

RESPONDING TO THE NEEDS OF INDIGENOUS PEOPLE WHO INJECT DRUGS

FINDINGS FROM THE RESEARCH PROJECT:

**'Using Rapid Assessment Procedures to Investigate
the Impact of Injecting Drug Use Amongst Indigenous
Australians in Metropolitan Adelaide'**



ABORIGINAL DRUG AND ALCOHOL COUNCIL (SA) INC.

JULY 2003



**Aboriginal
Drug and Alcohol
Council (SA) Inc.**



**ISMHPU
Indigenous Substance Misuse
Health Promotion Unit**



On behalf of the Aboriginal Drug and Alcohol Council (SA) Inc I would like to present this research report to the wider audience to raise the issues of injecting drug use amongst Indigenous Australians. For too long these issues have been shrouded in misinformation and almost the 'ostrich in the sand' mentality. It is only by having research such as this that we can lift the shroud and begin the process of bringing the issues to the attention of the community.

I was once told that denial was not the name of a river in Egypt, but for a long time our community has been in denial about the extent of injecting and the harms caused by it. I hope that the issues raised in this report will prompt government bodies and other agencies to become more serious about this issue and its impact on the community.

ADAC believes that without ongoing research into injecting drug use amongst Indigenous injectors we cannot begin to start the process of healing and recovery. We are hopeful that research such as this can be conducted on an ongoing basis so as to best enable community organisations to plan and shape interventions that will bring about sustained help for those experiencing the effects of injecting drug use.

Because to do nothing condemns not just this group of people in the survey, but also the 450 children collectively in their care, to an uncertain future.

Yours in the Struggle
Isabella Norvil
ADAC
Chairperson

Foreword: Isabella Norvil



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ABBREVIATIONS USED

ABS:	Australian Bureau of Statistics
ACSA:	AIDS Council of SA
ADAC:	Aboriginal Drug and Alcohol Council (SA) Inc.
AHC:	Aboriginal Health Council
AHREC:	Aboriginal Health Research Ethics Committee
AHW:	Aboriginal Health Worker
AIDS:	Acquired Immune Deficiency Syndrome
APOSS:	Aboriginal Prisoners and Offenders Support Service
AUDIT:	Alcohol Use Disorders Identification Test
BBV:	Blood Borne Virus
CNP:	Clean Needle Program
CPR:	Cardio Pulmonary Resuscitation
DASC:	Drug and Alcohol Services Council
HBV:	Hepatitis B Virus
HCV:	Hepatitis C Virus
HIV:	Human Immunodeficiency Virus
IDRS:	Illicit Drug Reporting System
IDU:	Injecting Drug Use
LMNC:	Lower Murray Nungas Club
NCETA:	National Centre for Education and Training on Addiction
NDRI:	National Drug Research Institute
NSP:	Needle and Syringe Program
NU-HIT:	Nunga Users HIV Intervention Team
OATSIH:	Office of Aboriginal and Torres Strait Islander Health
RAM:	Rapid Assessment Methodology
RAP:	Rapid Assessment Procedures
SAPOL:	South Australia Police
SAVIVE:	SA Voice for IV Education
SDS:	Severity of Dependence Scale
SIF:	Supervised Injecting Facility
TAFE:	Technical and Further Education



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- Indigenous and non-Indigenous key consultants
- participants in the community consultations
- Indigenous people who inject drugs who provided feedback on the research
- Indigenous people who inject drugs (307) who participated in the survey
- staff members of the National Centre for Education and Training on Addiction (NCETA), the Drug and Alcohol Services Council (DASC) and ADAC who commented on project reports.

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- McDonalds Family Restaurants
- National Drug Research Institute (NDRI), Curtin University
- Noarlunga Health Village
- Muna Paiendi
- Nunkuwarrin Yunti
- Salisbury Greater Union Cinema
- South Australian Voice for Intravenous Education (SAVIVE).



PROJECT PARTICIPANTS

The following people were directly involved in planning and implementing the project.

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The Project Team received valuable assistance from:

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- Ms Leanne Ho, student at Flinders University of South Australia
- Ms Anne Hayes, Consultant.

The Peer Interviewing Team consisted of:

- Deb • Marie • Louie • Laurel Lee • Shannon • Ray • Jenny

The Project Advisory Committee included:

- Mr Damon Brogan, SAVIVE
- Ms Deb Walker, Muna Paiendi
- Ms Susan Cameron, Nunkuwarrin Yunti
- Mr Harry Harun, Nunkuwarrin Yunti
- Dr Nick Williams, Adelaide Central Community Health Service - The Parks
- Dr William Donohue, Hepatitis C Council of SA and C Clearly Project, Adelaide University
- Mr Alwin Chong, Aboriginal Health Council SA.

EXECUTIVE SUMMARY

Study Methods

This report presents the results of a project undertaken by the Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), in collaboration with the National Centre for Education and Training on Addiction (NCETA), to study injecting drug use among Indigenous people in Adelaide, South Australia (SA). The study was funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH), a division of the Commonwealth Department of Health and Ageing, and endorsed by the Aboriginal Health Research Ethics Committee (AHREC). The study employed the rapid assessment and response methodology, an action oriented approach that aims to collect data rapidly and inform the development of interventions specific to the community of interest. This report presents data collected between May and August 2001 from three sources including interviews with 58 key consultants, a survey of 307 Indigenous people who inject drugs, and a series of community consultations.

Key Consultant Interviews

Key consultants described:

- the increasingly widespread nature of injecting drug use within the Indigenous community
- the apparent popularity of injecting heroin or speed (or both)
- frequent polydrug use, for example, concurrent use of cannabis and alcohol with other illicit drugs
- an increasing trend towards injecting benzodiazepines
- patterns of use dictated more by drug availability than by drug of choice.

Key consultants identified that injecting drug use within the Indigenous community has:

- replaced alcohol as the main drug of concern for Indigenous people
- increased the social disadvantages of the Indigenous community
- negatively impacted on the physical and psychological well-being of injectors
- contributed to family breakdown, interfered with parenting responsibilities and caused disruption, stress and shame for families
- caused considerable stress within and between families due to inconsistencies in the way drug use issues were handled
- perpetuated the seemingly 'never-ending' cycle of grief and loss through death and family disruption.

Another consistent theme was the lack of culturally appropriate services. Mainstream services were viewed as uninviting and impersonal, too highly regulated, and having too few Indigenous staff.

Methadone was generally considered an effective way of responding to opiate dependence, however, support for methadone was not unanimous. Many key consultants mentioned the rigid rules and regulations for 'getting on' methadone, the lack of prescribers, the difficulties accessing dispensing pharmacies, and the relatively high cost. Key consultants suggested that the stigma associated with methadone use resulted in negative community attitudes and a lack of family and community support for it.



Survey of Indigenous People Who Inject Drugs

An examination of the drug use patterns of survey participants revealed that:

- heroin, speed, alcohol, cannabis, tobacco, benzodiazepines and methadone (used licitly and illicitly) were the drugs most commonly used
- most survey participants were polydrug users, using about four different drugs or drug types during the last 6 months
- the most common drug combinations were cannabis and heroin, cannabis and amphetamine, amphetamine and alcohol, heroin and alcohol, or heroin and methadone
- twelve percent of survey participants were registered on a methadone program.

Examination of the injecting practices of survey participants revealed that:

- the average age of first injection was 18 years, and heroin was most commonly the first drug injected
- speed was often the first drug injected, but it was also more likely than heroin to have been used by another method on the first occasion of use
- new syringes were usually bought from pharmacies, obtained free from clean needle program outlets, or obtained from friends¹
- the most recent place of injecting was at a private home (60%)
- the most common forms of syringe disposal were sharps disposal containers, fit packs to rubbish bin, or directly in rubbish bin
- sixty six percent of survey participants 'almost always' use a new syringe whenever they inject
- twelve percent of survey participants had used a syringe after another person in the last three months (defined as 'sharers').

'Sharers' were more likely than 'non-sharers' to:

- be dependent on both alcohol and illicit drugs
- have a greater number of health, social and injecting related problems
- be heavier polydrug users
- have used speed more frequently.

Most survey participants believed they were at 'low' or 'very low' risk of contracting HIV, hepatitis C (HCV), or hepatitis B (HBV), because they did not share injecting equipment, they practiced 'safe sex', or they had been vaccinated for HBV. Forty one percent of survey participants disclosed a positive HCV status. Despite high testing rates, responses to questions about blood borne viruses were frequently inconsistent, suggesting poor knowledge about transmission and care.

Scores on the Severity of Dependence Scale (SDS) revealed that:

- ninety percent of those who stated that heroin caused them most concern were dependent
- seventy eight percent of those who stated that speed caused them most concern were dependent.

1. The South Australian Needle and Syringe Program (NSP) is called the Clean Needle Program (CNP). Clean Needle Program and clean needle program outlet are the terms used throughout this document.

**The survey also revealed that:**

- almost one quarter (21%) of survey participants had overdosed
- there are high levels of misinformation regarding appropriate response to overdose
- eighteen percent of participants always or mostly inject alone
- thirty seven percent of those who had ever overdosed had done so deliberately.

Over half (51%) of the survey participants had ever been in prison. Of these, 44% had injected in prison. Of those who injected in prison, 74% had shared syringes.

The survey revealed no significant differences in drug use patterns between participants over 25 years of age and those under 25 years of age.

Injecting drug use contributed to a range of concerns related to 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. Survey participants also reported difficulties with family and personal relationships, legal problems, financial problems and accidental injury.

Interpreting Key Consultant Interviews and Survey Results

An examination of survey results and key consultant interviews suggests that Indigenous people who inject drugs may be less likely to be recreational drug users and more likely to be dependent users. The survey found that dependence was a factor in participants' contact with the police and health services. Dependence may also have been a factor in participants' high use of heroin during a period when heroin was either hard to access or low quality (the 'heroin drought'). Dependence was also found to be a factor in experiencing increased drug related harms and/or engaging in unsafe injecting practices.

Although misinformation and lack of knowledge have contributed to participants' unsafe injecting practices, those who inject have generally attempted to do so as safely as possible, using the information and resources available to them. There was some syringe sharing, but sharing of other injecting equipment was more likely. Results suggest that re-using one's own syringe may be a common practice amongst Indigenous people who inject drugs. The research team were unable to come to a conclusion regarding a cultural obligation to share syringes, as key consultants were divided in their views and it was not raised in the survey. Survey results indicate that there is a lack of information regarding other aspects of injecting (for example appropriate use of swabs and filters) that may explain key consultants' reports of Indigenous injectors experiencing vein care problems.



Results of Community Consultations

Five forums were held with community members and other people who participated in the project, including the Project Advisory Committee. Issues identified in the community consultation forums included:

- blood borne virus transmission
- risks associated with polydrug use
- appropriate overdose prevention and response strategies among people who inject drugs, their family members, community members and health and community workers
- barriers to accessing the clean needle program outlets and other services
- risks associated with speed use, lack of treatment for amphetamine dependence and lack of appropriate services
- access to services and early intervention strategies for young people
- methadone and other pharmacotherapies
- injecting in prison including risks of injecting, transmission and treatment of blood borne viruses, post release support and prison peer education programs.

A consultation was held with a group of eight Aboriginal people who inject drugs and individual consultations were held with 25 Aboriginal people who inject drugs. These consultations were designed to identify issues that may have been overlooked in the survey. Issues raised by participants included:

- drug law reform (ie decriminalisation or legalisation)
- police targeting street dealers and user dealers
- provision of prescription heroin to opiate dependent people
- alternative methods to injecting
- difficulties of trying to balance a drug using lifestyle with other responsibilities
- need for appropriate harm reduction information.

Recommendations

A number of specific recommendations resulted from the project. Recommendations were informed by community feedback and input from the Project Advisory Committee. The recommendations describe a vast range of strategies - some can be implemented on a community level while others are policy level strategies. There is an expectation that the Indigenous community will be involved in the development and implementation of any strategies arising from these recommendations. Particular issues that have been identified include those relating to:

- improving Indigenous peoples' access to methadone and other pharmacotherapies
- implementing harm reduction strategies in prison, including prison clean needle programs, peer education, support programs and post release support
- increasing the range and accessibility of services, by reducing barriers to accessing existing services and developing Aboriginal specific services
- implementing peer education programs, ranging from 'drop-in' style services to outreach programs



Responding to the Needs of Indigenous People Who Inject Drugs

- developing Aboriginal specific harm reduction information, presented in a variety of formats, on safer injecting, drug treatment options, HCV, polydrug use and speed use
- development of overdose education, including information on prevention and response, and provision of CPR and first aid training for the Indigenous community
- increasing the Indigenous community's knowledge of injecting drug use issues, with the aim of reducing the shame and stigma experienced by Indigenous people who inject drugs
- developing partnerships between mainstream and Indigenous services
- improving communication between drug and alcohol organisations and the Indigenous community
- increasing the social and emotional support available to Indigenous people who inject drugs and their families, including grief and trauma counselling and support for Indigenous injectors with dependent children
- investigating creative strategies to address drug related harms, such as supervised injecting facilities, heroin as a maintenance treatment and non-custodial sentences for drug related crimes.



INTRODUCTION

This study is the second one to examine the harms experienced by Indigenous people who inject drugs in SA. ADAC also led the first research project in Murray Bridge, in 1997, in collaboration with the Lower Murray Nungas Club (LMNC), and NCETA. The results of the earlier study, along with other research findings, led to ADAC's decision to initiate this study among urban Indigenous people who inject drugs.

The project was funded by OATSIH, a division of the Commonwealth Department of Health and Ageing. It was endorsed by AHREC and NCETA assisted in project development and data analysis and interpretation.

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, their knowledge of the risks associated with injecting drug use, and their knowledge of, and access to services
- improve the available knowledge base about Indigenous injecting drug use to inform the development of appropriate responses and services
- determine whether rapid assessment and response is a valuable method for conducting research in Indigenous communities.

This study is the largest single study of Indigenous injecting drug use in Australia. Involving 307 Indigenous participants, it has enabled ADAC to understand drug use trends and injecting practices among Indigenous people in metropolitan Adelaide. ADAC has already begun to use this information to assist the Indigenous community to develop appropriate responses to drug related harms.

This report gives a description of the research methodology and results, in addition to a discussion of the implications of the results. The report also recommends a number of strategies to address some of the harms experienced by Indigenous people who inject drugs.

The research data contained in this report is described in more detail than in the Community Report (ADAC, 2002). The Community Report was written to provide Indigenous community organisations with a preliminary summary of the research and a list of draft recommendations for feedback and approval. The research data contained in this report has been updated since the publication of the Community Report. As a result, in some instances the two reports may show minor differences (1% - 5%) in statistical data.

SOUTH AUSTRALIA'S URBAN INDIGENOUS POPULATION: DESCRIPTIVE STATISTICS

Demographic Characteristics

Geographic Distribution

In 2001, there were 23,377 Indigenous people living in SA, comprising 1.6% of the total state population of 1,470,057 (Australian Bureau of Statistics 2002).

The Australian Indigenous population is a young one. In 2001, an estimated 34% of Indigenous people living in Adelaide were between 15 and 34 years of age (Australian Bureau of Statistics 2002). Approximately 58% of Indigenous people living in Adelaide were younger than 25 years compared to 32.5% of the total Adelaide population. Approximately 46.5% were younger than 18 compared to 23% of the total Adelaide population. Approximately 40% of Indigenous people living in Adelaide were younger than 15 years old compared with 19.5% of the total Adelaide population. Only 2.4% of Indigenous people living in Adelaide in 2001 were aged 65 years or older compared with 14.6% of the total Adelaide population.

Health

Life expectancy for Indigenous people (56 years for males and 63 years for females) is approximately 20 years less than the national average (Australian Bureau of Statistics 2001). Death rates for Indigenous people are higher than in the general population, up to five to six times higher in the 35 - 54 year age group (Australian Bureau of Statistics 2001). Many of the conditions common to the Indigenous population (ie diabetes, high blood pressure, low birth-weight and obesity) lead to kidney disease, resulting in the need for dialysis. In addition, access to health care has been consistently lower for Indigenous people compared to other Australians (Australian Bureau of Statistics 2001).

Families

In 2001, there were 3737 Indigenous families residing in Adelaide (Australian Bureau of Statistics 2002). Seventy six percent of those families (2857/3737) had children (including non-dependent students and other non-dependent children). Of Indigenous families with children under 15 years of age, 54% (1194/2205) were two parent families and 46% (1011/2205) were single parent families. Twenty seven percent of all Indigenous families comprised of a single parent with children younger than 15 years of age compared to 8.6% of non-Indigenous families (Australian Bureau of Statistics 2002).

Employment / Unemployment

In 1996, 24.3% of Indigenous South Australians were unemployed, approximately 2.4 times the state unemployment rate of 10.3% (Australian Bureau of Statistics 1998). Statistics indicate that Indigenous people in metropolitan areas are less likely to be employed than Indigenous people living in rural areas and non-Indigenous people in rural and urban areas (Australian Bureau of Statistics 1998).

Income

In 1996, the median weekly personal income for Indigenous South Australians was \$214, over \$60 per week less than the median weekly personal income of \$275 for all South Australians (Australian Bureau of Statistics 1998). Indigenous South Australians were more likely to receive less than \$160 per week and less likely to earn more than \$800 per week than all South Australians.

The median weekly family income for Indigenous South Australians was \$480, compared to \$667 for non-Indigenous South Australian families (Australian Bureau of Statistics 1998). Indigenous families were less likely to earn over \$1000 per week, and more likely to earn less than \$300 per week, than non-Indigenous South Australian families.



Table 1: Weekly individual income 2001: Indigenous people aged 15 years and over residing in Adelaide, SA (n=9062)

Weekly Individual Income	Percentage of People Earning
Negative/nil income	6.7%
\$1-\$199	7.8%
\$120-\$199	22.7%
\$200-\$399	25.7%
\$400-\$599	14.0%
\$600-\$799	6.9%
\$800-\$999	3.3%
\$1,000 or more	3.2%
Not stated	9.7%

Education

Indigenous people are less likely to complete secondary school and less likely to have post secondary school qualifications than the general population. In 2001, only 37.5% of Indigenous Adelaide residents had completed year 11 or 12 compared to 53.6% of the general population (Australian Bureau of Statistics 2002).

Indigenous people are also more likely to have never attended school than the general population. In 2001, 1.2% of Indigenous Adelaide residents had never attended school, compared to less than 1% for the general population (Australian Bureau of Statistics 2002).

Table 2: Highest level of schooling completed: people aged 15 years and over residing in Adelaide, SA

Highest Level of Schooling Completed	Indigenous People	Total Population
Year 8 or below	12.2%	10.2%
Year 9 or equivalent	11.1%	6.9%
Year 10 or equivalent	23.2%	18.7%
Year 10 or below	46.5%	35.8%
Year 11 or equivalent	19.0%	18.8%
Year 12 or equivalent	18.5%	34.8%
Year 11 or 12	37.5%	53.6%
Still at school	6.4%	3.4%
Did not go to school	1.2%	<1.0%
Not stated	8.4%	6.3%

PRISON

Incarceration Rate

Nationally, it is estimated that 1 out of 30 Aboriginal males are incarcerated (Human Rights and Equal Opportunity Commission 1997). Indigenous South Australians are 17 times more likely to be incarcerated than non-Indigenous South Australians (Levy and Butler 2000). Young Indigenous Australians are more likely to be approached by police and more likely to receive the harshest available sentence option (personal communication, Gary Clarke 2001) ² As a result, they are over-represented in prisons and juvenile correctional institutions.

In 1996, a higher proportion of Indigenous South Australians were in prison (1.3%) than non-Indigenous South Australians (0.8%) (Australian Bureau of Statistics 1998). Of the 899 Indigenous South Australians residing in non-private dwellings on census night in 1996, 30.6% were either in an adult prison or a juvenile correctional institution, compared to 3.3% of non-Indigenous South Australians (Australian Bureau of Statistics 1998).³

Indigenous youth are 13.7 times more likely than non-Indigenous youth to be in juvenile correctional institutions (Human Rights and Equal Opportunity Commission 1997). In 1996, 22% (18/83) of young people in SA juvenile correctional institutions were Indigenous (Australian Bureau of Statistics 1998). Sixty seven percent of the deaths of Indigenous people during police operations (eg car chases) were among young people under age 20 years, compared with 11% of deaths of non-Indigenous people (Jackson 2001).

Injecting Drug Use in Prison

The high rate of incarceration of Indigenous people places them at increased risk of contracting HCV in prison through unsafe injecting practices. A high proportion of people in Australian prisons have a history of injecting drug use and many of them continue to inject in prison. At least 33% of males and 66% of females in Australian prisons are HCV positive (Jackson 2001). It is estimated that 32% of people in South Australian prisons were there for drug related offences, and 70% - 80% of all offenders have experienced drug related problems (Government of South Australia 2001).

The risk of overdose also increases with incarceration. A study conducted in New South Wales comparing mortality inside and outside of prison found that the number of overdose deaths in prison was 20 times higher than outside prison (Levy and Butler 2000). Another study found that 7% of all overdoses were among people who had been released from prison within the previous month (Levy and Butler 2000).

Drug Use

Illicit Drug Use in SA – General Population

The 2001 National Drug Strategy Household Survey reported that approximately 0.8% of people in SA had ever injected drugs (Australian Institute of Health and Welfare 2002). Nationally, 39% of males and 30% of females who have ever injected drugs had injected in the last 12 months (Drug and Alcohol Services Council 2002). Assuming SA follows a similar pattern, approximately 7305 males and 1838 females living in SA have injected drugs in the last 12 months.⁴

In 2001, the Illicit Drug Reporting System for SA (IDRS-SA) indicated that heroin remained the drug of choice for the majority of people who inject drugs, but the proportion of people using heroin had decreased (Longo, Humeniuk, Christie and Ali 2002). This reduction in use has been attributed to the 'heroin drought', the decrease in the availability and purity of heroin, beginning in December 2000 and continuing throughout 2001 (Longo et al 2002).

