

Investigating the Impact of Injecting Drug Use in Indigenous Communities in Metropolitan Adelaide

**Carol Holly
Jodie Shoobridge**

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Introduction

In 2001, the Aboriginal Drug and Alcohol Council (ADAC) conducted the largest single study of Indigenous people who inject drugs in Australia. The size of the study (over 300 participants) has enabled ADAC to collect enough data to establish some of the drug use trends and injecting practices of Aboriginal people in metropolitan Adelaide who inject drugs. ADAC has already begun to use this information to assist the Indigenous community in developing interventions and responses to drug related harms.

Background

The 2001 study was the second study about Indigenous people who inject drugs that ADAC has been involved in. A similar project was conducted in 1997. This project was a collaborative venture between ADAC, The Lower Murray Nungas Club and the National Centre for Education and Training on Addiction (NCETA). The 1997 project was also designed to examine the harms associated with injecting drug use in an Aboriginal community (Murray Bridge, South Australia). The information obtained from this project, in addition to other research findings, contributed to ADAC's decision to conduct the 2001 study of injecting drug use amongst urban Indigenous people (metropolitan Adelaide).

This report has been produced to provide a summary of the aims and objectives of the project, the methodology used, a brief description of the main findings, and preliminary recommendations.

If you require additional information about the project, or would like any questions answered, please contact the Project Officer, Carol Holly, or State Director, Scott Wilson, at ADAC on (08) 8362 0395.

Context

The daily experience of socio-economic inequities may place Indigenous people at greater risk of problematic drug use by contributing to poor self-esteem (Lane, 1993; Dunlop and Ezard, 1997).

At the time of the 1996 census there were approximately 22,000 Indigenous people living in South Australia, comprising 1.5% of the total state population of 1,474,300 people. The Indigenous population is a young one - approximately 39% of Indigenous South Australians are under 15 years old and the median age of Indigenous South Australians is 20 years, compared with a median age of 35 years for the total SA population.¹

Indigenous people face social disadvantage on every level. The unemployment rate for Indigenous people in SA is 24.3%, approximately 2.4 times the state unemployment rate of 10.3%. Three times as many Indigenous families as other families are single parents with children under 15. Indigenous people are less likely to stay and complete secondary school and are more likely to leave school at age 15 or less.²

¹ 1996 Census of Population and Housing Aboriginal and Torres Strait Islander People, South Australia, Australian Bureau of Statistics 1998.

² Ibid

In 1996 the median weekly personal income for Indigenous South Australians was over \$60 per week less than the median weekly personal income of the total SA population. Indigenous families are less likely than other families to earn a high family income (over \$1000 per week) and are more likely to earn a low family income (less than \$300 per week).³

Indigenous Australians are more likely to be approached by police and more likely to receive the harshest available sentence option. As a result, Indigenous people are over represented in prisons and juvenile correctional institutions. The majority of people in prison have a history of drug use and many continue injecting drugs whilst incarcerated.

In the period between 1992 and 1999, 6% of Indigenous HIV diagnoses recorded IDU as the method of transmission, compared to 3% of non-Indigenous diagnoses⁴. During the same period Indigenous notifications of HIV occurred at a rate of 5.2 per 100,000 (non-Indigenous notifications were 5.5 per 100,000) but while the non-Indigenous rate declined steadily over this period the Indigenous rate did not.⁵

In the year 2000, Indigenous people made up almost 6% of Hepatitis C diagnoses in SA. Injecting drug users comprised 94% of the 88 new HCV transmissions⁶ in SA in 2000, 17% (15 of the 88) were Aboriginal identifying (Clinic 275 Annual Report 2001). Assuming similar patterns of transmission, this would indicate that 14 of the 15 Aboriginal identifying new transmissions occurred in people who inject drugs.

There is evidence that in some Aboriginal communities, every family has been touched in some way by injecting drug use (Lehmann and Frances 1998, Edwards et al 1999). There are still many misconceptions in the community about harm reduction, denial about injecting drug use, and shame – not only for Indigenous illicit drug users, but also for their families.

A contributing factor to the lack of services for Indigenous people who inject drugs, is the fact that information on injecting drug use within Indigenous communities is based largely on anecdotal evidence. The lack of appropriate consultation and research into Indigenous injecting drug use translates into a lack of culturally appropriate services.

All of these factors combine to paint a picture of a section of the community in immediate need of access to Hepatitis C prevention and treatment, harm reduction information and appropriate drug treatment programs.

