily, >twice/week	43	
	<Once/week	32	

Jurisdiction	Frequency of injecting	Opioid (%)	Speed (%)
Adelaide	Day of or before survey	66	
	In the last week	19	
	In the last month	7	
	Not in last month but in last 2–3 months	5	
Lower Murray	5 times weekly to daily	35	—
	4 times weekly	12	—
	2–4 times/week	—	26
	Weekly	—	5
	Weekly to monthly	18	—
	Fortnightly	—	16
	Monthly or less	35	53
Darwin	Daily	66	
	of whom, 2–3 daily	22	

ANSPS: Australian Needle and Syringe Program Survey

IDRS: Illicit Drug Reporting System

IDU: injecting drug user

Table 6 summarises the frequency of injecting in each jurisdiction where such information is available. This table also demonstrates the gaps in the information available for many jurisdictions. More importantly, it demonstrates the lack of consistency in the surveys, so that the data between these jurisdictions are difficult to compare.

3.3.2.5 Injecting practices and risk behaviours

This section examines the available evidence on some of the injecting practices and risk behaviours of Aboriginal people who inject drugs, including re-using practices, location and context of use, and knowledge of risk behaviours.

Assessing the re-using practices of people who inject drugs is inherently challenging, as individual, community and contextual perspectives on what constitutes ‘sharing’ may vary. Additionally, respondents may provide what they believe to be more socially desirable answers, thereby skewing the data collected. In some cases, several questions

addressing the notion of sharing and re-use of injecting equipment may be asked in order to allow for the cross-checking of the responses. Based on responses to several questions, a Brisbane-based study of Aboriginal people who inject drugs determined that re-use was very high, with 39 per cent of respondents reporting re-using injecting equipment in the past month and 63 per cent of those who were under 20 reporting re-using (Larson et al., 1999).

Some studies comparing the injecting practices in the general population of people who inject drugs in rural and urban areas have found no difference in the level of use of non-sterile injecting equipment (Aitken et al., 1999; Day et al., 2006; Gray et al., 2001). However, others have noted differences in re-using practices between people who inject drugs in urban and rural areas (Lawrinson et al., 2005). In an Adelaide-based study of Aboriginal people who inject drugs, two-thirds reported that they almost always used a new syringe, while only 12 per cent had used a syringe after use by someone else in the past three months (Holly & Shoobridge, 2004). By contrast, in rural South Australia, 48 per cent of surveyed Aboriginal people who inject drugs reported having ever re-used injecting equipment, with 28 per cent doing so in the past 12 months and 8 per cent doing so in the past week (Shoobridge et al., 2000). In yet another South Australian study, the proportion of people who inject drugs who reported re-using injecting equipment other than needles increased from 2006 (27%) to 2007 (32%). This increase follows a decrease in the re-use of injecting equipment other than needles from 2004 through to 2006 (Richards, 2008).

In Western Australia, higher levels of sharing were also reported. Forty-three per cent of Aboriginal people who inject drugs interviewed acknowledged that they normally re-use injecting equipment (Gray et al., 2001). Of those who reported normally sharing, 14 per cent said they share only after they have injected (i.e. lending of injecting equipment), while 30 per cent reported they have shared injecting equipment after others had injected (Gray et al., 2001). However, the majority who re-used injecting equipment reported doing so only with a partner or with certain people (e.g. siblings) (Gray et al., 2001). Ten per cent insisted that they never re-use injecting equipment, but may do so in prison if there is no alternative (Gray et al., 2001). Other studies have also reported that re-using injecting equipment is most likely to occur while in prison (Coupland et al., 2005).

In the same Western Australian study, participants more commonly reported re-using other injecting paraphernalia, such as bags for mixing drugs, spoons, filters and water (Gray et al., 2001). This finding is consistent with the general literature on people who inject drugs, which has found higher rates of re-using other injecting-related equipment (Black et al., 2008). Studies have also found higher rates of re-using one's own equipment (Holly & Shoobridge, 2004; Shoobridge, 2000).

One of the earlier studies of Aboriginal people who inject drugs, conducted in the Lower Murray in 1997, reported a concern emerging from consultations that Aboriginal cultural values of sharing within kinship and community ties may affect the practices of re-using injecting equipment (Shoobridge et al., 2000). Interestingly, it was noted in the course of conducting this literature review that this notion of a 'culture of sharing' among Aboriginal people who inject drugs is

often referred to in the literature and seems to have potentially become accepted as fact despite the apparent lack of any attempt to systematically test this hypothesis. Gray et al. (2001) note that, in their study involving interviews with 74 Aboriginal people who inject drugs in urban and rural settings, this notion never emerged through the exploration of the dimensions of re-using injecting equipment. Similarly, the authors of a study of 307 Aboriginal people who inject drugs in Adelaide indicated that they found no evidence that the cultural value of sharing among Aboriginal peoples had any impact on injecting practices (Holly & Shoobridge, 2004). Indeed, the practice of limiting re-using injecting equipment only to one's partner or close friends or relations has been consistently found in the literature on injecting drug use practices within the general population of people who inject drugs (Iversen et al., 2008; Ross et al., 1994). Therefore, this practice may be found in general, and may not be unique to Aboriginal cultures.

Studies of Aboriginal people who inject drugs suggest that, while some tend to inject alone, it may be more common to inject within a group (Coupland et al., 2005; Gray et al., 2001). There are risks inherent in both practices. Injecting alone may reduce the risk of blood-borne virus transmission, but it is also a risk factor for overdose morbidity and mortality (Darke et al., 1999). Conversely, using within groups or networks of people who inject drugs may be associated with increased sharing of the drug injected, leading to potential contamination of injecting equipment (Koester et al., 2005).

In Western Australia, of the surveyed Aboriginal people who inject drugs 12 per cent usually injected alone, 12 per cent with a partner, and 69 per cent reported they usually inject with friends, family members or partners (Gray et al., 2001). In this study, most participants indicated that they normally inject in their home or the home of a friend or family member. However, over one-quarter reported that they usually inject in public spaces such as toilets or parks, and an additional 23 per cent reported that they inject anywhere. This practice was more common with younger Aboriginal people who inject drugs (Gray et al., 2001). Injecting in public spaces may reduce the likelihood of using safer injecting practices (Southgate et al., 2003). Common locations of injecting include homes, parks, public toilets and stairwells, with privacy playing an important factor (Coupland et al., 2005).

Knowledge of risks related to blood-borne viruses among Aboriginal people who inject drugs seems to be generally low, but it is basically consistent with the general population of people who inject drugs (Gray et al., 2001; Roberts & Crofts, 2000). There is also a low level of sophistication of knowledge related to risks for hepatitis B, HIV and particularly hepatitis C (Coupland et al., 2005; Edwards et al., 1998; Gray et al., 2001; Larson et al., 1999). There is also some evidence that, among Aboriginal people who inject drugs, hepatitis C may be considered inevitable and essentially unavoidable (Coupland et al., 2005), a finding which is consistent among other populations of people who inject drugs, given the relatively high prevalence and association with injecting drug use (Coupland et al., 2005; Roy et al., 2007; Wozniak et al., 2007). This has implications for harm reduction messages for hepatitis C.

3.3.3 Summary

The literature suggests that there is no one particular drug or class of drugs that is predominantly used by Aboriginal people who inject drugs. As with the general population of people who inject drugs, poly-drug use emerges as the most important pattern of use, including a significant use of substances that may not be injected, such as cannabis, alcohol and tobacco. In terms of drugs most injected, amphetamines and heroin appear to be most common, but this is affected by drug availability. Heroin appears to be the most common first drug injected, although amphetamines are often ingested via other routes of administration before transitioning to injection.

The evidence suggests that use of non-sterile injecting equipment may be high and that the re-use of other injecting paraphernalia is very common. Re-use of non-sterile injecting equipment and other risk practices may be influenced by the setting in which injecting occurs, such as a group of people, alone, while in prison, or with a partner. Knowledge of risk behaviours and the level of sophistication of understanding related to blood-borne virus transmission may be low, but not necessarily inconsistent with that of the general population of people who inject drugs.

3.3.4 Gaps and ways forward

Based on this review of the literature, there appear to be several apparent gaps and issues to be addressed with respect to our understanding of the types of drugs and patterns of drug use among Aboriginal people who inject drugs. Most importantly, there are many inconsistencies in data collection tools and the types of questions asked when examining patterns of drug use. This means that most of the data available from different

jurisdictions and sources are not comparable, making it difficult to gain an accurate assessment of Aboriginal people who inject drugs across jurisdictions and settings. Establishing a clear set of information needs with respect to drug use patterns may help to provide a framework for researchers examining this issue. Furthermore, developing a data collection tool for gathering such information could help to ensure consistency in the data collected in different studies and facilitate the comparability of the findings. Such inconsistencies have been noted elsewhere (Australian Institute of Health and Welfare, 2005).

Another limitation to our understanding of the patterns of Aboriginal injecting drug use is the reliance, in some cases, on community perceptions and consultations with key stakeholders. Community perceptions may not reflect the real experiences, contexts and histories of people who inject drugs. In several jurisdictions, the best indication of people who inject drugs among Aboriginal communities is based only on community perceptions. However, some authors have noted inconsistencies between community perceptions and the reports of Aboriginal people who inject drugs. Some have noted a lack of data to support an oft-cited perception that Aboriginal cultural traditions of sharing may impact on the re-using of injecting equipment (Gray et al., 2001; Holly & Shoobridge, 2004). Gray et al. (2001) also note other inconsistencies related to the harms associated with Aboriginal injecting drug use and the initiation to injecting within a prison setting, both of which are explored in later sections. This issue highlights the importance of the direct inclusion of Aboriginal people who inject drugs in research, programming and policy development.

3.4 Injecting drug use in different settings

3.4.1 Regional, rural and remote differences

3.4.1.1 Prevalence of injecting drug use

Several studies have attempted to assess injecting drug use in rural and remote areas. However, there are numerous challenges inherent in doing so, which have been discussed in detail in section 2.2. In rural and remote Aboriginal communities, very few studies have attempted to assess the prevalence of injecting drug use. In fact, in the case of the National Aboriginal and Torres Strait Islander Social Survey and of the National Aboriginal and Torres Strait Islander Health Survey, the substance use form is not included in remote areas (Australian Bureau of Statistics, 2006; 2004a). Furthermore, the National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994, which provides some of the best detail on the prevalence of injecting drug use among Aboriginal Australians, included populations that were based only in urban areas⁶ (Australian Institute of Health and Welfare, 1995). This study did, however, find that the use of cannabis was more frequently cited by respondents living beyond capital cities, while drugs such as heroin, cocaine and amphetamines, as well as needle use, were more commonly cited by those living in capital cities.

Studies of the general population of people who inject drugs, including national surveys, tend to focus on urban samples, as recruitment is often facilitated through NSPs in higher density areas of use (Aitken et al., 1999; Day et al., 2006). However, these studies have attempted to compare data between regional cities and capital cities (Aitken et al., 1999; Day et al., 2006).

A few studies have been conducted on substance use in remote communities in the Northern Territory. One study involved a random sample of over 300 participants from Arnhem Land (Clough et al., 2004). It focused specifically on cannabis use and how it may interact with other substance use, but the authors noted isolated incidents of the use of speed. However, it is not noted whether these incidents involve injecting; and the available data suggest that amphetamines are not always injected (Holly & Shoobridge, 2004; Larson et al., 1999). Another study in the same remote region, which focused on patterns and changes in substance use, did not include a discussion of injecting drug use (Clough et al., 2002). In this study, the researchers and the community chose to focus on the use of substances that were capturing media attention, including alcohol, kava, cannabis and petrol.

A Western Australian study conducted in Perth and four other towns in the state was unsuccessful in recruiting Aboriginal people who inject drugs in the Broome area (Gray et al., 2001). The authors cite the low evidence of injecting drug use in remote areas, despite substantial evidence of illicit drug use by other modes of administration. Other challenges to recruitment may have included the stigmatised nature of illicit drug use,

⁶ It should be noted that the Australian Bureau of Statistics definition of 'urban' used for this study included areas with population clusters of 1000 or more people.

such that people may not want to identify as injectors. This may particularly be the case given that interviews were conducted by Aboriginal interviewers. In this study, the authors did find that the prevalence of various indicators of injecting drug use was lower in non-urban areas, and concluded that much of the increase in Aboriginal injecting drug use in Western Australia was concentrated in Perth.

A study conducted in New South Wales attempted to examine patterns of drug use and harms among people who inject drugs in two different communities – one was rural and one was urban, although it was not considered an area of high drug use. The sample was a convenience sample of self-identified people who inject drugs and therefore cannot be considered representative (Day et al., 2006). Nonetheless, 22 per cent of the participants identified as Aboriginal – 25 per cent of the rural sample and 18 per cent of the urban sample. In a similar study conducted in Victoria, 19.5 per cent of the rural sample identified as Aboriginal, compared to only 1.6 per cent of the urban sample⁷ (Aitken et al., 1999). Given the limitations of the convenience sampling, no analysis was conducted on data from Aboriginal people who inject drugs; instead, the study focused on rural versus urban injecting drug use practices. One interesting finding in the New South Wales study was that less than half of the rural people who inject drugs were initiated into injecting in their rural area, but rather had done so in a variety of locations (Day et al., 2006). Both of the rural sample populations also reported less frequent drug use than their urban counterparts (Aitken et al., 1999; Day et al., 2006).

In Victoria, the Well Person's Health Check is conducted across 11 Aboriginal communities to provide education, early detection and treatment for a range of health issues (Waples-Crowe, 2005). Based on data collected between 1999 and 2002, as many as 9.6 per cent of over 1200 respondents had ever injected or currently injected drugs.

A study using rapid assessment methodology of Aboriginal injecting drug use, conducted in a rural South Australian community, identified a convenience sample of 25 Aboriginal people who inject drugs (Shoobridge et al., 2000). Another study in the regional South Australian community of Gallinlyalla (the local Aboriginal name for the area around Port Lincoln) found that the use of heroin and amphetamines, as well as the misuse of prescription medication, was a common concern to the Aboriginal community, although not necessarily at the top of their list of concerns (Franks, 2006). In a series of community focus groups, injecting drug use was raised as an issue contributing significantly to community breakdown (Franks, 2006). Similarly, a series of community consultations in seven other rural and regional towns in South Australia revealed that injecting drug use was of particular concern in nearly all of the communities (Aboriginal Drug and Alcohol Council, 1997). Most indicated the use of heroin and amphetamines, as well as other potentially injected substances (including a variety of prescription medications and methadone) (Aboriginal Drug and Alcohol Council, 1997).

⁷ Note: based on differences in sample sizes, this equates to approximately only seven urban and nine rural individuals.

The Australian Institute of Criminology conducted a survey of police stationed in urban and non-urban areas in Queensland, the Northern Territory, Western Australia and South Australia. The survey revealed police perceptions that injecting drug use is occurring in non-urban as well as urban areas (Putt & Delahunty, 2006). Amphetamines, in particular, were identified as being widely available in both urban and non-urban communities, with police indicating that existing networks in non-urban communities that coordinate the supply of cannabis may facilitate a ready supply of amphetamines (Putt & Delahunty, 2006).

3.4.1.2 *Patterns of drug use*

Some of the literature suggests different patterns of drug use in rural and regional areas versus urban centres, particularly larger capital cities. In a New South Wales study comparing rural and urban injecting drug use, where one-quarter of people who inject drugs in rural areas identified as Aboriginal, both groups reported using and injecting a wide variety of drugs. However, morphine was much more commonly used among people who inject drugs in rural areas, and amphetamine use was also more frequent among people who inject drugs in rural areas (Day et al., 2006). There was a similar finding of greater use of morphine in Darwin (Roberts & Crofts, 2000). Although Darwin is a capital city, the relative size and geographical location may render it more comparable to regional centres than to other capital cities. The greater use of pharmaceutical opioids may be due to lack of availability of other drugs, such as heroin, in regional and rural areas and may be as much an issue for non-Aboriginal people who inject drugs as for Aboriginal people who inject drugs.

In a study comparing rural and urban injecting drug use (including both Aboriginal and non-Aboriginal injecting drug use) in Victoria, where 1.6 per cent of urban and 19.5 per cent of rural participants identified as Aboriginal, the injection of amphetamines was more commonly reported among rural people who inject drugs (80%) (Aitken et al., 1999). By contrast, people who inject drugs in urban areas reported more use of heroin (Aitken et al., 1999). In this study, people who inject drugs in rural areas had injected a smaller range of drugs (Aitken et al., 1999).

In the lower Murray region of South Australia, amphetamines and misuse of prescription medication seem to be more common than heroin use, despite heroin being the drug of choice. In Gallinella, in rural South Australia, alcohol and cannabis were of primary concern to the community, but amphetamines were also considered prevalent in the community, and heroin to a lesser extent (Franks, 2006).

In terms of injecting practices and risk factors, there does not seem to be a clear distinction between rural and urban-based injecting drug use. Some studies have found no difference in re-use of non-sterile injecting equipment practices (Aitken et al., 1999; Day et al., 2006; Gray et al., 2001), while others have documented riskier practices in one setting or another (Lawrinson et al., 2005).

Urban-based Aboriginal people who inject drugs appear to inject more frequently than those in non-urban areas (Coupland et al., 2005). This has also been noted in other studies comparing rural and urban-based injecting drug use (Aitken et al., 1999; Day et al., 2006). One study found high levels of testing for hepatitis B among rural and urban injecting drug users in New South Wales (Day et al., 2006). However, urban

participants reported having been tested more recently than rural-based people who inject drugs (Day et al., 2006). This study also found that, while almost half of the population studied had received the hepatitis B vaccination, more rural-based people who inject drugs than urban-based reported not being aware of the vaccine (17% and 7%, respectively; this difference is not statistically significant).

What is important to note, with respect to our understanding of rural versus urban injecting drug use, is that much of the available data is based on studies involving Aboriginal and non-Aboriginal respondents. Given the challenges of study recruitment in rural areas, sample sizes tend to be relatively small, with the resulting representation of Aboriginal people who inject drugs being even smaller. Specific analyses of data related to Aboriginal people who inject drugs in rural settings are therefore limited by these small sample sizes.

3.4.2 Prisons

Despite comprising 2.5 per cent of the overall Australian population, Indigenous Australians account for 25 per cent of the approximately 30 000 people incarcerated in Australian prisons at any one time (Australian Bureau of Statistics, 2009). The ratio was lowest in Victoria (5.5%), but was as high as 40.5 per cent in Western Australia and 81.8 per cent in the Northern Territory.

Drug use may be a common factor leading to criminal behaviour and incarceration. Recent research has found that 71 per cent of prison entrants had used illicit drugs within the 12 months prior to incarceration (Australian Institute of Health and Welfare, 2010). The

Australian Institute of Criminology reports that Aboriginal male offenders report higher levels of drug use and dependency compared to non-Aboriginal offenders (Putt et al., 2005). However, Aboriginal offenders were more likely than non-Aboriginal offenders to attribute their criminal behaviour to alcohol than to illegal drugs (Putt et al., 2005). This is consistent with only 1.5 per cent of Indigenous Australians' 'most serious offence/charge' being 'illicit drug offences' (Australian Bureau of Statistics, 2009).

In their study of Aboriginal male offenders, Putt, Payne and Miller (2005) found that heroin, amphetamines, street methadone, cocaine, benzodiazepines, ecstasy and hallucinogens were the most common recently used substances prior to incarceration. Aboriginal offenders were more likely to inject amphetamines than their non-Aboriginal counterparts, while injection rates of heroin were similar. Although the rates of recent cocaine and street methadone (i.e. diverted methadone) use were relatively low among Aboriginal male offenders, a substantial proportion of those who had used them reported injecting these drugs (59% and 73%, respectively).

Despite the illicit nature of drug use and the ostensibly secure nature of prisons, illicit substances appear to be present and used by prisoners. The most recent Australian Needle and Syringe Program Survey found that, of the 254 participants who had been in prison in the year prior to the survey, more than one-third (93 people) indicated that they had injected while in prison (Iversen et al., 2008).

Several of the key studies of Aboriginal people who inject drugs have found similar indications of injecting drug use within prisons. An Adelaide study found that over 50 per cent of the participants had been incarcerated, of whom 44 per cent had injected while they were in prison (Holly & Shoobridge, 2004). A similar study conducted in a rural South Australian community found that a higher proportion of participants (84%) had been in prison, with just over half reportedly injecting while incarcerated (Shoobridge et al., 2000).

Studies have noted that sharing commonly occurs within the context of prison and may in fact be limited to this setting in some instances (Coupland et al., 2005; Gray et al., 2001; Holly & Shoobridge, 2004). One study found that, of those reporting injecting while in prison, 52 per cent reported that they always shared (Holly & Shoobridge, 2003).

A Brisbane study found that the occurrence of injecting drugs in prison was common in the study sample of Aboriginal people who inject drugs, as was re-using non-sterile injecting equipment while incarcerated (Larson et al., 1999). It also found that five of the study participants reported that their first initiation to injecting had occurred while in prison (Larson et al., 1999). The study reported that injecting was relatively rare among people who had been in juvenile detention centres. However, when it did occur, it usually seemed to involve re-using non-sterile injecting equipment (Larson et al., 1999).

In a study of people who inject drugs in Western Australia (Perth, Bunbury, Kalgoorlie, Geraldton and Bunbury), 43 out of 74 participants (58%) had spent time in prison (Gray et al., 2001). However, less than one-

quarter reported that they had injected while incarcerated and only one reported injecting for the first time while incarcerated (Gray et al., 2001). Another study noted that only two participants reported injecting for the first time while in prison (Shoobridge et al., 2000).