Use of heroin is not restricted to any particular community or population in SA, but concentrated use tends to occur in the inner western suburbs (ie Angle Park, Ferryden Park, Mansfield Park and Croyden),

2. Gary Clarke is a peer educator at SAVIVE, a peer based service for people who inject drugs. Gary has extensive knowledge of local networks of injectors and their injecting practices.

3. Dwellings such as hospitals, nursing homes, institutions, staff quarters, hotels/motels, refuges and boarding houses.

4. Estimation based on 2001 census population data (749,200 males and 765,700 females) for SA (Australian Bureau of Statistics 2002).



the Port Adelaide area and the outer northern suburbs (Elizabeth and Salisbury) (Longo et al 2002). According to South Australian census maps (Appendix 1a and 1b) these areas have a high proportion of residents who are unemployed, and also have a high proportion of Indigenous and culturally and linguistically diverse (CALD) residents (Australian Bureau of Statistics 1997).

There are an estimated 4700 dependent opiate (ie heroin, morphine) users in SA. There were 2522 people registered on an opiate substitution program (including public, private and prison methadone or buprenorphine) in SA in the 2000/2001 financial year, with the majority receiving methadone (Drug and Alcohol Services Council 2002).

In 2001, the IDRS-SA recorded an increase in the use of speed, particularly methamphetamine (aka crystal meth) (Longo et al 2002). Methamphetamine is stronger than amphetamine, and is believed to be associated with a higher incidence of drug related mental health problems. The areas with a higher concentration of speed use are the inner west/Parks area, the outer northern suburbs and the outer southern suburbs (ie Noarlunga and Christies Beach) (Longo et al 2002). These suburbs have high unemployment rates and a high proportion of Indigenous residents (Australian Bureau of Statistics 1997).

In 2001, the IDRS found a slight increase in the use of cocaine in Australia. Twenty seven percent of IDRS respondents nationally had recently used cocaine compared to just 20% in 2000 (Longo et al 2002). But evidence suggests that cocaine is not commonly used, nor widely or easily available in SA (Longo et al 2002).

Illicit Drug Use Among Indigenous People

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 and Dunlop and Ezard 1997).

The 1994 National Household Survey indicated that urban Indigenous people were more likely to have ever used, or be currently using, illicit drugs than the general urban population (Commonwealth Department of Human Services and Health 1996).

When compared to the general population, Indigenous people in urban areas were:

- more likely to have used cannabis
- more likely to have ever injected drugs
- four times more likely to be current injectors
- younger when they first used illicit drugs.⁵

Nationally, Indigenous people are admitted to hospital for mental disorders related to drug use at four times the expected rate (Australian Bureau of Statistics 2001). Statistics from two South Australian hospitals indicate that there is an over representation of Indigenous people in hospital admissions for overdose (personal communication, Dick Leeson 2001).⁶ In the 2000/2001 financial year, 5.3% (12/225) of overdose separations (discharges) at Queen Elizabeth Hospital were among Indigenous people. For the same year, Lyell McEwin Hospital reported that 6% (14/233) of overdose separations were among Indigenous people.

Alcohol And Tobacco Use

Indigenous people are approximately twice as likely to smoke tobacco than the general population. The 2001 National Health Survey found that 62% of Indigenous people smoked tobacco compared to 23% of non-Indigenous people (Australian Institute of Health and Welfare 2002).

The 1998 National Drug Strategy Household Survey found that Indigenous people were less likely to drink alcohol than the general population, but were more likely to drink at harmful levels (Miller and Draper 2001). Indigenous respondents were more than twice as likely to drink alcohol at harmful levels than non-Indigenous respondents (8% compared to 3%).

5. Including heroin, cocaine, cannabis, designer drugs, pharmaceutical drugs and inhalants.

6. Dick Leeson is the statistician at Queen Elizabeth and Lyell McEwin hospitals.



Blood Borne Viruses

Hepatitis C

In 2001, Aboriginal people only comprised 1.5% of the South Australian population, but accounted for 8.2% (69/844) of all HCV notifications (STD Services 2002). This amount is five times the expected rate of notification based on population size. HCV notifications among Aboriginal people have increased from 5.8% (54/935) in 1999 (National Centre in HIV Epidemiology and Clinical Research 2000).

In 2000, there were 88 new HCV transmissions in SA, comprised of 17% (15/88) Aboriginal people and 94% (83/88) of people who inject drugs (STD Services 2002). Assuming similar patterns of transmission among the Aboriginal cases, approximately 14 of the 15 Aboriginal cases may be who inject drugs.

For new transmissions there is no significant difference between the odds of being diagnosed in prison or out of prison (personal communication, Dr William Donohue 2001).⁷ This would suggest that the much greater rate of new transmissions among Aboriginal people cannot be attributed to increased testing during incarceration. More Indigenous people have undergone dialysis procedures due to a higher rate of kidney disease amongst Indigenous Australians, therefore blood transfusions that occurred before 1990 (when HCV blood testing began) may account for some of the transmissions.

HIV

Between 1992 and 1999, 6% of Indigenous HIV notifications recorded injecting drug use as the method of transmission, slightly higher than the rate for non-Indigenous diagnoses (National Centre in HIV Epidemiology and Clinical Research 2000). Between 1992 and 1998 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 (Australian Indigenous HealthInfoNet, 2001).

7. Dr William Donohue is currently employed as the project officer for the hepatitis C care and prevention project, C Clearly. Dr Donohue's knowledge of HCV and his commitment to educating communities about the virus has led to his involvement with the Hepatitis C Council of SA, ADAC and other community based organisations.



LITERATURE REVIEW ON INJECTING DRUG USE AMONG URBAN INDIGENOUS COMMUNITIES

Although it is acknowledged that injecting drug use has a negative impact on the Indigenous community, for various reasons, the issue is often put into the 'too hard basket'. Assessing the prevalence of injecting drug use in the Indigenous community has been difficult because it is rarely acknowledged as a problem, and not seen as a priority, especially compared to the alcohol problem. Many people in the Indigenous community are still in denial about injecting drug use and there is a strong sense of shame, not only for the illicit drug user but also their family. Injecting drug use is believed to be a relatively new practice within Australian Indigenous communities. Nonetheless, it is believed to be increasing and currently affects almost all Indigenous communities to some extent, particularly urban communities.

The lack of research, consultation and hard data on injecting drug use in the Indigenous community has meant that culturally appropriate programs and services have not been developed and funded by government. Anecdotal evidence indicates that HCV may be highly prevalent among Indigenous injectors. There appears to be a high rate of overdose among Indigenous injectors and they do not appear to be accessing clean needle program outlets. Clearly, many Indigenous injectors are not benefiting from national and state harm reduction strategies.

There are still misconceptions and conflicting attitudes in the Indigenous community about harm reduction. The community can see the need for protecting the health of people who inject drugs, while continuing to also promote a drug free lifestyle and to respect those who don't use and don't want their families to use (Edwards, Frances and Lehmann 1999).

Aboriginal communities are concerned that they do not know enough to support those who inject drugs (Smith and Newton 1997 and Edwards et al 1999). There is evidence that most Indigenous people who inject drugs are not accessing either mainstream or Indigenous services. Nevertheless, the projects for Indigenous injectors that do exist have been shown to have a positive impact, not only by raising awareness of drug issues in the community, but also by raising the self esteem of Indigenous people who inject drugs (Lane 1993).

Overview of Literature

Information on injecting drug use within Indigenous communities is based largely on anecdotal evidence - very little quantitative research has been done in this area. The few studies that have been done have been based on small samples. At the commencement of this project, research on Indigenous injecting drug use had only been conducted in three states (South Australia, Queensland, and Victoria) (Lane 1993; Shoobridge, Vincent, Allsop and Biven 1998; Eldridge 1997; Larson 1996; and Edwards et al 1999). Other studies have looked at a range of drug use within Indigenous communities or have identified Indigenous injectors within broader samples of injectors (Correll, MacDonald and Dore 2000; Perkins, Sanson-Fisher, Blunden, Lunnay, Redman and Hensley 1994; Roberts 1998a; Roberts 1998b; Roberts 1999; Smith and Newton 1997; and South Australian Police 1999).

In 1993, the Nunga Users HIV Intervention Team (NU-HIT), the first project for Indigenous injectors, was established. It published *The NU-HIT Evaluation Report* including a section based on data compiled from a small representative group of 31 Aboriginal injectors (Lane 1993). Throughout the 11 months that NU-HIT was based at the AIDS Council of SA, the project had contact with 124 Indigenous injectors and indirectly accessed a further 450. By bringing Indigenous injecting drug use into the open, NU-HIT paved the way for discussion of the issue within the Indigenous community.

Shoobridge et al (1998) used rapid assessment methodology to examine injecting drug use practices among Indigenous people in the Lower Murray region of SA. This method utilises a variety of tools to collect data while continually cross checking results. Both Indigenous injectors and other key community members were consulted to identify risk taking behaviour, understand injecting practices and identify

community concerns. For the survey component of the research, 25 local Indigenous people who inject drugs (19 male, 6 female) were interviewed.

The University of Queensland published *The IDU Working Papers #1-4*, focusing on drug use among Indigenous people residing in Brisbane (Larson and Currie 1995; Larson 1996; Larson, Shannon, Brough and Eldridge 1997; and Eldridge 1997). *The IDU Working Paper #1* provides an overview of service providers' perspectives of drug use by Indigenous people (Larson and Currie 1995). *The IDU Working Paper #3* examines the use of tobacco, alcohol and other drugs by young Indigenous people (Larson et al 1997). *The IDU Working Paper #4* examines findings from discussions with young Indigenous injectors (Eldridge 1997). Only the *IDU Working Paper #2* includes statistical data on Indigenous injectors (Larson 1996). This paper is based on interviews with 77 Indigenous people who had injected drugs at least once in the past 12 months. Participants consisted of 53 males and 24 females, with a median age of 21 years (range 13 to 44 years).

Edwards et al (1999) documented results from interviews with 30 Indigenous injectors and 30 other community members. The research, published by the Victorian Aboriginal Health Services Co-operative, was undertaken as a response to the concerns of Aboriginal health workers, as well as family and friends of people who inject drugs, about increasing drug use and transmission of blood borne viruses. In addition to interviews, the researchers involved Aboriginal health workers, service providers, doctors, Indigenous injectors, and their families in group discussions.

Correll et al (2000) analysed data collected from Indigenous participants in the Australian Needle and Syringe Program (NSP) surveys. The 7316 survey respondents made up approximately 50% of injectors attending participating needle and syringe programs between 1995 and 1998. A total of 395 (5.4%) respondents identified as Indigenous. This is more than double the 1996 census figure of 2.1% of the general population (Australian Bureau of Statistics 1998).

Perkins et al (1994) surveyed a random sample of 531 Aboriginal people living within the geographical boundary of the New South Wales Aboriginal Medical Services. A separate questionnaire was used to assess the prevalence of illicit drug use in the Aboriginal community.

The Northern Territory AIDS Council has produced a series of reports, *Snapshots I-IV* (Roberts 1998a; Roberts 1998b; and Roberts 1999), presenting the results of surveys of clients of the Northern Territory AIDS Council needle exchange, including Indigenous injectors. The reports give an overview of characteristics of needle exchange clients and provide a comparison between responses during the wet and dry seasons. *Snapshot II: The Dry* (Roberts 1998a) includes responses from 129 injectors, 18 of whom identified as Indigenous. *Snapshot III: The 1998 Wet* (Roberts 1998b) includes 121 responses, including 16 Indigenous injectors. *Snapshot IV: The 1999 Wet* (Roberts 1999) includes responses from 104 injectors, including 16 Indigenous injectors.

ADAC's report, *Statewide Substance Misuse/Injecting Drug Use Report* (Smith and Newton 1997) examines the educational needs of the Aboriginal community in SA with regard to injecting drug use and blood borne viruses. The researchers consulted 254 community members (not necessarily people who inject drugs) and came up with 53 issues and 60 recommendations.

The South Australian Police report, *Report on Illicit Drug Use by the Aboriginal Community in Metropolitan Adelaide* (1999), examines the extent of, and association between, crime and illicit drug use within the Aboriginal community in Adelaide. This report also focuses on the social consequences of illicit drug use by Indigenous South Australians.



Trends in Indigenous Injecting Drug Use

Reasons for Using Drugs

Indigenous people often use drugs as a means of coping with, and escaping from, unhappiness, emotional pain or low self-esteem, which may have a myriad of causes including:

- lack of cultural identity, family fragmentation, and generations of disadvantage (Shoobridge et al 1998)
- physical, emotional and sexual abuse and neglect, experienced usually institutionally but also within the family (Edwards et al 1999)
- unemployment, stolen generation issues, poor health and inequality (Dunlop and Ezard 1997 and Lehmann and Frances 1998)
- boredom, through lack of employment or meaningful activity, particularly among young people (Gray and Morfitt 1996; Eldridge 1997; Shoobridge et al 1998; and Edwards et al 1999)
- a lack of positive role models for young people (Eldridge 1997 and Shoobridge et al 1998)
- a need to belong/peer pressure for young people (Edwards et al 1999 and Shoobridge et al 1998).

Types of Drugs Used

Use of heroin and speed by Indigenous injectors follows similar patterns to mainstream injectors (ie first drug injected, drug of choice, most recent drug used). Indigenous injectors have reported heroin or speed as the most frequently injected drug (Lane 1993; Edwards et al 1999; Shoobridge et al 1998; and Larson et al 1997). Recent surveys report a trend toward increased heroin use (McKetin et al 2000; and Topp, Darke, Bruno, Fry, Hargreaves et al 2001).

Shoobridge et al's (1998) Lower Murray sample was more likely to have used heroin recently (68%) than Correll et al's (2000) NSP sample (43%) or Larson's (1996) Brisbane sample (27%). Pharmaceutical morphine was the most commonly used opiate among all injectors in Darwin and was the most recent drug used for between 56% and 93% of Indigenous injectors in Darwin (Roberts 1998b and Roberts 1999).

Although speed may not be the preferred drug of Indigenous injectors, it is commonly the most frequently used drug, possibly due to price and availability. Shoobridge et al (1998) found that although speed was the preferred drug of only 8% of participants, 76% had used speed in the previous 12 months. Speed was also the most recent drug used by 73% of the Brisbane sample (Larson 1996). Speed use by Indigenous injectors in Darwin increased from less than 10% of the sample in 1998 to 25% in 1999 (Roberts 1998a and Roberts 1999). Lane (1993) points out that speed use tends to be more problematic than other drug use - over half of the speed users in the NU-HIT survey had experienced long term problems associated with its use.

Indigenous injectors may be less likely to use cocaine than non-Indigenous injectors. Cocaine was used by only 16% (4) of the Lower Murray participants in the 12 months prior to the survey (Shoobridge et al 1998) and was not common as a drug of choice amongst the Victorian sample (Edwards et al 1999). All of the Lower Murray participants who had used cocaine had spent time in New South Wales and only one was ever a regular user, while living in Sydney (Shoobridge et al 1998). The 1999 IDRS reported much higher rates of recent cocaine use (67% - 94%) among all people who inject drugs (McKetin et al 2000).

Indigenous injectors are more likely to be polydrug users than non-Indigenous injectors. Polydrug use was reported by 18% of Indigenous participants in the NSP surveys, compared to only 8% of non-Indigenous participants (Correll et al 2000).



Initiation Into Injecting

More young people are using drugs, including Indigenous youth (Lane 1993; McKetin et al 2000; and Larson, Shannon and Eldridge 1999). Aboriginal youth are commencing drug use earlier than non-Aboriginal youth (Larson et al 1999). The mean age of initiation for Indigenous injectors may be as low as 17.8 years (Larson 1996), approximately 1 year younger than the 18.7 years recorded for all people who inject drugs (McKetin et al 2000). Larson et al (1999) reported that 50% of Indigenous injectors were 16 years old or younger the first time they injected and 55% of those that had been injecting for less than 2 years were between 12 and 15 years old the first time they injected.

Service providers have reported that the age of initiation into injecting drug use has decreased and more young people are using drugs than in the past (Larson and Currie 1995 and Larson 1996). One study of Indigenous injectors showed that half of the respondents were 16 years old or younger when they first injected drugs (Larson 1996).

Use of Other Drugs and Alcohol

The Lower Murray survey found that 72% of respondents had used alcohol in the 12 months prior to the survey, and of those, 72% drank at levels harmful to their health (Shoobridge et al 1998). Although the scoring system that was used, the Alcohol Use Disorders Identification Test (AUDIT), classified those who drank at harmful levels as dependent, the authors suggest that it is more likely they were binge drinkers. This belief is supported by evidence that although alcohol was consumed infrequently by half of the drinkers, all of the drinkers had consumed harmful levels of alcohol in the past 12 months. In comparison, Perkins et al (1994) found that only 57% of a general sample of Indigenous people drank alcohol, although many of them were binge drinkers.

National studies show that smoking is more prevalent among Aboriginal people than non-Aboriginal people (Australian Bureau of Statistics 2001). A high percentage (96%) of the Lower Murray sample identified themselves as smokers (Shoobridge et al 1998). In comparison, Perkins et al (1994) reported that only 50% of a random sample of Indigenous people smoked.

The Lower Murray Indigenous community believed that local Indigenous injectors use other drugs such as cannabis, prescription drugs (codeine, rohypnol, other benzodiazepines) and alcohol more frequently than injectable drugs (Shoobridge et al 1998). All but one of the Lower Murray sample had used cannabis, 88% (22/25) reported use within the past 12 months and 40% (10/25) reported daily use. Over 70% of Larson's (1997) sample had ever used cannabis; and 25% used cannabis at least once a week. Both studies concluded that polydrug use and injecting drug use had a greater impact than cannabis use (Shoobridge et al 1998 and Larson 1997).

Although the use of petrol within urban Indigenous communities is not widespread, it does occur. Perkins et al (1994) reported that 8% of males and 4% of females had used petrol in an urban setting.

Characteristics of Indigenous People Who Inject Drugs

Poverty and Unemployment

Perkins (1994) recognised a relationship between unemployment and drug use in the Aboriginal community. Eldridge (1997) suggested that using drugs can be a distraction from the limited opportunities that are associated with living in a low socio-economic area.

Shoobridge et al (1998) reported that only 12% (3) of the Lower Murray sample had full time employment and 88% were in receipt of a government benefit. Forty six percent had an annual income of less than \$10,000 and 72% less than \$15,000 (Shoobridge et al 1998). Two thirds of the Indigenous injectors in Larson's (1996) Brisbane study had never been employed.



Accommodation

Many Aboriginal injectors have insecure accommodation, living in a number of different residences in a given period. Thirty six percent (9/25) of the Lower Murray survey participants had lived in three or more residences in the 12 months prior to being interviewed and one of the participants described their status as itinerant (Shoobridge et al 1998). Over half were dissatisfied with their current living conditions and a number were living in short term accommodation such as rehabilitation centres and supported accommodation. Forty percent of the Brisbane sample had lived in five or more places in the previous 12 months (Larson 1996).

Homelessness is an issue that may be overlooked due to an assumption that the supportive family structure of Indigenous Australians ensures accommodation for young people who are unable to live at home (Eldridge 1997). In addition to the direct impacts of homelessness, there is the added disadvantage of having little or no structure to life, making it difficult to attend scheduled appointments or receive social security benefits.

Education

More than half (52%) of the Lower Murray survey participants completed year 10, but 16% left before completing year 9 and only 8% completed year 12 (Shoobridge et al 1998). A high proportion (88%) of participants had commenced or completed tertiary study, but there was a marked gender difference (6 males, 1 female) among those who gained tertiary qualifications.

The average school leaving age of Indigenous injectors in Brisbane was 15 years old, although 13% (10/77) left school at age 13 or younger and 19% (15/77) left school at age 14 (Larson 1996). Approximately 40% (31/77) had commenced either TAFE or university and 20% (16/77) had undertaken an apprenticeship or on-the-job training.

Injecting in Prison

Approximately 20% of South Australia's prison population is Aboriginal. Eighty six percent of Aboriginal people in prison between 1994 and 1998 had a history of prior imprisonment, compared to 58% of non-Aboriginal prisoners (South Australian Police 1999). Considering the high rate of Indigenous incarceration, it is not surprising that high numbers of Indigenous injectors have spent time in prison or in juvenile detention centres. In Brisbane, 50% of respondents under 21 years of age and 36% of respondents over 18 years of age had spent time in prison or in juvenile detention centres (Larson 1996). Over 50% of those who had been to prison had injected there. Eighty four percent of the Lower Murray sample had spent time in prison and 57% had injected while in prison (Shoobridge et al 1998).

Many Indigenous injectors reported that they injected for the first time in prison (Lane 1993; Larson 1996; and Shoobridge et al 1998). In prison, education efforts are negated by the lack of suitable alternatives to sharing syringes. Indigenous injectors with a prison history have revealed that syringes are reused multiple times (eg 50 or more prisoners sharing one syringe) (Edwards et al 1999). In addition to education programs in prison, there is a need for support programs and services for newly released prisoners (Smith and Newton 1997; Lehmann 1998; and South Australian Police 1999).

Problems Related to Injecting Drug Use

Lane (1993) indicated that the vast majority of drug users do not experience major problems with their drug use and that social and economic factors contribute to drug related harms. Aboriginal injectors are more at risk of harmful use because of their daily experience of inequity (ie poor health, unemployment, dispossession and discrimination) and associated low self esteem (Lane 1993 and Dunlop and Ezard 1997). Shoobridge et al (1998) indicate that since so many other factors also contribute to poor health within the Aboriginal community, it is difficult to isolate specific drug related problems.

The Indigenous injectors in the Lower Murray survey had high levels of dependence to heroin and speed (Shoobridge et al 1998). Seventy six percent (16/21) of participants who completed the Severity

of Dependence Scale (SDS) rated as dependent. The rate of dependence to speed was 66% and heroin 62%. Results from the Brisbane survey found that dependence was more likely for heroin users and those who had been using long term (Larson 1996).