Overview of Aims

The title of the project described in this report is Using Rapid Assessment Procedures to Investigate the Impact of IDU amongst Indigenous Australians in Metropolitan Adelaide. The aims of the project were to:

- assess the impact of injecting drug use on the Indigenous community
- gather information on the injecting practices of Indigenous people who inject drugs, their knowledge of the risks associated with injecting drug use and their knowledge of and access to services
- improve the available knowledge base on Indigenous IDU and inform further development of responses and services
- determine if Rapid Assessment Procedure is a valuable method of conducting research in Aboriginal communities.

³ Ibid

⁴ HIV/AIDS, Hepatitis C and Sexually transmitted Infections in Australia Annual Surveillance Report 2000

⁵ Australian Indigenous Health *InfoNet* (2001, 18 June) *Summary of Indigenous Health Status, June 2001*

⁶ A new transmission is a positive test after previously testing negative

Time Schedule

The project commenced in January 2001, with the employment of the project officer. A review of existing literature on Indigenous injecting drug use was conducted and released in March 2001. Key Consultant interviews commenced in May and continued throughout May and June. Peer interviewers commenced training in July and conducted surveys throughout August. The remainder of the time since September 2001 has been spent analysing and interpreting the data gathered throughout the research phase of the project.

Who Was Involved

Over 500 people were involved throughout the course of the project. They consisted of representatives of Indigenous and non-Indigenous organisations, community members, Indigenous people who inject drugs, and families and friends of Indigenous illicit drug users.

The project was funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH), a division of the Commonwealth Department of Health and Ageing. The project has been endorsed by the Aboriginal Health Research Ethics Committee. The National Centre for Education and Training on Addiction (NCETA) assisted in project development and data analysis and interpretation.

The project was supported by a Project Advisory Committee, consisting of community members representing a wide range of expertise in drug and alcohol issues. Committee members participated in the development of the research, provided ongoing feedback on the findings, and represented issues and/or concerns of their community, organisation or service.

ADAC utilised Peer Interviewers (Aboriginal people with experience of injecting drug use) to conduct the interviews for the IDU Survey. Peer Interviewers were able to develop a rapport with survey participants as a result of shared or similar experiences. The Peer Interviewers' knowledge of practices and language used within the local injecting drug using community also established their credibility with the survey participants.

Methodology

Rapid Assessment Procedures

The project utilised a research tool called Rapid Assessment Procedures (also called Rapid Assessment Methodology or Rapid Assessment and Response), which are a way of utilising a variety of methods to collect information about communities or groups of people at a particular point in time. The assessments are done over a short period of time, using methods such as focus groups, interviews and surveys to assess behaviours (ie injecting practices) and risks. Using a variety of methods, and continually cross checking the information learned using one method against information learned using another (triangulation), a picture of what is occurring can be built up. Rapid Assessment is useful in identifying appropriate interventions and identifying some of the barriers to initiating interventions.

Consultant Interviews

The first research phase of the project involved conducting interviews (Consultant Interviews) with key members of the community who have contact with, or first hand knowledge of, Indigenous people who inject drugs. Individual interviews were conducted as well as group interviews. Consultants were asked about the ways that drug use was affecting the Aboriginal community and were also asked to talk about some of the issues for Indigenous people who

inject drugs and their families. They were also asked to describe what they knew of the injecting practices of Indigenous people who inject drugs.

IDU Survey

The second research phase consisted of a survey of Indigenous people who inject drugs to find out more specific information such as injecting practices, access to services, drug related problems and knowledge of harm reduction/safe using. The IDU Questionnaire is based on the survey that ADAC conducted in Murray Bridge, with additional questions related to recurring themes and issues from the Consultant Interviews.

The seven Peer Interviewers conducting the surveys initially accessed Aboriginal injecting drug users known to them and eventually, through 'snowballing' (making new contacts through referrals or introductions), accessed other Aboriginal people who injected drugs. Survey participants were paid for their time in addition to being provided with information packs containing harm reduction resources. Three Peer Interviewers had needle exchange licences and were able to provide clean syringes to survey participants if requested.

Community Feedback

The third phase of the project consisted of holding consultations with the Indigenous community (including Indigenous people who inject drugs), and also those working with Indigenous people who inject drugs. Small group and individual consultations were held. Consultations consisted of discussing the research results with participants and exploring the implications of the results. ADAC then drafted a number of recommendations based on the issues raised in the consultation process. The draft recommendations will be disseminated to the Indigenous community for feedback and approval.

Summary of Consultant Interviews

Consultant Profile

Most consultants were recruited through direct contact with the interviewer, other members of ADAC, a member of the Project Advisory Committee or someone else involved in the project. Fifty-eight people participated as key consultants in a total of 28 interviews. One interview was held with a group of 24 people and the remainder of the interviews were held with between 1-3 people. A small number of interviews occurred through taking advantage of unexpected opportunities. These impromptu interviews were unstructured and informal, mostly focussing on the interviewee's specific area of knowledge. Participants were requested to answer each question as well as they could, while restricting their answers to their own knowledge or experience rather than hearsay.