In an analysis of interviews and focus groups with Aboriginal people who inject drugs across Australia, several factors or contexts emerged as contributing to initiation into injecting; however, exposure in a prison setting does not appear to have been noted (Coupland et al., 2005). Gray et al. (2001) note a common perception, particularly among community members and service providers, that initiation to injecting among Aboriginal Australians often occurs while they are incarcerated. However, this hypothesis does not appear to have been systematically tested, nor does it seem to be supported by the available literature on the drug-use histories of Aboriginal Australians.

3.4.3 Movement between settings

Although not systematically covered in the literature, the mobility of the Aboriginal population (e.g. between urban and remote communities or between prisons and community settings) and the mobility of Aboriginal people who inject drugs are often referred to. Community members have raised concerns about people being initiated into injecting while in regional centres or prison, and then returning to communities or remote settlements, effectively importing injecting practices and potentially subsequent harms such as blood-borne viruses (Aboriginal Drug and Alcohol Council, 1997; Putt & Delahunty, 2006). This was found to be the case in the New South Wales study of urban versus

rural-based people who inject drugs, where less than half of the rural injectors were initiated into injecting in their rural community (Day et al., 2006).

A survey of police in urban and non-urban communities across several Australian states suggested that illicit substances used in remote communities are primarily brought in and distributed by those returning from urban and regional centres (Putt & Delahunty, 2006). In some cases, drugs may be brought in by Aboriginal community members, and in other cases by non-Aboriginal people (Putt & Delahunty, 2006).

A Canadian study aimed to assess the impact of the mobility of Indigenous people who inject drugs in Canada. It did this by examining medical charts and data on place of residence in a cohort of self-identified Indigenous people who inject drugs over a seven-year period. The study found high rates of movement between on-reserve (Indigenous communities) and off-reserve (town or urban centre) settings, effectively moving the harms associated with injecting drug use and infectious diseases between these settings (Callaghan et al., 2007).

There does not appear to be any research in Australia that has examined this issue, particularly with respect to Aboriginal people who inject drugs. However, given the limited understanding of rural and remote injecting drug use, in particular, and the incidence of hepatitis C and HIV among Aboriginal people who inject drugs, such research may be warranted.

3.4.4 Summary

This section highlights some of the particular contextual factors that may impact on Aboriginal people who inject drugs. The literature suggests that the patterns and practices of people who inject drugs may differ between urban and rural settings, and between prison and community settings.

Injecting drug use appears to be much more prevalent in urban settings and may be associated with riskier injecting practices. Similarly, injecting practices in prison place Aboriginal people who inject drugs at an increased risk of contracting blood-borne viruses. Movement between these settings may have important implications with respect to risk practices and associated harms; however, this aspect is not well understood in the Australian context.

3.4.5 Gaps and ways forward

Given the challenges in accessing Aboriginal people who inject drugs, particularly with respect to anonymity, few studies have been able to focus specifically on injecting drug use in rural and remote Aboriginal communities. However, those that have may provide methodological examples that could be replicated in other areas, particularly where there is concern in relation to, or evidence of, injecting drug use. A significant gap appears to be our understanding of the implications of the mobility patterns of Aboriginal people who inject drugs, as they transition between urban and rural settings, or prison and community settings. Movement may be necessary in order to access treatment services, respite from drug using or drug markets. A better understanding of this issue and its implications is warranted.

3.5 Gender and age differences

3.5.1 Gender differences

Most available data suggest that injecting drug use is more common among men. The National Drug Strategy Household Survey has consistently revealed more males who inject drugs than females (Australian Institute of Health and Welfare, 2008a). Similarly, populations of people who inject drugs in the Illicit Drug Reporting System and the Australian Needle and Syringe Program Survey consistently have a higher proportion of males injecting drugs (Black et al., 2008; Iversen et al., 2008).

This pattern seems to be consistent among Aboriginal people who inject drugs as well. The National Drug Strategy Household Survey found that Aboriginal males were more likely to have injected and to have used illicit substances including cannabis, speed and hallucinogens (Australian Institute of Health and Welfare, 1995). Similarly, samples of Aboriginal people who inject drugs represented in the Illicit Drug Reporting System and the Australian Needle and Syringe Program Survey appear to consistently have a higher proportion of males (Black et al., 2008; Iversen et al., 2008).

However, while the proportion of Aboriginal females involved in injecting drug use may be consistently lower than that of Aboriginal males, it appears as though Aboriginal females who inject drugs may be more prevalent than their non-Aboriginal female counterparts, relative to non-Aboriginal males who inject drugs. For example, the Australian Needle and Syringe Program Survey data from 2003–07 suggest that the proportion of Aboriginal

female respondents, while lower than that of Aboriginal male respondents, is higher than that of non-Aboriginal female respondents⁸ (Iversen et al., 2008).

Gray et al. (2001) came to a similar conclusion, based on their research in Aboriginal people who inject drugs in Western Australia. They suggest that injecting drug use is increasing rapidly among Aboriginal people in Western Australia and that the difference in prevalence between Aboriginal and non-Aboriginal females is widening more rapidly than that between Aboriginal and non-Aboriginal males (Gray et al., 2001).

An analysis of the demographic characteristics, drug-use histories and current use patterns of the Sydney-based Illicit Drug Reporting System data from 1996–2003 was conducted by Breen, Roxburgh and Degenhardt (2005). This analysis revealed that females who inject drugs were more likely to identify as Aboriginal Australian and that this has steadily increased over time. The authors also found that females injecting drugs were more likely to engage in high-risk behaviour such as re-using non-sterile injecting equipment and engaging in sex work (Breen et al., 2005).

In a Brisbane-based study of Aboriginal people who inject drugs, the gender distribution was 69 per cent male and 31 per cent female (Larson et al., 1999). In an Adelaide-based study, the distribution was 60 per cent male and 40 per cent female (Holly & Shoobridge, 2003), whereas in the Lower Murray region of rural South Australia the distribution was 76 per cent male and 14 per cent female (Shoobridge et al., 2000). In Western Australia, 57 per cent of a sample of Aboriginal people who inject drugs were male and 43 per cent were female (Gray et al., 2001).

⁸ Note: there are limitations to these data as a convenience sample and this trend has not been tested for statistical significance.

A study in the Australian Capital Territory of Aboriginal people who inject drugs found a gender distribution of 65.3 per cent male and 34.7 per cent female (Dance et al., 2004).

3.5.2 Age differences

Based on recent data from the Australian Needle and Syringe Program Survey, the average age of first injection among the general population of people who inject drugs has remained relatively stable at 18 years of age, ranging from about 10 years old to over 50 years⁹ (Iversen et al., 2008). The average age of Australian Needle and Syringe Program Survey respondents has increased from 31 years in the 2003 survey to 35 years in 2007 (Iversen et al., 2008). This is similar to the average age of participants in the Illicit Drug Reporting System of 35.8 years, which has also increased since 2000 when the average age was 28.8 years (Black et al., 2008).

Community perception suggests that people who inject drugs may begin earlier among Aboriginal Australians, and that the age of first injection has decreased over the years (Holly & Shoobridge, 2003). The National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994 found that the average age of first trying most illicit substances was younger than that within the general population (Australian Institute of Health and Welfare, 1995). The average age of first use of heroin by Aboriginal people who inject drugs was 17.5 years compared to 20.2 years for the general population (Australian Institute of Health and Welfare, 1995). For cocaine, which was injected by 73 per cent of those reporting its use, the average age of first use was 18.5 years compared to 21.6

years in the general population (Australian Institute of Health and Welfare, 1995). Conversely, for amphetamines the average age of first use was slightly older at 19.5 years compared to 19.0 years for the general population (Australian Institute of Health and Welfare, 1995).

More recently, in an analysis of differences in demographic characteristics, drug-use histories and current use patterns of the 2006 Illicit Drug Reporting System data, the authors found that people who inject drugs who were under 25 years of age were more likely to identify as Aboriginal (Degenhardt et al., 2008a). Younger people who inject drugs were also more likely to be engaged in higher risk behaviours associated with injecting, including injecting daily and more often, providing used injecting equipment to others, and engaging in drug dealing and property crime (Degenhardt et al., 2008a). This is consistent with a study conducted in New South Wales of 336 people under the age of 25 years who inject drugs, which found that early onset injecting (under 17 years) was associated with identifying as Aboriginal, as well as other characteristics such as homelessness and having a family member who injected (Abelson et al., 2006). This study also concluded that earlier onset injecting was associated with increased vulnerability to risk taking.

In a Brisbane-based study of Aboriginal people who inject drugs, the age of participants ranged from 13 years to 44 years, 50 per cent of whom were under 21 years (Larson et al., 1999). Based on this same sample, the average age of first injection was 17.8 years and 39 per cent of the sample had injected before the age of 16 years (Larson et al., 1999).

⁹ One case of initiating into injecting at the age of 3 years and another at the age of 5 years are also documented. However, these cases appear to be anomalies.

In the Northern Territory, Meyerhoff (2000) suggests that the average age of Aboriginal people who inject drugs may be relatively old, at 33 years. However, this finding is based on Australian Needle and Syringe Program Survey data collected at one NSP and therefore may be a better reflection of those accessing that particular NSP, rather than the broader Aboriginal population of people who inject drugs (Meyerhoff, 2000).

Studies in South Australia of Aboriginal people who inject drugs have found varying results. The age and gender distribution of an Adelaide-based sample was similar to the general population of people who inject drugs, based on the sample of people who inject drugs in the Illicit Drug Reporting System (Holly & Shoobridge, 2004). However, Shoobridge et al. (2000) found a slightly younger average age and a much smaller proportion of female participants among rural Aboriginal people who inject drugs from the Lower Murray region. The average age of first injection was 17 years for the rural sample (Shoobridge et al., 2000) and 18 years for the urban sample (Holly & Shoobridge, 2004).

Holly and Shoobridge (2004) noted that the participants in both the Adelaide and the Lower Murray studies in South Australia were much older than a Western Australian sample of Aboriginal people who inject drugs. The South Australian sample had an average age of 26.5 years (Holly & Shoobridge, 2004). In the Western Australian study, Gray et al. (2001) report that the age of first injection ranged from 8 years to 42 years, with 34 per cent injecting by 14 years of age and 40 per

cent injecting for the first time between the ages of 15 years and 19 years. There was no difference in age of first injection by gender or location (metropolitan or regional setting) (Gray et al., 2001). In an Australian Capital Territory study of Aboriginal people who inject drugs, Dance et al. (2004) report that the mean age of their sample was 27 years, with 31 per cent falling under the age of 21 years. The average age of first injecting in this sample was 20 years (Dance et al., 2004).

In a study of Aboriginal male offenders, the average age of first use for amphetamines, cocaine and heroin ranged from 18 years to 22 years (Putt et al., 2005). This did not differ significantly from the age of first use for non-Aboriginal male offenders (Putt et al., 2005).

Health survey data of young offenders between the ages of 12 years and 19 years reveal that young Aboriginal offenders experience a slightly higher rate of hepatitis C infection than young non-Aboriginal offenders (7.3% and 5.3%, respectively), although the difference is not statistically significant (van der Poorten et al., 2008). There was also no statistically significant difference in the reported rate of injecting drug use, although it was slightly higher at 18.6 per cent among young Aboriginal offenders compared to 13.4 per cent among young non-Aboriginal offenders (van der Poorten et al., 2008). For both populations, injecting drug use and heroin use were the only statistically significant risk factors for hepatitis C (van der Poorten et al., 2008).

3.5.3 Summary

The evidence provides some indication of a potential increase in the prevalence of injecting drug use among Aboriginal females and that the proportion of female Aboriginal people who inject drugs may be slightly higher than that of non-Aboriginal females who inject drugs. The literature also seems to indicate that Aboriginal people who inject drugs may be more likely to be younger and may be initiated into injecting at a younger age. There is some evidence to suggest that younger injecting drug users engage in riskier injecting practices; however, there also appear to be regional variations in age and gender distribution. Some suggest that regional differences may be more significant than cultural background (Holly & Shoobridge, 2004).

3.5.4 Gaps and ways forward

Once again, based on challenges in accessing Aboriginal people who inject drugs, it may be more difficult to access women and those who are younger, as they are commonly a more challenging group to access among the general population of injecting drug users. Coupland et al. (2005) point out that the specific risk behaviours of Aboriginal females who inject are not well understood.

3.6 Associated harms

Based on the literature, numerous harms associated with injecting drug use among Aboriginal Australians have been identified. There is often an overlap between harms associated with injecting drug use and the factors that may contribute to it (Holly, 2001; Larson et al., 1999). For instance, factors such as poverty and lack of employment opportunities may contribute to injecting drug use, but also may be confounded by injecting drug use (Holly, 2001). A study in Brisbane sampled Aboriginal people who inject drugs and found that illicit drugs were reported to be used often to help cope with problems and worries, but in turn contributed to problems with family and friends, work or school, health and the criminal justice system (Larson et al., 1999).

Van der Sterren, Anderson and Thorpe (2006) have classified the harms into three broad categories:

- harms to the individual – such as problems related to health, finances, relationships, employment or studies, and criminal behaviour
- harms to the family – such as personal safety, financial security and the long-term welfare of the family
- harms to the community – such as inter-generational impacts and community breakdown.

This section examines the literature related to each of these categories.

3.6.1 Harms to the individual

Harms to the individual associated with injecting drug use include harms related to health, relationships, finances, work or study, and criminal behaviour.

3.6.1.1 Health-related harms

Harms range from general health issues to specific diseases or conditions such as blood-borne viruses, mental health problems, suicide and overdose. In Western Australia, 67 per cent of Aboriginal people who inject drugs reported health problems other than blood-borne viruses (Gray et al., 2001). General health problems include weight loss, loss of fitness, withdrawal symptoms, vein damage, hot and cold sweats, lack of appetite, mood swings, track-marks, thirst, lack of energy, heart problems and difficulties sleeping (Gray et al., 2001; Holly & Shoobridge, 2003; Shoobridge et al., 2000; van der Sterren et al., 2006).

The transmission of blood-borne viruses entails significant consequences associated with injecting drug use generally. The prevalence of blood-borne viruses within the Aboriginal Australian population of people who inject drugs has been discussed previously in section 3.2.1. Also of note is the association between injecting drug use and two hepatitis A outbreaks in northern Queensland in the late 1990s (Merritt et al., 1999). Injecting drug use was found to be a significant risk factor in these outbreaks.

A range of mental health issues has been noted in the literature, some of which may be actual mental health conditions while others are self-perceived effects on one's mental wellbeing. In a sample of Aboriginal people from rural South Australia who inject drugs, two-thirds reported self-perceived mental health problems associated with their drug

use (Shoobridge et al., 2000). In a Melbourne study involving interviews with Aboriginal people who inject drugs, most interviewees focused on the harms related to emotional and spiritual wellbeing (van der Sterren et al., 2006). For example, Aboriginal people who inject drugs have noted concerns about their mental health, mood swings, reduced enjoyment of life, loss of self-worth, memory problems and erratic behaviour, as well as depression and paranoia (Gray et al., 2001; Holly & Shoobridge, 2003; Shoobridge et al., 2000; van der Sterren et al., 2006).

Related to the issue of mental health is the association between injecting drug use and suicide. In a study of Aboriginal people who inject drugs undertaken in the lower Murray region of South Australia, over half of the sample had attempted suicide on at least two occasions (Shoobridge et al., 2000). Of those who had attempted suicide, most reported that they were intoxicated on at least one of those occasions and noted that this had played a role in facilitating the decision to action suicidal ideation (Shoobridge et al., 2000).

One study conducted in the Northern Territory examined data from the National Coroners Information System (NCIS) and the Confidentialised Uniform Record File (CURF) from 2001 to 2005. The CURF data confirmed the role alcohol and other substance use and comorbid mental, physical and behaviour disorders play in contributing to suicides (Hanssens, 2007). The author identified suicide clusters in remote communities, where a number of suicides would occur within a limited timeframe. Thus suicide, whether prompted by substance use or not, may have an effect within communities leading to broader implications (Hanssens, 2007).

Some have suggested that the rate of overdose among Aboriginal illicit drug users is very high and that most families may be affected by an overdose death (Holly, 2001). An Adelaide study involving Aboriginal people who inject drugs found that 21 per cent had overdosed at some point, and that 37 per cent of those who had overdosed indicated that they had done so intentionally (Holly & Shoobridge, 2004).

A Western Australian study of Aboriginal people who inject drugs found that 24 per cent reported overdosing, but the study noted that this was less than half that reported among the general injecting population in Perth (Gray et al., 2001). However, 28 per cent claimed to know what to do in the event that someone overdosed, while 20 per cent 'sort of' knew what to do. Only about 12 per cent of respondents reported that they had a first aid certificate and could resuscitate if an overdose occurred (Gray et al., 2001).

3.6.1.2 Implications for relationships

For people who inject drugs, the implications for familial and personal relationships have also been noted in the literature (Franks, 2006; Gray et al., 2001; Holly & Shoobridge, 2004). In Western Australia, 44 per cent of Aboriginal people who inject drugs reported difficulties maintaining the relationship with their partner due to behaviours associated with drug use and the impact on sexual performance (Gray et al., 2001). A study of substance use in a rural South Australian community found that people who inject drugs were often stigmatised and not accepted by the community (Franks, 2006). Others have also noted the isolation that can result from engaging in injecting drug use (van der Sterren et al., 2006). The association between criminal behaviour and

injecting drug use may further jeopardise familial relationships and isolate individuals from their families as a result of the potential for negative implications for the safety of the family (van der Sterren et al., 2006).

3.6.1.3 Criminal behaviour

The South Australian Department of State Aboriginal Affairs (2002) notes a strong link between property taking, property crime, drug dealing and illicit substance use. Aboriginal prisoners have been found to be disproportionately represented in some offence categories that may have a drug component, such as property crime, minor drug offences, home invasions and assaults (South Australia Department of State Aboriginal Affairs, 2002). Indeed, legal problems have been noted in studies of Aboriginal injecting drug use (e.g. Gray et al., 2001; Holly & Shoobridge, 2003; van der Sterren et al., 2006). Of Aboriginal people who inject drugs surveyed in Western Australia, half indicated that they had resorted to crime in order to buy drugs, including stealing, fraud, assault, armed robbery and drug dealing (Gray et al., 2001).

In a study of the substance-use histories of prisoners and police detainees, a higher proportion of Aboriginal offenders reported using alcohol and illicit drugs prior to the commission of an offence for which they were arrested (Putt et al., 2005). However, their non-Aboriginal counterparts were more likely to report only using illicit drugs prior to the commission of an offence (Putt et al., 2005). Half of Aboriginal male prisoners attributed their most recent serious offence to drug use and intoxication (Putt et al., 2005).

3.6.1.4 Implications for finances, employment and study

Finally, harms to the individual associated with injecting drug use also include those related to financial problems and employment and studies. As noted above, crimes may be committed in order to support substance use and financial problems are commonly noted among Aboriginal people who inject drugs, as are the loss of employment or a lack of motivation to pursue studies or seek employment (Gray et al., 2001; Holly & Shoobridge, 2003; Shoobridge et al., 2000; van der Sterren et al., 2006). In Western Australia, 42 per cent of surveyed Aboriginal people who inject drugs reported difficulties maintaining employment or education (Gray et al., 2001). Lehmann and Frances (1998) also noted that some injecting drug users may become involved in sex work in association with their injecting drug use. This may have further implications for blood-borne virus transmission and sexual health.

3.6.2 Harms to family

Most studies of Aboriginal injecting drug use note the significant harms to families, as well as to the individual (Franks, 2006; Gray et al., 2001; Holly & Shoobridge, 2004; Larson et al., 1999; Lehmann & Frances, 1998; Putt & Delahunty, 2006). Injecting drug use appears to contribute to the breakdown of family by interfering with parental responsibilities and causing considerable distress, instability and shame (Western Australia Drug and Alcohol Office, 2007; Holly & Shoobridge, 2004; Lehmann & Frances, 1998). In a Western Australian study involving Aboriginal people who inject drugs, 13 per cent had lost custody of their children at one time (Gray et al., 2001).

Families may also experience theft of goods by the drug user in order to support substance use (Lehmann & Frances, 1998). Furthermore, in some cases the family economy may be dependent on drug dealing, the funds from which may also support the drug use of one or more family members (Lehmann & Frances, 1998). Lehmann and Frances (1998) estimate that in Melbourne, due to the high prevalence of injecting drug use among Aboriginal people and the small size of the community, all Aboriginal families may be affected by injecting drug use in some way.

In rural areas, injecting drug use has been seen as contributing to the psychological and spiritual breakdown of families, with implications for intergenerational substance use as a result of negative role modelling (Franks, 2006; van der Sterren et al., 2006). Extra burden may be placed on grandparents or other relatives who may have to care for the children of people who inject drugs (van der Sterren et al., 2006). Some have also associated illicit substance use in rural and remote areas with family violence, child neglect and the sexual exploitation of young people (Putt & Delahunty, 2006).

Interestingly, Gray et al. (2001) gathered the perceptions of the most significant harms associated with injecting drug use from the perspectives of Aboriginal people who inject drugs, as well as from service providers and community members. The authors noted a discrepancy between these perspectives. While service providers identified perceived health and criminal behaviour to be the most significant harms to the individual, Aboriginal people who inject drugs felt that the harms to their relationships with family and other relatives were most significant (Gray et al., 2001). These were followed by criminal behaviour and financial harms, with health-related harms coming last (Gray et al., 2001). This finding has interesting implications for

program planning and messages intended for Aboriginal people who inject (Gray et al., 2001). These findings also highlight the importance of including the perspectives of Aboriginal people who inject drugs in service planning.

3.6.3 Harms to community

It has been suggested that injecting drug use among Aboriginal Australians has harmful implications, not just for the individual and their family, but also for the broader community (Dance et al., 2004; van der Sterren et al., 2006). As a result of the negative implications for relationships with families and friends, the loss of children who may be removed from their drug-using parents, the isolation of Aboriginal people who inject drugs from their families, community and culture, and the finding that few Aboriginal families may be *unaffected* by injecting drug use, there is evidence to suggest that Aboriginal 'cultural health is under threat' (van der Sterren et al., 2006, p. 221; Dance et al., 2004; Ministerial Council on Drug Strategy, 2006).