Sharing Injecting Equipment

Evidence suggests that Indigenous injectors share injecting equipment more often than the general population of injectors. The 1999 IDRS reported that only 20% of all respondents shared syringes, significantly less than the 29% who reported sharing in 1995 (McKetin et al 2000). The NSP survey revealed a higher rate of syringe sharing among Indigenous people who inject drugs than in the general population of injectors (Correll et al 2000). Larson (1996) reported that 50 - 60% of Indigenous injectors had shared syringes in the previous 12 months. Shoobridge et al (1998) reported that 48% of Aboriginal injectors had shared syringes at least once. Results of the Brisbane survey suggest that half of the participants had shared syringes (Larson 1996). Larson and Currie (1995) reported that 70% of Indigenous injectors shared on occasion.

Indigenous injectors may have a different concept of sharing to non-Indigenous injectors (Larson et al 1999). Indigenous injectors may not consider sharing with family/kin, or with those of the same HIV or HCV status, as sharing. For example, although 72% (18/25) of the Lower Murray participants indicated that they did not share syringes, two people did not consider borrowing a used syringe to be sharing; two people did not consider it to be sharing if it was with a close relative or partner; and three people did not consider it to be sharing if the other person had the same HIV/HCV status (Shoobridge et al 1998). Over half (56%) of the Lower Murray injectors shared filters, spoons, and/or tourniquets (Shoobridge et al 1998).

Shoobridge (1998) connects the high rate of sharing amongst Indigenous injectors to cultural attitudes to harm reduction and suggests that Indigenous injectors resent being told what to do by 'white' society. Indigenous injectors may also regard blood borne viruses as a 'whiteman's disease' (Shoobridge 1998 and Junga-Williams 1998).

Indigenous injectors are not getting appropriate information on safe injecting practices. Larson and Currie (1995) reported that 15% (6/40) of Indigenous respondents did not know how to inject safely and 30% (12/40) did not understand the meaning of safe injecting.

Although lack of information significantly contributes to needle sharing amongst injectors, Larson and Currie (1995) suggest that other reasons for needle sharing include:

- poor literacy skills
- impatience to inject
- shame of obtaining injecting equipment
- living on the street
- desire to join in
- having a special relationship with another injector.

It appears that young injectors are more likely to engage in risky behaviour than older ones. The Brisbane survey recorded a 63% rate of recent needle sharing by Indigenous users under 20 years of age, almost twice the rate of older users (Larson 1996).

Overdose

Indigenous injectors experience a much higher overdose rate than non-Indigenous injectors and anecdotal reports suggest that nearly every Indigenous family has been affected in some way by overdose. Larson (1996) found that 52% of Indigenous heroin users (ie those who last used heroin) had overdosed or witnessed an overdose. Of the 11 respondents who had overdosed, two had been deserted by friends, three were alone at the time, and six had been given either mouth-to-mouth resuscitation or other assistance. The high number of injectors who usually or sometimes inject alone also increases the



potential for fatal overdose (Larson 1996 and Shoobridge et al 1998).

Indigenous Australians have the highest rate of youth suicide in the world and 73% of Indigenous Australians have contemplated suicide (Junga-Williams 1998). Shoobridge et al (1998) reported that intoxication often facilitated the decision to attempt suicide. More than half (52%) of the Lower Murray participants had attempted suicide at least twice, and 92% of those reported being intoxicated for at least one of the attempts (Shoobridge et al 1998).

Blood Borne Viruses

Although there has been national education for people who inject drugs, many Indigenous people who inject drugs are still unclear about blood borne virus (BBV) issues. Larson (1996) found that most Indigenous injectors perceived themselves to be at very low risk of HIV infection even though many of them shared syringes. This perception may relate to the fact that 71% of participants did not know anyone who was HIV positive. The study also found that 26% had engaged in injecting practices (other than sharing syringes or needle stick injury) that put them at risk of HCV transmission.

HCV seroconversion rates amongst Indigenous injectors vary from under 40% to over 70% (Larson 1996; Shoobridge et al 1998; Roberts 1998a; and Roberts 1998b). The Indigenous injectors participating in the NSP surveys showed a mean HCV seroconversion rate only slightly higher than the non-Indigenous participants (Correll et al 2000). However, Indigenous injectors under 25 years old had a much higher prevalence of HCV (38%) than their non-Indigenous counterparts (23%). HCV prevalence was also higher for Indigenous injectors who had been injecting for less than 3 years. Junga-Williams (1998) contacted 50 young Indigenous injectors over a three month period, 40 of whom were HCV positive and 5 of whom were HIV positive. Roberts (1998b) reported that 12.5% of Indigenous participants in Darwin were HIV positive, while Roberts (1999) reported that 6.25% of Indigenous participants were HIV positive. The Northern Territory injectors appear to have a higher rate of HIV (8.1%) compared to injectors nationally (1.5%) (McKetin et al 2000). Other studies recorded a zero rate of HIV amongst Indigenous injectors (Larson 1996 and Shoobridge et al 1998).

The Lower Murray and Darwin injectors reported high rates of HIV and HCV testing compared to mainstream samples (Appendix 2). Forty eight percent of the NU-HIT clients surveyed had been tested for HIV and 66.7% knew someone who was HIV positive (Lane 1993). Junga-Williams (1998) suggested that involuntary testing is a common occurrence and may account for the high numbers of Indigenous injectors who have been tested for blood borne viruses. It is also possible that testing rates are high because the samples consisted of Indigenous injectors who had come into contact with services and therefore had more access to testing.

Sexual Health

In the Lower Murray sample, 28% of participants reported never using condoms with casual partners and 12% reported rarely, or sometimes, using condoms with casual partners (Shoobridge et al 1998). Twenty four percent reported always using condoms. Community consultants believed that Aboriginal people prefer not to use condoms for cultural reasons and that Aboriginal people believe they are not susceptible to blood borne viruses.

In the NU-HIT survey, 38% rated their knowledge of safe sex practices as high, 35.5% rated their knowledge as good, and 25.5% rated their knowledge as average. Their ratings for their community's awareness of safe sex, safe drug use and HIV ranged from low to fair (Lane 1993).

Access to Programs and Services

Harm Reduction Programs

There are a number of reasons why Indigenous injectors do not access harm reduction programs and services, including cultural issues, confidentiality concerns, and shame of being identified as a drug user (Lane 1993; Larson 1996; and Shoobridge et al 1998). Aboriginal health services pose a particular risk for injectors since health workers may be connected to the injector's family (Lane 1993 and Shoobridge et al 1998).



Larson et al (1999) reported that Indigenous injectors in Brisbane were not benefiting from peer education and harm reduction programs. A large number of Indigenous people who inject drugs (69%) obtained injecting equipment from pharmacies, thereby missing out on the benefits of a clean needle program. Clean needle programs also allow users to collect syringes in bulk. For example, most injectors who accessed NU-HIT collected injecting equipment for between 1 and 40 other injectors (Lane 1993). The higher cost of injecting equipment at pharmacies means that people tend to buy only what is immediately needed, increasing the chance of sharing once the equipment runs out. In addition, clean needle programs provide peer education opportunities that are not available through pharmacies.

In Brisbane, younger or less experienced users were not accessing any needle exchanges, relying on friends for their supplies instead (Larson 1996). Young injectors tend to fall through the gaps when it comes to accessing services. Youth services rarely address drug issues adequately and drug services are not equipped to deal with youth. Some believe that the lack of services for young drug users is a result of denial of youth drug use. Providing services for young injectors means admitting that young people are using and injecting drugs (Eldridge 1997). The lack of services for young Aboriginal people in Melbourne has resulted in service providers sending young Aboriginal women to Adelaide for detoxification services (Edwards et al 1999).

Treatment Services

Lehmann and Frances (1998) reported that access to treatment services is too slow for Aboriginal people who inject drugs and so it is easier to continue drug use than to wait for assistance. The NU-HIT survey reported that two-thirds of Indigenous users who wanted to detoxify did not (Lane 1993). Forty eight percent (12/25) of the Lower Murray injectors had ever used methadone, yet only four of them had ever been in a registered methadone program (Shoobridge et al 1998). Of the 650 clients registered with the South Australian Public Methadone Program in April 1997, only 12 clients identified as Indigenous (Shoobridge et al 1998).⁸

Indigenous Community Involvement

Consultations with Indigenous communities have identified the need for community involvement, ownership, and self-determination when undertaking research with, or establishing services for, Aboriginal drug users (Larson 1999; Gray and Morfitt 1996; Edwards et al 1999; and Alati 2000). Consultation with the Aboriginal community goes a long way toward ensuring culturally appropriate services for Indigenous injectors, but it is only a start. Consultation with Aboriginal injectors is necessary to support self-determination and ensure their ownership of services or programs. Appropriate responses can only come about through direct involvement of Indigenous injectors (Larson 1996; Shoobridge 1998; South Australian Police 1999; and Arabena 2000).

8. There are now specific services providing methadone for opiate dependent Aboriginal people in SA.



STUDY METHODS

Rapid Assessment and Response

Rapid Assessment and Response (also called Rapid Assessment Methodology or Rapid Assessment Procedures) was the guiding methodology in this research. The World Health Organisation's (WHO) draft field guide, *Rapid Assessment and Response Guide on Injecting Drug Use* defines it as "a means for depicting the extent and nature of social and health problems and for suggesting ways in which they may be improved." (World Health Organisation 1998).

Rapid Assessment and Response utilises a variety of methods to collect information 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 (eg injecting practices). Using a variety of methods, and continually triangulating information allows researchers to build a clearer picture of the subject of interest. Triangulation is also useful to confirm the accuracy of information. If the same information emerges from different sources, using different methods, it is more likely to be accurate. Rapid assessment and response is useful in identifying appropriate interventions and the barriers to implementing these interventions.

Ethical Considerations

This project was guided in ethical matters by two useful papers:

- *Practical and Ethical Guidelines for Research Involving People Who Use Drugs Illicitly*, a draft consultation paper published by the New South Wales Users and AIDS Association (Madden 1997).
- *Young, Black and Injecting Drugs: An Exploration of Ethical Issues Surrounding Research into Injecting Drug Use by Young Indigenous Australians*, published by Danila Dilba Health Service Illicit Drug Program (Meyerhoff 2001)

Both of these papers provided a useful discussion of the ethics involved in undertaking research with people involved in illegal behaviour. The papers also suggested guidelines regarding paying research participants, involving people who inject drugs, debriefing mechanisms, the responsibilities of researchers, and the rights of research participants.

The Aboriginal Health Research Ethics Committee endorsed the project.

Literature Review

The project commenced with a review of literature on injecting drug use amongst Aboriginal Australians, including an assessment of gaps in existing information. In addition, a number of sources (Aboriginal health organisations, alcohol and drug services and user organisations) were contacted for copies of resources produced for Indigenous illicit drug users. At the time of the literature review, the National Drug Research Institute report on Indigenous illicit drug use had not been published. Although this report has since been useful for data comparison, it has not been included in the literature review (Gray, Morfitt, Williams, Ryan and Coyne 2002).

Key Consultant Interviews

Recruitment of Key Consultants

To inform the community about the project, a flier describing the project's aims, and calling for people to participate as key consultants, was circulated within various health, welfare, drug and alcohol, and Aboriginal services (Appendix 3). Although less than one third of key consultants were recruited through the flier, it did generate community interest in the project. ADAC received a number of calls from people asking for further information. Most key consultants were recruited through the social or professional

networks of those involved in the project. A smaller number of key consultants were referred to the project by other key consultants.

Initial contact with potential key consultants was generally by phone, followed by a brief letter confirming the interview date and time.

Fifty-eight people participated as key consultants in a total of 28 interviews. One interview was held with a group of 24 key consultants and the remainder of the interviews were held with between one to three key consultants. Twenty-nine key consultants identified as Aboriginal, 28 as non-Aboriginal and one as a Torres Strait Islander.

Thirty-four percent (20) of the key consultants were recruited through direct contact with the interviewer. These people were either known to the interviewer or were people who had responded to the flier. Twenty-six percent (15) of the key consultants were recruited by ADAC staff members. Sixteen percent (9) were recruited through a member of the Project Advisory Committee and 9% (3) were recruited through someone else who had been involved in the project. Fifteen percent of consultants (9) were recruited through other means (ie work colleagues or contact with someone who knew about the project). Three percent of consultants (2) found out about the project as a result of being at one of the services while the interviewer was present.

Prior to the interview, potential key consultants were given an information sheet (Appendix 4) explaining the aims of the project, the role of key consultants and the role of the interviewer. The interviewer also gave a verbal explanation of the contents of the information sheet. Those who agreed to participate then signed a consent form (Appendix 5).

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.

Conducting Key Consultant Interviews

Each key consultant completed a background information form covering their type of work, cultural background, source of information regarding the project, source of knowledge of, and frequency of contact with, Indigenous injectors (Appendix 6).

The Key Consultant Interview Schedule (Appendix 7) covered:

- geographic area of knowledge
- patterns of drug use
- problems associated with drug use
- risk taking behaviour
- services for Indigenous injectors
- methadone program issues
- other interventions.

Key consultants were asked to answer each question as well as they could, while restricting their answers to personal knowledge or experience rather than hearsay.

After the interview, the interviewer filled out the Researcher Information Sheet (Appendix 8) recording the interviewee's alias, contact number, type of work, level of knowledge and any outstanding aspects of the interview.

The key consultant interviews utilised qualitative methods to identify issues that would inform the survey of injectors. The resultant information forms a key component of the triangulation process of using information from a variety of sources to substantiate survey findings.



Survey of Indigenous People Who Inject Drugs

Recruiting and Training Peer Interviewers

The Project Advisory Committee decided to utilise Aboriginal people with experience of injecting drug use as peer interviewers. The advantages of using peer interviewers include their ability to recruit survey participants, their credibility with the target population, and their ability to check responses based on their 'insider' knowledge.

Members of the Committee, and staff of clean needle programs and Aboriginal health services were asked to recruit Aboriginal people who inject drugs (current or past injectors) to attend a one-day training and consultation workshop.

Seven people attended the peer interviewer training. Sessions covered safer drug use, harm reduction, the role and activities of ADAC, the Indigenous injectors project, and the roles and responsibilities of peer interviewers. At the end of the training day, all participants were invited to become involved in the project as peer interviewers and attend further training sessions.

The peer interviewers expressed an interest in providing harm reduction information and clean injecting equipment to the people they interviewed. So, the peer interviewers were given a range of resources to study and the merits of each resource were discussed at the following training day. Subsequently, information packs consisting of the most appropriate resources for Indigenous injectors were developed. Three of the peer interviewers had needle exchange licences and were able to provide clean injecting equipment on request.

Peer interviewers were expected to work as a team, supporting and encouraging each other. Interviewers were supplied with mobile phones that they were allowed to keep at the conclusion of the interviewing process. Cab-charge vouchers were available for travel to and from ADAC. The cost of any travel to meet with interviewees was the responsibility of the peer interviewers. Some of the peer interviewers were on parole and were worried about the risks of being seen with known users or dealers. To offer some security, peer interviewers were supplied with photo identification and a letter explaining their employment and duties.

IDU Survey Interview Schedule

The Adelaide Metropolitan Lifestyle and Drug Use Questionnaire (Appendix 9) was based on the survey that ADAC conducted in 1997 in Murray Bridge, SA. The 2001 survey included additional questions related to issues arising from the key consultant interviews. The National Drug Research Institute was consulted to ensure that the survey results would be comparable with similar survey work being conducted there.

The questionnaire covered:

- demographic background
- social background
- drug use history
- physical and mental health history
- blood borne viruses
- injecting history
- injecting practices
- overdose experience



- injecting in prison
- needle exchange experience
- drug and alcohol services
- methadone issues (for opiate users and for those currently on methadone)
- any other comments.

Pilot Testing the Survey

Peer interviewers gained practical experience in conducting the surveys by participating in practice interviews with each other and with ADAC staff members. The practice interviews were also a useful method of pilot testing the survey with the target population. Comments from peer interviewers resulted in improvements to the survey questions.

Recruiting Participants

Between July and August 2001, seven peer interviewers interviewed 307 Indigenous people who inject drugs and who were living in and around metropolitan Adelaide. The peer interviewers were employed on a short contract for the period of the survey phase, and each peer interviewer completed between 24 and 76 interviews. Average interview length was 30 minutes (range 10-90 minutes).

People were eligible to participate if they identified as Aboriginal and had injected drugs at least once in the previous 6 months or were on a methadone program. Participants were recruited directly by peer interviewers, through word of mouth, and by referral from service providers. Fliers were placed at health, welfare, and drug and alcohol services and distributed by peer interviewers (Appendix 10). People who found out about the project through fliers contacted the peer interviewer for their area, who ensured their eligibility and arranged a time for an interview. The majority of participants were interviewed in public places such as community health centres, needle exchanges, cafes, shopping centres and at ADAC. Some were interviewed in their homes, or the peer interviewer's home.

Prior to the interview, participants were given an information sheet (Appendix 11) and verbal information on ethics approval, confidentiality, criteria for participating, the right to refrain from answering questions, and the right to withdraw from the interview at any time. The participant then signed a consent form (Appendix 12) and received payment of \$35.

Conducting the Survey

The survey was conducted over a period of four weeks. Interviewers were paid a weekly rate allowing them to complete as many surveys as possible. This system also allowed for the same rate of pay for all interviewers for each of the four weeks of interviewing.

The results of the survey were analysed using Statistical Package for the Social Sciences (SPSS) (Norusis 1993). A tertiary student was employed to enter the data. The amount of missing data (ie where no answer was recorded) was minimal (ranging from .3% to 4%), therefore missing data has been accounted for in the survey analysis to keep the sample (n=307) consistent.

Community Consultations

The aims of the community forums were to provide opportunities for the Indigenous community to comment on the research and give some feedback to ADAC regarding the research findings. This process is consistent with rapid assessment and response methodology.

Aboriginal health workers at the main community health centres were informed of ADAC's plan to hold consultations with the Aboriginal community and invited to become involved in the planning. Fliers



were placed in Indigenous organisations, and distributed through peer interviewers and peer educators (Appendix 13). Although ADAC was unable to pay participants, the project team attempted to provide as much assistance as possible to encourage attendance (eg childcare and transport). Peer interviewers assisted in holding the consultations.

Community consultation forums were held at Nunkuwarrin Yunti Aboriginal Health Service, The Parks Community Health Centre and the Port Adelaide Community Health Centre. Attendance at the forums ranged from very few to about 20 people. One consultation was held following the ADAC Annual General Meeting and included a number of participants from regional SA (ie Coober Pedy, Ceduna, and Yalata).

Consultations were held with about 25 Aboriginal people who inject drugs. The individual consultations were held in day centres, parks, needle exchanges, cafes and community health centres. Information regarding these consultations was distributed via word-of-mouth, through NU-HIT, and peer educators.

The individual consultations with Aboriginal people who inject drugs were informal and brief, more appropriately described as conversations than interviews. The 'interviewer' encouraged Aboriginal injectors to bring up own their issues without prompting and, to keep the process informal, took no notes during the conversation. A summary of the main points was recorded after the interview. The consultations were an attempt to pick up on issues that may have been overlooked in the survey. Each individual consultation was completed in less than 10 minutes and the participants were paid \$20 for their time.

RESULTS OF KEY CONSULTANT INTERVIEWS

Profile of Key Consultants

Recruiting Key Consultants

Fifty-eight key consultants participated in a total of 28 interviews. One interview was held with a group of 24 key consultants and the remainder involved one to three key consultants. Twenty-nine key consultants identified as Aboriginal, 28 as non-Aboriginal and one as a Torres Strait Islander. Key consultants were recruited via a variety of methods including through:

- direct contact with an interviewer (34%)
- ADAC staff members other than interviewers (26%)
- Project Advisory Committee members (16%)
- work colleagues or someone else not involved in the project (15%)
- someone else who had been involved in the project (9%)
- attendance at the services where interviews were conducted (3%).

Key Consultants' Source of Knowledge About Injectors

Most key consultants knew about injecting drug use in the Indigenous community through their work in the health services, social services, drug and alcohol services or legal field. Some key consultants were involved with more than one service or organisation. Other sources of knowledge included community involvement (ie volunteering or committee memberships), the 'grapevine' or networking, social contact with Aboriginal people who inject drugs, and personal experience of injecting drug use.

Table 3: Key consultants' source of knowledge of injecting drug use

Source of Knowledge	Number of Consultants	Percentage of Consultants
Work	55	88%
Community involvement	21	36%
'Grapevine'	14	24%
Acquaintance who injects	14	24%
Friend who injects	14	24%
Various organisations	12	21%
Family member who injects	8	15%
Personal experience	4	7%



Key Consultants' Employment

Key consultants were employed in a range of fields, but the majority worked in the health services or drug and alcohol services.

Table 4: Key consultants' employment background

Field of Work	Number of Consultants	Percentage of Consultants
Health services	24	41.0%
Drug and alcohol services	13	22.0%
Community member	6	10.0%
Community development	5	9.0%
Social services	4	7.0%
Youth services	4	7.0%
Legal services	1	1.7%
Administration	1	1.7%

Frequency of Contact with Aboriginal People Who Inject Drugs

Most key consultants (24%; 14/58) reported weekly contact with Aboriginal people who inject drugs. Approximately 19% of key consultants (11/58) had daily contact and the same number were in contact every couple of days. Fourteen percent (8/58) had monthly contact; 12% (7/58) were unsure of the frequency of contact (ie unsure which clients were injectors); 7% (4/58) had no personal contact; and 5% (3/58) had contact every couple of months.

Numbers of Aboriginal People Who Inject Drugs Known to Key Consultants

The number of Aboriginal people who inject drugs known to key consultants ranged from very few to a large number. Nineteen percent (11/58) were in contact with 10-50 Aboriginal people who inject drugs; 10% (6/58) were in contact with 2-10; and 5% (3/58) were in contact with more than 50.

Some key consultants found it more accurate to estimate how many Indigenous injectors they saw in a given period (ie per month). Seven percent (5/58) were in contact with less than 10 per month; 5% (3/58) were in contact with between 10 and 50 per month; and 3% (2/58) saw over 50 per month.

Twenty percent of key consultants (12/58) were unsure of the numbers; and 6% (4/58) stated "a handful", "not many", "quite a few" or "many" rather than giving a numerical estimation.