Most consultants knew about IDU related issues in the Aboriginal community through their work in the health, social services, drug and alcohol or legal field. Others knew about IDU issues through involvement in the community or through the 'grapevine'. Social contact with Aboriginal people who inject drugs was also a source of knowledge (ie through acquaintances, friends or family members who used drugs).

Contact with Indigenous people who inject drugs ranged from daily contact to contact every couple of months. Four consultants stated they had no personal contact with Aboriginal people who inject drugs and 7 people were unsure, acknowledging that it was possible they were in contact with people who inject drugs without being aware of their using status.

The number of Indigenous people who inject drugs known to consultants also varied, ranging from very few to a large number of injectors. Eleven people were in contact with between 10 and 50 Aboriginal injectors and 3 people were in contact with more than 50 Aboriginal injectors. Some consultants found it more accurate to estimate how many users they saw in a given period (ie per month). This ranged from less than 10 Aboriginal injecting drug users per month to over 50 Aboriginal users each month. Six consultants were unable to estimate the number of Aboriginal injecting drug users with whom they were in contact.

Drug Use Patterns and Practices

Drug Use Patterns

Consultants were united in perceiving the extent of injecting drug use in the Aboriginal community to be widespread, with nearly all Aboriginal families in suburban Adelaide affected in some way by a family member, or someone close to the family, using. Consultants commonly believed that injecting drug use was an increasing trend amongst Aboriginal people. Many were concerned that the age of first drug use appeared to be decreasing as a result of exposure to, and awareness of, drugs from early age.

Heroin or speed (or both) was most frequently stated as the drug most often injected by Aboriginal injectors. A number of consultants stated that Aboriginal illicit drug users were predominantly polydrug users, including lots of cannabis and alcohol use. Some consultants reported noticing increased injecting of benzodiazapines. Consultants perceived drug use to be supply driven, stating that when their drug of choice was not available, Aboriginal injectors would rely on what they could get. Methadone and benzodiazapines were mentioned as drugs that were often used as ‘fillers’. A couple of consultants referred to the heroin ‘drought’ that was happening at the time⁷.

Injecting Practices

The majority of consultants believed there had been an uptake in use of Clean Needle Programs (needle exchanges) by Aboriginal people who inject drugs but there was still some unsafe using and sharing of syringes as a result of Aboriginal users’ tendency to use ‘on the run’ (ie unplanned, spur of the moment use) and getting small quantities of syringes at a time. In about half of the interviews (13 interviews) consultants believed that sharing syringes generally occurred only with partners or close friends, or when people were anxious to use their drugs immediately. Consultants added that sharing of injecting equipment *other than syringes* (ie spoons, filters, mix) was more widespread. Overall, consultants believed that awareness of safer using was on the increase, but in extreme circumstances Indigenous users’ need for a ‘hit’ may override awareness of safe practices.

Knowledge of Blood Borne Viruses

Most consultants reported that, in general, the Aboriginal community’s knowledge of blood borne viruses had increased in the last 5 years, and that there was awareness and broad knowledge in the community despite not enough specific messages targeting Indigenous people. Consultants reported that Indigenous people who inject drugs were getting tested for

⁷ Beginning in late 2000/early 2001 and continuing throughout 2001, there has been a marked decrease in the purity/quality and availability of heroin throughout Australia. Reports indicate the ‘heroin drought’ was associated with a decrease in frequency of heroin use and an increase of use of other substances (cocaine and methamphetamine) (IDRS 2001, NDARC)

Blood Borne Viruses (BBVs) although sometimes they would wait until they went to prison because there was easier access to testing in prison. When asked about HIV, consultants commonly stated that the injecting drug users they knew did not regard HIV as a users' issue.

Many consultants believed that the large numbers of Indigenous users who were Hepatitis C (HCV) positive was resulting in a blasé attitude towards this virus, especially as many Indigenous injectors knew many HCV positive people who were well. In addition, consultants believed that Indigenous users made a direct association between HIV and illness/dying/hospitals etc that they did not make between these issues and HCV. Consultants were concerned that Aboriginal people who inject drugs were unclear of symptoms, long term effects and treatment of Hepatitis C. Consultants also said that many Indigenous users had a fatalistic view regarding Hepatitis C because many Aboriginal people had low expectations about life in general and had no belief that services were able to meet their needs.