Some have noted that injecting drug use and illicit substance use in general may lead to a reduction in community participation and involvement in sport, family, work and cultural activities (Western Australia Drug and Alcohol Office, 2007; Putt & Delahunty, 2006). Substance use and harms may also contribute to a loss in respect for Elders (Western Australia Drug and Alcohol Office, 2007). Furthermore, future social structures may be affected due to a reduction in the next generation of Elders (van der Sterren et al., 2006). This has the potential to undermine Aboriginal culture and the strength of the community (Dance et al., 2004; van der Sterren et al., 2006). Injecting drug use can also contribute to ongoing grief and loss within the community (Holly & Shoobridge, 2004; van der Sterren et al., 2006).

Finally, illicit drug use may divert funds from the community into the illicit drug market, having implications for local community economic development (Western Australia Drug and Alcohol Office, 2007). Increases in social disadvantage in the broader community may result (Holly & Shoobridge, 2004).

3.6.4 Summary

Within Aboriginal communities, injecting drug use has implications not just for the individual and the family, but also for the cultural safety of the broader community. Individual harms are experienced in relation to health and wellbeing, interpersonal relations, criminal behaviour, and employment and study opportunities. It has been suggested that harms to families and communities threaten the social fabric and cultural health of Aboriginal communities, and that approaches to minimising the harms associated with injecting drug use must take these broader harms into consideration (see the following section).

3.6.5 Gaps and ways forward

Based on this literature review, the *harms* associated with injecting drug use among Aboriginal Australians appear to be well documented and understood. What is not understood is the most effective and appropriate way to move forward. This is explored more fully in the following section on service responses. Based on the inconsistencies noted between the perceptions of community and service providers and those of Aboriginal people who inject drugs with respect to the most significant harms (see Gray et al., 2001), it is apparent that the perspectives of people who inject drugs must also be included in order to ensure the appropriateness and effectiveness of responses.

3.7 Service responses

This section explores how services have responded to Aboriginal people who inject drugs and to alcohol and other drugs issues, including the factors for, and barriers to, the success of such services. Responses have ranged from specific harm reduction services for Aboriginal people who inject drugs, to family and home support services, detoxification programs, primary health care and other health services. Responses also include alcohol and other drugs counselling, cultural involvement, alternatives to criminal justice approaches (e.g. diversionary programs), prevention and abstinence.

The service responses discussed below relate to the predominant services referenced in the literature. The issues and barriers to accessing existing services are also discussed.

3.7.1 Harm reduction approaches

Harm reduction is discussed extensively in the literature. Harm reduction was generally conceived of broadly and covered a range of interventions. The Australian Government Department of Health and Ageing (2007) notes that 76 per cent of Aboriginal-specific substance-use services offer some form of harm reduction. In fact, Gray (2005) claims that harm reduction has received greater emphasis in Australia than elsewhere in the world. However, while it may seem contradictory, 89 per cent of Aboriginal-specific substance-use services reportedly work within an abstinence model of treatment, and simultaneously provide harm reduction services (Australian Government Department of Health and Ageing, 2007).

Despite the seemingly widespread implementation of harm reduction services, the need for more services is frequently noted

(Aboriginal Drug and Alcohol Council, 1997; Edwards et al., 1998; Lehmann & Frances, 1998; Gray et al., 2001). Gray et al. (2001) particularly emphasise the need for a comprehensive state-wide strategy on drug use in Aboriginal communities, specific harm reduction information and education materials for distribution in needle packs, and more services in prisons. The Western Australia Drug and Alcohol Office (2007) reports on the need to expand NSPs to rural and remote areas.

Holly and Shoobridge (2004) note that alternatives to injecting need to be provided and more harm reduction information is required. Van der Sterren, Anderson and Thorpe (2006) note that few mainstream harm reduction interventions effectively include family and community in an Aboriginal context. Gray, Haines and Watts (2004) discuss the importance of increasing Aboriginal health worker training to provide harm reduction due to their increased involvement in the provision of harm reduction services.

3.7.1.1 Needle and syringe programs

An Aboriginal needle and syringe program in South Australia, Nu-Hit, is described in some detail (Gray & Morfitt, 1996; South Australia Department of State Aboriginal Affairs, 2002). This was reportedly the first service of its kind in Australia. It offers a range of services including fixed-site and outreach NSP services, education, opioid substitution treatment, and support for homeless people, as well as prison and sexual health services. While this approach is considered to be culturally appropriate, confidentiality concerns may be apparent for some Aboriginal people who inject drugs, particularly if such an NSP were established in a rural or remote area (Western Australia Drug and Alcohol Office, 2007).

3.7.1.2 Opioid substitution treatment

Some opioid substitution treatment and methadone maintenance therapy programs have been established particularly for Aboriginal people who inject drugs (Holly, 2001; Ministerial Council on Drug Strategy, 2006; Teasdale et al., 2008; Aboriginal Drug and Alcohol Council, 1997; Holly & Shoobridge, 2004), although Shoobridge et al. (2001) suggest there is a significant need for more access to methadone for Aboriginal populations. Williams et al. (2008) describe a specific program for Aboriginal users, delivered through a partnership approach. The program was first implemented without the community's approval due to poor perceptions and understanding of the benefits of the program; acceptability of the program subsequently improved with time.

3.7.1.3 Peer approaches

A need for broader implementation of peer approaches has been noted (Holly, 2001; Holly & Shoobridge, 2004). Consideration must be given to community perceptions and awareness to ensure support for such approaches and adequate support for peer educators (Holly, 2001). Interestingly, the literature suggests some support within Aboriginal communities for additional harm reduction services which may typically be considered controversial, such as safe injecting facilities (Holly & Shoobridge 2004; Gray et al., 2001) and heroin trials (Holly, 2001; Aboriginal Drug and Alcohol Council, 1997; Holly & Shoobridge, 2004).

3.7.1.4 Sobering-up centres and night patrols

Finally, a significant body of literature exists related to sobering-up centres and night patrols (e.g. Dawe et al., 2006; Gray, 2005; Gray et al., 2001; Gray & Morfitt, 1996). Such programs were established in response to harms resulting from alcohol use; however, they provide important examples of harm reduction strategies developed by and for Aboriginal communities (Gray & Morfitt, 1996). While most of these programs likely service people also affected by illicit substances, consideration should be given to their capacity to respond to the issues particular to injecting drug use. Gray (2005) has suggested that there is good evidence for the effectiveness of such services, and notes the need for broader implementation (Gray & Morfitt, 1996).

3.7.2 Family and home supports

General reference to the provision of a broad set of support services is frequently noted (Black et al., 2007; Krieg, 2006; Shoobridge et al., 2000; Gray & Morfitt, 1996; Williams et al., 2008). This includes support both for individuals experiencing substance use and for their families and communities. Holly (2001) identified the need for support for Aboriginal mothers and families of users in particular. Teasdale et al. (2008) cite that broader support is needed to break the cycle of substance use and incarceration. Aboriginal women's support groups are also raised (Teasdale et al., 2008), as is the need to provide assistance for families, including parents and grandparents (Putt et al., 2005; Aboriginal Drug and Alcohol Council, 1997; Western Australia Drug and Alcohol Office, 2007).

The Australian Government Department of Health and Ageing (2007) states that 89 per cent of government-funded Aboriginal and Torres Strait Islander substance-use services provide family or community support, and 97 per cent of services offer support once clients have returned home after receiving residential treatment. Some of these services include the Nunga Way Out program and Grannies Group for grandparents of substance-using grandchildren (South Australia Department of State Aboriginal Affairs, 2002). Other examples include support for families at Wu Chopperen Health Service in Cairns (Dawe et al., 2006), support to get off drugs, non-judgmental support for users and families, accurate information about drugs and their effects for users and families, and help to stay drug-free in the community (Edwards et al., 1998).

3.7.3 Detoxification and rehabilitation programs

A number of studies make reference to the need for detoxification services, as those currently available may be culturally inappropriate or inaccessible for Aboriginal users (Gray & Morfitt, 1996; Franks, 2006; Edwards et al., 1998; Lehmann & Frances, 1998; Western Australia Drug and Alcohol Office, 2007). There is also a significant lack of suitable residential rehabilitation services that are culturally appropriate and supportive (Lehmann & Frances, 1998). However, there appear to be some existing examples of detoxification programs in particular, such as the Council for Aboriginal Alcohol Programs Services in Darwin, which provides residential withdrawal (Dawe et al., 2006). Williams et al. (2008) report on the establishment of a detoxification group in a particular commu-

nity, which developed a home detoxification kit. However, the kit was poorly used due to lack of safe houses at which to undertake detoxification (Williams et al., 2008).

3.7.4 Primary health care and other health services

A need for a variety of health services is noted in the literature, including primary health care, health promotion and alternative healing approaches. While many examples of primary health services for Aboriginal people may exist, there may be specific challenges and barriers to access for Aboriginal people who inject drugs. These challenges and barriers will be explored more fully in a later section.

Some examples of existing services include the Winnunga Nimmityjah Aboriginal Health Service in the Australian Capital Territory (Black et al., 2007), the Nunga Way Out program (South Australia Department of State Aboriginal Affairs, 2002), and the Wu Chopperen Health Service in Cairns, all of which work within a health promotion approach (Dawe et al., 2006).

In one opioid substitution treatment program, general practitioners (GPs) and antenatal care are provided for pregnant women accessing the service (Williams et al., 2008). Williams et al. (2008) also noted healing days run by individual services which included alternative and traditional therapies, such as crystals and meditation, to support healing for substance users. While the efficacy of such approaches may be debated in the wider medical literature, it seems that providing a diversity of services is important in meeting the variety of needs present in a community, whether it be an Aboriginal community or not.

3.7.5 Cultural involvement

The Australian Government Department of Health and Ageing (2007) reports that 100 per cent of Aboriginal services provide cultural involvement of some kind as a key treatment approach. A particular example is the Aboriginal Kinship Program in South Australia (South Australia Department of State Aboriginal Affairs, 2002).

The approach of employing cultural methods as a form of treatment may include exploring awareness of physical, mental, emotional, spiritual, cultural and social effects of alcohol and other drugs, as occurs at the Council for Aboriginal Alcohol Programs Services in Darwin (Dawe et al., 2006). The Aboriginal Drug and Alcohol Council (1997) advocates the need for healing centres that can address individual aspects of treatment for alcohol and other drugs in combination with responding to transgenerational cultural issues.

3.7.6 Alternatives to criminal justice approaches

The Western Australia Drug and Alcohol Office (2007) recommends that drug diversion programs should be promoted and expanded. In South Australia, 6.7 per cent of drug diversion services are provided to Aboriginal and Torres Strait Islander clients (South Australia Department of State Aboriginal Affairs, 2002). Aboriginal courts and other criminal justice programs are also discussed (South Australia Department of State Aboriginal Affairs, 2002; Western Australia Drug and Alcohol Office, 2007). Williams et al. (2008) describe a partnership between a mainstream health service with an Aboriginal-specific component, drug courts, Aboriginal courts and corrections services, which enables clients to continue opioid substitution treatment uninterrupted if they are incarcerated.

3.7.7 Additional alcohol and other drugs services

Additional alcohol and other drugs services discussed in the literature include counselling and drug prevention programs. Edwards, Frances and Lehmann (1998) make reference to counselling as an intervention for Aboriginal alcohol and other drugs services. Dawe et al. (2006) report that the Wu Chopperen Health Service in Cairns provides counselling; the South Australia Department of State Aboriginal Affairs (2002) identifies the Nunga Way Out program as providing counselling; and Williams et al. (2008) note that the Aboriginal Kinship Program also does so. Gray and Morfitt (1996) identify a particular need for life skills counselling which can minimise harms without necessarily requiring abstinence.

Gray et al. (2005) note that more significant investment is needed in prevention programs among Aboriginal communities. Such programs need to focus not only on education, but also on broader community programs that provide opportunities for community involvement, recreation and leadership development.

Williams et al. (2008) describe the provision of education on opioid substitution treatment for community leaders and its potential benefits in order to build trust in and understanding of the treatment over time. Edwards, Frances and Lehmann (1998) outline the importance of providing clear information to the broader Aboriginal community about drugs and their effects, and where and how to access services.

3.8 Issues and barriers to access

Several barriers to accessing existing services are commonly noted in the literature. These issues are often interrelated, and include a lack of cultural sensitivity and appropriateness of mainstream services, a lack of expertise within Aboriginal-specific services, confidentiality, shame and discrimination, negative perceptions of services, and physical barriers.

3.8.1 Cultural sensitivity and appropriateness

It is commonly stated that Aboriginal people may find mainstream services culturally inappropriate or insensitive to their needs (Edwards et al., 1998; Holly, 2001; Meyerhoff, 2000; Ministerial Council on Drug Strategy, 2006). Furthermore, mainstream harm reduction strategies are not always transferable to Aboriginal communities (Gray & Morfitt, 1996; van der Sterren et al., 2006). Teasdale et al. (2008) suggest that there has been little research on the acceptability of mainstream treatment services among Aboriginal people. In particular, traditional Western models of psychotherapy or behaviour interventions may be inappropriate as they do not take into account family and community, are uninviting and impersonal, and may require highly clinical environments to operate (South Australia Department of State Aboriginal Affairs, 2002; Holly & Shoobridge, 2004; Teasdale et al., 2008). These issues may be further compounded by a lack of integration and coordination between mainstream and Aboriginal services (Gray, 2005; Holly & Shoobridge, 2004).

Youth services may be lacking in knowledge of drug use and especially in culturally appropriate responses (Holly, 2001; Holly & Shoobridge, 2004). Similarly, alcohol and other drugs services may not have appropriate knowledge or capacity to work specifically with youth or Aboriginal young people (Holly, 2001; Holly & Shoobridge, 2004). This means there is likely to be a particular gap in service provision for young Aboriginal people who inject drugs (Western Australia Drug and Alcohol Office, 2007; Ministerial Council on Drug Strategy, 2006; Teasdale et al., 2008).

3.8.2 Capacity of Aboriginal-specific services

There are a number of references to the possibility that staff in Aboriginal services may be under-skilled and under-resourced to respond to drug issues (Gray et al., 2001; 2004; Larson et al., 1999; Ministerial Council on Drug Strategy, 2006; Shoobridge et al., 2000). This may be due to a traditional focus on alcohol, rather than illicit drugs (South Australia Department of State Aboriginal Affairs, 2002; Ministerial Council on Drug Strategy, 2006; Shoobridge et al., 2000). Holly (2001) reports that often little harm reduction or peer education training has been provided to workers in Aboriginal services and any training given has tended to focus on abstinence. There are also reports of a lack of amphetamine-specific services or training for workers (Western Australia Drug and Alcohol Office, 2007; Holly & Shoobridge, 2004).

The Aboriginal Health and Medical Research Council (2004) also found that many Aboriginal health workers acknowledged less than optimal knowledge of blood-borne viruses and the need for training surrounding blood-borne viruses (e.g. alcohol and other drug workers and mental health workers unaware of NSP locations). Many workers were also

unaware of the key guiding policies and strategies steering blood-borne virus education, prevention, health promotion, treatment and care.

3.8.3 Confidentiality

The literature notes issues and concerns related to the potential lack of confidentiality or anonymity for Aboriginal people who inject drugs in accessing harm reduction services, for fear of being identified as an injector (Day et al., 2006; Edwards et al., 1998; Holly, 2001; Meyerhoff, 2000). These concerns extend to both mainstream and Aboriginal-specific services (Holly & Shoobridge, 2004; Larson et al., 1999; Shoobridge et al., 2000). Syringe vending machines have often increased access to sterile injecting equipment for particularly marginalised people who inject drugs; however, poor placement of some syringe vending machines has also been raised as an issue (Day et al., 2006). The literature suggests that Aboriginal people who inject drugs, particularly those in rural settings, tend to use pharmacies or other users as their most common sources of injecting equipment (Day et al., 2006; Larson et al., 1999). However, costs may then become a barrier when accessing pharmacies.

3.8.4 Shame and discrimination

Many Aboriginal people may not access services because of the potential for or experiences of discrimination (Day et al., 2006; Gray et al., 2001; Holly & Shoobridge, 2004). This may occur in services that specifically provide treatment for drug users (Day et al., 2006). Meyerhoff (2000) notes that many staff in mainstream services claim that they prefer to refer Aboriginal people who inject drugs to Aboriginal-specific services, which may be perceived by Aboriginal clients as discriminatory.

Any discrimination or stigma that may be experienced can further compound feelings of shame (Edwards et al., 1998; Holly, 2001; Holly & Shoobridge, 2004; Meyerhoff, 2000; Shoobridge et al., 2000). These feelings of shame may also prevent Aboriginal people from accessing Aboriginal-specific services (van der Sterren et al., 2006).

McNally and Latham (2009) found that the connection between hepatitis C and drug use is often a cause of discrimination. Shame and shyness can make reaching and supporting drug users a challenge for Aboriginal people and for people providing support and care. There is often a heightened sense of shame that accompanies everyday experiences of drug users.

3.8.5 Perceptions of harm reduction approaches

A number of specific issues with harm reduction are reported in the literature. In particular, tensions between harm reduction and abstinence approaches may be apparent (Shoobridge et al., 2000). This may result in varying levels of support for using harm reduction interventions in Aboriginal community-controlled spaces (van der Sterren et al., 2006) or the belief that a new definition of harm reduction is needed (Gray & Morfitt, 1996; van der Sterren et al., 2006).

Similarly, policing practices that target Aboriginal drug users can actually increase drug-related harms, despite being associated with the broader approach of harm minimisation through undertaking supply reduction strategies (Holly & Shoobridge, 2004; Maher et al., 2004).

There may also be a lack of community understanding of addiction (Aboriginal Drug and Alcohol Council, 1997). In particular, Lehmann and Frances (1998) identify a lack of understanding of harm minimisation within many communities. In some cases, this can put Aboriginal health workers as well as alcohol and other drugs workers at odds with the community (Holly, 2001). Gray and Morfitt (1996) identify poor community support for NSPs due to fear that they will encourage injecting drug use. However, after four years of operating Nu-Hit (an Aboriginal NSP), some concerns appear to have been resolved.

In relation to opioid substitution treatment, there have been particular difficulties with the validity of this treatment type. This has resulted in: reluctance to admit to residential treatment those clients who are on opioid substitution treatment (Ministerial Council on Drug Strategy, 2006); limited community and familial support for those undertaking opioid substitution treatment (Holly & Shoobridge, 2004); and implementation of a poorly used detoxification service rather than opioid substitution treatment (Williams et al., 2008). Day et al. (2006) report that, even in services providing opioid substitution treatment, there may be stigma associated with such treatment among staff. Teasdale et al. (2008) discuss perceptions that opioid substitution treatment may affect a person's 'Dreaming'.

3.8.6 Physical barriers

A real barrier to successful interventions may be that services are difficult to access (Day et al., 2006; Holly & Shoobridge, 2004). Physical barriers to services may include their geographical location and their hours of operation.

Geographical access may be a concern for those in remote areas (Australian Government Department of Health and Ageing, 2007) and can be worsened by historical allocations of funding which can lead to an imbalance in the spread of interventions available in particular places (Gray, 2005). In particular, lack of access to drug diversion programs in non-urban areas was raised as an issue (van der Poorten et al., 2008; Putt & Delahunty, 2006) and may be evidenced through underrepresentation of Aboriginal people in these services (South Australia Department of State Aboriginal Affairs, 2002).

Dawe et al. (2006) discuss concerns that many treatment centres place people out of their communities while they are receiving treatment, isolating them from family and community healing processes. Restricted hours of operation may be another barrier to access (Holly, 2001), as is lack of access to prescribers for opioid substitution treatment and cost of services (Holly & Shoobridge, 2004; Day et al., 2006). Lack of awareness of services available may be another issue (Holly, 2001; Day et al., 2006; Holly & Shoobridge, 2004). Public transport may be completely lacking, meaning that travel to services – where they exist – can be difficult and, in some cases, impossible (Teasdale et al., 2008).

3.9 Factors for successful interventions

The literature cites numerous factors that may contribute to more successful interventions for Aboriginal people who inject drugs. These are discussed in the following sections.

3.9.1 Community originated and controlled

Some measure of control by the community in the planning and implementation of services was identified as an important factor for success (Dawe et al., 2006; Holly & Shoobridge, 2004). Gray (2005) and Strempel et al. (2003) describe Aboriginal community control as relating to social accountability to the broader community. The importance of Aboriginal-specific and controlled treatment services has been specifically identified by Aboriginal people who inject drugs (Holly, 2001).

Some have argued that services developed with the community are essential to their success (Shoobridge et al., 2000). Opportunities for Aboriginal people who inject drugs to be involved in addressing substance use in their communities are viewed as essential to the success of community-wide interventions (Teasdale et al., 2008). This is evident particularly given the discrepancies noted earlier in relation to community and service provider perceptions and the experiences of Aboriginal people who inject drugs.

Interestingly, some authors highlight that an increasingly more positive perception and understanding of harm reduction within Aboriginal communities seem to be emerging and this trend may contribute to community support for and participation in interventions (Holly, 2001; Ministerial Council on Drug Strategy, 2006).

3.9.2 Cultural elements

Some have identified the need to focus on strengthening cultural identity and connections (Western Australia Drug and Alcohol Office, 2007; Ministerial Council on Drug Strategy, 2006). Services should offer a place of cultural safety to all community members, including people who inject drugs (van der Sterren et al., 2006).

Gray and Morfitt (1996) recognise that there are skills in Aboriginal communities for responding to substance use in culturally appropriate ways and these can be drawn upon by service providers. The Western Australia Drug and Alcohol Office (2007) considers that services have a role in strengthening Aboriginal culture and employing it as a protective factor in preventing substance use. Dawe et al. (2006) cite the example of the Council for Aboriginal Alcohol Programs Services in Darwin using culturally appropriate styles of prevention and treatment by integrating Aboriginal culture into the treatment process, rather than considering it as an 'add-on'.