Drug Use Patterns and Practices

Extent of Drug Use

Key consultants indicated that injecting drug use is widespread and increasing within the Aboriginal community, with nearly every Aboriginal family in metropolitan Adelaide affected in some way. Key consultants expressed concern that the age of first drug use appeared to be decreasing as a result of early awareness and exposure to drugs.

Two key consultants suggested that Aboriginal people were generally consumers of drugs and were rarely involved in dealing or manufacturing. Another two key consultants believed there was an increase in young Aboriginal people involved in dealing, adding that older people may involve young people since they receive lesser convictions if caught.

Drug of Choice

Heroin or speed (or both) was most frequently nominated as the drug most often injected by Aboriginal people who inject drugs. A number of key consultants stated that polydrug use, including alcohol and cannabis use, was predominant in the Aboriginal community. Some key consultants reported an increase in the number of people who inject benzodiazapines.

Key consultants indicated that drug use was supply driven, meaning that when the drug of choice was not available, Aboriginal injectors would use whatever was available. Key consultants believed that methadone and benzodiazapines were used to increase the effects of low-grade heroin. There was a perception among key consultants that Aboriginal people become dependent soon after commencing use – one key consultant believed that ‘use’ equals ‘dependence’ among Aboriginal injectors. A couple of key consultants suggested that the heroin ‘drought’ had contributed to increased use of cocaine and speed.⁹ Reports of increased cocaine and methamphetamine use are consistent with IDRS data that showed a 7% increase in cocaine use and a 29% increase in methamphetamine use in SA between 2000-2001 (Longo et al 2002).

Age and Gender

There was diversity in key consultants’ perceptions of the age range and gender breakdown of Aboriginal people who inject drugs, possibly due to contact with different client groups. Generally, key consultants believed that the age of Aboriginal injectors ranged from under 14 years to over 40 years. They believed that more Aboriginal males inject drugs than do females.

Access to Clean Needle Program

Key consultants indicated that Aboriginal people who inject drugs are accessing clean needle program outlets. One consultant suggested that Aboriginal men sometimes preferred to send their female partners to obtain syringes due to feelings of shame. However, some believed that sharing syringes was still a problem as a result of a tendency to use ‘on the run’ (ie unplanned, spur of the moment use) and to hold only small quantities of syringes.

Injecting Practices

In 13 interviews, key consultants believed that sharing syringes generally occurred only with partners or close friends, or when people were anxious to use their drugs immediately. They believed that, in general, Aboriginal injectors were less likely to have concerns about sharing syringes with friends, relatives and people with whom they had a stable sexual relationship. They added that sharing of injecting equipment other than syringes (ie spoons, filters, mix) was more widespread.

Some key consultants indicated that aspects of Aboriginal culture might encourage sharing of syringes and other injecting equipment. For example, the tradition of ‘what’s mine is yours’, and the notion of blood ties (ie people within the same family or clan having the same blood), may be encouraging

9. 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.



sharing within families. One key consultant mentioned that the concept of family could extend to solidarity amongst prisoners, thereby also encouraging sharing amongst 'brothers' in prison. Another key consultant believed that in general there was no cultural pressure to share injecting equipment, except possibly in rural areas where family ties were stronger.

Overall, key consultants believed that awareness of safe injecting practices was increasing. Nonetheless, in extreme circumstances the need for a 'hit' may override awareness of safer practices. Three key consultants mentioned that reusing syringes (whether shared or not) was a common practice among Aboriginal injectors. Reasons for this practice may include their desire to obtain only a small number of syringes from clean needle program outlets or pharmacies (thus giving the impression that they were using less) and their desire to carry only one syringe at any time. One key consultant, a clean needle program worker, mentioned that some Aboriginal injectors do not use filters and some re-use filters.

Knowledge of Blood Borne Viruses

Most key consultants reported that knowledge of blood borne viruses within the Aboriginal community has increased in the last 5 years. They indicated that this awareness and knowledge existed despite the lack of specific messages targeting Indigenous people. Key consultants reported that Aboriginal people who inject drugs were being tested for blood borne viruses, although some waited until they were imprisoned since access to testing was easier in prison. They also reported that Aboriginal injectors rarely discussed HIV since it was not regarded as an injector's disease or risk. Key consultants believed that there was better knowledge and awareness of HCV than HIV due to the association between HCV and injecting.

Key consultants believed that the high prevalence of HCV positive Aboriginal injectors was leading to a blasé attitude towards the virus, especially since many HCV positive people appeared to be well. In addition, key consultants believed that Aboriginal injectors made a direct association between HIV and illness, dying, and hospitals that they did not associate with HCV. Key consultants were concerned that Aboriginal people who inject drugs were unclear of the symptoms, long-term effects and treatment of HCV. One key consultant stated that there was some shame in being HCV positive, especially for pregnant women. Some consultants believed that many Aboriginal injectors had a fatalistic view regarding HCV because they had low expectations about life in general and had no belief that services were able to meet their needs.

*"[It's] not the Aboriginal way to run to a doctor unless you really have to."
(community member/injector)*

Awareness of Harm Reduction Messages

Key consultants reported that Aboriginal injectors who accessed services were more knowledgeable about safe injecting practices. Some also believed that a large number were not receiving harm reduction messages. Key consultants believed that injectors who were homeless, transient or recently arrived from rural areas, and those who were less educated, were less knowledgeable of harm reduction practices. Key consultants identified the lack of culturally appropriate education materials as a key concern and indicated the need for greater involvement of Aboriginal people in the development of appropriate educational materials.

Impact of Injecting Drug Use on Urban Aboriginal Community

Key consultants were united in the perception that injecting drug use had an impact on the whole of the Aboriginal community. Some believed that drug use has become a bigger problem than alcohol use for urban Aboriginal communities. There was concern that the Aboriginal community was no longer a close community and that injecting drug use had devastated traditional culture and values.

"...ripping the heart out of Indigenous culture." (drug and alcohol worker)

Impact on Families

In over half of the interviews (18 interviews), key consultants mentioned that family breakdown was a problem associated with injecting drug use. Injecting drug use affects families who are already struggling, causing disruptions, stress and shame. Key consultants reported that families often did not accept or understand a family member's drug use, and often felt ashamed of having a family member who was injecting drugs. As a result, Indigenous people who inject drugs may be ostracised by their families. Some key consultants mentioned that offering any kind of support (eg childcare, money, food, or shelter) was seen as acceptance of drug use. They also said that some people in the community believed that families offering such support were not bringing about behaviour change.

Impact on Children

Many key consultants were concerned about the impact of injecting drug use on Aboriginal children. In 11 interviews, key consultants expressed concern that some people who inject drugs were unable to care for their children and were passing responsibility onto older people. In eight interviews, key consultants reported that Aboriginal children were also being directly exposed to drug use. This 'normalisation' of drug use, and the lack of more positive alternatives, was resulting in drug users becoming role models for young Aboriginal people.

Social Disadvantage

Key consultants reported that injecting drug use was increasing the social disadvantage experienced by the Aboriginal community.

*"...contributing strongly to the disadvantaged position that Aboriginal people are in."
(drug and alcohol worker)*

They also believed that injecting drug use was contributing to Aboriginal peoples' low self worth, generalised poverty, and poor health. Key consultants spoke of the poor health of Aboriginal people who inject drugs, some of whom are facing chronic health problems as a result of their lifestyle.

"Often Indigenous users don't eat/don't look after themselves, they are often cold and hungry. They rarely seek medical help - they may not know where to go so a minor problem becomes major due to being unaware." (health worker)

One key consultant reported that more people were seeking treatment for vein problems in recent months and more clients had damaged veins and/or difficult to access veins.

In 19 interviews, key consultants raised concerns about the impact of drug related crime and subsequent incarceration. Key consultants reported that drug use contributes to the revolving door of jail and poverty where financial disadvantage leads to crime and then incarceration. Key consultants were particularly concerned about the numbers of young Aboriginal people in jail.

"...the increased custody rate will lead to an increase of deaths in custody." (lawyer)

Overdose

In 15 interviews, key consultants discussed the impact of overdose deaths on the Aboriginal community. In eight interviews, key consultants identified the lack of knowledge of resuscitation techniques amongst Aboriginal injectors as a contributing factor in overdose deaths.

"Basic first aid skills are not known in Aboriginal households." (drug and alcohol worker)

Some key consultants (five interviews) suggested that Aboriginal people who inject drugs are reluctant to call an ambulance for fear of the police. Key consultants believed that the poor relations between the police and Aboriginal people was contributing to this reluctance, reporting that many Aboriginal people believed that police routinely attended overdoses. As a result, response to overdose is poor – people 'freak out', panic, and may abandon the person who has overdosed.

Key consultants believed that there is also a lack of knowledge of how to prevent an overdose (ie factors that can lead to an overdose). Key consultants believed many Aboriginal overdoses were related to prison release when drug tolerance is low or to combining heroin with benzodiazepines or alcohol. The inconsistent strength of drugs was also mentioned as a contributing factor in overdoses.

A number of key consultants were concerned about the devastating effect of overdose deaths, in particular deaths of young people.

“The Aboriginal community is already losing 30 years of life due to [poor] health – let alone loss from drugs.” (Aboriginal health worker)

Differential Impacts of Alcohol, Cannabis and Injectable Drugs

In general, key consultants believed that while alcohol was still a problem, injecting drug use had a more dramatic impact on the Aboriginal community. The problems associated with injecting drug use were bigger and more noticeable. Key consultants believed that alcohol was more accepted, frequently used in social ceremonies and celebrations, and did not divide the community as much as injecting drug use. They said that alcohol was used more socially, while injectable drugs, particularly heroin, were used secretly and in isolation. Some key consultants stated that alcohol use was more widespread, more ‘in your face’, and alcohol was cheaper and easier to obtain than injectable drugs.

A number of key consultants commented that there was less violence associated with injecting drug use compared to alcohol use, particularly less domestic violence. There was a perception that heroin and cannabis did not seem to make people aggressive, but that,

“...alcohol and violence go hand in hand.” (Aboriginal health worker)

In two interviews, key consultants were concerned about the aggressive behaviour associated with speed use, noticing an increase in psychotic or violent behaviour associated with stronger speed.

There were some differences in key consultants’ perceptions of the impact of cannabis on the Aboriginal community. Some key consultants had noticed problems associated with cannabis use, while others had not. There was, however, a common belief that cannabis is stronger than it used to be and contains more additives. In about one quarter of the interviews (seven interviews), key consultants saw no real problems associated with cannabis use in the Aboriginal community. These consultants regarded cannabis as a stable part of urban Aboriginal culture.

In seven interviews, key consultants mentioned that the Aboriginal community was concerned about mental health issues associated with cannabis use, and/or cannabis psychosis, particularly for those predisposed to mental illness. Two key consultants mentioned behavioural effects similar to heroin dependence, where cannabis users become frantic when they run out of cannabis and will do anything to score more. Two key consultants believed that cannabis was a stepping-stone to harder drugs.

In just under one quarter of interviews (six interviews), key consultants saw no real difference in impact between various drugs. They stated that injectable drugs, alcohol, cannabis, and pharmaceutical drugs were not a part of traditional Aboriginal culture and all were damaging the community. One key consultant stated that the only difference between injecting drug use and alcohol use was that the harmful effects of injecting drug use occurred sooner than the harmful effects of alcohol use.

Access to Services

The lack of culturally appropriate services was a consistent theme, mentioned in 18 interviews. Key consultants reported that Aboriginal clients viewed the atmosphere of mainstream drug and alcohol services as uninviting and impersonal, with few Aboriginal workers with whom they could identify or feel comfortable. In seven interviews, key consultants believed that services were too rigid, with too many rules and regulations.

Barriers to Accessing Services

In almost half of the interviews (13 interviews), key consultants mentioned lack of confidentiality as a major barrier to service access, especially for Indigenous focussed services. Key consultants reported that the fear of being identified as an injector by immediate or extended family members prevented many Aboriginal injectors from accessing Indigenous focussed services.

In nine interviews, the shame and stigma attached to injecting drug use was seen as a barrier to accessing both mainstream and Indigenous focussed services. Key consultants reported that fear





or expectations of discrimination often prevented Aboriginal people from accessing drug and alcohol services. A key consultant working with young Aboriginal people believed that Aboriginal illicit drug users personalised their drug use, believing that because they used drugs they were bad or something was wrong with them, possibly due to ignorance about drug issues. Mistrust of the system was mentioned as a barrier to accessing services in almost one quarter of interviews (six interviews). Historically, Aboriginal Australians have been fearful of government authorities and haven't felt that services exist for their benefit. One key consultant pointed out that there was a basis for this mistrust.

"Aboriginal people are more likely to be approached by police, and in every level of the legal system are approximately 10 times more likely to be discriminated against and sentenced to the least favourable option." (peer educator)

Key consultants also mentioned other barriers such as:

- lack of awareness of services
- lack of knowledge about services
- lack of confidence
- service location
- service hours
- rigid access criteria
- difficulty communicating
- lack of coordination between services.

Key consultants also reported that isolation from family and community were barriers to accessing inpatient services (eg detoxification or residential services), and that locked doors at night reminded Indigenous people of the criminal justice system.

Key consultants commented that service utilisation often depended on the reputation of that service in the community. One key consultant pointed out that sometimes the community's perceptions of a service were inaccurate or based on mixed messages.

Improving Access to Services

Key consultants suggested a number of ways to improve access to services for Aboriginal people. They suggested establishing more Indigenous specific services and ensuring that the Aboriginal community (including those who inject drugs) was involved and consulted. They also suggested increasing partnership and collaboration between Indigenous and mainstream services by working together and increasing communication between agencies.

Key consultants believed that services needed to be more flexible and have less rigid access criteria. They need to increase employment of Aboriginal workers, from reception to counsellors. Key consultants also suggested that services hold regular cultural awareness sessions for their staff, address broader social, legal, and family issues, provide greater emotional and social support, and include family or significant others. One key consultant stated that accessibility stems from:

"...recognition that Indigenous people operate differently so [the service] needs to work differently." (drug and alcohol counsellor)



Methadone Program

Access to the methadone program was discussed in 14 interviews. Attitudes toward the methadone program were generally positive. In nine interviews key consultants believed that methadone had provided benefits to Aboriginal opiate users. In only three interviews, key consultants thought there were few benefits to methadone.

Benefits of Methadone

The most commonly mentioned benefit of methadone was increased stability and associated improved lifestyle for the injector and their family (five interviews). Key consultants considered methadone to be a factor in healing the rift between injectors and their families. The increased stability that methadone provided enabled people to renew relationships with their family and children.

Other benefits included reduced illegal activities, fewer risks associated with injecting, and not having to suffer through withdrawal. One key consultant commented that methadone has,

*“...allowed people to get on with life without getting sick and needing to start looking for a hit.”
(methadone program worker)*

One key consultant stated that a benefit of being on a methadone program was that related issues could also be addressed. In two interviews, key consultants saw no cultural difference in the benefits of methadone.

“Methadone has the same benefits for Aborigines as for any opiate user.” (peer educator)

A number of key consultants acknowledged that methadone did not suit everyone and a range of options is needed.

Concerns About Methadone

The key consultants who saw no benefit to methadone were mainly concerned with the properties of methadone, for example, the strength of methadone and difficulties in reducing the dose. One key consultant reported that being on methadone did not necessarily mean giving up heroin, and that the person may gain a new drug dependency. There was a perception that methadone was better for the community (eg reduced crime) than for the individual. Three key consultants raised the issue of dental problems associated with methadone. Other concerns included the possible dangers associated with methadone diversion (ie overdose), and possible increased cannabis or alcohol use (although this was not regarded as a major concern).

Barriers to Accessing Methadone

The two biggest barriers to access to methadone for Aboriginal people included the lack of methadone prescribers (and dispensers) and the cost. Key consultants reported that Aboriginal people have difficulty finding a chemist to dispense methadone to them because of a shortage of dispensers and discrimination towards Aboriginal people. Many key consultants (12 interviews) believed that the expense of daily travel to and from the chemist was a barrier to access. The cost of methadone was mentioned as a barrier in seven interviews.

“The money [is a barrier] - even for people who can manage their finances because it’s a huge chunk of their income.” (medical practitioner, community health centre)

Key consultants also believed that the rigid structure of rules and regulations presented a barrier to access (seven interviews). The strict regulations leave no room for people to fulfil community or family obligations such as spending time with family in rural communities or travelling to funerals. Key consultants considered this rigidity to be an indication of a general lack of cultural understanding. As one consultant reported,

“...[negotiating the system] demands a level of organisation which can be hard without support.” (methadone program worker)

Barriers to Benefiting from Methadone

Key consultants in six interviews believed that the Aboriginal community held negative attitudes towards methadone due to a lack of knowledge about methadone. A number of key consultants reported that methadone might not be an option for some injectors due to a lack of family and community support and the stigma associated with it. Other injectors could also contribute to negative attitudes towards methadone, so there may be:

*“...peer pressure to keep using by friends [who] bad mouth ‘done’
(methadone program worker).”*

One key consultant stated that Aboriginal people often attempted to keep their methadone use confidential, only to be shamed when the pharmacist dispensed the dose publicly.

Key consultants reported a lack of ongoing support and backup for clients within the program (six interviews). Key consultants also reported a lack of skilled workers to provide support and counselling, little progress monitoring, and no clear goals for clients.

*“...you can’t just give out methadone and [have] no support services.”
(Aboriginal legal rights worker)*

Improving Access to Methadone

Key consultants were asked how the program might be made more accessible to Aboriginal people. The suggestions included increasing information about methadone (five interviews) and increasing community involvement in the program (five interviews). They also expressed a need for more appropriate information for potential clients and their families. Key consultants suggested an education campaign for the Aboriginal community regarding the benefits of methadone and addressing stereotypes and myths.

In three interviews, key consultants suggested that methadone should either be provided free or subsidised.¹⁰ Two key consultants suggested providing a transport service to take clients to and from their dispensing pharmacies.

Key consultants emphasised the need to establish an Aboriginal specific methadone program and to employ more Aboriginal workers in mainstream programs. Some key consultants noted that an Aboriginal specific program might be impeded by feelings of shame and concerns about family connections. They believed that there should always be a choice between mainstream and Aboriginal specific programs for Aboriginal people who inject drugs.

Key consultants also suggested that there needed to be a wider range of support services, including client support and follow-up, strategies for people coming off methadone and encouragement for clients to look beyond methadone.

The Main Needs of Aboriginal People Who Inject Drugs

Key consultants identified a range of harm reduction needs including supervised injecting facilities, heroin trials, prison programs, improved access to sterile injecting equipment, increased access to treatment and support services, and improved referrals to appropriate services. Consultants most frequently mentioned the need for an improvement in clean needle programs and related services (14 interviews).

Key consultants regarded the employment of peer educators as an appropriate way to offer support and information to Aboriginal people who inject drugs. They stressed the need for confidentiality and credibility in peer educators, including workers that are,

*“culturally appropriate to **urban** Aboriginal people.” (peer educator)*

10. Although methadone is subsidised in all states of Australia, individual pharmacies charge a dispensing fee that can vary from \$3 to \$7 per dose.



Key consultants identified a need for more information on safer injecting practices and alternatives to injecting.

In 11 interviews, key consultants identified a need for more choices in treatment services, specifically a better range of culturally appropriate drug treatment services, including Aboriginal specific detoxification services and long-term residential services. Some key consultants suggested exploring the feasibility of alternatives to methadone treatment. Those who mentioned alternative pharmacotherapies regarded buprenorphine as a preferable option because withdrawal is less severe than withdrawal from methadone and it doesn't have to be taken daily. One key consultant mentioned ultra rapid opioid detoxification, but did not regard it as a suitable option for Aboriginal injectors.

*"Aboriginal clients are reluctant to use programs that offer hospitalisation."
(methadone program worker)*

Some key consultants emphasised the need for holistic services that address a range of emotional and social issues, offer long-term support and focus on health promotion and early intervention strategies.

Key consultants also identified the need for more and better information/education (10 interviews), support for families of people who inject drugs (nine interviews) and counselling, particularly grief counselling (six interviews). Key consultants suggested that welfare support be provided to families who provide financial support to a family member who is an injector.

Key consultants indicated that Aboriginal injectors need access to a safe environment, for example a safe place at night, a safe place to use drugs, and a safe place to meet (three interviews). In two interviews, key consultants mentioned the need for law reform so that Aboriginal people who inject drugs can access drugs of recognisable qualities and quantities.

Social Equity

In five interviews, key consultants raised the need for social equity, recognising that Aboriginal people probably use alcohol and other drugs to escape poverty and boredom. One key consultant indicated that low literacy and education levels equate to poverty and poor health, which increases the chances of engaging in the negative aspects of drug use.

"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." (prison 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." (drug and alcohol worker)



RESULTS OF SURVEY OF INDIGENOUS PEOPLE WHO INJECT DRUGS

Demographic Characteristics of Participants

Three hundred and seven Indigenous people who inject drugs participated in the survey. The median age of participants was 32 years (range 14-54 years). Sixty percent of participants were male. Forty percent of participants lived in housing trust accommodation. Thirty eight percent resided in the western suburbs. The median age of leaving school was 15 years (range 6-18 years). Sixty six percent of participants were unemployed and Jobstart was the main source of income for 48% of participants.

Table 5: Demographic characteristics of survey participants (n=307)

Age (median years)	32
Gender	
Male	60%
Female	40%
Area of Residence	
Western	36%
Southern	23%
Northern	19%
Port area	10%
Not specified	5%
Central	4%
Eastern	1%
No fixed address	1%
Type of Residence	
Housing trust	40%
Family	34%
Share accommodation	11%
Hostel	6%
No fixed address	6%
Buying/renting alone	2%
Buying/renting with partner	<1%
Other (not specified)	1%


Table 5: Demographic characteristics of participants (continued)

School Education (median years)	15
Education Level	
Still at school	
Left before Year 7	<1%
Year 7	4%
Year 8	13%
Year 9	29%
Year 10	29%
Year 11	13%
Year 12	5%
Not specified	7%
Employment	
Unemployed	66%
Home duties	18%
Study	10%
Employed full time	2%
Employed part time/casual	4%
Community Development Employment Program	1%
Not specified	1%
Source of Income	
Jobstart	48%
Pension	23%
Sickness/disability pension	12%
Study assistance	9%
Youth allowance	4%
No government benefit	2%
Not specified	1%
Other/don't know	<2%
Community Development Employment Program	<1%



Length of Residence in Adelaide

Seventy four percent of participants had lived in Adelaide for most of their life, while 11% had moved to Adelaide in the last 12 months. Twelve percent had lived in Adelaide for at least a year.