Impact of IDV on the Indigenous Community

There was a widespread belief amongst consultants that injecting drug use impacted on the whole of the Aboriginal community. Some believed that drug use has taken over from alcohol use as one of the main problems affecting urban Indigenous communities. Many consultants were concerned that the Indigenous community was no longer a tight community as a result of the devastating effect of injecting drug use on traditional culture and values.

Consultants reported that injecting drug use was increasing the social disadvantage experienced by the Indigenous community. They believed that injecting drug use was contributing to Aboriginal peoples' low self worth, generalised poverty, and poor health. Consultants spoke of the poor health of Indigenous people who inject drugs, some of whom were facing chronic health problems as a result of their lifestyle and its associated risks.

Family breakdown as a result of injecting drug use was mentioned in over half of the consultant interviews (18 interviews). IDU was affecting families who were already struggling - interfering with parenting, causing disruptions within families, stress and shame. Consultants reported that families often showed a lack of acceptance or understanding of a family member's drug use. Some consultants mentioned that a family offering support may be seen to be supporting a family member's drug use/addiction through their behaviour (for example by looking after children or giving money/food/shelter etc), and some people in the community believed that families offering such support were not bringing about behaviour changes.

Many consultants were concerned about the effect that drug use in the community was having on Aboriginal children. Consultants said that 'normalisation' of drug use (ie drug use being accepted as normal), and exposure to drug use was resulting in illicit drug users becoming role models due to a lack of alternative, more positive role models for young people.

The impact on the Aboriginal community of crime and subsequent incarceration was mentioned in the majority of consultant interviews (19 interviews). Consultants reported that drug use was leading to the revolving door of jail and poverty - where financial disadvantage leads to crime, which leads to incarceration and impacts on all family members. Consultants were particularly concerned about the numbers of young Aboriginal people in jail.

The devastating effect on the community, and the grief and trauma associated with overdose deaths, was a concern for many consultants. Consultants believed that poor relations between the police and Aboriginal people contributed to reluctance to call for an ambulance to attend an overdose because many Indigenous people who inject drugs did not believe the message

regarding police involvement. As a result, response to overdose is poor. Lack of knowledge of resuscitation techniques amongst Aboriginal injectors was also believed to be a contributing factor in overdose deaths.

Consultants believed that, in addition to lack of knowledge about responding to overdose, there was a lack of knowledge among Indigenous injectors regarding overdose prevention (ie causes or contributing factors of overdose). A number of consultants regarded prison release (lowered tolerance), or combining pills or alcohol with heroin as the most common contributing factors to Indigenous overdose. The inconsistent strength of drugs was also mentioned as a contributing factor in overdoses.

Access to Services

The lack of availability of culturally appropriate services was a consistent theme, mentioned in 18 of the 28 interviews. Consultants stated that Aboriginal clients viewed the atmosphere of mainstream Drug and Alcohol services as uninviting and impersonal, adding that there were not enough Aboriginal faces or workers that Aboriginal injectors identified with and felt comfortable with. Consultants also believed that the rigidity of services was a barrier, that services had too many rules and regulations (7 interviews).

In almost half of the interviews (13 interviews) lack of confidentiality was mentioned as a major barrier to service access, especially to Indigenous focussed services. Consultants reported that the possibility of being identified as an injecting drug user by family members (immediate or extended family) prevented many Aboriginal injectors from accessing Indigenous services. The shame and stigma attached to injecting drug use was seen as a barrier to accessing both mainstream and Indigenous services.

Additional barriers to accessing services were believed to be: Indigenous users' lack of awareness of services, location (services are not where clients live), not fitting criteria for access, and inconvenient opening hours. Other barriers mentioned were Indigenous users' lack of confidence regarding their ability to communicate their needs and lack of coordination between services. Isolation from family and community were believed to be barriers to Indigenous access of inpatient services (such as detox or residential services), as locked doors at night reminded Indigenous people of the criminal justice system.

Methadone Programs

Benefits Of Methadone

Indigenous peoples' access to methadone was discussed in 14 consultant interviews. Attitudes toward the methadone program were generally positive – methadone was considered to be a factor in healing the rift between illicit drug users and their families. The increased stability that methadone provided enabled people to renew relationships with their family and children. Other benefits raised were reducing the necessity for illegal activities and reducing the risks associated with injecting.

Concerns About Methadone

A number of consultants considered that methadone did not suit everyone and there was a need for other options. Some consultants did not believe methadone was beneficial at all. One consultant pointed out that being on methadone did not necessarily mean the person had given up heroin and they may end up with an additional drug dependency. There was a

perception that methadone was better for the rest of the community (in terms of reduced crime etc) than for the client. Three consultants raised the issue of dental problems associated with methadone.