3.9.3 Flexibility

Employing strategies that are flexible and allow for response to local and individual conditions is paramount to success, according to Gray (2005). Gray and Morfitt (1996) expand on such strategies, including the need to allow for community-based identification of harms, the adaptation of appropriate strategies to respond to these harms, and the provision of support to the community to implement the strategies.

At a more practical level, flexibility is described in terms of broadening of opioid substitution treatment dosing hours (Teasdale et al., 2008); operation outside normal business hours (South Australia Department of State Aboriginal Affairs, 2002); having a booking system as well as a drop-in clinic (Teasdale et al., 2008; Williams et al., 2008); and providing syringe vending machines with 24-hour access (Gray et al., 2001). Within mainstream services, offering priority assessment to Aboriginal clients after referral may be another way to provide flexible services which are also timely (Teasdale et al., 2008).

3.9.4 Family and community focus

Strengthening and supporting families to cope with illicit drug use (South Australia Department of State Aboriginal Affairs, 2002) and targeting harm reduction interventions towards families and communities (van der Sterren et al., 2006) are recommended as ways to address harms comprehensively. Putt, Payne and Miller (2005) suggest that offering educational and vocational opportunities through alcohol and other drugs treatment may further assist with addressing family and community harms.

3.9.5 Partnerships

Partnerships are needed between mainstream and Aboriginal-specific services where strong collaboration and communication occur and capacity is built to provide appropriate service responses within Aboriginal services (Ministerial Council on Drug Strategy, 2006; Teasdale et al., 2008; van der Sterren et al., 2006).

Williams et al. (2008) provide a number of examples for how this partnership could occur. One service raised the possibility of an opioid substitution treatment program with the community, and subsequently developed this service in partnership with them. Another key partnership occurred between a mainstream health service with an Aboriginal-specific component, drug courts, Aboriginal courts and corrections. The Western Australia Drug and Alcohol Office (2007) considers that partnerships improve continuity of care between services and reduce structural barriers to clients getting assistance.

3.9.6 Consumer choice

While Aboriginal-specific services are clearly integral to the provision of culturally appropriate and accessible services (Gray & Morfitt, 1996), mainstream services must also be accessible to Aboriginal people (Edwards et al., 1998; Ministerial Council on Drug Strategy, 2006). While many Aboriginal people will prefer Aboriginal-run services (Shoobridge et al., 2001), having a choice of service provider helps to cater for those who do not necessarily feel comfortable to access Aboriginal services to address substance use issues (van der Sterren et al., 2006).

Teasdale et al. (2008) cite the implementation of an Aboriginal-specific opioid substitution treatment program within a mainstream health service. Williams et al. (2008) report that the use of a mainstream health service to introduce an Aboriginal alcohol and other drugs program meant confidentiality for Aboriginal community members but also the feeling that the service had a degree of community ownership.

A strategy that may assist with improving the accessibility of mainstream services, and therefore providing greater choice to those in need of services, is to employ Aboriginal workers (Teasdale et al., 2008; Gray et al., 2001; Williams et al., 2008; Australian Government Department of Health and Ageing, 2007). Offering choice within a service is also important (Shoobridge et al., 2000; South Australia Department of State Aboriginal Affairs, 2002; Holly, 2001). Offering a number of treatment options such as opioid substitution treatment, counselling, support, education and harm reduction rather than a cure allows users the opportunity to access the best service for their needs (Shoobridge et al., 2000; Williams et al., 2008).

3.9.7 Responding to diversity

Gray and Morfitt (1996) highlight the need to recognise the diversity across and within Aboriginal communities and to resist defining harm reduction narrowly or providing one service for everyone. Strempel et al. (2003) point out that what works in one community may not work in another, and local histories and culture need to be taken into account in planning services and treatment options.

3.9.8 Workforce development and training

Accessible training and workforce development opportunities for workers in both mainstream and Aboriginal-specific services are one aspect of successful interventions (Ministerial Council on Drug Strategy, 2006; Teasdale et al., 2008). Van der Sterren, Anderson and Thorpe (2006) identify a need to resource Aboriginal services to provide drug programs, while the South Australia Department of State Aboriginal Affairs (2002) considers that this is particularly important in remote communities due to the importance of retaining health staff. Non-Aboriginal staff may need specific training to develop an appropriate level of cultural sensitivity and understanding (Teasdale et al., 2008; Western Australia Drug and Alcohol Office, 2007).

3.10 A culturally appropriate model of harm reduction

The importance of developing services that address underlying causes or contributing factors to substance use is highlighted by a number of authors (South Australia Department of State Aboriginal Affairs, 2002; Lehmann & Frances, 1998; Putt et al., 2005). This may have implications for the current conceptualisation of harm reduction within a mainstream context (Dawe et al., 2006). That is, the concept of harm reduction may need to be expanded or reconceptualised with Aboriginal communities (Dawe et al., 2006; van der Sterren et al., 2006).

Van der Sterren, Anderson and Thorpe (2006) have developed a model of harm reduction that incorporates Aboriginal values and explicitly acknowledges the 'range of conflicting values, and reflects the need for a breadth of services and programmes that address these tensions' (p. 219). They argue that an appropriate harm reduction model for Aboriginal communities needs to:

- address broader harms, including those to the family and community
- promote drug-free lifestyles and prevent initiation to injecting
- provide support and choices to people who inject and want to stop (van der Sterren et al., 2006).

An Aboriginal model for harm reduction has also been developed in Canada by the Canadian Aboriginal AIDS Network (2007).

The need to go beyond the individual to the family and community in reducing the harms in all domains is identified in the National Drug Strategy: Aboriginal and Torres Strait Islander Complementary Action Plan (Ministerial Council on Drug Strategy, 2006). This strategy appears to incorporate many of the recommendations that have emerged from the literature on Aboriginal substance use over the years.

The need for a whole-of-government approach to address structural factors that can be considered as contributing to problematic substance use within Aboriginal communities has also been noted (Gray, 2005). Furthermore, Gray (2005) suggests that services themselves need to become more holistic in their approaches by employing multi-pronged strategies and programs (Aboriginal Drug and Alcohol Council, 1997; Teasdale et al., 2008). Strempel et al. (2003) define holistic approaches as being collaborative and involving a range of formal and informal aspects which include local-level representation and involvement.

4. Consultation findings

This chapter outlines the key findings identified during the consultation phase of the project. The consultations aimed to explore more deeply the themes, issues, opportunities and gaps in knowledge identified in the literature review.

A number of themes emerged during the key informant interviews, which have been categorised as:

Gaps in knowledge and responses

- Data – including data collection, sample sizes, national data sets, purpose of data and quality of data
- Policy – frameworks and structures
- Aboriginal drug use – including issues of stigma, denial and shame, drug types used, rates of use
- Research – including barriers to undertaking research, ethics approval, funding, health economics research, Aboriginal researchers.

Opportunities available to improve services

- Service delivery – including accessing injecting equipment, confidentiality, Medicare rebates, service models and workforce.

Priority areas to target

- Subpopulations – geographical location, prisoners, dual-diagnosis and comorbidity, men who have sex with men, sex workers, and homeless and displaced people.

Where possible, the key themes identified above have been considered in the context of differences across urban and rural and remote parts of Australia.

4.1 Gaps in knowledge and responses

4.1.1 Research methods

Key informants discussed a range of issues and approaches to conducting research with Aboriginal people who inject drugs. A number of key issues that emerged were research methodology, ethics approval and research personnel. These will be discussed below.

There was no clear consensus among key informants as to an appropriate methodological approach to conducting research with Aboriginal people who inject drugs. Many key informants suggested that researchers should follow the National Health and Medical Research Council (NHMRC) road map for research with Aboriginal communities, particularly when writing research proposals and funding submissions. The NHMRC road map was designed as a 'strategic framework for the development of a health research agenda which engages Aboriginal and Torres Strait Islander communities with researchers, health service delivery and policy makers' (National Health and Medical Research Council, 2002). The road map includes the development of research theme criteria that must be met in order to ensure that research conducted will lead to significant improvements to Aboriginal and Torres Strait Islander people's health.

On this note, some key informants highlighted the process of seeking ethics approval as a barrier in researching Aboriginal injecting drug use. Although acknowledged as an important aspect of research accountability, ethics approval was cited by key informants as a lengthy and often costly process when conducting research. Further, some key informants felt that the barriers associated with obtaining ethics approval were so great that Aboriginal people who inject drugs were often excluded from research samples in order to avoid the delays associated with obtaining approval.

I have certainly been part of research projects where people will take out asking an Aboriginality question because it has to go through ethics approval and it takes too long.

Some key informants highlighted disparities between states in the approach to ethics approval and, in particular, their focus on the methodological approach of the research rather than the potential harms that may arise through conducting the research. Conversely, other key informants were very supportive of the ethics requirements needed to research Aboriginal injecting drug use. Ethics approval ensures that the Aboriginal community will benefit from the research undertaken and the methodology is approved prior to conducting research.

Key informants also highlighted the importance of using Aboriginal researchers as well as peer researchers to collect data. Peers in this context include people who inject drugs, Aboriginals working with people who inject drugs, and Aboriginal people. Key informants stressed the importance of researchers following cultural protocols including speaking to Elders and community members prior to entering the community. In particular, key informants discussed the benefits of using

peers in research, suggesting that peers will develop ownership over the research project and a consequent desire to make a meaningful contribution to the health of their community. Peer-led research can also lead to the development of more appropriate and relevant research questions and ensure that these questions will be answered with honest and meaningful responses.

The use of peers is highly valued within the Aboriginal community. However, the evidence base for this approach could be strengthened to ensure rigour and validity in research outcomes.

4.1.2 Data

A number of clear issues emerged relating to data during the key informant interviews. These included: lack of available accurate and representative data; the methods used to collect Aboriginal illicit and injecting drug use data; data sources; the focal point of data collection; and the purpose of data collection. These issues are discussed below.

Key informants regularly highlighted the lack of available data as a key gap in the knowledge base in order to make evidence-informed decisions about Aboriginal injecting drug use. Many key informants highlighted the importance of developing a clear evidence base concerning Aboriginal injecting drug use and the associated harms. Key informants stated the current evidence base is incomplete, fractured and often lacking in basic quantitative and qualitative information. Anecdotal evidence was noted as often being the source of, and measure for, Aboriginal injecting drug use. Further, because the collection of data on Aboriginal injecting drug use is so poor, estimates and anecdotal evidence of injecting drug use are often taken as fact.

Key informants highlighted an urgent need for definitive, nationally representative information around patterns and prevalence of Aboriginal injecting drug use. These data are essential for the development of evidence-informed programs and policies that can better address the needs of Aboriginal people who inject drugs. In particular, data on prevalence of HIV and hepatitis at a local and national level are required.

4.1.3 Data collection

While there are some data sources available that examine Aboriginal injecting drug use, there are limitations to their value and use. Many key informants highlighted that current data collection and data sets are not transferable across jurisdictions and therefore do not provide an accurate picture of Aboriginal injecting drug use at a national level. There is, therefore, a reduced ability to compare and benchmark these data.

Key informants working at both mainstream and Aboriginal health services stressed a need for data on Aboriginal injecting drug use and associated harms to be collected at a local and state level. A greater understanding of Aboriginal injecting drug use at a local level would better prepare such services to respond to the issues and needs of Aboriginal people who inject drugs and therefore provide appropriate services to this group.

While national data collections do exist, many indicated that these existing data collections are inadequate. The first National Aboriginal and Torres Strait Islander Health Survey, conducted in 2005, is one example where a separate substance use form was completed on a voluntary basis but was implemented only in non-remote areas.

Many of the current methods of data collection are inadequate and often exclude key groups, including those Aboriginal people who inject drugs who live in rural and remote areas, as well as those who don't access mainstream health services. The Australian Needle and Syringe Program Survey was highlighted as one such example where data are limited to those Aboriginal people who inject drugs who actually access NSPs in each jurisdiction. The National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994 is an example where data were collected specifically on Aboriginal illicit drug use, but data collection has not been continued on a regular or routine basis.

Key informants suggested that ascertaining Aboriginal and Torres Strait Islander status should be part of the core set of data collected from all mainstream health service clients. These informants noted that all research with people who inject drugs should record Aboriginal and Torres Strait Islander status. Often people prefer to guess rather than ask about Aboriginal status, as they are afraid asking will be offensive.

It should just be standard data collection as part of the core sort of minimum data set in terms of accessing health services or whatever; and where it's then part of specific research within research, where it's a specific Aboriginal health project or where it's something else, you know.

4.1.4 Data sources

Key informants stated that, by improving the sensitivity of data collection tools, service responses could be further refined. This would involve the inclusion of indicators such as the cultural identification of a person, and if respondents identified as Aboriginal or Torres Strait Islander, further questions could be asked in relation to drug-taking history and behaviours. This step would improve the depth of data collected on the issues of injecting drug use among Aboriginal Australians. However, key informants also highlighted that, although the Australian Needle and Syringe Program Survey is a good source of data collection, conducting a review of data over a period of time is labour-intensive and costly. The resources required to systematically review the data over time would require extensive funding commitments.

We have got a lot of data from the Australian NSP Survey, but having the resources to actually be able to systematically go back to have a look at that ... very labour-intensive ... we're just not kind of well resourced to be able to get the most out of that data set because there's not enough people.

Other key informants emphasised the value in using a variety of data sources to compile a picture of injecting drug use rates and associated harms in Aboriginal communities. The use of hospital and police records was suggested as a way of obtaining valuable information from unorthodox data sources. The 2001 study conducted by Gray et al. at the National Drug Research Institute at Curtin University of Technology in Western Australia is one such example where data from traditional data sources were combined

with data from hospital morbidity data, hepatitis C notification data and drug offences data to estimate prevalence of injecting drug use among Aboriginal Australians.

4.1.5 Data topics

Key informants also suggested using these existing data sources as a means to measure incidence and prevalence of Aboriginal injecting drug use over a period of time. This would provide a better understanding of injecting drug use in Aboriginal communities. Again, key informants identified the Australian Needle and Syringe Program Survey as one possible survey where data on incidence and prevalence of Aboriginal inject drug use could be measured over a long period of time.

There's all kinds of things that you can do, we're looking at the moment, not with Aboriginal injectors, but creating a pseudo cohort and looking at incidence, estimating incidence from prevalence of different time periods ... you can look at anyone and anything as long as they're attending an NSP in Australia in that survey.

Some key informants said that the harms associated with injecting drug use, and in particular the harms that individual Aboriginal injecting drug use may cause to the family, are largely unknown. One key informant suggested that more research is needed to document the harms and costs of injecting drug use.

One of the big gaps I think is actually documenting the harms to families and the costs to families. We have some idea, we know it's a problem, but how much of a problem? And then what supports can we put in place for those families and the people that are bearing the brunt?

In particular, key informants suggested that the economic cost of injecting drug use for Aboriginal communities needs to be documented and analysed. According to one key informant, a better understanding of the economic cost of injecting drug use on the family and the individual, who may turn to crime to support the habit, is needed so that services can be designed to address and support families.

People who do drugs of this nature, and can't afford them, find the money somewhere and they'll either go and steal it from someone else that they don't know, but more often than not they're stealing it from people they know. So we need to know that sort of impact on families as well. What is the absolute immediate economic cost of providing a drug user's habit, and how are they getting it?

Key informants also spoke of the importance of data collection on injecting drug use in prison populations. One key informant noted a lack of qualitative data on the learned behaviour of injecting in prison and the implications this learned behaviour may have once prisoners are released. Injecting practices that involve quick administration to avoid being caught by prison officers were highlighted as an example of learnt behaviour that, upon release, may be passed on to the broader community of people who inject drugs. Improvements to qualitative data, including documenting learned injecting behaviours, would improve the understanding of health risks experienced by Aboriginal prisoners.

4.1.6 Data usage

Research findings can be used in a really derogatory way, so what you find is that there can be some really punitive responses from that research.

Many key informants highlighted the collection of data and its subsequent use as a concern for Aboriginal communities. The reluctance of Aboriginal people who inject drugs to be involved in research was linked to apprehension over how collected data will be used. In particular, there are concerns over who owns it, access to the data, who controls it, how it is analysed, and the potential impact of data analysis on the community. The way in which the Aboriginal community might be portrayed in research was another key concern. Many key informants suggested that the continued negative publicity many Aboriginal communities face concerning illicit and injecting drug use has caused many Aboriginal people who inject drugs to be apprehensive about research.

There is always negative publicity about the Aboriginal community. To go and do research that has negative connotations is really, you know, hard for the community.

In order to alleviate these concerns, key informants suggested that Aboriginal people who inject drugs and who participate in research must be ensured anonymity during the research, as well as being provided with research outcomes that Aboriginal people who inject drugs understand and can translate into positive reasons for participating in the research.

4.2 Opportunities available to improve quality and access

This section discusses service responses to Aboriginal people who inject drugs. Key informants highlighted a number of issues and challenges inherent in delivering services as well as offering suggestions for improvements to current service response. These issues fall into four distinct categories: workforce capacity; access to services; Aboriginal input into service planning and evaluation; and police. These issues are discussed below.

4.2.1 Workforce capacity

Key informants highlighted workforce-related issues as a major barrier in providing appropriate services to Aboriginal people who inject drugs. The two main issues highlighted were: staff training and education, and variance in training levels; and staff retention within both Aboriginal health services and mainstream health services.

Key informants stressed the need for staff working in both Aboriginal health services and mainstream services to be better equipped to deal with the specific needs of Aboriginal people who inject drugs. While some staff have the requisite knowledge and skills, further improvements need to be made in the area of injecting drug use and associated harms, as well as general harm reduction principles. Further, some key informants suggested that staff knowledge of the processes and referral pathways into treatment also needs further development.

Identified training needs included: the importance of client confidentiality; exploring the issue of stigma and discrimination associated with injecting drug use; and the benefits of harm reduction and services such as those provided by NSPs.

Some key informants recommended that Aboriginal-specific drug and alcohol training be provided for staff working in both mainstream and Aboriginal health services through a nationally accredited course which would provide staff with a recognised qualification. This formal qualification would ultimately increase the capacity of services to respond to drug and alcohol issues in Aboriginal communities.

Key informants also discussed the need for staff working in mainstream services, and who work directly with Aboriginal people who inject drugs, to undergo cultural sensitivity training before working with Aboriginal clients. Further, some key informants suggested that all non-Aboriginal staff, in either mainstream or Aboriginal health services, must complete cultural sensitivity training prior to visiting any Aboriginal community.

Staff retention was also highlighted as a problem within both Aboriginal health services and the mainstream health sector. Retention of qualified health workers is particularly important in the Aboriginal health service sector as familiarity and trust of staff members are crucial when building relationships with Elders and key community members within Aboriginal communities. When staff turnover is high in an organisation, these trust relationships are often lost and take time to rebuild. Further, because of the sensitive nature of the topic, some key informants urged the need for consistency in the approach of staff where issues of illicit and injecting drug use are discussed with Aboriginal communities.

The constant change in staff at a mainstream service was identified as affecting the service's capacity to provide culturally appropriate care to Aboriginal clients. Mainstream services often lack the capacity to provide continuous cultural sensitivity training. Subsequently, when staff turnover in the organisation is high, organisational knowledge can be lost.

The role of Aboriginal health workers in mainstream services is of particular importance. These positions have the capacity to focus on the specific needs of Aboriginal clients and facilitate relationships and interaction between other health workers who may have contact with these clients. Retention of these staff is problematic, as there are often unmet training needs as well as insufficient funded positions to meet demand and little support or understanding for the role. As a consequence, levels of job satisfaction are low and turnover is high. Aboriginal health workers in mainstream services are often not supported culturally by their organisation. The cultural norms within Aboriginal communities, to which people in these positions are expected to adhere, may not be recognised by mainstream workplaces and, consequently, this may have an adverse effect on attraction of staff and their retention in these positions.

4.2.2 Aboriginal input into service planning and evaluation

Key informants proposed that Aboriginal input into service planning and evaluation, particularly from Elders and key community shareholders, is integral to ensuring service responses are culturally appropriate. Community engagement in all aspects of service design and delivery would ensure that more successful responses are likely to be developed.

4.2.3 Improving access

Key informants identified access as a key issue of concern during the consultations. Access to diverse and culturally appropriate services was seen by many as the most important component needed in service response, in order to ensure the needs of Aboriginal people who inject drugs are met in

both mainstream and Aboriginal health services. A number of related issues that key informants identified include: general access to services; access to injecting equipment; and service choice, including diversity of services available. These issues are discussed below.

Key informants highlighted the lack of access to appropriate services as a key gap in service response to Aboriginal people who inject drugs. Of particular concern was the lack of access to sterile injecting equipment and related health services to Aboriginal people who inject drugs living in rural and regional areas of Australia. The difficulty in accessing harm reduction and drug treatment services in terms of geographical location and clinic opening hours was seen as a major gap in service response. Further, certain jurisdictions place limits on the number of NSPs allowed to operate in particular areas, which can in turn reduce the availability and access to harm reduction services for Aboriginal people who inject drugs. The absence of syringe vending machines in particular jurisdictions was also highlighted as an issue of concern.

The lack of available and appropriate services for Aboriginal people who inject drugs is not only an issue confined to rural and regional parts of Australia. Many key informants highlighted access as a key gap in service response in capital cities across Australia. Major issues of concern include: lack of after-hours access to NSPs; lack of Aboriginal-specific rehabilitation and detoxification centres; and lack of access to sterile injecting equipment in some Aboriginal health services. However, where there is lack of access, referral to other agencies was reported.