Living Circumstances

Twenty five percent of participants reported that during the past 6 months they did not live with other people who injected drugs. Participants reported living with another person who injected drugs: some of the time (23%); all the time (16%); most of the time (15%); and about half the time (12%) during the previous 6 months.

Post-Secondary Education

Thirty six percent of participants had undertaken further education since leaving school. Of those:

- 47% attended college or Technical and Further Education (TAFE)
- 44% attended a trade or apprenticeship program (30 completed)
- 7% attended university (3 graduated)
- 2% studied Year 12 at an adult education institution.

Friends and Family

Sixty seven percent of participants reported that about half of their friends injected drugs. Twenty six percent reported that most, or all, of their friends injected drugs. Only 6% reported that none of their friends injected drugs.

Thirty five percent of participants were in a relationship at the time the survey was conducted. Of those, 73% reported having an Aboriginal partner, and 66% reported having a partner who also injected drugs. Of those who reported having a partner who also injected drugs, 27% reported that their partner was currently using alcohol and other drug services.

Fifty five percent of participants had at least one child; and of these, 14% had at least five children. Twenty five percent of those with children had just one child; 22% had two children; 24% had three children; and 14% had four children. Of those with children, 29% were the primary carers of their children.



Table 6: Primary carers of children of survey participants (n=168)

Primary Carer	Percent of Parents
Participants as primary carers	29%
Ex-partner	26%
Shared role with partner	13%
Kids grown and left home	13%
Family	10%
Shared with family	7%
Shared with previous partner	2%
Foster care	<1%

Drug Use History and Trends

Drug Use History

The drugs most likely to ever have been injected included heroin (82%), speed (70%), opiates other than heroin (29%), and methadone (25%). The drugs most likely to have been used in the last 6 months were heroin (97%), speed (68%), alcohol (66%), cannabis (62%), and tobacco (55%).

Table 7: Drug use history of survey participants (n=307)

Drug Class	Ever Tried	Ever Injected	Used in Last 6 Months
Heroin	99.7%	82%	97%
Yarndi (cannabis)	89%	-	62%
Amphetamine (speed)	79%	70%	68%
Tobacco	77%	-	55%
Alcohol	75%	2%	66%
Benzodiazepines	59%	15%	34%
Methadone	49%	25%	34%
Other opiates	42%	29%	26%
Hallucinogens	31%	9%	11%
Cocaine	26%	12%	8%
Stimulants	13%	4%	4%
Designer drugs (incl. ecstasy)	2%	5%	7%
Inhalants	10%	-	3%
Pituri	5%	-	<1%
Other drugs	2%	<1%	1%



Drug of Choice

Sixty six percent of participants preferred only one drug. Of these:

- 56% preferred heroin
- 33% preferred speed
- 11% preferred cannabis (yarndi)
- 2% preferred benzodiazepines
- 1% preferred methadone
- <1% preferred opiates.

Thirty two percent of participants nominated more than one drug (range 2-5 drugs). Of these:

- 92% preferred yarndi (cannabis)
- 59% preferred amphetamine
- 39% preferred opiates
- 37% preferred heroin
- 24% preferred benzodiazepines
- 17% preferred hallucinogens
- 3% preferred cocaine
- 3% preferred alcohol
- 3% preferred ecstasy.

Patterns of Drug Use

Further detail regarding patterns of use (ie when last used and frequency of use) can be located in Appendix 14. Tobacco, cannabis (yarndi), heroin, and methadone were the drugs most likely to have been used on a daily basis. By comparison, cocaine, inhalants and 'designer' or 'party' drugs, such as ecstasy were rarely used, with fewer than 10% of the sample having used these in the last 6 months.

Money Spent Per Heroin Hit

One hundred and ninety one of the participants who reported using heroin provided information on the amount they spent per 'hit'. Of those, 82% spent between \$50 and \$100 per hit and 5% spent \$200 or more per hit. The median was \$75 per hit (range \$25 - \$400).

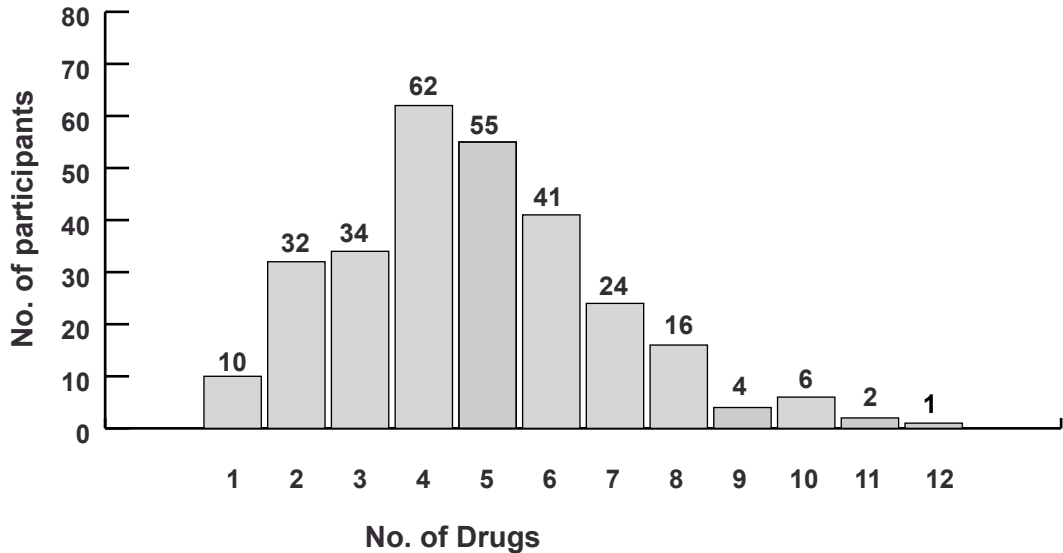
One hundred and eighty of the 191 participants provided information on their weekly expenditure on heroin. They reported spending between \$50 and \$5000 per week to support their drug use. Fourteen percent reported spending between \$1000 and \$5000 per week. Excluding this group, the median weekly expenditure was \$350 (range \$50-\$900).



Polydrug Use

Most participants (97%) reported having used more than one drug at the time the survey was conducted. They had tried a median of seven different drugs at some point in their lives (range 1-14) and were currently using a median of four drugs (range 1-12).¹¹ Three percent (10) of participants had used only one drug and, of those, three people had only ever used heroin.

Figure 1: Number of drugs tried by survey participants in the last 6 months (n=307)



The most common drug combinations were cannabis (yarndi) and heroin (26%); yarndi and speed (20%); speed and alcohol (7%); and heroin and alcohol (7%). Cannabis was the drug most commonly used in combination with other drugs.

Table 8 describes polydrug use trends, but it should be noted that these drugs are not always used at the same time. For example,

- 40% of participants reported using both heroin and speed at least once a week, though not necessarily at the same time
- 46% reported using both heroin and speed at least once a fortnight
- 51% reported using both heroin and speed at least once a month.

11. Current use is defined as having used at least once in the previous six months.

Table 8: Types of drugs usually used in combination

N	Cannabis	Heroin	Amphetamine	Alcohol	Ecstasy	Cocaine	Pills	Opiates	LSD	Methadone
65	X	X								
51	X		X							
18			X	X						
18		X		X						
18		X								X
15		X					X			
15	X		X	X						
10			X					X		
9	X			X						
6	X		X					X		
5	X						X			
4	X	X								X
3		X						X		
2				X			X			
2			X				X		X	
2			X		X					
2		X						X		X
1	X									X
1	X							X		
1	X					X				
1							X	X		
1				X						X

Breaks from Drug Use

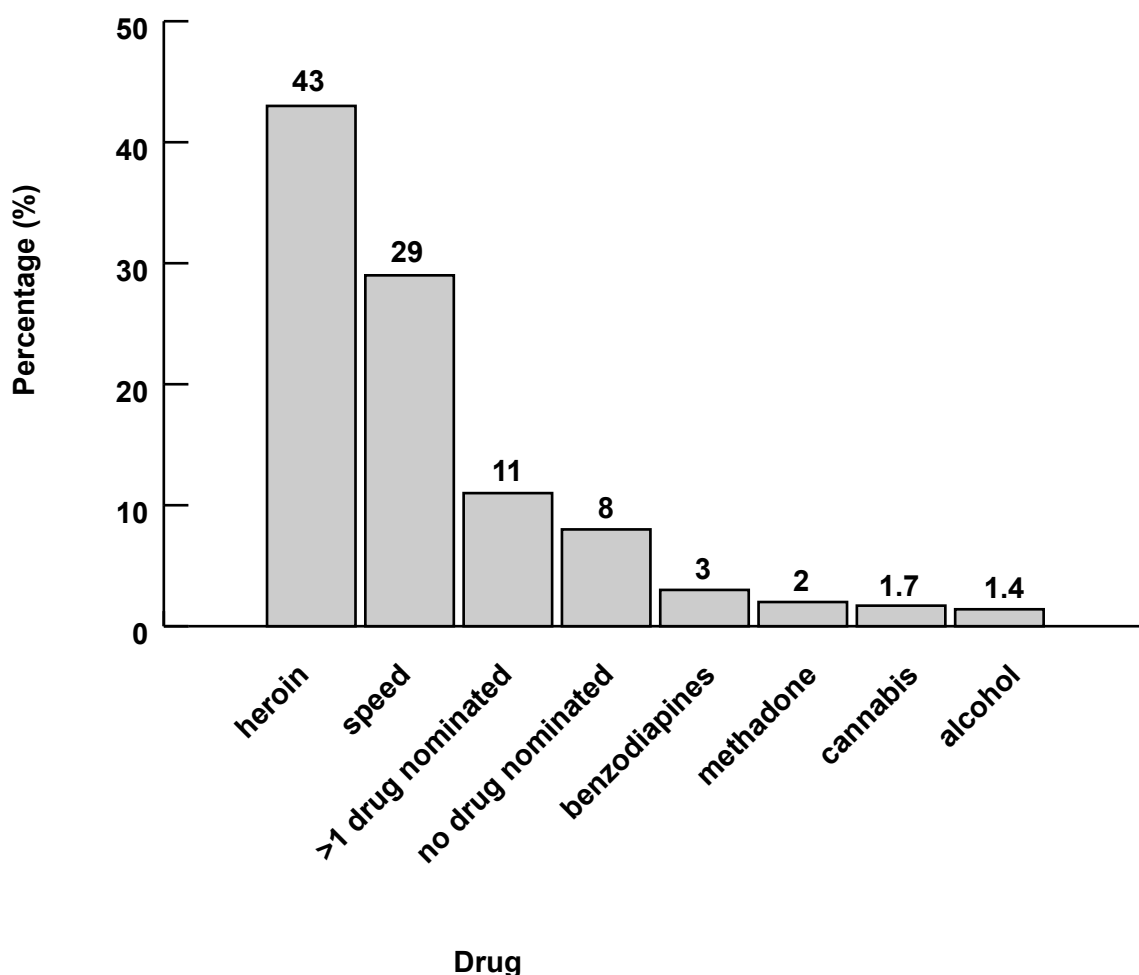
Half of the participants (50%) provided information on the length of time they injected drugs without a break. Of those, 43% had been injecting for a year or more without a week-long break, and 8% indicated they had never had a break of more than a week.

Table 9: Longest period of time without a break from injecting of more than a week (n=153)

Time Without Break	Percentage
One to two weeks	<1%
2 weeks to a month	10%
1 to 3 months	22%
3 to 6 months	16%
6 months to a year	18%
1 to 2 years	10%
3 years or more	16%
Never had a break of more than a week	8%

Drug Dependence

Figure 2: Drug nominated of most concern to survey participants (n=307)





The majority of participants indicated that either heroin (43%) or speed (29%) was the drug of primary concern. The remaining drugs were of primary concern for only a small percentage of participants: benzodiazepines (3%); methadone (2%); cannabis (2%); and alcohol (1%). Eleven percent of participants indicated that more than one drug was of primary concern to them.

Severity of Dependence Scale

The Severity of Dependence Scale (SDS) (Gossop, Darke, Griffiths, Hando and Powis et al 1995) was used to assess participants' levels of psychological dependence. The mean score on the SDS was 9.26 (s.d.=3.45).

Of those who nominated heroin as their drug of primary concern, 90% scored higher than five, suggesting psychological dependence on the drug (Strang, Griffiths, Powis and Gossop 1999). Similarly, of those who nominated amphetamines as their drug of primary concern, 78% scored more than four, suggesting psychological dependence (Topp and Mattick 1997). Previous research has found that higher scores on the SDS are related to high risk behaviours, such as unsafe injecting practices, sharing of injecting equipment, and high risk sexual behaviours (Gossop et al 1995). This study found similar patterns including:

- the more frequently heroin was used, the higher the dependence score
- higher SDS scores were associated with a greater number of physical, social and emotional difficulties
- higher SDS scores were associated with recency of sharing syringes (using syringes before and after someone else)
- higher SDS scores were associated with sharing of other injecting equipment, such as spoons, filters, tourniquets and mix
- higher SDS scores were associated with an increased perception of risk of contracting HIV, HBV and HCV.

For further information regarding the risks associated with higher SDS scores, refer to Appendix 15.

Patterns of Alcohol Use

Seventy five percent of participants had 'ever tried' alcohol, and of these, 3% had ever injected it. Sixty six percent of participants had used alcohol at least once in the previous 6 months. Of those who had used alcohol in the previous 6 months:

- 40% drank once a week or more
- 32% drank every day
- 15% drank monthly
- 6% drank infrequently (fewer than 3 occasions in the last 6 months)
- 5% drank fortnightly.

Alcohol Dependence and the AUDIT (Alcohol Use Disorders Identification Test)

To investigate patterns of alcohol use over the past 12 months in more detail, participants were asked to complete the Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Asland, Babor, de la Fuente and Grant 1993). The questions are designed to reflect quantity of alcohol used, drinking behaviour, unpleasant or unwanted reactions and presence of alcohol-related problems.

The AUDIT results reported here are from the 172 participants who had consumed alcohol in the previous 12 months and returned a completed AUDIT. Seventy six participants stated that they had never tried alcohol, 25 had not consumed alcohol in the past 12 months, and 34 AUDITS were incomplete.

Table 10: AUDIT scores for males and females (n=172)

AUDIT Score	Low Risk (0-6 females) (0-7 males)	Hazardous/Problematic (7-12 females) (8-12 males)	Harmful/Dependent (13 or more)
Females (n=61)	20%	28%	52%
Males (n=111)	14%	18%	68%
Total	16%	21%	63%

The median score on the AUDIT was 16 (range 1-39). The majority (63%) of AUDIT respondents were drinking at harmful/dependent levels. A further 21% were drinking at hazardous/problematic levels. Only 16% were consuming alcohol within the low risk range.

Significantly more males than females scored within the harmful/dependent range, with average scores of 18.7 and 15.7 respectively ($t(170)=1.97$, $p=.05$).

The first set of questions (1-4) in the AUDIT is designed to assess alcohol consumption levels. In sum:

- 47% of AUDIT respondents consumed alcohol two or more times per week
- 82% consumed more than five standard drinks in one session on a typical drinking day
- 65% consumed six or more standard drinks at least once a week.

The second set of questions (4-6) assesses alcohol dependence/drinking behaviour. In sum:

- 31% experienced difficulty stopping drinking on a weekly basis or more frequently
- 29% failed to do what they were expected due to their drinking, at least once a week
- 37% needed a morning drink after a drinking session at least weekly.

The third set of questions (7-8) relates to adverse reactions from alcohol use. In sum:

- 28% experienced guilt or shame as a result of their drinking behaviour, on a monthly basis, or more often
- 35% were unable to remember events during a drinking session, on a monthly basis or more often.

The fourth set of questions (9-10) relates to alcohol related problems. In sum:

- 27% had been injured in the last year as a result of their drinking
- 31% had received advice to cut down from a friend, health worker or general practitioner.



Injecting Behaviour

Age at First Injection

The average age of first injection was 18.29 years (sd = 4.2). Fifty one percent of participants were under 18 years old when they first injected. Twelve percent were 14 years old or younger when they first injected. Only two people reported being as young as 10 or 11 years when they first injected. Three percent were 30 years or older when they first injected.

First Drug Injected

The first drug injected by participants was:

- heroin (48%)
- speed (45%)
- morphine (2%)
- cocaine (<2%)
- speed ball (heroin and speed) (<1%)
- ecstasy (<1%)
- methadone (<1%)
- opium (<1%)
- benzodiazepines (<1%)
- methadone and speed (<1%).

Method of Administration on First Use

Some participants had used a drug by another method before making the transition to injecting.

For participants who first injected heroin (144):

- 10% had previously smoked it
- 5% had previously snorted it
- 2% had previously swallowed it.

For participants who first injected speed (139):

- 45% had previously snorted it
- 10% had previously swallowed it
- 3% had previously smoked it.

Assistance with First Injection

Eighty one percent of participants received some assistance when they first injected. Of those, 76% received assistance from another Aboriginal person. Of those who received some assistance, they received it from:



Responding to the Needs of Indigenous People Who Inject Drugs

- relatives (45%)
- friends (39%)
- partners (14%)
- people known to them (6%)
- a dealer (2%)
- street people (1%)
- someone they had recently met (1%).

Ten percent of participants injected themselves the first time they injected. Six percent allowed another person to inject them on the first occasion.

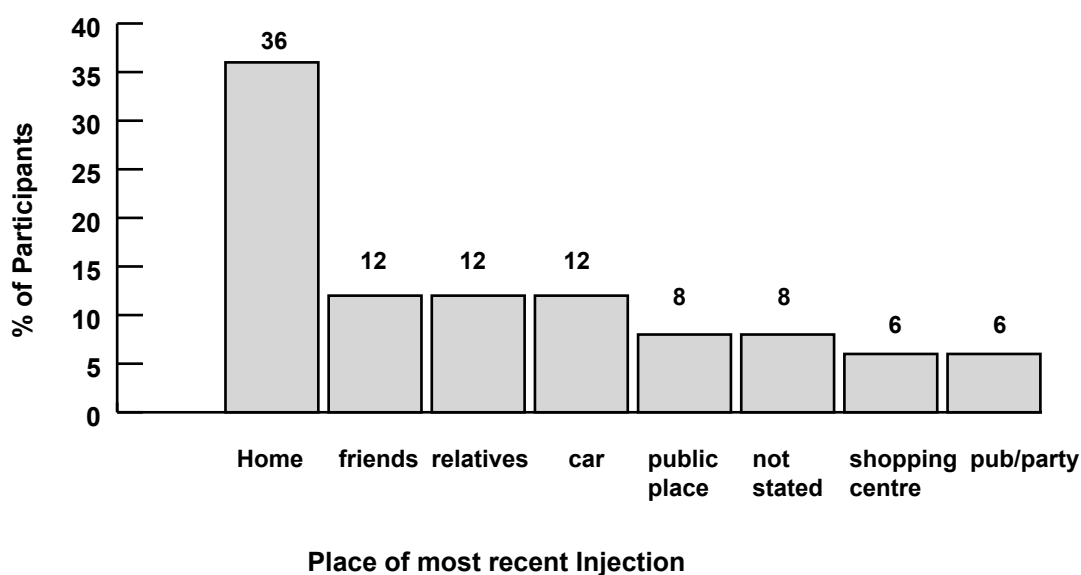
When Last Injected

Most participants (66%) had injected drugs either the day before, or the day of, the interview. Nineteen percent had injected in the last week; 7% in the last month; and 5% in the last 1-3 months.

Where Most Recently Injected

When they last injected, participants were most likely to be at home (36%); in the home of friends (12%); in the home of relatives (12%); or in a car (12%).

Figure 3: Location of most recent injection (n=307)





Physical, Social and Emotional Well Being

Participants reported a median of eight (range=1-14) physical health symptoms, mostly loss of appetite, hot and cold flushes, lack of energy and aching muscles. Participants reported a median of nine (range=1-12) mental health symptoms, mostly mood swings, reduced enjoyment of things, sleeping problems and lack of enthusiasm for life. Participants reported a median of five (range=1-10) injection related problems, mostly track marks, shaking and shivering on injection, and nausea and headache.

Participants reported a median of five (range=1-10) social problems, mostly financial problems and difficulties in relationships with family, friends and other people.

Table 11a: Physical health symptoms

Problem	(n=307)
Poor appetite	82%
Hot/cold flushes	80%
Lack energy	79%
Aching muscles/joints	76%
Headache	69%
Nausea	65%
Teeth	51%
Breathing problems	49%
Stomach	48%
Liver	39%
Skin	33%
Virus	25%
Heart problems	17%
Other	16%

Table 11b: Mental Health symptoms

Problem	(n=307)
Mood swings	84%
Less enjoyment of things	84%
Sleeping problems	84%
Lack enthusiasm	82%
Depression	81%
Poor memory	81%
Poor concentration	79%
Anxiety	67%
Paranoia	58%
Bad dreams	47%
Hallucinations	36%

Table 11c: Injection related problems

Problem	(n=307)
Track marks	81%
Shaking/shivering	66%
Nausea	55%
Headache due to hit	54%
Vein problems	52%
Hurt self while intoxicated	41%
Dirty hit	27%
Virus from injecting	22%

Table 11d: Social problems

Problem	(n=307)
Financial	93%
Family	76%
Friends	73%
Other people	73%
Legal	61%
Partner	55%
Accidents	36%
Studies	15%
Other issues	13%
Work	10%

Several of the physical and mental health symptoms reported are consistent with opiate withdrawal (eg hot and cold flushes, poor appetite, lack of energy, nausea and muscular aches and pains). Other symptoms may be considered features of intoxication (eg intoxication-related accidents, headache, mood swings, anxiety, paranoia and nausea). It is possible that other symptoms may have been direct consequences of poor injecting practices, such as viruses from injecting and dirty hits. Considering the high rate of daily opiate and polydrug use amongst this sample, the range and frequency of symptoms reported here is not unexpected.