Barriers to Accessing Methadone

The biggest barriers to Indigenous access to methadone were perceived to be the lack of availability of methadone prescribers, the lack of dispensing pharmacies, and cost. Consultants believed that the expense of daily travel to and from the chemist (12 interviews), coupled with the cost of methadone (7 interviews), could present a financial barrier that was too difficult to overcome for those on low incomes. Consultants reported that lack of dispensing pharmacies and discrimination towards Aboriginal people has meant that Aboriginal clients have had difficulties in finding a chemist to dispense their methadone.

A number of other barriers to accessing methadone were mentioned such as: the program's rigid structure of rules and regulations; the lack of backup and ongoing support within the program; and the stigma associated with methadone - resulting in negative community attitudes and a lack of family and community support for those on the methadone program.

The Main Needs of Indigenous People Who Inject Drugs

The main needs of Indigenous people who inject drugs were addressed in 19 out of the 28 interviews. Increased options/choices in treatment were seen as a priority, specifically Indigenous specific treatment options and exploring the feasibility of treatment alternatives (such as buprenorphine) rather than concentrating on methadone. Some consultants emphasised the need for holistic services that address a range of emotional and social issues rather than focussing on substance use. These services would offer long-term support and focus on health promotion and early intervention strategies.

The most frequently mentioned needs of Indigenous injectors were improved access to Clean Needle Programs (CNPs) and related services for people who inject drugs (14 interviews), information/education (10 interviews), support for families of people who inject drugs (9 interviews) and counselling, particularly grief counselling (6 interviews). Other needs mentioned were access to a safe environment (ie a safe place to use drugs and a safe place for users to meet), peer education, law reform and social equity. Consultants raised the need for recognition that Aborigines probably use drugs and alcohol to escape boredom/poverty etc.

“Its bigger than just a drug problem - social equity starts with Centrelink breaching, not enough housing etc. The increase in drugs [use] is a symptom of increased difficulty of living in this society” (Indigenous support worker)

“[I] see it as a signal that our society is not coping with changes/pressures and the most vulnerable will seek solutions to cope” (D&A worker)

Summary of Survey Phase

Three hundred and seven (307) Aboriginal people participated in the survey phase of the project. They were an average age of about 32 years, with an age range of 14 to 54 years. The sample consisted of 60% male and 40% female injecting drug users.

A third of the sample (35%) was in a relationship at the time of the survey and 66% of those who were in a relationship (71 people) had a partner (mostly Indigenous) who also injected drugs.

Ninety three percent (N= 286) said that half or more of their group of friends also injected drugs.

The average age of leaving school was 15 years, and 49% had completed at least Year 10. There were 36% who had studied since leaving school, mainly in technical or trades areas.

A total of 97% received some government benefit - 66% of those were unemployed and the rest generally received parenting or study benefits. Only 3% of the sample (N=9) had stable employment.

Drug Use Patterns

Drugs most often used in the last 6 months were

Heroin (97%), speed (methamphetamine) (68%), alcohol (66%), yarndi (cannabis) (63%), tobacco (55%), benzodiazepines (34%) and prescribed or 'diverted' methadone (34%). Most people were polydrug users, using about 4 different drugs or drug types during the last 6 months. Drugs most commonly used together were yarndi and heroin, yarndi and speed, speed and alcohol, heroin and alcohol, or heroin and methadone.

Heroin was used by 97% of the sample in the last 6 months (N=297) and 85% of these people (N= 252) used heroin at least once a day.

Speed (methamphetamine) was used by 68% in the last 6 months (N=209); 32% of these used daily (N=67) and 36% (N=75) used at least once a week.

Yarndi (cannabis) was used by 68% of the sample in the last 6 months (N=209) and 90% of these people used every day (N=188).

Tobacco was used daily by 54% of the sample (N=166).

Alcohol was used by 66% of the sample in the last 6 months (N=202), 32% of these people (N=66) drank alcohol everyday.

Injecting Behaviour

The average age of first injecting was 18 years, with heroin the drug most likely to have been injected on the first occasion of use. Speed was also nominated as the first drug injected, although it was more likely than heroin to have been used by a method other than injecting the first time it was used.

Eighty one per cent of the sample had received assistance on the first occasion they injected (N=249); 62% received assistance from another Indigenous person (N=190). Most (96%) of

those who sought assistance knew their 'injecting helpers' well (relatives, friends, partners, or people known to them).

The most recent place where people injected was either at home or at a friend or relative's place (68%). On the last occasion of injecting, 36% of the sample injected in a public place such as a car, shopping centre or pub.

The most common forms of syringe disposal were sharps disposal containers, fit packs to rubbish bin, or directly in rubbish bin. Less than 7% of the sample said that they threw used syringes 'outside' or gave them to friends, although 22% saved used syringes for later use (N=68).