Port Hedland, Western Australia

Port Hedland is an isolated, remote mining town situated in the north-west of Western Australia, 1800 km north of Perth. Port Hedland is a transient town, used by many of the fly-in, fly-out workers as a base. Its population can range from 15 000 to 20 000 and is made up of a wide multicultural mix, including approximately 15 per cent Aboriginal Australians.

The Hedland Well Women's Centre

The Hedland Well Women's Centre is a mainstream community-based women's health service situated in Port Hedland. Opened in 1990, the Centre aims to enhance the health and wellbeing of women in the Port Hedland area. This unique service provides support and assistance to women in all aspects of their lives. The Centre offers a large selection of free services including: information, referral and advocacy in all areas of women's health; counselling; support groups; women's health promotion; home away from home; educational courses; and a successful needle and syringe program.

Needle and syringe program

The Hedland Well Women's Centre has actively operated an NSP since 2000. An enhanced secondary NSP, the service is run through grants from the Western Australia

Health Department. A total of 1406 clients visited the NSP between 2008 and 2009, with 15 530 syringes distributed during this period. Aboriginal clients represent 53 per cent of the NSP client profile. Male injecting drug users are the majority of clients, with 30 per cent Aboriginal males and 39 per cent non-Aboriginal males.

Men are always welcome at the Hedland Well Women's Centre. At times when it is difficult to protect the confidential nature of a visit, i.e. during women's gatherings and meeting times, the Centre informs male clients through its *Fit News* newsletter and on the day through signage and verbal communication. This ensures the best outcome for all clients, with the NSP becoming part of a holistic women's health service. Although the Hedland Well Women's Centre's core business is women's health, the NSP has been incorporated into the Centre with no disruption to other services and no conflict between clients. The NSP has proven to be so successful that many of the female and some male partner NSP clients now use other services at the Centre.

The Hedland Well Women's Centre is a demonstrated model of service delivery that successfully engages with male and female Aboriginal people who inject drugs. Through incorporating an NSP into a community-based mainstream women's health service, the Centre provides a successful model that could be adapted to, or incorporated into, other services.

Some key informants also raised access to safe injecting facilities in urban areas. Access to this type of facility would benefit Aboriginal people who inject drugs through providing access to trained medical staff and counsellors, medical facilities on location that reduce the possibility of death resulting

from overdose, access to appropriate health promotion and safe injecting education, and access to sterile injecting equipment. There is currently one supervised injecting facility operating within Australia. Some key informants proposed that this number should increase to include safe injecting facilities

in other states. One key informant said that, in an area known for high rates of Aboriginal injecting drug use, a safe injecting facility would benefit not only Aboriginal people who inject drugs but also the local community.

I think there needs to be a safer injecting centre there, not right there, maybe up the road a bit. I think there are people in the community that also think that.

Key informants also highlighted the poor uptake of drug treatment services, including opioid maintenance treatment, by Aboriginal people who inject drugs. Aboriginal people who inject drugs have less treatment episodes compared to non-Aboriginal people who inject drugs and are less likely to have been on opioid maintenance treatment programs. Lack of access to opioid maintenance treatment, particularly in regional, rural and remote areas, could reduce the number of Aboriginal people who inject drugs accessing treatment. The strong Aboriginal community support for abstinence was also suggested as a possible contributing factor for poor uptake of opioid maintenance treatment, with key informants stating that some community members believe it condones drug use. Although ready access to opioid maintenance treatment programs does not assume condoning drug use, services are prevented from being delivered in all instances.

There is part of a prevailing, I guess, understanding in the Indigenous community that abstinence is the only way and that harm reduction ... is saying it's OK. So their view around methadone and bupe is that you are just maintaining a drug habit ... I think the other thing is access to services. So those who aren't in city areas, you know, their access to services is quite limited, particularly some of those really remote communities.

Other themes highlighted by key informants included the need for some Aboriginal health services to be more 'injector friendly and drug familiar'. Many felt that Aboriginal health services are not closely enough involved in the delivery of services to Aboriginal people who inject drugs, particularly in their capacity to provide sterile injecting equipment, hepatitis treatment and pharmacotherapy. Other key informants believed that Aboriginal health services need to provide more education about safe injecting and prevention of blood-borne viruses.

If Aboriginal health services were to increase specific health and education services to Aboriginal people who inject drugs, the potential for improvements to access and choice for Aboriginal people who inject drugs would be achieved. However, limited funding, the range of services provided, the ability to obtain prescribing doctors and the cost of providing pharmacotherapy services, including the medication cost, may affect an Aboriginal health service's ability to provide these services.

Alternatively, some key informants held the view that some Aboriginal people who inject drugs preferred to access equipment from mainstream services due to confidentiality issues.

When people didn't have a problem, they wanted to sort of keep their use under wraps, they would go to non-Indigenous services, but once they had a problem, once they thought that their drug use was a problem, that's when they wanted an Indigenous service. They didn't want to go to a mainstream service then.

While both Aboriginal health services and mainstream services have developed policies and procedures around client confidentiality, as well as a code of conduct with which staff must comply, confidentiality was still highlighted by many key informants as a

potential barrier for Aboriginal people who inject drugs to access services. That is, because of the nature of Aboriginal communities and families, clients were likely to be known to the personnel of Aboriginal health services, particularly in smaller settings. This local familiarity may prevent Aboriginal people who inject drugs from accessing services because they are concerned that they will be identified.

Concern around stigma and anonymity may lead Aboriginal people who inject drugs to seek alternative means to obtain sterile injecting equipment. Key informants noted that some Aboriginal people who inject drugs will access equipment through the National Diabetes Service Scheme or through family members who are diabetic patients. Aboriginal people who inject drugs will sometimes obtain equipment from pharmacies or pharmacy NSPs on the pretext that they have diabetes. This means that this subgroup of Aboriginal people who inject drugs may miss out on vital health promotion and safe injecting education. In order to improve access to health messages, one key informant suggested eliciting the support of Diabetes Australia to provide safer injecting messages. It was acknowledged that this would be challenging and that other means may need to be employed including using peer networks to ensure health messages are reaching this subpopulation.

It would be a big step getting Diabetes Australia on board with safer injecting messages because it's not really their gig in a sense, but there might be some other ways, specially through peer work, that information can be shared.

In essence, the issues highlighted all go towards identifying diversity of service response as integral to ensuring that the needs of Aboriginal people who inject drugs are met.

Many key informants suggested a range of service delivery models is needed to increase access for Aboriginal people who inject drugs. These include: primary sites; secondary sites; mobile outreach; syringe vending machines; hospitals; pharmacies; and Aboriginal health services.

I don't think one shoe is going to fit all. You have got to have choices for people. Some people will choose Aboriginal services, some people won't choose Aboriginal services, and if they choose not to use the Aboriginal services, then we need to make sure that the other services are meeting their needs in an appropriate way, and things like that.

4.2.4 Police

Some key informants expressed concern over the reluctance of Aboriginal people who inject drugs to carry used equipment until it can be disposed of safely because of concerns that used equipment may be used by police officers as a basis for further searching.

Aboriginal people [are also] more likely to get struck by police and if they're carrying injecting equipment, then that can be used [against them]. So then they have more incentive to want to dump equipment.

Key informants discussed the importance of the police force and police officers maintaining an understanding of the issues relating to injecting drug use and harm reduction. Increased training for police officers on the principles of harm reduction, including the importance of NSP services, was considered to be critical to ensuring police awareness and understanding of harm reduction principles. This would be relevant to all people who inject drugs and not just those from Aboriginal communities.

4.3 Improving service models

Within the current service delivery system there is debate about what the ideal model of service delivery should be for Aboriginal people who inject drugs. Key informants had competing ideas on what constitutes an appropriate method of service delivery. Many key informants believed there is no ideal approach or model, and nor should there be. Rather, current service models are more than capable of addressing the needs of Aboriginal people who inject drugs. Conversely, some key informants believed Aboriginal health services are best placed to provide a holistic model of service delivery that will meet the needs of Aboriginal people who inject drugs. These competing perspectives are discussed below. This section will also suggest a model of service delivery that is best equipped to deal with the needs of Aboriginal people who inject drugs.

4.3.1 Service models

Currently a variety of service approaches exists to respond to the needs of Aboriginal people who inject drugs. These fit roughly into two categories: those that exist within Aboriginal health services; and those that exist within mainstream health services. Within each of these models is a variety of approaches to service delivery, some of which overlap. While Aboriginal health services predominantly address health in a holistic way, mainstream services tend towards delivering more specialised services focusing only on the drug use of the individual.

Aboriginal community-controlled health services are the only services that provide a holistic approach to health issues. [They are] not just addressing injecting drug use but it's also social and emotional well-being issues that go hand in hand with this. You can't isolate one and not deal with the other.

Key informants discussed a variety of service models designed to respond to the needs of Aboriginal people who inject drugs. Many models, within both Aboriginal health services and mainstream services, often place clients in silos. This was reinforced by the view that current service models rarely offer a smooth and supported transition between harm reduction and treatment-based services. Key informants suggested that services should be designed to be flexible and should be able to cope with the diversity of needs that clients bring to the service. In essence, a more seamless approach to service delivery is required. Achieving this is likely to require significant changes to current models and will also require different funding mechanisms to be put in place.

Many key informants believed that Aboriginal health services are best placed to offer the support needed by family members and communities. Further, many suggested that the family and the community must be considered alongside the spiritual and healing needs of the Aboriginal people who inject drugs and cannot be considered in isolation. Some key informants criticised mainstream health services for inadequately addressing the broader needs of Aboriginal people who inject drugs, including family and spiritual needs. This is clearly stated by the following key informant who believed the broader social determinants of Aboriginal health must be considered when delivering services to Aboriginal people who inject drugs.

It's having a look at the whole person and surroundings. It's not just the one issue that the person is dealing with — mainstream services do not understand this. There are overlapping issues that need to be dealt with, i.e. housing, unemployment, children, prison, injecting drug use. It's just one of a number of competing issues.

However, Aboriginal health services often have competing service priorities and therefore injecting drug use is not seen as a priority compared to more important health issues, e.g. chronic diseases such as heart disease and diabetes. Aboriginal community-controlled health services, like other non-government organisations, are guided by policy priorities and funding availability largely dictated by government bodies. In order to continue delivering a viable service, organisations will therefore prioritise based on available funding which can restrict the type of programs they can deliver. The COAG agenda (see section 2.3) is one example where the focus for funding is primarily aimed at chronic disease and does not prioritise harm reduction programs.

[In Aboriginal health services] it's difficult to get any kind of attention or coverage for this particular issue [injecting drug use] when there's somebody who has lost their legs from diabetes and Uncle Fred's had a heart attack and he is probably not likely to live another week or two and the whole family is all upset, and the health worker is trying to deal with that. There are so many competing issues that a virus that could potentially become deadly in five or ten or twenty years time is not necessarily the immediate thing that they want to deal with.

One key informant suggested that providing Aboriginal health services with incentives to engage with Aboriginal people who inject drugs may be one way of getting injecting drug use on the agenda of Aboriginal health services. This would, however, require a national review of existing funding arrangements and health priorities within Aboriginal health services.

In terms of engaging or having better relationships with local communities with people who inject drugs, there might be some way of incentivising them to do that.

Many key informants felt that there was limited diversity in mainstream service delivery models, suggesting that the one approach is often repeated across the state with little contemplation of the local factors that may impinge on the appropriateness of this model. Given this generic approach to service delivery, mainstream services need to become expert at linking up with the various other components of the service and support sectors such as housing, income support, and employment placement. In the absence of service diversification, there needs to be a broadening of service provider connections to enable clients to access those services offered by external organisations, but which may not be readily accessible by clients.

Key informants spoke of the importance of the types of messages that are given to people who inject drugs and who access services, whether they are Aboriginal health services or mainstream health services. It was seen as particularly important to provide clients with alternatives to the abstinence-based model.

[When] we talk about abstinence in sex or in drugs, we talk about abstinence, that's the highest thing. The reality is that people aren't going to do that. So if we continue to beat that drum ... we're missing a whole group of people that aren't going to listen to that, so what the discussions now in this ... what is achievable and what's real for those people on the street? So for people who inject drugs, what does that mean? Is it that we talk more around, and we already do the stuff around, how to inject properly? If you don't want to inject, you're smoking or doing whatever, but is that a reality? ...

it's about trying to really be real about the message we're now giving. I mean you always aim for the top. What we're finding is that message is getting lost, because if that's your message, then people aren't going to be listening to it, so with harm reduction what really is going to get through, what's real?

Other key informants, however, spoke of the importance of not seeing harm reduction and abstinence as mutually exclusive. Services can and do place abstinence in a hierarchy of harm reduction, which would include information on other accepted ways to reduce the harms associated with injecting drug use.

I believe people get mixed up sometimes and sometimes deliberately ... around what actually is harm reduction for different areas of drug use. Harm reduction isn't in competition with abstinence at all, and that's another big thing. Abstinence is a form of harm reduction, it's the ultimate form of harm reduction. You can't have any harm if you don't use anything.

Some key informants identified the importance of including peers and peer educators in service models, in both Aboriginal health services and mainstream services. Many suggested that peer education is a powerful tool for providing information, particularly as there is inadequate infrastructure within mainstream services to ensure that culturally appropriate support is provided to Aboriginal people who inject drugs. However, it could be difficult to actually recruit Aboriginal peers, as they may not want to be publicly identified. As with peer-based research, improvements could be made around the use of peers; in particular, ensuring peer educators receive adequate training for their role and have access to up-to-date information.

Although Aboriginal health services and mainstream health services usually exist interdependently of one another, there is often some form of partnership between services in their responses, and delivery of service, to Aboriginal people who inject drugs.

Many key informants suggested that mainstream services are in a good position to offer support to Aboriginal health services wishing to implement harm reduction services, such as NSP and pharmacotherapy. This included the recommendation that mainstream services offer support to develop their capacity to deal with other needs that may arise, including hepatitis A and B vaccinations and hepatitis C treatment and counselling. However, in most jurisdictions, these mainstream health services are secondary NSPs; as such, they are not necessarily funded to provide NSP services. Therefore, the likelihood of such mainstream services providing support to Aboriginal health services in the absence of funding and dedicated personnel is improbable.

Notwithstanding existing partnerships, key informants generally considered that there could be better collaboration between Aboriginal health services and mainstream services. Many key informants believed that collaboration or partnership between the two sectors would improve both services' ability and capacity to respond to the needs of Aboriginal people who inject drugs. One key informant suggested this service method be thought of as: 'a collaboration between two services, meeting halfway or meeting at a central point'.

Partnership model between Gippsland Lakes Community Health and Lakes Entrance Aboriginal Health Association

In January 2005, a community meeting was held between Gippsland Lakes Community Health (GLCH) and local Aboriginal community members. There was concern within the community regarding access to health services provided by GLCH. Historically, the Aboriginal community had missed out on funding for health and community support services, and members of the community had become more isolated over the years.

From this meeting, agreement was reached committing GLCH to supporting and resourcing a range of initiatives including the establishment of the Lakes Entrance Koori Elders Group, now the Lakes Entrance Aboriginal Health Association (LEAHA). This was supported by the GLCH Board and Executive team. The GLCH recognised that whilst there was a solid history of working with the Lakes Entrance Aboriginal community, there was an urgent need to improve this relationship in order to see an improvement in the health and wellbeing of the community. And so, a formal partnership agreement was entered into by both organisations.

The original priorities for the partnership to address were:

- establishment of a resource centre within the GLCH–Lakes Entrance site
- commitment to reconciliation from the Board of GLCH
- increased access to medical services
- establishing a range of community events and activities.

Four key processes have been used over the last five years to build the partnership model and achieve the original outcomes: increasing employment of Aboriginal workers at GLCH; increasing the number of reconciliation events and celebrations; increasing the range of Aboriginal health programs delivered by GLCH or other agencies in Lakes Entrance; and resourcing and supporting the role of LEAHA.

Outcomes have included:

- increased level of access to GLCH services by Koori clients
- opening of the Koori Community Centre (2007)
- increased funding for Koori health services such as Healthy for Life/Aboriginal Chronic Care and Health Promotion and Yoowinna Wurnalung Healing Service
- emerging signs of greater harmony within the community
- moves towards local reconciliation.

The Board of LEAHA has met continually since 2005 and became incorporated in late 2007. The organisation has a Board of Management consisting of nine local Elders and a general membership of over 50. LEAHA and GLCH have signed a Partnership Agreement outlining their ongoing commitment to the model through shared resourcing and governance. Both parties see this partnership as a practical and effective framework for strengthening reconciliation in the Lakes Entrance community. The integration of service delivery, community space and governance provides the model with a sustainable base.

In 2009, LEAHA and GLCH won the Victorian Public Health Care Secretary's Award for improving the health and wellbeing of Aboriginal people in Victoria.

4.3.2 A suggested model of service delivery

[What] we haven't really engaged very much in Australian research and in policy and practice is understanding the historical trauma and its impact on current communities, current generations. And you know, I think there has been a little bit of lip service paid to it but there are examples ..., little pockets of examples, I think in New Zealand and Canada, where it has been a focus of ... service delivery, policy making and of research. I think that's the next frontier for work in Australia ... to acknowledge it in a mature and sensible way. After the hysteria of the apology, to actually say now how can we respectfully address that so it doesn't re-traumatise the people still living with the effects of trauma but addresses it. And again it's not just it, it's huge, but addresses that in ways that can make progress, that just don't keep churning around in the same old trauma.

The 1989 National Aboriginal Health Strategy defined Aboriginal health not just as the 'physical well-being of an individual but ... the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life' (National Aboriginal Community Controlled Health Organisation, 2008).

Aboriginal health and wellbeing require consideration of the broader factors in a person's life – over and above their physical health. The absence of a disease is not considered a 'good health status'. Rather, there

are larger issues at hand, such as community acceptance and family functionality, which contribute to the health of an individual, and indeed his or her community.

A model of service delivery within the harm reduction and drug treatment service sector that acknowledges the Aboriginal definition of health and subsequently offers services that address the multifaceted needs of Aboriginal people is integral to ensuring that the health needs of Aboriginal Australians are met. A number of key informants have suggested that what is required is a model of service delivery that works across three different social dimensions: the individual; the family; and the community. This model of service delivery is believed to be best suited to address the health needs of Aboriginal Australians by taking into account the social, cultural and emotional wellbeing of Aboriginal clients while also recognising the competing influences and potential support roles the family and community can play. Planning and delivering services to Aboriginal clients separate from the family and community ignore the broader impacts these groups play in the health of Aboriginal people.

In this instance, some key informants were critical of mainstream health services, arguing they fail to take into account the family and the community when planning and delivering health services to Aboriginal people who inject drugs. Mainstream services tend to focus on the individual, providing treatment to a person for a problem. However, there is an increasing shift in mainstream health services towards a more holistic approach to health care that involves the family and the broader community in general service delivery. This shift towards a more holistic approach to health care, although not a new concept, is increasingly being seen as a valid approach towards health services design and delivery.

4.3.2.1 Families

Families are the best people to help people get over, to deal with, any issue.

Families, and the role families play during drug treatment, were key themes mentioned throughout the key informant consultations. Families have the potential to play a crucial role in the success of an individual's experience in drug treatment, particularly when family members reinforce positive health behaviours. Many key informants believed the family context must be considered in the design of all harm-reduction and drug-treatment models regardless of whether they are run by mainstream or Aboriginal health services. In order to translate this potential to actual capacity and capability, service models need to include a range of strategies that work towards building skills and knowledge within the family unit.

However, while many suggested that families had a key role to play in treatment and recovery, many families also play a role in an individual's drug use. Some key informants highlighted that exposure to injecting drug use within the family network can lead to initiation into injecting drug use.

Most of them have started using because family members were using.

Many key informants spoke of the need to break the cycle of injecting drug use in some Aboriginal families. If services fail to take into account the impact injecting drug use has on families and provide services that fail to address these broader harms, the cycle of drug use will likely continue.

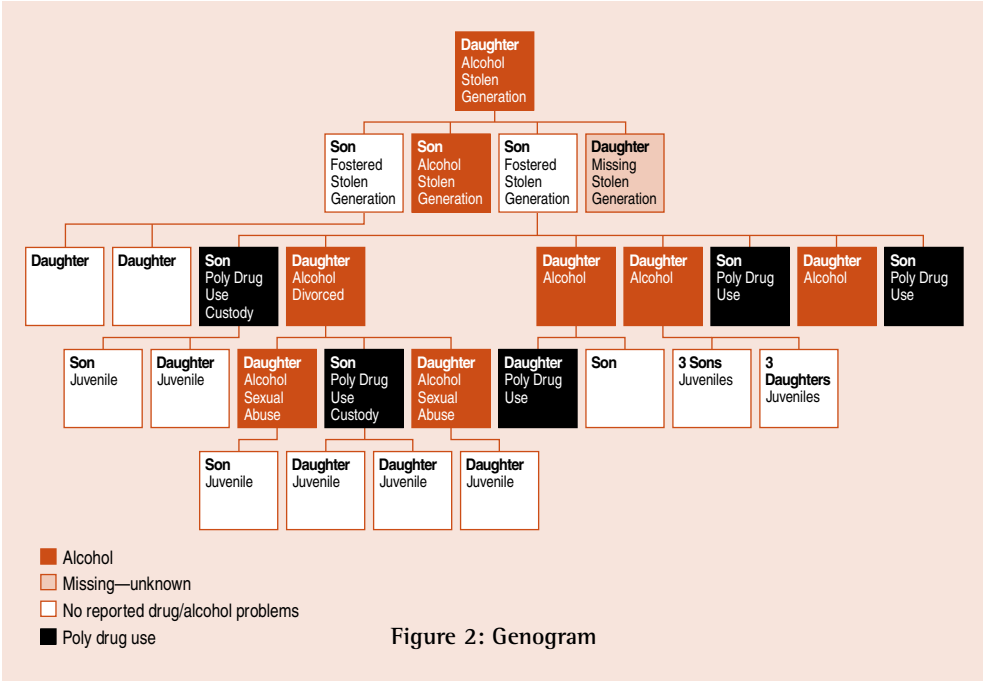
If you dealt with the family as the unit, rather than the individual, because let's face it, it's usually the closest people to you that are unfortunately the ones who end up with the biggest harm, really. And then, they become isolated as well. I think

that if you don't do something with that unit, then I can tell you exactly where the next user's going to come from, and it more than likely will be other siblings, or other relatives within that family unit. I was just thinking of my nephew; I know of over 29 people that he initiated [into injecting].