Participants were also asked to describe any health problems for which they were receiving treatment, and any medications prescribed. Eighteen percent of participants reported being on medication (not including methadone or buprenorphine). Of those who were on medication, most were taking benzodiazepines (43%); followed by antidepressants (33%); prescribed opiates (7%); anticonvulsants (6%); and salicylates (4%). Seventeen percent of those on medication were prescribed more than one medication.

Medications being used were consistent with the conditions described. For example, 31% of those receiving medication were being treated for depression; 17% for sleep disorders; and 15% for anxiety.

Overdose

Twenty one percent of participants reported having overdosed after injecting. Of those who ever overdosed, 67% reported overdosing more than 12 months previously. Of those who overdosed in the last 12 months (33%), one had overdosed in the last month; two in the last 1-3 months, 11 in the last 3-6 months, and seven between 6 and 12 months previously.

Of those who had overdosed, 92% had done so while using heroin. Others reported overdosing on speed, alcohol and benzodiazepines, or an unidentified combination of drugs.



Reasons for Overdose

Sixty two participants (20%) provided information on the most likely cause of their most recent overdose. The reasons for overdose included:

- having taken too much of a drug (50%)
- having mixed drugs or drugs and alcohol (32%)
- having had a lowered tolerance (10%)
- the drug quality exceeded their tolerance (5%)
- lack of sleep (2%)
- deliberate attempt (2%).

Experience of Overdose

Of those who had ever overdosed, 63% reported that an ambulance had been called during their last overdose, and of those, 60% remembered being taken to hospital. Of those who had ever overdosed, 19% were revived or monitored by others (ie by being watched, doused in water, walked around a room, or put in the shower); 8% recovered without assistance; 5% didn't recall what happened; 3% reported being 'drop and runs' at the hospital; and 2% were resuscitated by police.

Thirty three percent of participants had been with other people when the other person overdosed. Of those, 56% called an ambulance; 35% tried to revive the person (eg slapping their face, blowing water up their nose or using basic first aid); 9% drove the person to a hospital; 3% were frightened and either did nothing or ran away; and 4% resulted in police involvement.

Nine percent of those who were present at an overdose, witnessed an overdose death.

Police Attendance at an Overdose

Participants believed that police might attend an overdose in the following situations:

- only when a death occurred (49%)
- uncertain when police should attend (15%)
- when called (either by ambulance or other people) (10%)
- when the circumstances were suspicious (4%)
- automatically when ambulances were called (3%)
- when children were involved (3%)
- where dealing/dealers were involved (2%)
- 'when it suited them' (2%)
- if the overdose occurred in a public place (2%)
- 'every time' an overdose occurred (2%).

Only two participants (<1%) thought that police shouldn't attend an overdose under any circumstance.

Responding to Overdose

Eighty one percent of participants reported that they would help another person during an overdose. Fifty two percent said they would call an ambulance. Only 23% of participants described basic first aid techniques (ie CPR, coma position or airway management). Three percent of participants indicated that they would drive the person to hospital, but 4% indicated that they would not wait to see the outcome of their assistance. Two people (<1%) said they would call the police, and another six (2%) were uncertain what action they would take.

Deliberate Overdose

Thirty seven percent of those who had ever overdosed reported doing so deliberately. When asked about the circumstances leading to their deliberate overdose, participants mentioned suffering from depression, having relationship difficulties, being upset due to deaths in the family, and feeling suicidal.

Blood Borne Viruses

Perceptions of Contracting Blood Borne Viruses

Table 12: Perception of risk of contracting a blood borne virus (n=307)

Perception of Risk	HIV	HBV	HCV
Very low	73%	71%	61%
Low	9%	7%	5%
Medium	9%	9%	8%
High	4%	3%	3%
Very high	3%	5%	14%

Participants generally perceived their risk of contracting a blood borne virus to be 'low' or 'very low'. Eighty two percent reported their risk of contracting HIV as either low or very low; 78% reported their risk of contracting HBV as either low or very low; and 66% reported their risk of contracting HCV as either low or very low.

Of the 258 participants who described their chance of contracting a blood borne virus as very low:

- 62% indicated that they did not share syringes
- 7% stated they always used clean syringes
- 4% indicated that they practiced 'safe sex'
- 4% indicated that they were 'careful'
- 2% said they were 'clean' people.

Of those that rated their risk of contracting HIV as low or very low (251), four stated that they did not believe they would be unlucky enough to contract HIV, and two stated that "they didn't care" about any possible risks.

Of those that rated their risk of contracting HCV as low or very low (203), 53% stated that they did not share syringes and 33% stated that they were already HCV positive.



Of those that rated their risk of contracting HBV as low or very low (239), 49% stated they did not share syringes and 31% stated they had been vaccinated or had previously contracted HBV.

Six percent of participants believed they were at high risk of contracting HIV. This group also tended to believe their risk of contracting HBV and HCV was high. Fourteen percent of participants rated their risk of contracting HCV as very high. Of those, 34% attributed their increased risk to equipment sharing and 27% attributed their increased risk to lifestyle factors.

Testing for Blood Borne Viruses

Over 90% of participants had been tested for each of the three blood borne viruses listed, but only 60% had been tested within the last 6 months. A small proportion (1%) was uncertain if they had ever been tested, and around 6% of the sample had never been tested.

Table 13: Recency of testing for blood borne viruses (n=307)

Recency of Testing	HIV	HBV	HCV
Ever tested	90%	91%	90%
Within the last six months	55%	55%	55%
Never been tested	6%	5%	6%
Uncertain	1%	1%	1%
HBV Vaccinated	N/A	66%	N/A

Participants Identified as HCV Positive

Consistent with ethical approval, participants were not directly asked about their blood borne virus status. Interviewers were, however, instructed to take note when participants volunteered that they were HCV positive. Forty three percent of participants volunteered information about their HCV status and 41% volunteered that they were HCV positive.

Of those who volunteered they were HCV positive (125), 36% perceived that they were protected from further infection, and therefore, rated their risk of contracting it again as 'low'. Eighteen percent rated their risk as 'low' because they stated (sometimes inconsistently) that they didn't share syringes. Fourteen percent rated their risk of contracting HCV as moderate to high. Only 5% of those who volunteered being HCV positive considered their risk of contracting it again as very high. This group rated their risk of contracting other viruses as 'low' or 'very low'. Only two people mentioned awareness of the various strains of HCV.

Injecting Equipment

New Equipment

New injecting equipment was obtained from pharmacies, clean needle program outlets, friends, outreach workers, and dealers.

Thirty seven percent of participants usually collected five syringes or less each time. Twenty six percent collected a box of 100 or more; 27% between 6 and 10 syringes; 5% up to 20 syringes; and 3% usually collected between 20 and 100 syringes.

Fifteen percent of participants (47) stated that there were places that they would not go to obtain injecting equipment. Of those, 36% indicated that they didn't like going to pharmacies because of the cost, staff attitudes, or feelings of shame. Fifteen percent would not attend clean needle program outlets;



Responding to the Needs of Indigenous People Who Inject Drugs

13% would not attend community health centres; 13% would not obtain syringes from friends or dealers; 6% would not obtain syringes from hospitals; and 6% would not go places where they were made to feel shame.

Forty one percent of participants collected syringes for themselves; 36% collected for themselves and another person; 10% collected for four to five people; 7% collected for three people; and 4% collected for more than six people.

Disposal of Syringes

Participants stated that they disposed of their used syringes by:

- placing in sharps disposals (64%)
- placing in fit packs (or other containers) (30%)
- keeping them at home or saving them for later use (22%)
- placing in bin (12%)
- giving to friends or other people (7%)
- throwing used syringes 'outside' (2%).

Obtaining Water for Injecting

Water for mixing was most frequently obtained:

- from the tap (33%)
- by boiling it (28%)
- from a variety of sources (22%)
- from sterile ampoules (9%)
- from a bottle (ie spring water) (5%).

Injecting Hygiene

Although only 51% of participants reported sometimes, mostly or always swabbing their hands before injecting, a greater proportion reported swabbing the spoon (65%) or injection site (77%) before injecting. Eighty two percent reported at least sometimes swabbing the injection site after injecting.

**Table 14: Injecting hygiene practices (n=307)**

Cleaning Activity	Always or Mostly	Sometimes	Rarely or Never
Swab hands/fingers	19%	32%	48%
Swab spoon	27%	38%	34%
Swab injection site before injecting	33%	45%	22%
Swab injection site after injecting	38%	44%	18%
Swab other region/area	6%	4%	85%
Wash hands before injecting	26%	40%	33%
Wash hands after injecting	29%	37%	33%

Injecting in Company

Table 15: Injecting in the company of others in the last six months (n=307)

Injecting Company	Always	Most of Time	Sometimes	Once or Twice	Never
On your own	4%	14%	53%	9%	17%
With others	25%	21%	46%	3%	2%

The majority of participants indicated that they sometimes inject on their own (53%) and sometimes with other people (46%). Injecting with other people seems to be preferable to injecting alone. Forty six percent of participants indicated that they inject with other people always or most of the time, compared to just 18% who indicated that they inject alone always or most of the time. Seventeen percent of participants indicated that they never inject alone while only 2% indicated that they never inject with other people.

Sharing of Syringes and Other Injecting Equipment

Sharing Practices

Overall, about 64% of participants indicated that they had never used a syringe either before or after another person. Sixty one percent indicated that they had never used before another person, and 65% had never used after another person.

Overall, around one quarter of participants reported having used a syringe either before (26%), or after (22%) another person in the last two years.

Around 14% of participants had used before or after another person in the last two to three months. Twelve percent had used a syringe after another person in the last two to three months and 17% had used a syringe before another person in the last two to three months.

About 35% of participants had ever used a syringe before or after another person. Thirty seven percent indicated that they had ever used a syringe before another person and 33% had ever used after another person.

Table 16: Most recent occasion of using a syringe either before or after another person (n=307)

Before Another Person	%	After Another Person	%
never	61%	never	65%
>2years ago	10%	>2 years ago	11%
in last 1-2years	3%	in last 1-2years	5%
in last 3 months-year	7%	in last 3 months-year	5%
in last 2-3 months	17%	in last 2-3 monrths	12%

For the participants who reported ever using a syringe after another person (100), the median number of people who used a syringe before the participant on the last occasion of sharing was one (range 1-10). Similarly, for the participants who had ever used a syringe before another person (113), the median number of people who had used a syringe after the participant on the last occasion of sharing was one (range 1-11). There were no significant differences between males and females for using a syringe either before ($F(1) = .09, p = .80$) or after another person ($F(1) = .07, p = .80$).

Table 17: Number of people using a syringe before or after participant

After Participant	n=113	Before Participant	n=100
1	57%	1	59%
2	15%	2	11%
3	10%	3	8%
4	2%	4	4%
5-11 people	5%	5-11	8%
not stated	12%	not stated	10%

Frequency of Sharing Injecting Equipment

Table 18: Frequency of sharing injecting equipment (n=307)

Equipment Shared	Almost Always	Sometimes	Rarely or Never
Same spoon as others	24%	39%	36%
Same filter as others	23%	33%	41%
Same mix/water as others	23%	35%	41%
Same tourniquet as others	9%	22%	67%



Reasons for Using Another Person's Syringe

The main reasons cited for having shared another person's syringe (n=107) include:

- lack of availability of clean syringes (71%)
- they knew the person well so were unconcerned (33%)
- clean needle program outlet was closed (29%)
- they were 'hanging out' (25%)
- not worried or unconcerned about implications of sharing (15%)
- no transport to clean needle program outlet (13%)
- they were in prison (8%)
- didn't know sharing syringes was risky (4%)
- they were intoxicated at the time (1%).

Cleaning Syringes

Of those who provided detail regarding the method of cleaning the last time they reused a syringe (n=106):

- 54% used a cold water rinse
- 22% used a combination of bleach and water (including the 2x2x2 or 3x3x3 methods)
- 12% used a hot/boiled water rinse
- 3% used an alcohol swab
- 2% used disinfectant
- 2% boiled the syringe
- 1% used methylated spirits
- 1% used alcoholic drinks.

Comparison Between 'Sharers' and 'Non-Sharers'

'Sharers' were defined as those who used a syringe after at least one other person in the previous 2-3 months (12%). 'Non-sharers' were defined as those who never used a syringe after another person (65%).

Among the 37 'sharers', there were 21 males and 16 females. The median age was 31.5 years (range 16 to 49). Thirty percent of the 'sharers' completed Year 9; 32% completed Year 10; and 22% completed Year 11. There were no significant differences detected between 'sharers' and 'non-sharers' in age ($t(235)=.94$, $p=.35$), or level of education ($F(1, 221)=.34$, $p=.56$).

Forty percent of the 'sharers' had partners who inject drugs and 8% had partners who were accessing services for drug related problems.

Living with another injector significantly increased the likelihood of sharing. Thirty eight percent of 'sharers' live with another injector most or all of the time compared to 29% of 'non-sharers' ($F(1,215)=7.82$, $p=.006$).

There was no significant difference between 'sharers' and 'non-sharers' for frequency of heroin use ($F(1, 234)=1.50$, $p=.22$). Eighty nine percent of 'sharers' used heroin at least daily, with the remaining 11% using at least weekly.

The 'non-sharers' group were more frequent users of speed than the 'sharers' group ($F(1, 143)=5.81$, $p=.017$). Sixty seven percent of 'sharers' were current speed users, although their use of speed was less frequent than their use of heroin. Only eleven percent of 'sharers' were daily speed users; 22% were weekly users; 16% were monthly users; and 19% used speed fewer than three times in the last six months.

Of the 'sharers' who reported cannabis use, 84% were daily cannabis users. Of the 'sharers' who reported alcohol use, 50% drank alcohol daily.

Physical, Emotional and Social Well Being Implications for 'Sharers'

The 'sharers' group reported significantly higher scores on the AUDIT (mean score = 21.5, s.d.=10.78) than the 'non-sharers' group (mean score =16.5, s.d.=9.75) ($t(135)=2.17$, $p=0.032$).

The 'sharers' group also reported significantly higher scores on the SDS (mean score =10.14, s.d.=2.77) than the 'non-sharers' (mean score=8.06, s.d.=3.53) ($t(59.89)=4.00$, $p=.001$).

'Sharers' reported a significantly higher number of health related issues ($t(214)=2.55$, $p=.012$), injection related issues ($t(217)=2.70$, $p=.007$) and social issues ($t(219)=2.24$, $p=.000$) than 'non-sharers'. There were no significant differences for number of mental health issues ($t(226)=0.16$, $p=.88$).

Table 19: Mean number of physical and mental symptoms and injection and social problems – 'sharers' (n=37) compared to 'non-sharers' (n=201)

Group	Physical Health mean (s.d.)	Mental Health mean (s.d.)	Injection Problems mean (s.d.)	Social Problems mean (s.d.)
'Sharers'	9.0 (2.92)	8.5 (2.87)	5.9 (2.49)	6.3 (1.75)
'Non-sharers'	7.7 (2.71)	8.4 (2.72)	4.7 (2.39)	4.8 (2.00)



Over half of the ‘sharers’ reported recent testing for a blood borne virus. In sum:

- 57% had been tested for HIV in the last 6 months
- 54% had been tested for both HBV and HCV in the last 6 months
- 32% had been vaccinated for hepatitis A
- 70% had been vaccinated for HBV
- 49% volunteered that they had HCV.

‘Sharers’ perceived themselves to be at higher risk than ‘non-sharers’ of contracting a blood borne virus. They were more likely to have recently tested for blood borne viruses (‘non-sharers’ rates of testing: 53% for HIV, 50% for both HBV and HCV) and more likely to be HCV positive (34% of ‘non-sharers’ volunteered they were HCV positive).

Figure 4: Perception of risk of contracting HIV: ‘Sharers’ (37) compared with ‘non-sharers’ (201)

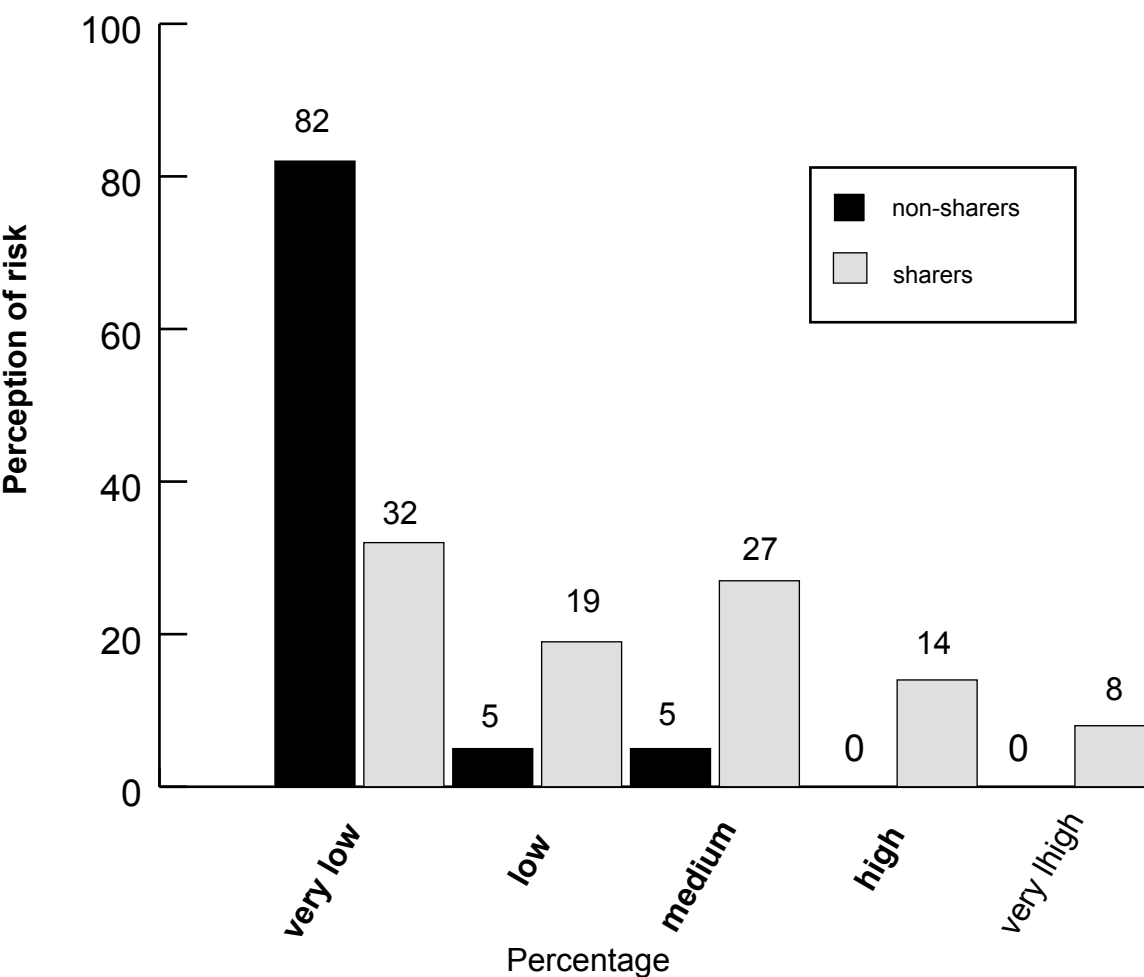


Figure 5: Perception of contracting HBV: 'sharers' (n=37) compared with 'non-sharers' n=201