There were 66% of participants who stated that they 'almost always' used a new syringe whenever they injected. Thirty to forty percent stated that they 'rarely' or 'never' shared other injecting equipment (filter, spoon, mix, tourniquet).

Twelve percent of the sample (N=37) had used a syringe after another person in the last 3 months. To explore information provided, they were grouped into the category of 'sharers' and compared with those who had 'never' used a syringe after someone else had used it.

New syringes were usually bought from chemists or obtained without cost from Clean Needle Programs (needle exchanges), although friends were also common sources.

Twenty five percent of the sample (N=77) practiced good injecting hygiene by washing their hands, and 33% (N=102) usually swabbed the area to be injected before injecting.

People in the 'sharers' group had similar characteristics to those who had never shared in terms of age, gender, age left school, number of times overdosed, and length of time injecting. However, those in the 'sharers' group were more likely than non-sharers to be dependant on both alcohol and illicit drugs, and to have a greater number of health, social and injecting related problems. Although those in the sharers group were more likely to be heavier polydrug users, and use speed more frequently than the non-sharers group, there were no differences in frequency of heroin use.

Perceptions Of Contracting Blood Borne Viruses (BBVs)

Eighty three per cent of the sample (N=255) believed that they were at 'low' or 'very low' risk of contracting HIV or hepatitis B. Generally, participants stated that their risk was low because they did not share injecting equipment, they practiced 'safe sex', or they had been vaccinated for hepatitis B. Seventy three per cent of the sample (N=224) believed they were at 'low' or 'very low' risk of contracting hepatitis C. Responses about how hepatitis C was contracted, and what constituted risk behaviour were more varied than for the other Blood Borne Viruses (BBVs), indicating inconsistencies in knowledge about the hepatitis C virus. Even so, 90% of the sample had been tested for the three viruses (N=276), and 60% had been tested within the last 6 months (N=184).

Social and Emotional Well Being

Access to General Health Services

Services most commonly used for general health problems included General Practitioners (56%), Aboriginal Medical Services (7%), and Community Health Centres (7%). Ten per cent

of the sample (N=31) said they did not seek assistance for general health issues. Half of the sample (51%) had informed their health workers that they had injected illicit drugs (N=154).

Other Services

Participants most commonly had contact with a GP (48%), the police (26%), a counselor (23%) or a welfare service (21%) as a result of problems associated with injecting drug use. Less than 20% had used drug withdrawal services, drug treatment agencies, hospitals or rehabilitation services. Most frequently mentioned reasons for accessing services were health issues, to have a break from or reduce drug use, legal issues or for clean syringes.

Physical, Social and Emotional Well Being

Participants' injecting drug use contributed to a range of concerns related to their physical, social and emotional well-being.

Withdrawal symptoms, vein problems, mood swings, reduced enjoyment of life, sleeping problems, depression and memory problems were among the issues most frequently attributed to injecting drug use.

Participants also said that their drug use had caused them difficulties with family and personal relationships, legal problems or had resulted in accidental injury. Financial problems were high on the list of concerns. Participants stated that they usually spent a median of \$75 per 'taste' or 'hit' (range \$25-400), with average weekly expenditure amongst the sample ranging from \$50 - \$2100 (although several claimed they regularly spent more than this).

Drug Dependence

Participants were asked to state which drug was of primary concern to them. Psychological dependence was measured using the Severity of Dependence Scale (SDS). Of the 133 participants who nominated heroin as the drug of most concern to them, 90% were likely to be dependent on the drug as measured by the SDS (N=120). Of the 89 participants who nominated speed as the drug of most concern to them, 77% were considered dependant (N=69).

This research supports findings from other samples of people who inject drugs, where higher SDS scores suggested;

- increased risk of experiencing problems in terms of physical, social or emotional well being
- higher likelihood of having recently used a needle after someone else, or of sharing injecting equipment, such as spoons, filters, tourniquets and mix
- higher perceptions of risk of contracting Blood Borne Viruses (BBVs).

Alcohol Related Harms

Fifty eight per cent of participants (N=177) had consumed alcohol in the last 12 months, and so were eligible to complete the Alcohol AUDIT, used to identify 'at risk' and 'harmful' drinking. Sixteen per cent (N=28) of those who completed the AUDIT were found to be drinking at levels considered to be at low risk of harm. Twenty one per cent (N=38) were found to be drinking at 'at risk' levels (levels indicating their alcohol use was likely to be causing them some problems). Sixty three percent of those who completed the AUDIT (or

36% of the total sample) were drinking at levels considered to be harmful to their health (N=111).