For those individuals who find themselves in social networks that subscribe to health-damaging behaviours, the capacity to successfully enter, and complete, treatment is significantly more challenging. This is demonstrated in the genogram outlined in Figure 2.

The potential for those families with a history of intergenerational drug use to offer an environment where positive health behaviours are reinforced may be limited. Similarly, their ability to provide support and assistance in an individual's drug treatment is reduced. Intergenerational drug use in a family and the subsequent need for additional support must be considered when delivering services to Aboriginal people who inject drugs. This is particularly the case when designing and delivering detoxification and drug-treatment services where health-damaging behaviour can prevent successful treatment.

Key informants also stressed that those people who are initiated into injecting by family members may miss out on important health messages. There was a concern that information about safe injecting practices and the risk of blood-borne virus transmission may not be passed on. Further, when information is passed on, it may not always be accurate. The lack of accurate information and education on injecting and associated health messages can lead to a range of health issues including blood-borne virus transmission and injecting-related injury and disease.



When people start using too, they start using how the person who shows them uses, and that sticks with them the whole time they're using.

Many key informants said that there is a continuum of issues that must be considered when working with Aboriginal people who inject drugs. The consideration of social inclusion and the broader social and structural factors that affect individuals and their families was seen as particularly important when considering harm reduction and drug-treatment programs for Aboriginal people who inject drugs.

Programs that might be relevant in that broader view are programs assisting vulnerable families, so you have child family support programs that are going to be important for outcomes 10, 15, 20 years down the track.

Some key informants stated that family and extended family bonds, including certain commitments that individuals have to families, must be considered when designing and delivering harm reduction and drug-treatment services. One key informant provided an example where an Aboriginal person on opioid maintenance treatment may be required to travel some distance for a family funeral. In this circumstance, in order to continue his treatment, takeaway doses, script renewals and dosing locations would all need to be considered. However, there is often little room for compromise from the regulatory body on opioid maintenance treatment, which may subsequently lead to a break in treatment.

Many key informants were critical of mainstream service providers and funding agencies for their apparent lack of understanding and consideration of the importance of Aboriginal families in the design and implementation of

harm reduction and drug treatment services for Aboriginal people who inject drugs. One key informant suggested that mainstream health services fail to understand the broader social determinants of Aboriginal health and the impact these social and structural influences have on the health and wellbeing of Aboriginal Australians. The informant stated that mainstream health services need:

to get an understanding of that disassociation from culture, that caused a lot of grief. This is beyond how mainstream normally works – they look at the individual rather than the bigger picture stuff. [There is a] need to focus more on the family and community.

Many key informants believed that mainstream services needed to develop mechanisms to better support and involve families and communities so that Aboriginal people who inject drugs were in turn supported. As discussed in section 3.3.2, mainstream health services are shifting towards a more holistic approach to health care that involves the family and the broader community. The adoption of this holistic model when providing services for Aboriginal people who inject drugs is considered to be central to ensuring that the needs of Aboriginal people who inject drugs are met. Families should be included and given information on drug use and what the processes of treatment are going to involve. There is a need to educate families on what addiction actually means and that there can be mental health issues that may also need assessment and treatment.

The importance of harm reduction and drug treatment services that take into account the needs of Aboriginal people who inject drugs who also have children was highlighted by key informants as integral to ensuring service engagement with Aboriginal clients.

As stated by one key informant, people who inject drugs rarely want to put their children into an environment where they may be at risk. However, they often lack the capacity to ensure their children are safe all of the time.

They want the best for their kids as well. They may not always be able to do that, and they need the support to be able to do that.

In essence, there needs to be increased access and support for Aboriginal people who inject drugs to seek harm reduction and drug treatment services. In particular, these services need to take into account the broader family needs of Aboriginal people who inject drugs, and need to have the capacity to accommodate children.

Sam's story*

Sam first started using heroin after her newborn baby was placed into state care after an amphetamine rage incident involving her then partner. Sam spent the next 15 years using heroin, offered to her by a friend as a painkiller, and cycling in and out of prison. During her most recent appearance in court, Sam's judge took notice of her past and the trauma she experienced through losing her child. The judge recognised the link between the trauma Sam had experienced and her substance misuse and noted the need for Sam to undergo counselling to deal with her underlying trauma. The judge opted to suspend Sam's sentence and recommended that Sam and her family attend counselling. The police appealed the judge's decision and won. Sam was sentenced to seven years' imprisonment.

* Name has been changed to ensure anonymity.

4.3.2.2 Community

In the design of a model of service delivery that aims to address the health needs of Aboriginal people who inject drugs, it is important to consider the impact that the broader Aboriginal community has on the health and wellbeing of an individual. The behaviour and possible impact the Aboriginal community can have on individual Aboriginal people who inject drugs are affected by broader social and structural factors. As one key informant noted, harm reduction and drug treatment services for Aboriginal people who inject drugs must take into account:

the bigger picture – the social and structural determinacy, the poverty, the dispossession – you cannot ignore everything else that is going on around the individual's drug use.

The social determinants of Aboriginal health (see section 2.2) have been shown to directly impact the lives of Aboriginal Australians at an individual and at a community level. The lasting effects of colonialism, poverty, dispossession from country, and institutionalised racism are most evident at a community level, which has led to the differential in all major socioeconomic and health indicators compared to non-Aboriginal Australians. Therefore, service planning must take into account development needs, such as housing and education of the community in which Aboriginal people who inject drugs reside, and their subsequent impact on the achievement of positive individual health outcomes.

Key informants highlighted the importance of community engagement and input into service design and provision (see section 4.2.2). One key informant spoke of a mainstream

health service that had failed to acknowledge the concerns the local Aboriginal community had over the running and location of the service.

I think it's something that the community have brought up for years and years. And so the service just doesn't listen to them. You know it's [i.e. the community is] not being heard.

The apparent lack of community engagement during the initial design and subsequent delivery of this particular health service meant that any apprehension the Aboriginal community had about the location and running of the service may not have been considered. The key informant suggested that, through better community engagement, particularly in the planning stage, many of the community's concerns could have been addressed immediately, prior to the service opening. However, community engagement should not be limited only to service design and planning, but should also be continuously considered and included once the service is operational.

Key informants also spoke of the importance of education for Aboriginal communities on the benefits of harm reduction as a method of service delivery. They suggested that importance be placed on information and education concerning the benefits of opioid maintenance treatment as a method of drug treatment rather than reliance on an abstinence-based model. Again, abstinence can be placed within a hierarchy of messages about harm reduction.

I think the biggest thing would be around how we educate the Aboriginal community, and in particular the Elders, around abstinence not being the only option and things like the OTP [opioid treatment programs] is the best form of treatment available. The evidence is there – how you get that information through and get that accepted is the big deal, I think.

Some key informants raised the role that Aboriginal community gatekeepers play and the subsequent barriers they may put up when harm reduction organisations or researchers are attempting to engage with a particular Aboriginal community. When gatekeepers are negative towards injecting drug use and subsequent harm reduction approaches, gaining entry into the community can be challenging. One key informant suggested that, in negotiations with community gatekeepers concerning the benefits of harm reduction and drug treatment services, the importance of harm reduction approaches must be highlighted in terms of benefits to future generations.

So that, I guess, is a reframing of issues. Some advice given to me recently was to frame the issue of drug users, how it affects Aboriginal people's futures, in terms of children. So, you know, we need to address parenting issues because it's an issue for the next generation of children who will become parents themselves and leaders of the community.

4.3.3 Culturally appropriate services

It was purportedly said by the manager or CEO of Nike ... that your brand is what people say about you when you are out of the room. So I think a culturally appropriate service is one that is deemed so by the people who use it when they're out of the service.

Many key informants raised the issue of providing culturally sensitive services. Throughout the consultations, it was apparent that there was no agreement on how a culturally appropriate service could be delivered or what it would look like. Rather, adding to the complexity, there was a variety of opinion in both service sectors. Key informants spoke of the importance of mainstream services displaying Aboriginal art in the foyer, having an Aboriginal name for the service and employing Aboriginal staff. Also highlighted was the importance of Aboriginal health services providing cultural sensitivity training to non-Aboriginal staff within their services.

There was some discussion about whether the principles of harm reduction, and therefore programs like NSP, are compatible with Aboriginal culture. There was a strong view that this was not necessarily the case. As one key informant suggested, when talking about NSPs:

The perception often is that it's not culturally acceptable, and I think that's a bit of a furphy. I mean saving lives is always culturally acceptable and particularly given the history of what's happen[ed] to Indigenous people in this country.

Nevertheless, a number of key themes emerge in relation to culturally appropriate services. These are discussed below.

4.3.3.1 Flexibility

Many key informants spoke of the need for services to be flexible in their delivery, to have opening times that were likely to coincide with community need, and in particular have flexible appointment times. These requirements were reported to be key features of a culturally sensitive service, whether provided by a mainstream or an Aboriginal health service. Key informants also noted the importance of health service staff having up-to-date referral information and knowledge of other harm reduction and drug treatment services in their jurisdiction.

Without really burdening people too much, as a worker you have got to know everything, but at least know your referral points, at least know how to connect people into other agencies. But [there] also needs to be more flexibility there too probably. I mean, you are looking at 9 to 5 services for people who aren't living 9 to 5 lives, so it's that kind of thing.

4.3.3.2 Collaboration – mainstream and Aboriginal health services

As expressed in section 3.3.1, key informants suggested that, in order to provide the best possible service response to Aboriginal people who inject drugs, both service sectors needed to engage with each other and, in turn, with Aboriginal people who inject drugs.

One key informant working within a mainstream health service spoke of working with Aboriginal health services in their jurisdiction to build rapport with staff and the broader

Aboriginal community. Staff regularly participate in events such as National Aboriginal and Islander Day Observance Committee week and have recently completed cultural competence training. The service is also working closely with one particular Aboriginal health service to have more Aboriginal-specific resources available at NSP outlets as well as displaying the Aboriginal flag.

The development of relationships and networks between mainstream and Aboriginal health services require continued commitment from staff at both services. However, this requires specific funding commitments aimed at supporting collaboration at a practical level. These informal relationships and networks between organisations often fail, even in larger services, and are not sustainable on their own. This could be due to the fact that there may be no designated staff member in each organisation whose role it is to ensure the collaboration is maintained over time, or because both organisations have differing policy and procedural requirements, e.g. Aboriginal community-controlled health services requiring approval by a board of management. One key informant suggested that collaboration between two services would be successful in the long term only if a common goal between the two service organisations was identified and agreed upon.

It's about making the effort to find the appropriate way to develop those relationships and continue those relationships and keep them strong and actually work on really finding out what's our common goal and how can we work there, I guess, on the common line – you have to really focus on it and keep reviewing it.

Although collaboration between Aboriginal health services and mainstream services was highlighted by many key informants as an important step in ensuring mainstream services provide a culturally safe environment for Aboriginal people who inject drugs, other key informants noted that mainstream services should not be considered as a substitute for Aboriginal health services. As one key informant noted:

Only Aboriginal organisations provide appropriate services ... mainstream services can provide culturally secure services ... they are not a substitute for community-controlled services ... You don't want to go back to the days when Aboriginal people felt discouraged from going to mainstream services, but we want to be sure that they're not provided as a substitute for Aboriginal services.

4.3.3.3 Policies and procedures

Key informants suggested that, in order for mainstream health services to provide adequate services for Aboriginal people who inject drugs, changes must occur at a policy level within the organisation. Engagement with the Aboriginal community, including linking up with Aboriginal organisations, was one of the important measures raised by key informants, which needed to be implemented at the organisational policy level. Through engagement with organisations like NACCHO, advice on forming committees and networks with Aboriginal health services could be obtained. Greater engagement between Aboriginal organisations and mainstream services would lead to improvements in mainstream organisations' structure and policy design, which would in turn lead

to mainstream services having increased capacity to provide a culturally safe place for Aboriginal people who inject drugs. As one key informant suggested:

[It's about] looking at all your systems and how they operate and getting advice on those, and some are no-brainers. You might have particular systems with particular intakes which aren't going to be... they are going to be disadvantageous for Indigenous access, so sorting them out and keeping them sorted out, not just sorting it out for a week and letting it drift back again.

Flexibility in relation to appointment times as well as missed appointments were noted as two important areas where mainstream organisations may need to revise their policies in relation to Aboriginal clients. Non-attendance at an appointment should be investigated before being counted as a non-attendance. There may be community reasons for this non-attendance, such as a death, the requirement to travel with family to the city, or other imperatives.

For whatever reason, more than likely the client won't get there till 5 or 10 past 9. So accept that, rather than what tends to happen, is you rock up, ask for your meeting, 'Oh sorry, you've missed your appointment at 9 o'clock, so we'll have to schedule you in for a fortnight's time,' or whatever. That client, more than likely, won't be coming back. So the mainstream services have to be a little bit more flexible. Not necessarily just let the mob off and that, but if they've got a legitimate reason.

Key informants spoke of the importance of hiring Aboriginal staff in mainstream services for improving engagement with Aboriginal people who inject drugs. Many indicated that this can lead to improved understanding of the cultural needs of Aboriginal clients as well as greater opportunities for collaboration between mainstream and Aboriginal health services. Key informants also highlighted the development of policies that secure recruitment and retention of Aboriginal staff as being central to ensuring adequate representation of Aboriginal staff within an organisation. As one key informant emphasised, once recruitment and retention of Aboriginal staff are part of organisational policy, the process of ensuring that staff are recruited and retained is an ongoing one:

What we did here, which I thought was very useful, we've gradually looked at recruitment and retention for, we have sort of broadened out a number of Aboriginal staff and it's an ongoing mission if you like.

Key informants discussed the value of cultural awareness training for mainstream health staff. Many suggested that, as part of organisational policy, cultural awareness training should be mandatory. One key informant spoke of the cultural awareness training he had recently completed. Designed and run by Aboriginal consultants, the training involved workshops and discussion on a range of issues. A major benefit of the training was the requirement that the whole organisation, of over 230 staff members including the chief executive officer, was required to participate. By including all staff members in cultural awareness training, and particularly including management, the organisation showed a whole-of-organisation commitment.

So it's actually turning on its head quite a bit of how your structure might work and having a commitment at the top, because until you get that commitment from the top ... the agency has to embrace change. It's a big step, you are going to have to change mentality, you have got to get your senior people on board.

An important way of signalling cultural appropriateness would be to have it written into the mission or vision statement of an organisation. That way, cultural appropriateness itself became part of the culture of service provision. However, in order for the inclusion of cultural appropriateness within a mission or vision statement to be effective, it needs to be used in conjunction with other policies and procedure that ensure a culturally sensitive and safe environment for Aboriginal clients.

Essentially, culturally appropriate service delivery was argued to be about leadership; that is, that the person in charge talks about Aboriginal people in an appropriate way and makes meeting their needs a priority for the people who work there. Cultural appropriateness was deemed to be a whole-of-organisation responsibility. However, this commitment must translate into action beyond motherhood statements.

So accept it's a big mission and work on it, but then also value it to the point that you're going to keep at it. So it's got to be in an agency's business plan, because if it's not in there, it's not going to happen, because that's how we all work. It's got to be number one when you're doing a funding submission; always have it at the forefront of your mind.

4.3.3.4 Confidentiality

Key informants highlighted the importance of ensuring confidentiality in both Aboriginal health services and mainstream services. A key component of providing a culturally appropriate service to Aboriginal people who inject drugs is ensuring client anonymity. As discussed in section 3.2.3, Aboriginal people who inject drugs are often concerned about accessing services because they fear being identified. This is often the case in Aboriginal health services, particularly in regional and rural areas, where clients accessing the service may be linked to health service personnel. This may lead to Aboriginal people who inject drugs being reluctant to access services for fear of being identified and the subsequent stigma they may experience as a result. Policies and procedures to guide practice in this area need to be developed and continuously monitored to ensure compliance.

4.3.3.5 Locally specific

Key informants spoke of the need for health services to be locally specific in their delivery of services to Aboriginal people who inject drugs. They considered it important for Aboriginal and mainstream health services to identify the types of clients who access their services and ensure these clients' needs are being met.

I think we actually have to say, who are our services for? And how do we meet everyone's needs? And how do we do that together?

Again, key informants highlighted consumer participation as an important component in culturally appropriate service delivery for people who inject drugs. The involvement of clients in the running of a service is an important way of engaging with clients and ensuring they continue to access the service. Informants also suggested that participation by clients, including Aboriginal people who

inject drugs, in the running of services and their involvement in service activities could lead to a greater understanding of the needs of clients and subsequently the delivery of culturally appropriate services. There are a number of services across Australia that have used consumer participation, including art groups and men's and women's groups, as a successful strategy with Aboriginal clients.

I think it is about consumer participation and services where people have a say. Where the users themselves become responsible for the notice board or the suggestions box and have a voice is what's important, not what's on the walls, that the staff overcome their stereotypes and their own discrimination to allow for a more inclusive service provision, and I think that's the way to go about it.

Key informants noted that both mainstream and Aboriginal health services needed to have better resources, including injecting information that is Aboriginal-specific. For mainstream services, simple measures could include offering culturally appropriate materials and information on blood-borne virus prevention and safe injecting, which use local terms, as an important part of providing services that are locally specific.

An understanding of traditional laws and customs as well as undertaking cultural awareness training were considered to be an essential component of successful service delivery to Aboriginal people who inject drugs. As one key informant noted:

You need to know what you can do and what you can't do because you are not going to be able to provide a service if you are not going to respect their culture and law ... because they are not going to want to listen to you, because you're not being respectful.

4.3.3.6 Non-judgmental service provision

But for me, I always say to people it's not about condoning behaviour, it's not about you even having to accept that behaviour. What you have to work out is how does this change your life? If that person walked through that door, you are paid to do a service regardless [of] who that person is. You have an obligation, because you are talking to another human being, you have an obligation to be respectful, you are being paid to do that, so get over it.

The importance of offering a non-judgmental service, where Aboriginal clients feel secure and assured of their anonymity, is a key component to providing a culturally sensitive service in both mainstream and Aboriginal health services. One mainstream key informant noted that the philosophy of service provision within her organisation is designed in such a way to ensure non-judgmental attitudes from staff members, which results in clients feeling comfortable to access their service. In turn, it is important that clients are aware of their rights and responsibilities when accessing a service.

For us, our service delivery should be no different to whoever presents, and everybody that presents should feel comfortable in presenting, that they are coming to a service where no opinions are being made about them.

The 'everyone is welcome' philosophy that some mainstream health services adopt appears to run counter to the suggested need to provide services that are culturally appropriate. It is important that this type of service delivery philosophy is grounded in evidence and that it does not lead to the indirect exclusion of any client group. Implementing procedures that document and

evaluate client access would ensure that no subgroup of people who inject drugs, including Aboriginal people who inject drugs, is disadvantaged by this approach.

Having staff in mainstream services who have had cultural awareness training would assist in non-judgmental service provision. There is also the benefit of workers themselves feeling better skilled to work with Aboriginal clients. However, as one Aboriginal key informant working in a mainstream organisation highlighted, individual staff behaviours have the capacity to undermine an organisation's philosophy regardless of what the organisation purports to offer, including a culturally safe and aware service.

Some of the slack stuff that comes out of their mouth is really inappropriate and I'm, like, I'm glad there are no Aboriginal clients in here at the moment because that would be just totally inappropriate. Then trying to address that issue is hard also, especially if you're the only one Aboriginal worker within an organisation.

Regardless of whether Aboriginal people who inject drugs access Aboriginal health services or mainstream health services, key informants spoke of the importance of providing confidential services in a non-judgmental safe environment.

All agencies should present as non-judgmental, respectful, inclusive, all of those things should be provided – but it is more than that ... the staff to actually uphold those things and to ensure that they're really happening, they're not just lip service.

4.4 Specific populations

This section discusses issues requiring consideration which are associated with specific populations found within the broader Aboriginal community.

4.4.1 Geographical location

There are specific issues for consideration associated with Aboriginal populations in urban, regional and remote locations. In urban and regional areas, there are more people who inject drugs and therefore higher demand for services, including treatment and support. There is also a higher prevalence of blood-borne viruses. Availability of illicit drugs is also greater in larger cities. While there may be better access in urban areas than in regional or remote areas, gaps still exist in service delivery and improvements in those services that are provided.

As previously discussed in section 3.2.3, access to services and equipment is an identified issue in remote areas. One key informant noted that he had worked in a remote community and had been prevented from handing out sterile injecting equipment because there was no appropriate disposal facility available.

In some instances, people travel long distances to do the right thing by themselves and their community. This means that there are those who do not travel, and as a result they were reported to be putting themselves at risk because of poor access to sterile injecting equipment.

Many key informants highlighted a lack of qualitative and quantitative data on injecting drug use among Aboriginal Australians in rural and remote areas, suggesting that much of the current knowledge is anecdotal.

In order to understand the extent of the problem and the subsequent risks, more localised research needs to be undertaken (see also section 4.1.3).

There is a large knowledge gap in relation to rural and remote communities. Further data collection and examination of the issues are warranted so that services can be better designed to meet the needs of these various communities.

4.4.2 Prisoners

The only way to do time is off your face.

Western Australia has the highest rate of incarceration of Aboriginal people in the world where 6 per cent of that state's Aboriginal population are in prison. Aboriginal people comprise 2.5 per cent of the Australian population, but approximately 24 per cent of the prison population (Australian Bureau of Statistics, 2007). Aboriginal people are over-represented in the prison population by a ratio of 10:1.