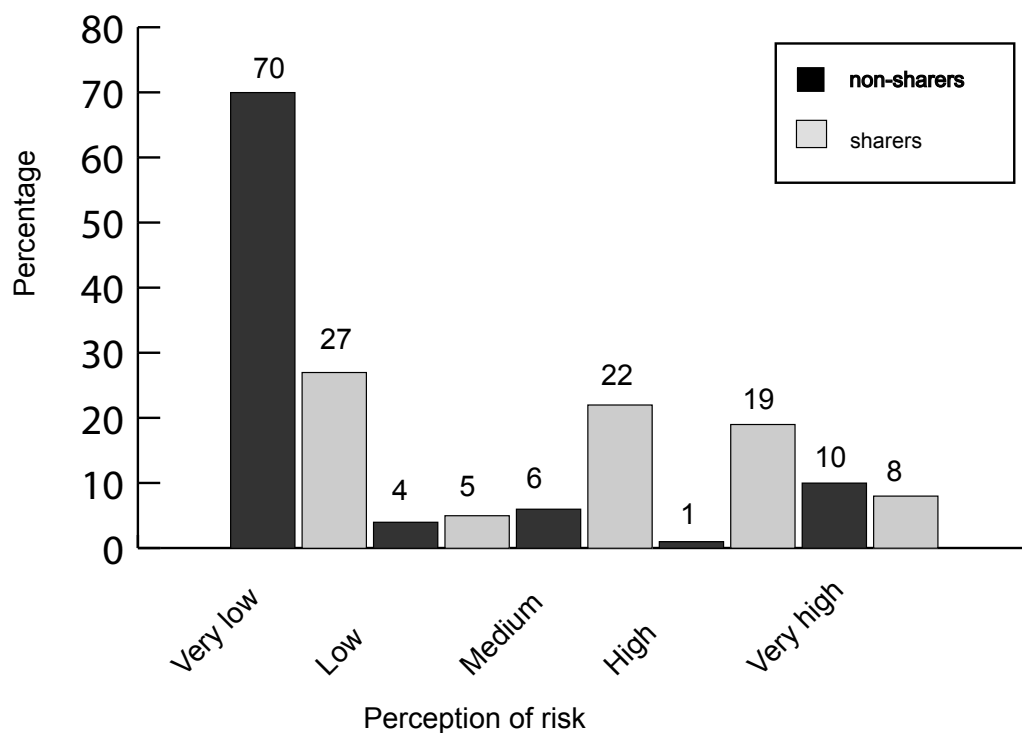
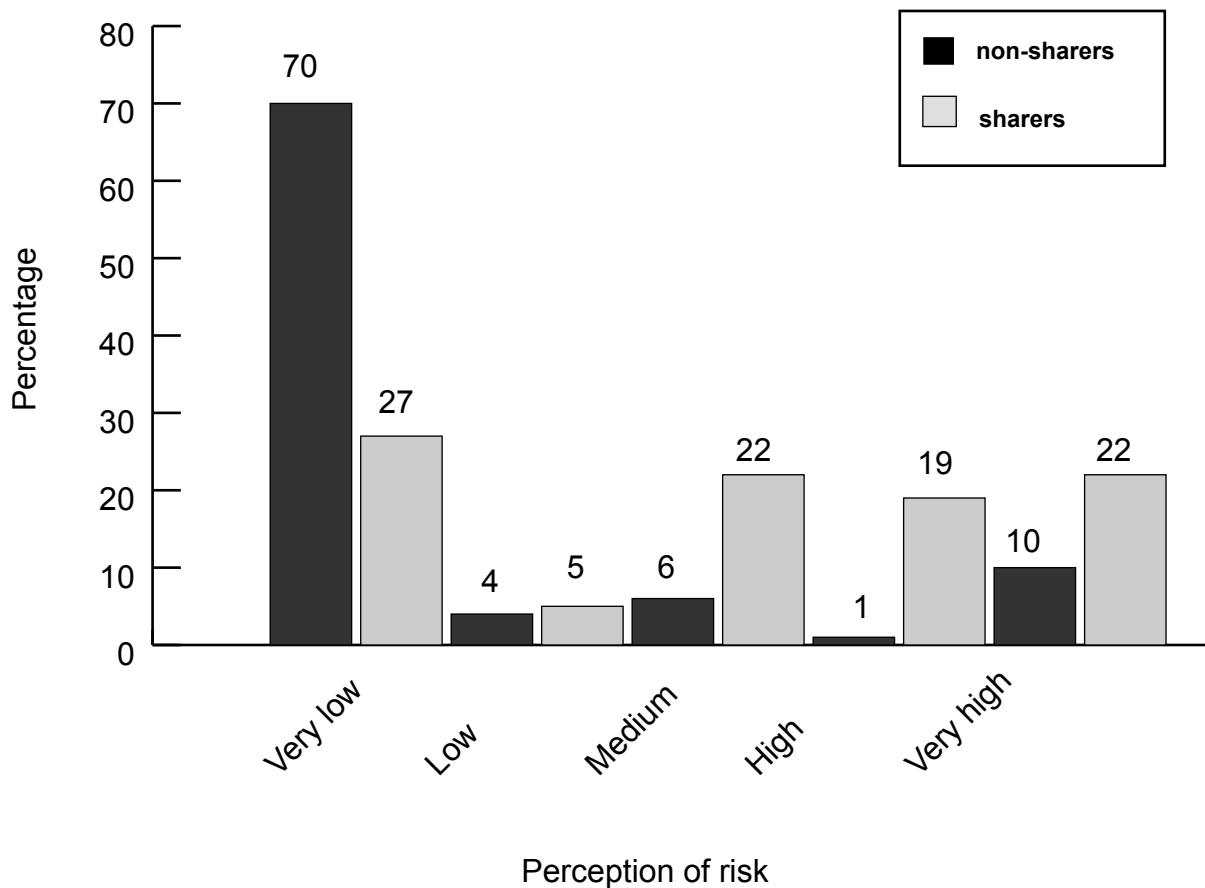


Figure 6: Perception of risk contracting HCV: 'sharers' (n=37) compared with 'non-sharers' (n=201)





Blood Borne Virus Status of People Who Used Syringes Prior to Participant

Participants (n=54) reported whether they knew (or assumed) the blood borne virus status of people they had shared syringes with in the previous six months, and also described their relationship to that person. Participants were more likely to share syringes if they knew, or thought they knew, the status of the other person. Participants were most likely to share syringes with someone with whom they had a close relationship and whose status they knew (eg partners (43%) or friends (39%)). Thirty five percent had shared syringes with another person without any knowledge of their status.

Table 20: Assumed blood borne virus status of people with whom participants shared syringes (n=54)

Relationship and Status	Percentage
Share with partner, status known	43%
Share with partner, status unknown	17%
Share with friend, status known	39%
Share with friend, status unknown	35%
Share with someone else, status known	28%
Share with someone else, status unknown	26%

Prison

Fifty one percent of participants had ever been imprisoned. Significantly more males (61%) than females (42%) had ever been imprisoned ($\chi^2(1)=10.21, p=.002$).

Forty four percent of those who had ever been in prison had injected while incarcerated. There was no significant difference between males and females for injecting in prison ($\chi^2(1)=3.99, p=.057$). Forty eight percent of males and 32% of females who had ever been in prison had injected while in prison.

Four percent of those who had been in prison, had injected for the first time while in prison.

Of those who had injected in prison (68), the drugs most frequently injected were heroin (69%), speed (8%), or a combination of heroin and at least one other drug (24%). Fifty two percent indicated that they always shared syringes when injecting in prison. Fifteen percent shared most times and 10% shared infrequently. Twenty four percent never shared another person's syringe when injecting in prison. There were no significant difference between males and females in sharing behaviour in prison ($F(1)=1.33, p=.25$).

Sixty two percent of those who injected in prison made an attempt to clean syringes every time. Only 3% indicated that they never cleaned syringes. Three percent indicated that they cleaned the syringes most times, 9% cleaned infrequently, and 9% were unsure if their syringes had been cleaned.

The most common methods for cleaning syringes in prison (n=58) were:

- bleach (41%)
- cold rinse (29%)



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- combination of detergent, bleach, hot and cold rinses (9%)
- bleach and cold water (7%)
- 'fill and shake' method (7%)
- detergent (5%)
- 2x2x2 method (5%).

Forty seven percent of participants who had been in prison reported that they did not inject in prison because they:

- were unable to inject safely (40%)
- were unable to access either money or drugs (23%)
- were not interested in using drugs while they were in prison (14%)
- had a short internment (11%)
- were not using at the time they were imprisoned (4%)
- wanted a break from drug use (4%)
- were concerned about the repercussions of being caught injecting (4%).

Service Utilisation

General Health Services

General practitioners were the preferred service for general health problems, with the Aboriginal Medical Service and community health centres the next most preferred services. Hospitals were an infrequent source of assistance for general health problems. Ten percent of participants did not seek any medical assistance at all.

Health worker Awareness of Participants' Injecting Drug Use

Fifty one percent of participants indicated that they had informed health workers of their injecting drug use. Eighteen percent believed that health workers did not know of their drug use; 18% were unsure whether health workers knew; and 3% believed that health workers knew through gossip.

Contact with Drug Related Services

Overall, seventy percent of participants had been in contact with drug related services within the last six months. Participants reported most frequent contact with general practitioners, police, counselling and welfare services. Drug treatment services accessed included those offered by the Drug and Alcohol Services Council, Nunkuwarrin Yunti, Adelaide Central Community Health Service (Port Adelaide) and the Aboriginal Sobriety Group.

Dependent injectors made up a substantial proportion of those who had accessed drug related services within the last six months. Eighty seven percent of participants were classified as dependent drug users, based on a Severity of Dependence Scale score of greater than 4. Of those who contacted a general practitioner, 91% were found to be dependent. Ninety four percent of those who had been in contact with police were dependent. Ninety four percent of those who had accessed counselling were dependent. Seventy six percent of those who had accessed welfare services were dependent.

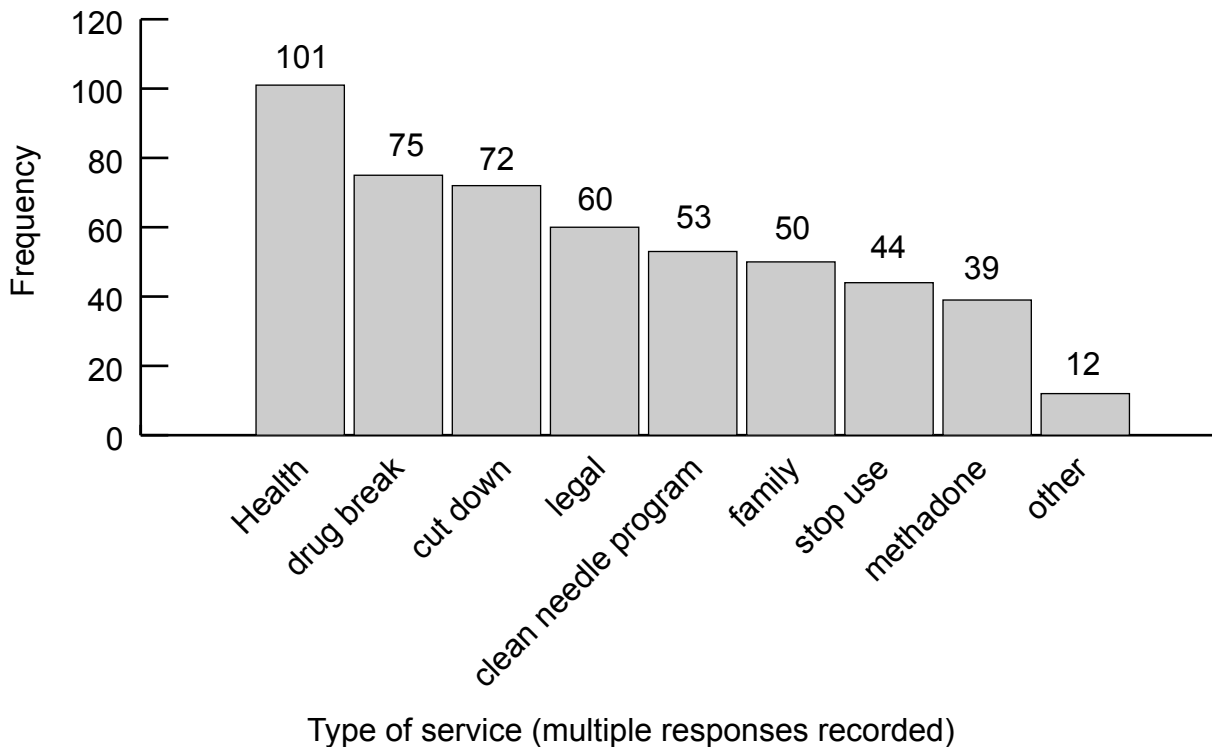
Overall, 30% of participants had no contact with drug related services in the last six months. Of those, 81% were classified as dependent users.



Reasons for Contacting Services

Of those who had contacted services (214), 47% had done so for health reasons. Thirty five percent indicated they made contact with services in order to have a break from drug use, and similarly, 34% wanted to cut down on their drug use.

Figure 7: Reasons why participants contacted services



Services of Most Benefit

Of the 214 participants who had used services in the last six months, 64% described which services had helped them the most, including:

- general practitioners (35%)
- counselling (19%)
- clean needle program outlets (14%)
- welfare services (7%)
- methadone program (4%).

Twenty two percent stated that no services had been helpful to them.

Difficulties Accessing Services

Nineteen percent of participants were unable to access a service they had sought. The reasons they were unable to access services were:

- placed on a waiting list for an appointment (25%)
- placed on a waiting list for a bed (19%)
- too ashamed to attend a drug related service (18%)



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- too unwell to leave home (5%)
- parenting issues (5%)
- not knowing which services were available (5%)
- transport problems (4%).

Issues for Young People

Young people were defined as those aged 25 years or younger at the time of the survey. There were 60 young people: 32 were males (53%); and 28 were females (47%). Only 8% of the young people in the survey were under 18 years old (range 14-25 years). The majority of young people (81%) had lived in Adelaide for most of their lives. Forty three percent of the young people lived in housing trust accommodation; 23% lived with relatives; 18% in shared accommodation; and 12% lived with at least one of their parents. The median school leaving age was 15 years old (range 12-17 years).

The only significant difference between the young survey participants and the rest of the participants was in the age at first injection. The mean age at first injection for young participants was 16.2 years compared to 18.8 years for the rest of the participants ($t(295) = -6.40, p < .003$). This pattern is consistent with IDRS data which found that injectors 25 years and under tended to inject for the first time at a younger age (mean 16.9 years) than injectors older than 25 years (mean 19.9 years) (McKetin et al 2000).

Participants' Comments

Forty one percent of participants provided further comments. Of those who commented, 50% stated that existing services did not suit their needs. Twenty two percent believed that alcohol and other drug services needed to be delivered by Indigenous organisations or Indigenous workers, and 3% believed that both Indigenous and non-Indigenous people could benefit from the same services.

Participants specifically noted a lack of services for Indigenous people in the southern region of Adelaide. Suggestions regarding an Indigenous 'one stop shop' (eg providing a number of services on one site) were common, especially in the southern region (6%), as were requests for Indigenous workers within established agencies (such as the southern methadone service). One person explained,

"...[We] need more facilities that are culturally appropriate where Aboriginal people can feel more comfortable about dropping in and picking up fits, attend awareness programs, or just somewhere to go and talk to someone about the drug use problems...and [we need] people working at ground level with users." (survey participant)



RESULTS OF COMMUNITY CONSULTATIONS

Consultation with Aboriginal Community

The aims of the community forums were to provide opportunities for the Aboriginal community to comment on this research and its findings. This process is designed to encourage the community to take ownership of the project and is consistent with rapid assessment and response methodology.

An initial forum was held with those who had participated as key consultants in the project. At this forum, a summary of the findings of the key consultant interviews was presented and participants were given an opportunity to give further feedback on the accuracy of the summary.

The Program Advisory Committee identified a number of issues arising from the research to serve as a starting point for discussions with the Aboriginal community. Aboriginal health workers were contacted to assist in informing the community of a series of forums. Peer interviewers assisted in running the forums and encouraging Aboriginal injectors (particularly people who had participated in the survey) to attend. ADAC ensured that childcare and transport were available and provided food for the forums, but was unable to pay people to attend.

Community consultation forums were held at Nunkuwarrin Yunti Aboriginal Health Service, the Adelaide Central Community Health Service (The Parks and Port Adelaide). Attendance at these forums ranged from very few to about 20 people. Another consultation was held following the ADAC Annual General Meeting and included a number of participants from regional SA (ie Coober Pedy, Ceduna, and Yalata).

Participants in the community forums discussed the most appropriate responses to the issues arising from the research and prioritised them in terms of immediacy. The forums also offered the opportunity for people to raise additional issues related to injecting drug use in the Aboriginal community.

Issues identified in the community consultation forums included:

- blood borne viruses (ie transmission, prevention, treatment and care)
- polydrug use (ie information on drug combinations, risks of overdose and dependence)
- overdose (ie appropriate prevention and response strategies)
- access to services (ie barriers to accessing the clean needle program and other services)
- use of speed (ie risks of, and treatment for, speed dependence)
- young injectors (ie access to services, drug related harms, and early intervention)
- methadone and other pharmacotherapies (ie access to methadone, support for clients and treatment alternatives)
- injecting in prison (ie risks of injecting, transmission and treatment of blood borne viruses, post release support and prison peer education programs).

Participants listed a number of services that they believe need to be implemented to address injecting drug use in the Aboriginal community including: improved clean needle program, detoxification services, counselling services, and HCV treatment. Participants stressed the need for ongoing information and support for families of Aboriginal injectors, including respite from the stress of supporting a family member with drug related problems.

Consultation with Aboriginal People Who Inject Drugs

Consulting Aboriginal injectors was equally important to this project as consulting other community members. Initially, few Aboriginal injectors participated in the forums, probably because of the stigma associated with injecting drug use, fear of discrimination, concerns about confidentiality and lifestyle issues. So, instead of group forums, individual consultations with Aboriginal injectors were held and they were paid \$20 for their time.

Consultations were held with 25 Aboriginal people who inject drugs. These were informal and brief, more appropriately described as conversations than interviews. Injectors were encouraged to raise their own issues without prompting and, to keep the process informal, no notes were taken during the session. A summary of the main points was recorded afterwards. These consultations were designed to identify issues that may have been overlooked in the survey.

Participants frequently mentioned the need for appropriately presented information on safe drug use and the need for peer education. A number of participants reported that pamphlets are not useful to them, suggesting instead that posters be displayed in public spaces (eg billboards and bus shelters). They also emphasised the power of 'word of mouth', and the need for information to be presented by,

*"...real people who have experienced it [drug use] and can tell [their] stories."
(Aboriginal speed user)*

Some of the older participants indicated that their own knowledge of safe injecting practices was adequate, but new or young injectors need educating. Some of the older participants appeared to feel protective toward younger injectors, expressing concern over their involvement in sex work and risky injecting practices.

Money issues were a priority for participants. Many of the participants indicated that without a car to get to a clean needle program outlet, they must pay for injecting equipment at pharmacies. Although pharmacies are closer, they are more expensive. A small number of injectors raised the issue of the cost of sterile water ampoules, and suggested that water be supplied free at clean needle program outlets. Some participants suggested that clean needle program outlets should provide a wider range of injecting equipment, including 3ml and 5ml syringes. This comment suggests that they are not accessing the peer operated clean needle program outlets, since these sizes are usually available there.

Participants frequently raised the issue of drug law reform (ie decriminalisation or legalisation) suggesting that decriminalisation may assist in reducing cannabis related home invasions and chemist break-ins. They strongly believed that the current police practice of targeting street dealers who were generally user dealers was unjust. In general, they supported the provision of prescription heroin to opiate dependent people. There was some interest in alternative methods of consuming drugs.

Participants talked about the day to day difficulties of trying to balance a drug using lifestyle with studying, working, or raising a family. Overall, the participants in these consultations raised many of the same issues as the key consultants, but placed more emphasis on appropriate harm reduction information and less emphasis on detoxification and rehabilitation services.

In addition to the individual consultations, a focus group was held with Aboriginal injectors, including some of the peer interviewers. Participants in this focus group suggested that information resources be developed on a number of specific issues, for example:

- names and contact details for the drug and alcohol workers in each area
- buprenorphine
- methadone, including the side effects of methadone, long term effects and information on the 'new' methadone (biodone)
- long term effects (including mental health effects) of drugs, especially methamphetamine
- specific resources for parents and families of Aboriginal people who inject drugs, covering the signs of problematic drug use, how to support a drug using family member, support groups and where to go for help.



DISCUSSION

Characteristics of SA Urban Indigenous Injectors

The gender and age distribution of participants in this study are similar to those found among a general population of injectors in Adelaide, but different to those found among a sample of Indigenous injectors in regional SA. Sixty percent of participants in this study were male and 61% of participants in the IDRS-SA in 2001 were male, but 76% of participants in the Lower Murray study were male (Longo et al 2002 and Shoobridge et al 1998). With a median age of 32 years, participants in this study were similar in age to the IDRS-SA sample (median age 32.5 years), but slightly older than the Lower Murray sample (median age 30 years) (Longo et al 2002 and Shoobridge et al 1998).

Participants in this study were less likely to have completed year 10 or undertaken tertiary studies than the IDRS-SA sample and also less likely to be employed (Longo et al 2002).¹² While this study reported similar secondary education standards to the Lower Murray study, the Lower Murray sample were more likely to have undertaken post secondary education and also twice as likely to be employed (Shoobridge et al 1998).¹³ The lower employment rate of participants is consistent with census data indicating that Indigenous people in rural areas and non-Indigenous people in all areas were more likely to be employed than Indigenous people living in urban areas (Australian Bureau of Statistics 2002).

There are some differences between this sample and a sample of Indigenous injectors from various locations in Western Australia (WA). Gray et al (2002) reported a lower median age (26.5 years) and slightly fewer males (57%) in the WA sample. The WA sample was as likely to have completed year 10 or above (54%), but less likely to have undertaken post-secondary education (12%) than participants in this study (Gray et al 2001).

These results suggest that regional differences are more significant than cultural background with the exception of education achievement where Indigenous people are disadvantaged regardless of where they live.

Patterns of Drug Use

Heroin and Amphetamine Use

Participants in this study reported a higher rate of past and recent heroin use than 2001 IDRS-SA injectors and were almost twice as likely to have used both heroin and amphetamines in the previous six months.¹⁴ They were also more likely to have used heroin than those in the WA survey (Gray et al 2001).

As this study was undertaken during a period when heroin was less available than usual (ie the heroin 'drought'), the rate of heroin use was higher than expected. Nevertheless, the high rate is not inconsistent with other data. For example, the Indigenous participants in the IDRS-SA reported higher rates of heroin use than the total sample.¹⁵

There is a possibility that regional differences may have contributed to the different drug use patterns in WA and Adelaide. Use of heroin, for example, appears to be more prevalent in the low socio economic areas of Adelaide where people from a diverse range of cultures, including Aboriginal people, co-exist. It also needs to be considered that this study was conducted in metropolitan Adelaide, while the WA study was conducted in regional centres (Kalgoorlie, Geraldton and Bunbury) and Perth.

12. ADAC sample: 47% had completed year 10; 36% had undertaken tertiary study; 6% were employed. IDRS (SA) sample: 73% had completed year 10; 53% had undertaken tertiary study; 16% were employed.

13. Lower Murray sample: 52% had completed year 10; 44% had undertaken tertiary study; 12% were employed.

14. Twenty nine percent of participants in this study had used both heroin and speed in the six months prior to being interviewed compared to just 16% of the IDRS-SA sample (Longo et al 2002).

15. Sixty five percent of the total IDRS-SA sample reported recent heroin use compared to 75% of the 20 Indigenous participants (Longo et al 2002).



The use of peer interviewers may be a factor in the higher rate of heroin use reported in this study. The majority of the peer interviewers involved in this study were opiate users and many survey participants were recruited from the peer interviewers' own social networks, or were referred by previous participants. This method of recruitment (snowballing) is useful in accessing marginalised and isolated populations, but can also result in recruiting people with very similar range of experiences (in this case heroin as the drug of choice).

Finally, despite the 'heroin drought', barriers to accessing drug and alcohol services may have left Aboriginal people with little choice but to continue using due to a lack of alternatives. Regardless of the reasons for the high rate of heroin use, there are significant implications for harm reduction for this group in terms of addressing issues such as overdose prevention and response, blood borne virus transmission, dependence and drug treatment options.