Overdose

Twenty one per cent of the sample (N=63) had overdosed after injecting, and 33% of these people (N=21) had overdosed in the last 12 months. Thirty seven percent of those who had ever overdosed (N=23) said that they had intentionally attempted to overdose. Nine people were present when someone else had not recovered from an overdose. Only 23% of the sample (N=70) described some knowledge of basic first aid that they could apply in an overdose situation.

Imprisonment

Whilst 53% of the sample had been in prison⁸ (N=163), this was more likely for males than females. Forty four per cent of those who had been in prison had injected while incarcerated (N=73), with heroin more commonly used than speed. Twenty four per cent of those who injected in prison said that they *never* shared (N=18), although 52% of those who had injected in prison reported that they *always* shared (N=38). Seventy two percent of those who had injected in prison (N= 53) said that they had made an effort to clean a used syringe prior to using it.

Methadone

Thirty- eight people, of a median of 31 years (range = 18-46) were registered on a methadone program, and were prescribed a median of 60mg a day. Forty three per cent of those currently on methadone had been on the program for two years or more (N=16).

The participants on a methadone program had similar characteristics (age, education, age first injected, prison history, for example) to those who were not on a methadone program. There were no differences between opiate users on methadone and opiate users not on methadone, in terms of pattern of heroin use or drug related harms (using health, social and emotional well being scales). However 55% of those on methadone stated that methadone helped to reduce withdrawal symptoms and cravings, helped improve their lifestyle, and helped them to cease involvement in criminal activity. Participants stated that negative aspects of methadone were the disruption to their life due to daily pickup (especially where children were concerned), dental problems, cost, and transport issues.

Gender Differences

Although there were a higher proportion of males than females in the sample, there were no gender differences in terms of general characteristics (age, education, prison history), drug use patterns, SDS or Alcohol AUDIT scores, or in health, emotional and social well being or injecting related issues. The only difference detected for gender was that men were more likely to have been imprisoned than women.

⁸ This includes adult prison or juvenile correctional institution

Community Feedback Summary

The initial forums to receive feedback on the research findings were held with people who had been involved in the project. The first forum was held for those who had participated as key consultants. The aim of this forum was to present a picture or 'snapshot' of injecting drug use in the Indigenous community based on the information gathered during the interviews, and to provide an opportunity for participants to give some feedback on whether the picture presented accurately reflected what they had said during the interviews.

A feedback session was held with the Peer Interviewer team and a number of individual consultations were held with Indigenous injectors. Participants in these sessions focussed on the information and service needs of Indigenous people who inject drugs and came up with a number of specific topics for information resources to address, for example:

- information on buprenorphine
- information on who the drug and alcohol workers are in each area - names, phone numbers, contact hours etc
- information on Methadone, including the side effects of methadone, long term effects and information on 'new' methadone (Biodone)
- information on long term effects of drugs - especially methamphetamine (speed) and associated mental health effects
- information for parents/families of Indigenous people who inject drugs - including signs of use and what to expect, how to support a drug using family member, support groups and where to go for help.

The lack of information on available services, particularly Clean Needle Program (CNP) sites, was an issue that also surfaced during the survey phase. ADAC addressed this issue immediately by developing a service directory that listed the contact details and whereabouts of needle exchanges, drug treatment services, welfare and legal services. The directory folds into a business card sized resource that can be carried in a wallet or pocket.

ADAC is also in the process of developing a series of harm reduction information resources about illicit drugs – the need to target information appropriately will mean that some resources may need to have 3 versions - 1 for illicit drug users, 1 for family members and 1 for the general community or health workers.

Recommendations

Recommendations were informed by community feedback sessions in addition to input from the Project Advisory Committee. Particular issues that have been identified include those relating to:

- hepatitis and other Blood Borne Virus information (transmission, prevention, treatment and care)
- polydrug use issues (information, drug combinations and associated risks eg. overdose, dependence)
- overdose (knowledge of response and prevention for people who inject drugs, family members, community members and health and community workers)
- access to services (barriers to accessing Clean Needle Programs and other services)
- amphetamine use (risks, treatment for amphetamine dependence, access to services)
- methadone and other pharmacotherapies (access to methadone, support for clients and information about treatment alternatives)
- prison issues (using in prison, Hepatitis C transmission, prison support programs and post release support).

ADAC have drafted a number of recommendations relating to issues identified throughout the project. Further consultation with the Indigenous community will assist in developing and refining the recommendations listed below:

1. Increase range and accessibility of existing services by:

- providing comprehensive training for Aboriginal Health Workers in Alcohol and Other Drug (AOD) issues, including Blood Borne Virus (BBV) education
- provision of cultural diversity education for non-Indigenous workers and increased employment of Aboriginal workers in AOD services at all levels
- inclusion of the client's family or partner when providing support services
- providing more flexibility in services by broadening the criteria for accessing, increasing opening hours and offering more services by 'drop-in' rather than by appointment
- ensuring that there is a choice available between mainstream and Indigenous specific services
- promoting and advertising services and providing information (available through Clean Needle Programs, outreach workers etc) on services and what they offer.