The whole prison situation is quite unbelievable in a sense with ... prison ... and the potential for infectious diseases within the prison system.

Some key informants were exasperated at the 'open state of denial' of authorities in relation to drug use in prisons, as everyone knows that it occurs, but prison authorities are either unable or unwilling to stop it. A broad appraisal of the prison setting would be worthwhile because of the increasing issues related to drug use and injecting drug use. This appraisal could include assessing the presence of injecting equipment that is actually in prisons as opposed to numbers being anecdotally reported.

There's such potential for spreading hepatitis C and mainly hepatitis C, hepatitis B too, in those settings and really I think corrections facilities need to have a much more open approach to harm minimisation and to facing the reality, rather than using this blind notion that it doesn't go on here.

Key informants noted that the process of injecting in prison brings with it particular risks. There is a higher prevalence of hepatitis C among Aboriginal prisoners than non-Aboriginal prisoners. Thirty-seven per cent of Aboriginal males are hepatitis C antibody positive compared to 31 per cent of non-Aboriginal males, and 72 per cent of Aboriginal females are hepatitis C antibody positive compared to 53 per cent of non-Aboriginal females (Butler & Papanastasiou, 2008). Prisoners are also likely to perform injections in a hurry, use unsterile equipment, and may not have access to quality peer education or harm reduction messages. Further, the risks are compounded for those who are initiated into injecting in prison due to the less than optimal environment and equipment.

I think the other thing we really underestimate is prisons ... and the impact that that has. A lot of these fellows are picking up drug use the first time in prison and then coming out.

If Aboriginal Australians have learned to inject in prison, they may share misinformation with their friends, which may lead to further poor injecting practices. This inaccurate sharing of information can also include misinformation on self-management of blood-borne viruses, as highlighted by one key informant:

I've had someone say, but everyone in prison told me, that if you eat healthy, then you get rid of hep C.

There is a need for prison health programs that include blood-borne virus education and strategies for prevention, which currently occur in some jurisdictions. One key informant suggested that Aboriginal females are particularly vulnerable to misinformation, and subsequently it is essential that they receive information on blood-borne viruses and sexual health education. Women often take messages they have learned in prison back to their communities on release and therefore it is essential that the information they receive is accurate. The capacity for interventions on blood-borne viruses and injecting drug use while incarcerated is seen as a valuable opportunity.

There are so many Aboriginal women incarcerated. There needs to be more information that they can then take back to their families, because usually when women are incarcerated, they are only in for short periods of time and they're going back into the community. So you can give them information and when they go out into the community, they can share that information.

Access to opioid maintenance treatment can be limited depending on where a prisoner is located. Where there is no availability of maintenance treatment, there is an increased risk that any people who inject drugs may resort to using unsafe practices such as those outlined above. Alternatively, one key informant responded:

Prisons can be seen as detox centres – prison is a place to clean up because there is less alcohol and less drugs.

Some people actually stop using drugs while in prison. As a service response, therapeutic centres should be established where people can be diverted away from prison, or alternatively, if that can't happen, treatment should be provided to people while in prison. In limited circumstances, some people can be

diverted into treatment and be required to comply with certain conditions to avoid gaol. These conditions may include abstinence and daily attendance at a drug treatment centre or counselling, or both.

It's a really good opportunity to treat, fix people's health and all the rest of it, so I mean that's how I see prisons. There should really be big therapeutic treatment centres where, first of all, yes divert people away from prison as much as you can. If people do go to prison, there should be much more of a treatment focus.

Adequately preparing Aboriginal prisoners for release is especially important. As sentences are often short, prisoners are not able to access longer-term programs aimed at prevention of relapse post-release. Without appropriate support and planning while in prison, there is also the potential for overdose immediately (up to 6 weeks) following release. As the majority of Aboriginal prisoners return to the community, prison may represent an ideal opportunity for extensive and comprehensive referral of Aboriginal people to appropriate services after release from prison.

We need to really look at the pathway through the criminal justice system for Aboriginal people and the follow-up afterwards. You know you have got your peak time of overdose six weeks after release, but your opiate users for example, you have got linking-in systems as well, so it's really working with those prison health and also the follow-up services as well around trying to promote NSPs and safer injecting. We know people continue to inject inside, we know that that's very unsafe ... I mean not just health, there's a whole welfare thing as well. We know that the first two weeks of release are a peak time for overdose for example, and also suicide as well.

The loss of Medicare entitlement was highlighted as one example where prisoners lose connection with health services while incarcerated. The loss of Medicare rights was seen as contributing to this disconnection.

The fact that you're on Medicare, then you're off it while you're in prison, then you kind of come back on it, it doesn't help from the individual's point of view; I don't think it helps from the service mix point of view.

One key informant highlighted Medicare eligibility for prisoners as an important step in reconnecting prisoners with the community. If prisoners were eligible for Medicare, then external organisations could enter prisons to provide education to prisoners and to conduct Aboriginal health checks which could be claimed through Medicare. Such suggestions have clear implications for how prison health care is funded and would require significant changes in policy.

Medicare could solve a lot of the problems and then, I suppose, in the course of the external groups coming in, that's where the education comes in and that connect with the community.

The juvenile justice system presents a unique opportunity to address drug-related issues within the Aboriginal population. Strategies such as screening and early identification and intervention are particularly relevant when dealing with young offenders. The provision of comprehensive education and information becomes even more critical in preparing juveniles for release to the community. Interventions also need to be appropriate to the length of stay within the justice system, with real links to ongoing treatment and support once back in the community.

Some key informants conducting research noted that prisoners are often keen to take part in any research aimed at improving health services. One key informant noted:

There's a whole lack of information. Prisoners in my experience are only too happy to do things that they perceive will improve their health and improve their lot and improve prison health services or offender health services ... So I think that would be my main comment – ethics committees are often a bit naive about the [prison] population.

In this sense, prison can be seen as an opportunity to conduct research with normally hard-to-reach populations. Prisoners are keener to be involved at this time than at other times when it can be hard to access them. Several researchers, interviewed as key informants, noted that prisoners were valued as participants in studies because they have nothing to lose by answering questions honestly.

4.4.3 Dual diagnosis and comorbidity

Evidence suggests that Aboriginal Australians experience mental health disorders at a higher rate than non-Aboriginal Australians. A large number of those Aboriginal Australians who experience mental health disorders have a history of comorbid substance misuse (Berry & Crowe, 2009). A 2006 study conducted in the Northern Territory in the period 2002–03 identified that 84 per cent of Aboriginal mental health admissions displayed 'psychosis, depression and substance-related disorders' (Nagel, 2006).

Particular attention needs to be given to those Aboriginal people who inject drugs with a dual diagnosis of mental illness and drug dependence. Key informants spoke of the importance of addressing the underlying

mental health issues that may lead Aboriginal people into injecting drug use. A greater understanding of the broader social and structural factors that have led to the poor health of Aboriginal Australians, including underlying trauma, would be an important step in reducing the harms associated with injecting drug use. Improvements to harm reduction services, including greater access to mental health practitioners for Aboriginal people who inject drugs particularly in regional and rural areas, were suggested as important steps forward in addressing the health needs of Aboriginal people who inject drugs. Part of this strategy would include ensuring culturally appropriate mental health services are provided.

One of the biggest things we found in our injecting drug users just through casual conversation is: a lot of reasons they use is to forget. And so if we identified some of the mental health issues that were driving the injecting drug use, we can come at it from both sides, we can make them safe through harm minimisation, address some of the problems.

Key informants spoke of the need for a more holistic approach in service delivery to Aboriginal people with mental health issues who inject drugs. Key informants stressed as essential the design of services that take into account the social determinants of health that may have led to mental health disorders, including trauma and disempowerment, while also taking into account the complex service needs of clients with a dual diagnosis. A more coordinated approach to planning and treatment is required to ensure these people are not further disadvantaged by their complex needs. Such an approach means a more coordinated service system that recognises the need to improve policy development, treatment pathways and information exchange.

4.4.4 Young people transitioning to drug use and injecting

As already mentioned in relation to juvenile offenders, young Aboriginal people who inject drugs require unique approaches to service delivery. Young Aboriginal Australians need programs suitable to their age and developmental stage; there are opportunities that exist for these young people. Adequate screening and early identification and intervention need to be built into every primary health-care interaction with young Aboriginal people. This group is particularly vulnerable to misinformation and gaps in understanding about harm reduction strategies to prevent blood-borne viruses and sexually transmitted infections. Enabling young people to increase their knowledge and understanding, as well as addressing why young people may move towards injecting in the first place, is essential to addressing generational change in the Aboriginal community.

Key informants spoke of the fatalistic view some young Aboriginal people feel towards their lives, which may lead to substance use. This despairing view adds to the complexity of service delivery needed for this subpopulation, many of whom may not be interested or willing to access health services. As one key informant noted:

[There is a] whole sort of fatalistic view of young Aboriginal men ... I think young Aboriginal women also have a fairly fatalistic sort of view [of] 'Who gives a shit? – I am going to be dead anyway. I will worry about what happens in the next day or so, or the next week, I am not planning for next month or next year.'

4.4.5 Men who have sex with men

Many key informants spoke of the acceptance and apparent lack of stigma associated with men who have sex with men in the Aboriginal community. Men who have sex with men and men who have sex with men who are transsexual (referred to as SistaGirls) are accepted and included in the Aboriginal community with limited stigmatisation and shame. However, the acceptance of men who have sex with men and SistaGirls within the Aboriginal community does not transcend to the injecting community. Many key informants found this perplexing:

Why is it that you can embrace SistaGirls and men who have sex with men and it's open and there's no ... stigmatisation or shaming or whatever associated with those population groups, and yet when it comes to injecting drug use, there is?

However, even though men who have sex with men and SistaGirls may experience limited stigma within the Aboriginal community, this subgroup, particularly those who also inject drugs, is increasingly vulnerable to HIV transmission. One key informant spoke of the increase in HIV in his jurisdiction, stating that HIV diagnoses in gay Aboriginal men are the highest they have ever been. A recent study undertaken in the area has shown high rates of unsafe sex among gay men who inject drugs. This may indicate some urgency around HIV transmission risks within men who have sex with men and SistaGirl subpopulations.

A lot of our boys were practising unsafe anal sex and they were injecting drugs as well.

Key informants spoke of the importance of taking into account the emotional and social wellbeing of men who have sex with men and SistaGirls in health service delivery. The holistic approach of considering the underlying social determinants that lead to drug use, and subsequently affect the health of men who have sex with men and SistaGirls, was highlighted as essential. One key informant spoke of his service, which provides a place for men who have sex with men to discuss their experiences including drug use, homosexual practices and exploration of their own identity. Taking into account the emotional and social wellbeing of Aboriginal clients allows services to better understand the complex needs of clients and the history that has led them into drug use.

Those are the things that we would probably like to see as the determinants [of] emotional and social wellbeing and how people move from having some fun, and then it becomes a habit and then it becomes a practice of self-medication ... [for] instabilities in life that are not being addressed either in the communities, or by any of the programs.

4.4.6 Sex workers

Aboriginal sex workers represent another subpopulation that is at high risk of poor health, while being difficult to reach through traditional health service delivery. Aboriginal sex workers will often fall into other sub-categories including men who have sex with men, SistaGirls, and homeless and displaced people. One key informant spoke of a recent study his service had undertaken in an Australian city, which discovered that 15 per cent of street-based sex workers identified as Aboriginal or Torres Strait Islander.

Aboriginal sex workers ... [are] doing opportunistic type work and they're doing work, you know, in and around their communities and they are really hard to target.

Key informants preferred outreach as the service method when targeting health promotion strategies towards Aboriginal sex workers. Outreach allows health workers to provide services to clients on the street, minimising disruption to their work. It also provides a platform for health workers to engage with clients and advertise their traditional services. One key informant working in an Australian metropolitan city noted that the majority of Aboriginal sex workers she treats are street-based sex workers. Many of these Aboriginal street-based sex workers inject drugs and are working to get money to use, or working in exchange for, drugs.

A lot of them [sex workers] are street-based workers and the reason they are working is because they've got a habit. So they're mainly working to support that.

Key informants spoke of the denial and shame associated with sex work in some Aboriginal communities, particularly in regional and rural areas. Sex work is a particularly sensitive issue for some Aboriginal communities. One key informant stated that sex work is very different in the Aboriginal community compared to the non-Aboriginal community, where non-traditional sex work, i.e. sex for favours or sex in exchange for goods, often occurs. This creates additional barriers to health workers' ability to target this subpopulation, particularly for Aboriginal people under 18 years of age who engage in sex for favours.

When you go into those communities, they flat out deny that it's going on. Even just talking to them about sex work, you know, there are people who deny it and people who don't want to acknowledge that is happening and other people will just speak out about it – it's the same as injecting drug use.

Recruitment of Aboriginal workers, particularly transgender workers, within peer-based sex worker organisations is a major gap in service response to Aboriginal sex workers. One key informant noted the lack of Aboriginal male and transgender health workers within his organisation as a major barrier to reaching this subpopulation. Recruitment into sex work organisations can often be difficult due to the fact that people are unwilling to be identified as a sex worker.

4.4.7 Homeless and displaced people

We know the longer you're homeless, the more likely you are to inject drugs.

Homeless and displaced Aboriginal Australians make up a vulnerable subpopulation of people who inject drugs, who often miss out on traditional health promotion and education as well as health-related services. Key informants highlighted the difficulty in engaging with this subpopulation, coupled with the environment in which they live, as a major barrier to delivering services to this group. Homeless and displaced Aboriginal people who inject drugs are less likely to access traditional fixed-site health services, and alternative methods of service delivery are often needed.

One key informant noted that the number of Aboriginal people who inject drugs accessing the local outreach service was far higher than those who access their fixed site. This was due to the high number of homeless people accessing the outreach service as well as the anonymity this service offered clients. The key informant highlighted the important role the outreach service plays in the delivery of health services to homeless and displaced Aboriginal people in his jurisdiction as a way of making first contact and engaging with clients.

If you want to access marginalised people who are basically living rough in the parklands, you do outreach. You can't have a fixed site and expect people driving their cars between 9 to 5.

Key informants highlighted the importance of taking health services directly to people rather than waiting for people to access fixed sites:

I think outreach was really effective – go where the people are. Instead of expecting the people to come to the services, you need to go where they are.

Nunkuwarnin Yunti

Nunkuwarnin Yunti is the leading Aboriginal community-controlled centre in Adelaide, South Australia. The centre provides Aboriginal people with health care and community support services. First incorporated in 1971, and formally named Nunkuwarnin Yunti of South Australia in 1994, the centre offers a wide range of services including: clinical services; family tracing and reunion services; family support services; counselling services; methadone program; healthy liver program; prison programs; outreach services; and a needle and syringe program.

Healthy Options Promotions and Education (HOPE)

The HOPE team delivers services to the Aboriginal community in South Australia, with a focus on prevention through educational and practical services. These services promote wellbeing and aim to equip Aboriginal people with the skills necessary to manage their health effectively. The HOPE team runs a number of programs including: Nu-Hit; the Healthy Liver Clinic; No Pulgi; and Drug Substitution, Options and Support (SOS).

The Nu-Hit Program

The Nu-Hit Program supplies sterile injecting equipment to members of the community through an NSP at the Wakefield premises and an outreach program run throughout greater metropolitan Adelaide. The service provides education and information to clients on blood-borne viruses, sexually transmitted infections, safe injecting education and the importance of safe disposal of injecting equipment. Clients are

provided with disposal containers for used equipment and are also able to dispose of used equipment at collection points. Other services offered include referral, advocacy and social support services. Nu-Hit workers develop strong relationships with clients with an aim to help clients move away from harmful activities and make positive health and lifestyle choices.

Healthy Liver Program

The Healthy Liver Program aims to improve health outcomes for people living with hepatitis and other liver-related problems through a holistic approach that incorporates nutrition, social inclusion and housing. The program provides education, information, support, pre- and post-hepatitis C discussions and blood tests, and hepatitis C treatment through the Healthy Liver Clinic. The Healthy Liver Clinic is the first service in Australia to offer hepatitis C treatment in an Aboriginal community-controlled health service setting.

No Pulgi: 'Outreach Health Service for Homeless People in the Adelaide Central Business District'

No Pulgi provides outreach primary health care services to homeless people in the Adelaide central business district. The program aims to improve the health of homeless people through: reduction of the incidence of preventable disease; client advocacy; the provision of education and resources with a health promotion focus; and referral to other health, housing and homeless support services. The service is run by Nunkuwarnin Yunti but is the product of a collaboration between the Royal District Nursing Service, Aboriginal Sobriety Group, the Central Western Adelaide Aboriginal Primary Health Care

Access Program (APHCAP), Central Northern Adelaide Health Services (Department of Health), and Drug and Alcohol Services of South Australia.

Drug Substitution, Options and Support (SOS)

The SOS program provides members of the Aboriginal community with assistance in accessing drug treatment programs. SOS provides clients with information and education on different treatment options. Clients are supported to link up with appropriate pharmacotherapy programs and detoxification services. The program also offers clients assistance with Legal Aid, Housing Trust and Centrelink-related issues.

The success of the HOPE programs can be attributed to Nunkuwarrin Yunti's holistic approach to service delivery. Services offered through the program are easily accessible and relevant, addressing the physical, psychological and social welfare needs of the individual. Services incorporate all aspects of harm reduction including: safer using information; sterile equipment provision; treatment support; and abstinence-based programs. This holistic approach to health care, enhanced by the service's commitment to intersectoral networking and collaboration, has ensured that Aboriginal clients feel comfortable and supported when accessing Nunkuwarrin Yunti programs.

5. Way forward

5.1 Gaps in knowledge and responses

A limited number of studies have explicitly attempted to assess patterns and prevalence of injecting drug use among Aboriginal Australians at a national level (see sections 3.2 and 3.3). Although there are a number of national and regional data sources that assess drug use, more could be done to provide a meaningful analysis specifically around injecting drug use among Aboriginal Australians. Therefore, there is an immediate need for data on Aboriginal substance use, and in particular injecting drug use, to be collected at a national level in order to compare jurisdictions, so that a clear understanding of Aboriginal injecting drug use nationally is obtained. Data collection needs to be consistent in its collection methodology, analysis and publication. Further, issues around ownership, control, access and distribution remain to be addressed.

The National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994 provides an example of a more in-depth analysis of substance use among Aboriginal Australians. Although it is perhaps the most extensive study ever undertaken to estimate the prevalence of licit and illicit drug use in Aboriginal Australians, the supplement has never been replicated. The inclusion of the Urban Aboriginal and Torres Strait Islander Peoples Supplement in every National Drug Strategy Household Survey would be a first step in improving the collection of data and knowledge on substance use among Aboriginal Australians. As the study is limited to urban areas and relies on self-identification, the inclusion of rural and remote communities is necessary.

The National Aboriginal and Torres Strait Islander Health Survey and the National Aboriginal and Torres Strait Islander Social Survey also collect some data on injecting drug use. As noted earlier, the use of drugs that may be injected, such as heroin, cocaine, methadone and hallucinogens, is not reported separately in either of these national surveys. The National Aboriginal and Torres Strait Islander Health Survey does not ask questions specifically relating to injecting drug use, nor about the method of administration of the substances that are reported. These surveys are also limited in their capacity to assess illicit substance use for those Aboriginal Australians living in rural and remote communities. It is suggested both the National Aboriginal and Torres Strait Islander Health Survey and the National Aboriginal and Torres Strait Islander Social Survey include questions specifically relating to injecting drug use and mode of transmission, including separate reporting on each injectable drug, and where possible, include rural and remote communities in survey sampling.

The Illicit Drug Reporting System and the Australian Needle and Syringe Program Survey, both conducted on an annual basis, monitor trends in the injecting population. These types of monitoring and surveillance surveys of substance use provide an important insight into substance use in the broader injecting community in Australia, and also provide an ideal opportunity to collect data on substance use among Aboriginal Australians. Although the Australian Needle and Syringe Program Survey provides an insight into the numbers of Aboriginal people who inject drugs accessing programs specifically designed for people who inject drugs, it also potentially misses an important subpopulation of Aboriginal people who inject drugs, namely those who access

pharmacy NSPs only or those who obtain injecting equipment through tertiary distribution. Sections 3.7.2 and 4.2.3 discussed the structural issues and barriers that often lead to the reluctance of Aboriginal people who inject drugs to access NSPs. It is therefore important that data from the Australian Needle and Syringe Program Survey are used in conjunction with other data sources to ensure a more accurate picture of Aboriginal injecting drug use. The use of data from hospital, pathology and police records is an example where obtaining valuable information from data sources can be achieved.

Many key informants noted during consultations that using existing data sources, such as the Australian Needle and Syringe Program Survey, could be beneficial as a way of measuring incidence and prevalence of Aboriginal injecting drug use over a period of time. Although requiring further funding and additional effort, this type of data analysis would provide rates of injecting drug use among Aboriginal Australians and identify whether these rates have increased over time.

Similarly in relation to patterns of drug use, the inconsistencies in data collection tools, as well as the types of questions asked when examining patterns of drug use, have meant that data collected from different jurisdictions and sources are often not comparable. The establishment of a clear set of information needs with respect to drug use patterns is as an important step in providing a framework for researchers examining this issue. The development of a minimum data set and common principles for data collection is recommended as an important step forward in ensuring consistency and comparability in data collected in different studies.

As previously noted in section 2.2.2, there is a lack of accuracy and consistency in documenting Aboriginal status in service use records and surveys. This leads to limitations in the use of indicator data as a way of measuring rates of the accessing of services by Aboriginal people who inject drugs. Therefore, it is recommended that the recording of Aboriginal status be collected as part of the core set of data from all mainstream health service clients.