2. Develop a range of Aboriginal specific services (in consultation with Aboriginal community and clients) that allow for Aboriginal ownership of problems and ways of dealing with them, including:

- aboriginal specific long term residential centre/therapeutic community and Indigenous specific detoxification services
- services that offer long-term support, address a range of emotional /social issues and focus on health promotion rather than substance use
- 'one-stop-shop' community centres that provide a variety of services at one site and that address needs ranging from provision of injecting equipment, peer education and life skills development to counselling, drug treatment and general health needs.

3. Implement a range of Peer Education Programs, specifically:

- outreach programs for hard to access people who inject drugs
- support and services for young Indigenous people, including increased employment, training and resourcing of Nunga Youth Peer Educators
- establishment of 'drop-in' style services (like an Indigenous SAVIVE) run by peers to enable Indigenous to access information, needle exchange, support etc.

4. Develop and disseminate Aboriginal specific Harm Reduction information, Including:

- development, through consultation with Indigenous people who inject drugs, of information presented in a variety of formats (written, posters, visual, through workshops etc) on safer using, drug treatment options, hepatitis C transmission, hepatitis C treatment and care and other harm reduction information
- development of overdose education including information on overdose prevention and response, and provision of CPR/ first aid training for the Indigenous community (particularly for Indigenous injectors and their families).

5. Develop information/education for the Indigenous community to increase knowledge and raise awareness of IDU issues, with the aim of reducing the shame and stigma experienced by Indigenous people who inject drugs.

6. Increase Aboriginal involvement and input into drug strategy and policy development.

7. Develop partnerships/collaboration between mainstream and Indigenous services and improve communication between organisations and the Indigenous community.

8. Implement Harm Reduction Strategies in Prisons with the aim of decreasing the risks of unsafe injecting, including but not limited to:

- development of Peer education programs for prisoners that include 'lifeskills' training and including post release support and follow-up to assist prisoners in their transition into life outside of prison and reduce the risks of harmful drug use
- increased availability of methadone/buprenorphine in prison, including provision of support and assistance to continue in treatment post-release
- trialing the provision of sterile syringes in prison.

9. Increase Social and Emotional Support available to Indigenous people who inject drugs by:

- increasing welfare support for Indigenous illicit drug users and their families, particularly for users with children, and including support for drug using parents to continue in the care of their children
 - increasing the availability of Grief and Trauma counselling
- establishing services/programs for parents/families of people who inject drugs that provide harm reduction information and support, including support for families who

have lost a family member to overdose or other drug related death or who have a family member incarcerated as a result of drug use.

10. Address the underlying issues of Indigenous social inequity (economic/health/education) to reduce the environment of social disadvantage that creates an increased demand for drugs and an increased likelihood of being involved in negative aspects of drug use.

11. Improve Indigenous access to methadone and other drug treatment programs and increase the likelihood of benefiting from methadone by:

- addressing the stereotypes/myths of methadone (and other pharmacotherapies) in the Indigenous community to reduce the stigma associated with methadone
- increasing the number of methadone prescribers and dispensing pharmacies, making it easier to get accepted on to treatment programs and providing more flexibility in rules and regulations
- providing immediate access to Aboriginal Dental Program (through Indigenous health services) for Aboriginal people who inject drugs and methadone clients
- implementing a scheme to subsidise the cost of methadone dispensing
- increasing support for clients reducing/coming off methadone (including provision of counselling and ongoing support/follow-up within methadone programs and ongoing support post methadone)
- increasing the drug treatment options for Indigenous illicit drug users by evaluating the efficacy of alternative pharmacotherapies, particularly buprenorphine
- investigating the possibility of conducting a trial maintenance treatment program for amphetamine dependent people.

12. Investigate creative harm reduction options and ways of addressing drug related harms, with a particular focus on strategies that have proven successful elsewhere, such as:

- implementation of options other than custodial sentences for Indigenous people who commit drug related crimes (including property crime)
- investigating the possibility of prescribing Heroin or Morphine as an alternative maintenance treatment to methadone, particularly for those who are not suited to methadone
- establishing Safe Injecting Facilities to reduce the incidence of opiate or other drug overdose
- decriminalising currently illicit drugs with the aim of reducing harms associated with injecting drugs of unknown quality and purity, and reducing the stigma of IDU that presents a barrier to accessing appropriate health care.