Key informants identified the importance of clear research and data collection processes that inform and lead to tangible improvements in health outcomes for Aboriginal people who inject drugs as being integral to researching Aboriginal injecting drug use. A clear way in which this can be achieved is through greater collaboration between Aboriginal and non-Aboriginal researchers and health services in all levels of research design, planning, evaluation and distribution of findings. A key step in improving data collection and research is through strengthening Aboriginal researchers and Aboriginal health service roles to have the capacity to undertake data collection and research into Aboriginal injecting drug use. The direct inclusion of Aboriginal people who inject drugs in research, programming and policy development is also desirable to ensure that the health needs of Aboriginal people who inject drugs are met.

Such collaboration and partnership between Aboriginal and non-Aboriginal health services are considered to be an important way forward, not only in securing accurate and meaningful data, but also in the delivery of health services for Aboriginal people who inject drugs. This will be discussed in section 5.2.

5.2 Opportunities available to improve services

Strengthening the workforce capacity and capability in both Aboriginal and mainstream health services is considered an important step toward improving service responses to Aboriginal people who inject drugs.

Flexibility and the recognition of local and individual conditions are central to the success of service delivery for Aboriginal people who inject drugs (see section 4.2.3). As discussed by key informants, flexibility in service delivery can include such simple measures as: operation outside normal business hours; and flexibility in relation to appointment times and missed appointments. Flexibility in service delivery can also be applied in providing syringe vending machines with 24-hour access, and takeaway doses for opioid maintenance treatment. Similarly, expanding service modes, including the provision of outreach services, is also considered to be an important approach to increase access to services, including access to sterile injecting equipment, particularly among Aboriginal people who inject drugs.

Understanding the cultural needs of employees and providing a flexible workplace are also important factors in improving services in both Aboriginal and mainstream health services. In particular, implementing job share policies that allow an Aboriginal health worker or Aboriginal liaison officer to share job roles with another worker will lead to better retention, particularly during times when family and community commitments may require staff to be absent for long periods of time. Through a supportive and flexible approach to employment of these workers, particularly in mainstream health services, an improved working environment can be created leading to more effective recruitment and retention of staff.

An increase in the capacity of the Aboriginal workforce, including an increase in the Aboriginal sexual health workforce, and implementation of a national network of Aboriginal alcohol and other drugs workers are central to improving service responses to Aboriginal people who inject drugs. New South Wales has an Aboriginal sexual health workforce that operates across the state. Queensland also has an Aboriginal and Torres Strait Islander sexual health workforce. By comparison, Victoria currently has no Aboriginal sexual health workers and relies on Aboriginal health workers to undertake this role. There is an urgent need to have a more consistent approach to investment in the sexual health workforce across jurisdictions so that needs are effectively met. This could include the provision of training and support for Aboriginal health workers in the area of sexual health as an interim measure while a national strategy is in development.

The New South Wales Aboriginal Drug and Alcohol Network, established in 2003 by the New South Wales Department of Health in conjunction with the Aboriginal Health and Medical Research Council and the Office for Aboriginal and Torres Strait Islander Health (NSW), provides an example of a network set up to share information, provide support, and build knowledge and capacity among Aboriginal drug and alcohol workers. Meeting quarterly, the group comprises Aboriginal drug and alcohol workers in Aboriginal community-controlled health services, the New South Wales Department of Health and Aboriginal community-controlled drug and alcohol rehabilitation centres (Thompson, 2008). Options for Aboriginal drug and alcohol workers to network should be further explored so that other mechanisms similar to the Aboriginal Drug and Alcohol Network are developed and supported.

Building capacity of the drug and alcohol sector to more effectively respond to the needs of Aboriginal people who inject drugs should include the availability of training in the form of a nationally accredited and standardised program. This would, in part, go towards recognising the specialised nature of this work and raising the profile of the skillset required to be effective in these roles. Therefore, options regarding the development and delivery of this type of program need to be explored at a national level.

Additionally, building the capacity of Aboriginal Australians working in the drug and alcohol sector through the development and delivery of programs specifically targeting this group is considered an important step forward. The Western Australia Drug and Alcohol Office, a registered training organisation, runs a nationally recognised Aboriginal Alcohol and Other Drug Worker Training Program, which results in a Certificate III in Community Services Work. The 12-month program operates in Western Australia, the Australian Capital Territory, New South Wales, South Australia and the Northern Territory and includes face-to-face learning and on-the-job training for Aboriginal Australians employed in the alcohol and other drug workforce. Similarly, the University of Sydney currently offers postgraduate Indigenous Health (Substance Use) coursework programs, which include a Graduate Certificate, Graduate Diploma and a Master of Indigenous Health (Substance Use). Increasing access to these programs would increase knowledge and skills among Aboriginal drug and alcohol workers.

Training and support are also required in order to increase the capacity of Aboriginal health services to deliver NSP services. A collaborative partnership between Aboriginal and mainstream health services provides an opportunity to share resources and increase the capacity of both sectors (see section 4.2). In relation to the provision of NSP services, a partnership between the two sectors allows for increased support for Aboriginal health services, particularly in the initial stages, to establish and maintain NSP services. Many key informants also noted that non-Aboriginal staff need specific training on cultural sensitivity and understanding to ensure a culturally appropriate response in service delivery to Aboriginal people who inject drugs.

The Making Two Worlds Work project has provided a model that can be used by mainstream health services to work more effectively with Aboriginal organisations as well as ensuring a more culturally appropriate level of service delivery where Aboriginal clients feel safe. Therefore, mainstream organisations working with Aboriginal people who inject drugs need to develop resources to support a culturally safe environment for both clients and staff. This should ideally be done in collaboration with local Aboriginal communities.

Making Two Worlds Work

Building the capacity of the health and community sector to work effectively and respectfully with our Aboriginal community

Making Two Worlds Work was a project conducted in partnership between Mungabareena Aboriginal Corporation and Women's Health Goulburn North East (WHGNE), based in northeast Victoria. The project was supported by the Upper Hume Primary Care Partnership and Wodonga Regional Health Service.

The project idea came about in 2005 after non-Aboriginal workers attended cultural training at Mungabareena Aboriginal Corporation. Workers requested the following for their service:

- locally produced Aboriginal artwork and images they could display in their agencies
- accessible information about local Aboriginal history and culture, protocols, key organisations and contacts
- resources to support their work with Aboriginal clients, families and community.

Making Two Worlds Work was developed as a resource kit for workers designed to strengthen the capacity of the health and community sector to work effectively and respectfully with the Aboriginal community through providing culturally competent health care.

Kit contents

Six colour posters, which were developed from original paintings depicting aspects of Aboriginal health and wellbeing.

Health and community services audit: *Working with Aboriginal People and Communities* – this audit tool supports agencies to audit their practices and provides a guide for agency planning and review. Key sections within the audit tool include: creating a welcoming environment, engaging with Aboriginal clients and communities, communication and relationships, developing cultural competence, staff training, working collaboratively and respectfully with Aboriginal organisations and services.

Checklist: *Working with Aboriginal Clients and Mungabareena Aboriginal Corporation* – designed to be displayed in the workplace, this poster provides workers with an overview of the types of day-to-day practices that are respectful of Aboriginal clients and the community.

Health promotion framework: *Using a Health Promotion Framework with an 'Aboriginal Lens'* – This planning and evaluation tool is designed specifically for health promotion initiatives with Aboriginal communities and can also be used as a prompt for all health promotion initiatives to ensure that the needs of local Aboriginal people are met.

CD – The CD contains 100 graphic images based on the six paintings. These images can be used by agencies when creating visual or written information for Aboriginal clients and community.

DVD – The DVD provides an explanation of ‘acknowledging country’ and ‘Indigenous welcome’ and details the importance of art for Aboriginal communities.

‘Welcome’ sticker – This sticker is designed to be displayed at services as a way for agencies to welcome Aboriginal and Torres Strait Islander people to their service.

Information guide – This guide compiles information for health workers on Aboriginal health, history and protocols. It also contains contact details for local Aboriginal and non-Aboriginal organisations

and services that provide support and services to Aboriginal people and communities.

Items in the resource kit are available to download from the WHGNE website. The kit is available for purchase from WHGNE for \$50.

This initiative won the 2009 Victorian Health Care Awards – Reducing Health Inequalities section.

(Making Two Worlds Work Project developed by Mungabareena Aboriginal Corporation and Women’s Health Goulburn North East, 2008.)

An increase in the number of Aboriginal health services providing NSPs is considered an important step forward in improving service availability and responses for Aboriginal people who inject drugs. Aboriginal health services often have competing service priorities largely dictated by government bodies’ funding availability. Therefore, injecting drug use is not always seen as a priority health issue (see section 4.3.1). Strategies such as the provision of financial incentives for the establishment of NSPs in Aboriginal health services should be considered as a way of increasing access and availability.

Up-to-date referral information and knowledge of other harm reduction drug treatment services in both Aboriginal and mainstream health services are integral to ensuring adequate service responses to Aboriginal people who inject drugs. Of particular importance are the development and support of treatment pathways unique to Aboriginal health services. Equally important is the availability of treatment options, including timely access to detoxification and rehabilitation services. There is also an urgent need for an increase in the availability of Aboriginal-specific detoxification and rehabilitation services nationally.

Sound planning, monitoring and evaluation, including the collection of Aboriginal-specific data, provide opportunities to improve service response to Aboriginal people who inject drugs. Accurate and timely data collection is integral to understanding patterns and prevalence of injecting drug use among Aboriginal Australians. Data collection is equally important in mapping service use and identifying client needs. Organisational policy in mainstream health services that includes monitoring and evaluation processes which involve Aboriginal input into planning and evaluation will ensure service responses to Aboriginal people who inject drugs are not only culturally appropriate but also meet the needs of Aboriginal clients. Similarly, in Aboriginal health services, the involvement of Aboriginal injecting drug users in the design, implementation and monitoring of harm reduction services ensures responses are tailored to meet the needs of this client group.

Review of performance measures and reporting requirements for services with Aboriginal injecting drug users as clients is also needed so that achievement of outcomes is consistently monitored. Indicators relating to data collection, service evaluation and the extent

to which the service collaborates with their community and other services would reinforce the importance of these issues and their impact on effective service delivery.

5.3 Proposed service model

An understanding of the health of Aboriginal Australians (see section 2.2) has traditionally focused on individual behaviours. It is, however, apparent that Aboriginal health is influenced by broader social and structural factors, including historical, cultural and political circumstances (Mitchell, 2007). A model of service delivery that takes into account the broader social determinants of Aboriginal health is required so that the needs of Aboriginal people who inject drugs are met.

An understanding of these broader social determinants of health, including the role of the family and broader community, is needed by all health services working with Aboriginal people who inject drugs. In the case of mainstream health services, increased education is necessary on the principles of culturally sensitive service provision for Aboriginal people who inject drugs, based on the importance of the individual, the family and the community and how these dimensions can be incorporated into service delivery for Aboriginal people who inject drugs. This would need to take into account local differences and a range of issues including, but not limited to: understanding of dispossession; trauma discrimination; holistic care; poverty; education; land rights; culture; and the resultant economic disadvantages in housing and education.

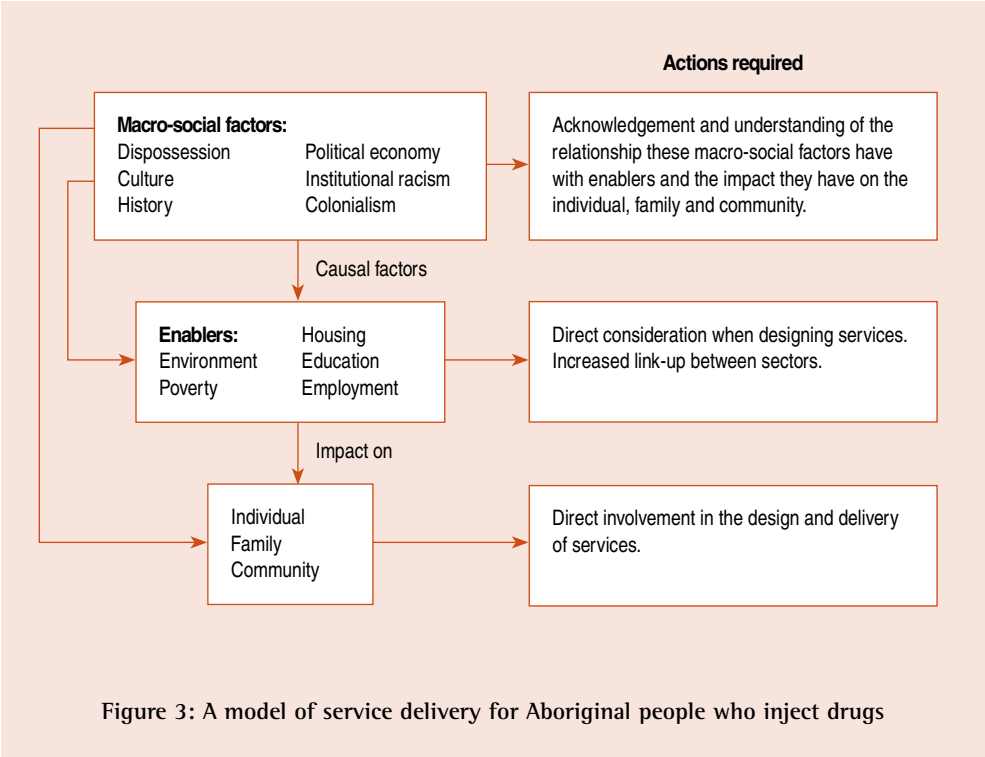
Models of service delivery within the harm reduction and drug treatment service sector should take into consideration the Aboriginal definition of health and incorporate the family and the broader community (see section 2.2). It is therefore proposed that a model of

service delivery be adopted within the harm reduction and drug treatment service sector that works across the three different social dimensions – the individual, the family and the community. This model is considered best suited to take into account the varying social, cultural and emotional needs of Aboriginal people who inject drugs, while also recognising the competing influences and potential support roles the family and community can play.

This proposed model provides a holistic approach to health care that incorporates a harm reduction framework while ensuring that a culturally appropriate level of service delivery is upheld. This model would be most successfully incorporated into mainstream services in collaboration with Aboriginal health services. An inherent challenge in implementing this type of model includes the limitations of current funding models available to mainstream health services. This relates to the fact that, while there are some mainstream services specifically designed to deliver NSPs, the majority of funding for NSPs is allocated to services that do not have harm reduction as their primary focus. Implementation of such a model would also require comprehensive evaluation against outcomes to ensure effectiveness.

There is a need for the establishment of Aboriginal-specific detoxification services and the expansion of Aboriginal-specific rehabilitation services (see section 3.9). Consideration should be given to expansion of Aboriginal residential rehabilitation programs and establishment of other forms of Aboriginal-specific detoxification services. This would require further funding and a trial period to ensure suitability and sustainability.

Critical elements of service delivery relating specifically to injecting drug users are referred to within the recommendations.



6. Conclusion

This report sought to document the dimensions and characteristics of Aboriginal injecting drug use, including associated harms, gaps in knowledge, and opportunities available to improve service responses.

One of the main findings of this project has been the lack of comparable, reliable national data upon which service design and delivery can be based. Findings have highlighted that improved data collection is needed so that a true measure of the depth of Aboriginal injecting drug use, and associated harms, may be available to funding bodies and service providers.

Another key finding of this project relates to the need to improve service responses for Aboriginal people who inject drugs. The need to increase knowledge and skills in both mainstream and Aboriginal health services, so that each sector is better equipped to meet the needs of Aboriginal people who inject drugs, is considered an important step forward. This can most effectively be achieved through increasing training and support for people working with Aboriginal people who inject drugs. This includes the availability of nationally accredited training for all Aboriginal drug and alcohol workers, targeted training for Aboriginal Australians working in the drug and alcohol sector, and cultural sensitivity training for mainstream health workers.

Issues associated with access to services have been highlighted throughout this report. This is particularly important within the context of injecting drug use and access to new injecting equipment. Increasing access to NSPs nationally is seen as an important step forward. Equally important is the availability of treatment options, including timely access to detoxification and rehabilitation services. There is also an urgent need for an increase in the availability of Aboriginal-specific detoxification and rehabilitation services nationally.

Similarly, this report highlights the need for more effective engagement with Aboriginal people who inject drugs in both mainstream and Aboriginal health services through improvement in service design and delivery. Acknowledgement of the stigma and shame often associated with injecting drug use, particularly within many Aboriginal communities, would go some way towards reducing potential barriers to accessing services. Reinforcement of the confidential nature of services would also provide some reassurance for those potential clients who are concerned about disclosure of information within small or tight-knit communities.

This report has also highlighted that Aboriginal Australians, and in particular those who inject drugs, are vulnerable to even poorer health outcomes than the rest of the Australian population. The social determinants of Aboriginal health are affected by a variety of social and structural factors, which are further compounded by substance use. A model of service delivery that takes into account the broader social determinants of Aboriginal health, and the impact these have on the health of Aboriginal people who inject drugs, is essential to ensure that the health needs of this vulnerable population are met.

A proposed model takes into consideration three dimensions – individual, family and community – when planning and delivering health services. The participation of Aboriginal communities in service planning is critical to ensuring local relevance and appropriateness. This extends to ongoing opportunities for evaluation of service delivery and provision of direct feedback to inform future decisions.

A range of recommendations that relate to the issues highlighted throughout the report follows.

7. Recommendations

The policy context for Aboriginal health is currently determined by the Council of Australian Governments (COAG) and the related National Partnership Agreement negotiated between the Australian Government and each state and territory. Directions in funding and service delivery are therefore currently being determined by negotiation with reference to the Partnership Agreement.

To achieve the health outcomes identified in this report, the following recommendations are designed and targeted at focusing greater resources and attention to improve service responses and thereby reduce the harms associated with injecting drug use among Aboriginal Australians.

To avoid duplication and achieve the best health return on investment, it is imperative that additional funding be made available. However, in the first instance, financial and other resource investments required to implement these recommendations should be drawn from a review of the current funding frameworks to determine if they are currently being targeted appropriately. In addition, it is crucial that any planned action in response to these recommendations requires meaningful consultation with key stakeholders operating at the service delivery level. This dialogue must also include Aboriginal communities and commence from the initial planning stage through to implementation to ensure maximum benefit is achieved for people who inject drugs. Failure to properly consult within a holistic framework of health defined by the Aboriginal community will limit the intended outcomes, as its members are the ones most affected by any proposed recommendations or consequent changes.

Policy development and funding

- Provide incentive grants to cover initial implementation costs for Aboriginal health services seeking to establish needle and syringe programs.
- Review existing performance measures and reporting requirements for those services that provide needle and syringe program services to Aboriginal people who inject drugs.
- Target an increase in the availability of sterile injecting equipment, particularly in regional areas of Australia. Strategies to achieve this goal may vary between communities and may include: the placement of syringe vending machines; enhancements to Aboriginal community-controlled health service funding; additional outreach mobile services; and additional support for pharmacy and hospital-based needle and syringe programs.
- In consultation with the Aboriginal community, design and implement a new policy structure for Aboriginal community-controlled service delivery which focuses on the harm reduction framework used within the drug treatment sector and which encompasses the interrelated social dimensions of the individual, the family and the community.
- Fund a site trial of Aboriginal-specific detoxification services within (or in partnership with) the community-controlled health sector.
- Establish a trial needle and syringe program in an Australian prison to enable access to harm reduction services already provided in the general community.
- Increase funding for the community-controlled health sector, in particular Aboriginal medical services, to enable greater education and training for, and provision of, needle and syringe programs.

Data collection

- Consistent with the National Drug Strategy Household Survey, hold the National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement triennially and expand it to include inner and outer regional areas of Australia.
- Expand the National Aboriginal and Torres Strait Islander Health Survey and the National Aboriginal and Torres Strait Islander Social Survey to include questions specifically relating to injecting drug use, including separate reporting on each injecting practice, and to include rural and remote communities in survey sampling.
- Develop a minimum data set and common principles for drug and alcohol services and Aboriginal community-controlled health services regarding Aboriginal injecting drug use to ensure consistency and to enable comparability of data collected.
- Implement improvements across data sets in the recording of Aboriginal status from all mainstream health service clients.
- Collect data in accordance with national Aboriginal health information guidelines, with particular emphasis on: consultation with Aboriginal communities on the design of relevant questions; and custodianship of data in relation to control, access, ownership and usage.
- Collect data that are outcome-focused and not used solely for the purposes of meeting funding requirements.

Service responses

- Promote a harm reduction framework within Aboriginal community-controlled health services supported by a workforce development strategy that builds capacity and capability in this area.
- Provide intensive support to Aboriginal health services in the start-up phase of establishing a needle and syringe program, including: assistance with operational planning in line with current risk and accreditation processes; policy development; workforce education and training; and provision of financial resources.
- Implement organisational policy in mainstream health services including: cultural sensitivity training for all staff; support for Aboriginal staff; and ongoing monitoring and evaluation processes. This would involve a high degree of consultation with the Aboriginal community to allow input into planning and evaluation.

Workforce development

- Build the capacity of the Aboriginal workforce through establishment of a national network of Aboriginal workers in alcohol and other drugs services.
- Ensure consistency in approaches to investment in the Aboriginal sexual health workforce across all jurisdictions. This may include the provision of education, training and support for Aboriginal health workers primarily engaged in the delivery of services in sexual and blood-borne virus health as an interim measure while a national strategy for alcohol and other drugs services is in development.
- Provide training in the harm reduction sector in the form of a nationally accredited and standardised program.
- Support for the National Aboriginal Health Worker competencies training package to enable inclusion of drugs and alcohol as an elective subject to enhance the workforce within Aboriginal community-controlled health services.
- Develop and deliver additional educational resources, greater support and cultural sensitivity training for all staff to assist Aboriginal staff retention and hence skills enhancement.
- Provide cultural competency training to all health care workers in mainstream health services.

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