Polydrug Use

This study suggests that polydrug use, an issue raised by key consultants, is highly prevalent among Indigenous people who inject drugs in metropolitan Adelaide. The two injectable drugs most frequently used in combination were heroin and speed, with 40% of participants having used heroin and speed at least once a week (not necessarily at the same time) in the six months prior to being interviewed. As mentioned previously, participants in this study were almost twice as likely to have recently used both heroin and speed than other SA injectors (Longo et al 2002).

Past research has tended to focus on single drug use (ie opiates, amphetamines, ecstasy), so there is little research available on the unique harms associated with polydrug use. This survey has been able to identify a number of harms experienced by Aboriginal people who inject drugs living in metropolitan Adelaide, the majority of whom are polydrug users. While this study will enable the Aboriginal community to plan interventions to reduce these harms, further research into the particular harms associated with polydrug use is needed.

Other Drug Use

Tobacco use by participants in this study was lower than other studies of injectors. The proportion of participants who had ever used tobacco was slightly lower, while the rate of recent tobacco use was significantly lower (Shoobridge et al 1998 and Longo et al 2002). The proportion of participants who were current smokers (54%) was approximately half that of the 1997 Lower Murray study (96%). The rate of tobacco use in this study is consistent with use by the general (non-injecting) Indigenous population (51%) (Australian Bureau of Statistics 2002). The lower proportion of smokers in this study may be a result of recent campaigns targeting Indigenous smokers.

The rate of alcohol use in this study (66%) was slightly lower than in the IDRS-SA (69%) and significantly lower than the WA (75%) and Lower Murray (72%) studies (Longo et al 2002; Gray et al 2001; and Shoobridge et al 1998).

Participants in this study were more likely to have recently used methadone (licit and illicit) (34%) than the Lower Murray participants (28%), but less likely to have recently used methadone than the IDRS-SA participants (43%) (Shoobridge et al 1998 and Longo et al 2002). The total IDRS-SA sample was more than twice as likely to be on methadone maintenance (31%) than those in this study (12%), while the proportion of Indigenous participants on methadone (10%) from the IDRS-SA was consistent with this study (Longo et al 2002).

Participants' use of benzodiazepines was consistent with the WA study, but lower than the IDRS-SA and Lower Murray studies (Gray et al 2001; Longo et al 2002; and Shoobridge et al 1998).¹⁶

16. Recent use of benzodiazepines: this study 34%; WA study 36%; IDRS-SA study 57%; Lower Murray study 64%.



The proportion of participants who had ever used cannabis was similar to other studies although participants were less likely to have reported recent cannabis use (Shoobridge et al 1998; Gray et al 2001; and Longo et al 2002).¹⁷ This study is also consistent with other studies that found that Indigenous injectors were less likely to use cocaine and/or ecstasy than non-Indigenous injectors (Gray et al 2001; Shoobridge et al 1998; and Longo et al 2002).

In sum, while there are similarities between this study and other recent studies in relation to drug use patterns, there are also important differences. In addition, it is difficult to generalise about drug use patterns and injecting practices when comparing samples of such dissimilar sizes. A more accurate method of assessing drug use patterns and trends for this group would be to replicate this research in a year or two and compare the results with the current study.

Dependence

This study found that Indigenous injectors may be less likely to be casual or recreational drug users and more likely to be dependent. The majority of participants were assessed as dependent according to the Severity of Dependence Scale (ie 90% of those who nominated heroin and 77% of those who nominated amphetamines). Also, many participants reported frequently experiencing opiate withdrawal symptoms, an indication of dependence, and key consultants reported that Indigenous cannabis users often exhibited behaviour consistent with dependence. The high rate of dependence supports the key consultants' belief that for Indigenous injectors, there is no distinction between 'use' and 'dependence' and they are more likely to become dependent soon after commencing use. Survey results, in addition to consultants' reports, suggest that Indigenous injectors may be at higher risk of psychological dependence.

Participants assessed as dependent made up a substantial proportion of those who had contacted services in the six months prior to being interviewed. For example, 91% of those who had contacted a general practitioner for injecting related issues were found to be dependent, as were 94% of those who had had been in contact with police.

Given these patterns of dependency, research is needed to understand why Indigenous drug users are at increased likelihood of dependence. This will enable specific harm reduction measures to be implemented to support Indigenous injectors with dependence issues. In addition, given that a higher SDS score was associated with more frequent and more recent sharing of syringes and other equipment and a higher perception of blood borne virus risk, addressing the issue of dependence may be a key strategy in decreasing the risk of contracting blood borne viruses.

Initiation into Injecting

This study supports the results of other studies that found that the mean age of first injection for Indigenous injectors is lower than for other injectors (Larson 1996; Shoobridge et al 1998; and Longo et al 2002).¹⁸ This study is also consistent with other studies that found that speed was the first drug injected by 40 - 50% of Indigenous participants (Shoobridge et al 1998 and Longo et al 2002).

While the proportion of participants who injected themselves the first time they injected is consistent with the Lower Murray study, the proportion of participants who were injected, or assisted to inject, by others follows a very different pattern. In the Lower Murray study over 80% were injected by others and less than 10% were assisted to inject by others (Shoobridge et al 1998). The pattern is reversed in this study where less than 10% of participants were injected by others and over 80% were assisted to inject by others. The increased numbers of Indigenous people injecting themselves on the first occasion of use (with some assistance) is a hopeful indication that harm reduction information has made its way into the drug using community, increasing peoples' knowledge of safer injecting practices.

Although this current sample has a similar pattern of initiation into injecting as the Lower Murray sample (age of initiation, relationship to initiator, first drug injected) (Shoobridge et al 1998), the current lifestyle of participants in this study appears to be more centred around injecting drug use. This is reflected in the

17. Ever used cannabis: this study 90%; WA study 88%; IDRS-SA study 97%; Lower Murray study 96%. Recent cannabis use: this study 63%; WA study 76%; IDRS-SA study 85%; Lower Murray study 88%.

18. Indigenous sample, mean age of first injection: this study 18.3 years; Larson's (1996) Brisbane study 17.8 years; and Lower Murray study 18.6

higher heroin use and lower use of non-injectable drugs such as tobacco, yarndi (cannabis) and alcohol by participants in the current study, who were also more likely to be dependent on their main drug of choice, less likely to perceive themselves to be at a low risk of contracting blood borne viruses and more likely to be in a relationship with another injector.

Injecting Practices

Where Most Recently Injected

Participants in this study most recently injected in the same types of places as participants in the WA study and Indigenous participants in the IDRS-SA (Gray et al 2001 and Longo et al 2002). However, compared to all participants in the IDRS-SA, participants in this study were less likely to inject at home (60% compared to 82%) and more likely to inject in a car (12% compared to 9%) or public place (14% compared to 6%) (Longo et al 2002). Injecting in public locations such as cars, side streets and public toilets may place participants at increased risk of contracting blood borne viruses or other infections (ie through injecting in a hurry and/or injecting in unhygienic locations). There is also a greater likelihood of prosecution as a result of being more visible.

New Equipment

Participants in this study were more likely to obtain syringes through clean needle program outlets (60%) than either the WA sample (22%) or the Lower Murray sample (none) (Shoobridge et al 1998 and Gray et al 2001). This result may be an indication of the effectiveness of peer-staffed clean needle programs in metropolitan Adelaide and the Nunga Users HIV Intervention Team (NU-HIT), an Indigenous specific clean needle program in Adelaide that also provides an outreach service.¹⁹ Despite the higher use of clean needle program outlets seen in this study, access is still lower than for non-Indigenous injectors, indicating a need for strategies to increase access for Indigenous injectors (Kelsall et al 2002).²⁰

Disposal of Syringes

The participants in this study generally practiced good syringe disposal procedures, with 64% regularly using sharps disposal bins and 30% regularly using 'fitpaks' or other hard containers. However, 22% of participants kept syringes for later use, supporting key informants' reports that many Indigenous injectors regularly re-use their own syringes.

Injecting Hygiene

About 28% of participants reported washing their hands either before or after injecting, an indication that there is some awareness of the efficacy of soap and water to prevent the spread of infections. However, a high proportion of participants (82%) reported swabbing the injection site after injecting.²¹ Key consultants reported an increase in vein problems among Indigenous injectors. These findings suggest the need to improve Indigenous injectors' knowledge of vein care issues. Providing tissues or wipes, and sealable plastic bags for disposal, at clean needle program outlets may also assist in addressing this concern.

Although only one key consultant reported that Indigenous injectors often do not use filters (especially when using drugs directly from the bag), clean needle program workers also report that speed users rarely use filters, supporting the accuracy of this statement. This finding suggests that some Indigenous injectors are unaware of the risks posed by injecting impurities or large particles of substances that are often found in drugs, particularly drugs bought on the streets.

19. In WA, syringes are not provided free through needle exchanges unless the client also returns used syringes.

20. Seventy five percent of a sample of 71 people who inject drugs (Victoria) reported needle and syringe programs as their main source of injecting equipment.

21. Swabbing with alcohol swabs after injecting slows down the clotting process (therefore increasing the amount of blood associated with injecting), and contributes to scarring of the injection site.



Sharing Practices

The experience of recent sharing of syringes in this study was consistent with the Lower Murray study and the IDRS-SA (both total sample and Indigenous participants) (Shoobridge et al 1998 and Longo et al 2002).²² The rate of 'ever' sharing (35%), while being higher than other recent samples of Indigenous injectors (30%; 15%), was lower than the earlier Lower Murray study (48%) (Gray et al 2001; Longo et al 2002; and Shoobridge et al 1998). The lower rate of sharing in more recent studies may be an indication of increased knowledge of safer injecting practices and supports reports by key consultants that there is increased awareness among Indigenous injectors of the risks of sharing syringes.

Gray et al (2001) suggest that sharing syringes as a result of cultural obligations may be a myth perpetuated by non-Indigenous workers. Key consultants in this study were divided in their views about whether Indigenous injectors felt any cultural obligation to share syringes. The survey results do not support the view that cultural obligation is a factor in syringe sharing. Among the reasons for sharing syringes reported by participants in this study, none indicated cultural obligations.

Injecting in Prison

The proportion of participants who had ever been in prison (55%), was consistent with the WA survey (58%) and the IDRS-SA (50%), but lower than the Indigenous participants in the IDRS-SA (75%) (Gray et al 2001 and Longo et al 2002). Lower Murray injectors were much more likely to have ever been in prison (84%) (Shoobridge et al 1998). However, 32% of the Lower Murray participants were in prison at the time of the survey (ie were interviewed in prison). If these incarcerated participants were not counted, the rate of incarceration for both studies is the same.

Participants in this study who had ever been in prison were approximately twice as likely to have injected in prison as those in the WA study (53% in this study; 23% in WA) (Gray et al 2001). This finding may be linked to the high proportion of dependent heroin users amongst this sample. Almost one quarter (23%) of those who did not inject in prison indicated that it was because they did not have access to money or drugs. This suggests that these participants would have injected in prison if they were able to.

The majority (74%) of participants who had injected in prison reported that they shared syringes at least sometimes. This finding reflects the lack of clean syringes in prison and highlights the inappropriateness of current prison policy in relation to blood borne virus transmission.

Eighteen percent of participants who had been in prison reported that they deliberately chose not to inject drugs in prison (ie they regarded imprisonment as an opportunity to take a break from using drugs). This suggests that Indigenous injectors use prison as a respite from drugs, rather than seeking drug treatment services.

Blood Borne Viruses

Although participants were not asked about their blood borne virus status, 41% volunteered that they had tested positive for HCV. The rate of HCV among this sample is higher than other samples of Indigenous injectors (16%; 36%; and 8%) (Larson 1996; Shoobridge et al 1998; and Gray et al 2001). Most participants perceived themselves to be at a high risk of contracting blood borne viruses, but felt that they did not have adequate knowledge of how to prevent transmission.

High rates of HCV and unsafe injecting practices (ie sharing in prison) among this sample suggest that HCV treatment and care will be an issue for this group of Indigenous injectors in future years. Therefore, planning needs to begin immediately on strategies to address this issue.

22. Recently used a syringe after someone else: this study 12%; Lower Murray study 12%; IDRS-SA total sample 10%; and IDRS-SA Indigenous participants 15%.

Overdose

Given the high rate of heroin use among study participants, and the frequency with which key consultants expressed concern about it, the rate of overdose in this study (21%) was lower than expected. Participants were approximately half as likely to have experienced an overdose as participants in the IDRS-SA (46%) or the Brisbane study (52% of heroin users) (Longo et al 2002 and Larson 1996).

This study found a high level of deliberate overdose. Over one third (37%) of those who had ever overdosed had done so deliberately (ie attempted suicide). The Lower Murray study also found a high rate of deliberate overdose (overdose was the reported method for 54% of those who had attempted suicide) (Shoobridge et al 1998). Shoobridge (1998) also reported that only 2% of a non-Indigenous sample of people who inject drugs had ever overdosed deliberately. Therefore, the lower overdose rate in this study may be a result of fewer Indigenous people surviving overdose. There is clearly a need for increased access to grief counselling in the Indigenous community.

This study also revealed a number of factors that increase the risk of overdose. There were high levels of misinformation regarding appropriate responses to overdose among survey participants. A quarter of participants (26%) were misinformed regarding police presence at an overdose and many participants believed that police would ignore policy if Aboriginal people were involved (resulting in fear of calling for an ambulance). There was also a high number of participants (53%) who reported injecting alone at least some of the time. These results indicate an urgent need for specific overdose education covering the risk factors associated with overdose, appropriate response to overdose, relevant first aid practices, ambulance service policy, and police policy and procedures.

Young People

This study found no significant differences between those over 25 years and those under 25 years in terms of drug use patterns and physical and emotional health and wellbeing. The expectation was that younger injectors would have less dependent patterns of drug use, and fewer health and welfare problems than those who had been injecting drugs for longer. The implication of this finding is that those under 25 years may have comparatively poorer outcomes in future years compared to their older counterparts. Unless the needs of these younger injectors are addressed now, health and social services may be unable to cope with them in future.

Drug and Alcohol Services

Access to Services

This study revealed that Indigenous injectors do not access relevant services for two main reasons: the services are not culturally appropriate to their needs; and injectors are ashamed of their drug use and/or afraid of experiencing discrimination. Although key consultants reported that many services lack cultural sensitivity, a number of services have attempted to address cultural issues. Nevertheless, they are still under-utilised. Australia's experience with peer based programs for people who inject drugs has been positive and suggests that peer programs for Indigenous injectors are likely to improve their self-esteem and reduce shame.

This study found that services face a dilemma in attempting to respond to the needs of Indigenous people who inject drugs. Key consultants and survey participants expressed concern over the lack of confidentiality within Indigenous specific services, while at the same time indicating a need for more Indigenous specific services and workers. This dilemma highlights the need for appropriate training and organisational policies regarding confidentiality issues. Development of discreet Indigenous specific drug and alcohol services, including clean needle program outlets and drug treatment services, should be regarded as a priority. In addition, mainstream services need to continue to improve to ensure Indigenous people feel comfortable accessing them.



Drug Treatment including Methadone

Only 12% of participants were on a methadone program, yet 39% reported using methadone that was not prescribed for them (diverted methadone). Some key consultants reported that there is a stigma associated with methadone and other maintenance pharmacotherapies in the Indigenous community. This stigma may prevent Aboriginal people from accessing methadone, and contribute to the shame felt by those on methadone. The illicit use of methadone may be a result of being unable to access methadone treatment, or it may be due to Indigenous opiate users preferring to have more control over the use of methadone (dose range, frequency of dosage etc). The issue of access to methadone and other drug treatment needs to be explored further.

Family and Community

Aboriginal culture and society is centred in the family. Family and kinship systems are not restricted to traditional Aboriginal communities but also exist in urban Aboriginal communities. The close family and community ties within the Indigenous community contribute to Indigenous peoples' sense of identity and self-worth.

The stigma associated with injecting drug use, and the ostracism by family and community, affects Indigenous injectors' sense of identity, causing them to feel that their value or worth in the community is reduced, resulting in feelings of shame. Community education strategies may increase awareness and improve knowledge of drug issues within the Aboriginal community, hopefully contributing to a change in attitudes. Reducing the stigma should improve the self-esteem of Indigenous people who inject drugs and increase the likelihood that they will access relevant services.

The close family and kinship ties of the Indigenous community need to be considered when developing services for Indigenous people who inject drugs. Mallard et al (1999) state that the Aboriginal family unit is pivotal to the physical and emotional health and well-being of Aboriginal people. Therefore, responding to the needs of the family unit, and providing support to the client's family members (including their extended family), should increase the likelihood of a successful outcome for Aboriginal injectors. Many key consultants were concerned about the destruction of Aboriginal families and communities as a result of injecting drug use, and supported drug treatment programs because they believed these programs are useful in helping Indigenous injectors renew relationships with their families.

Parenting Issues

A number of survey participants reported that their children were a motivating factor in seeking treatment. Survey participants also mentioned that parental responsibilities contributed to difficulties in accessing treatment. Considering that over half (55%) of survey participants were parents, support is clearly needed for Indigenous injectors with dependent children. The health and wellbeing of participants' children may be adversely affected by participants' lack of access to services that cater to the family unit, and culturally appropriate health, welfare, drug treatment and other drug and alcohol services. There is an immediate need for services that offer health and welfare support to Indigenous illicit drug users with children. Outpatient services need to provide on-site childcare, and residential treatment services need to provide facilities and support for keeping the family unit together.

Methodological Issues

Acceptability of Rapid Assessment and Response Methodology

As previously stated, this research project was informed by rapid assessment and response methodology. One of the aims of the project was to examine the relevance of this method for use among Indigenous communities. This approach enabled a wide range of members of the Aboriginal community and Aboriginal people who inject drugs to participate in the research. ADAC's intention was to ensure that the Aboriginal community was involved at all stages, and that any recommended interventions were informed by community participation. Overall, the feedback from participants has been very positive. The needs of people at the 'coal face' have informed the development of the recommendations, and will inform applications for funding interventions recommended by this project.



Our conclusion is that this methodology is suitable for this community. However, a community decision to undertake research should not be considered lightly, and in fact, future projects based on a similar methodology may be quite different from the one reported here. The community needs to be involved in the project from its initiation to its conclusion, a necessary part of the process to ensure that the community owns, can implement and maintain solutions to any identified problems.

Use of Standardised Instruments

This project also presented an opportunity to examine the adequacy of certain standardised instruments for use among Indigenous people (ie the Alcohol Use Disorders Indexing Test and the Severity of Dependence Scale). The Severity of Dependence Scale (Gossop et al 1995) had been previously found to be an acceptable tool amongst a sample of Indigenous injecting drug users in the Lower Murray region of SA (Shoobridge et al 1998). This instrument is increasingly being used in self-help materials for drug dependence and in clinical situations.

An examination of responses, and feedback from the peer interviewers, indicates that the use of these measures in the research did not present any particular difficulties for these participants. The apparent acceptability of these tools, and lack of reported language difficulties, suggest that there is potential for using these instruments as self-assessment tools for urban Indigenous injectors, or as clinical tools for health workers who are responding to their needs.



RECOMMENDATIONS

1. Increase the range and accessibility of existing services by:

- providing comprehensive training for Aboriginal health workers in alcohol and other drug issues, including blood borne viruses
- providing cultural diversity education for relevant non-Aboriginal workers
- employing Aboriginal people in alcohol and other drug services, at all levels
- including the client's partner or family when providing support services
- increasing service flexibility by broadening access criteria, increasing opening hours and offering more 'drop-in' services
- ensuring Aboriginal people have a choice between mainstream and Aboriginal specific services
- promoting and advertising services, including providing comprehensive information on what services are available.

2. Develop a range of Aboriginal specific services, in consultation with the Aboriginal community and Aboriginal clients, that enables Aboriginal people to take ownership of problems and their solutions, including:

- an Aboriginal specific long term residential centre or therapeutic community
- Aboriginal specific detoxification services
- long-term support services that address a range of emotional and social issues and focus on health promotion
- 'one-stop-shop' community centres that provide a variety of services at one site, including clean injecting equipment, peer education, life skills training, counselling, drug treatment and general health services.

3. Implement a range of peer education programs, specifically:

- outreach programs for Aboriginal people who inject drugs and are hard to access
- services for young Aboriginal people, with increased employment, training and support of Aboriginal youth peer educators
- 'drop-in' style services run by peers to enable Aboriginal people who inject drugs to access information, clean syringes, and support services in a peer education environment.

4. Develop and disseminate Aboriginal specific harm reduction information, through consultation with Aboriginal people who inject drugs, in a variety of formats, covering:

- safer injecting
- drug treatment options
- HCV transmission, treatment and care
- overdose prevention and response
- CPR and first aid.

5. Reduce some of the shame and stigma experienced by Aboriginal people who inject drugs by educating the Aboriginal community on injecting drug use issues.

6. Increase Aboriginal involvement and input into the development of drug policies and strategies.

7. Improve the links between mainstream and Aboriginal specific services by developing partnership projects, and improving communication between agencies.

8. Implement harm reduction strategies in prisons by:

- providing peer education programs and life skills training
- increasing the availability of methadone and buprenorphine in prison
- increasing post release support and follow-up to ease the transition to life outside prison, reduce the risks of harmful drug use, and encourage the continuation of relevant drug treatment
- trialling a clean needle program in prison.

9. Increase social and emotional support to Aboriginal people who inject drugs and their families by:

- increasing welfare support, particularly for Aboriginal people with children
- providing more grief and trauma counselling
- establishing programs and services for the parents and other family members of those who inject drugs, especially for those who have lost someone to overdose or other drug related death or have someone in prison.

10. Reduce the environment of social disadvantage that fuels the demand for drugs and increases the likelihood of harmful drug use, by addressing the underlying issues of Aboriginal social inequity (ie economic, health, education).



11. Improve access to methadone and other drug treatment programs for Aboriginal people and increase the likelihood that programs will benefit Aboriginal people by:

- subsidising the cost of methadone dispensing
- addressing stereotypes or myths about methadone (and other pharmacotherapies) to reduce the stigma associated with maintenance pharmacotherapies
- increasing the number of methadone prescribers and dispensing pharmacies
- revising access criteria to improve Aboriginal people's access to treatment
- being more flexible in rules and regulations
- providing immediate access to the Aboriginal Dental Program (through Aboriginal health services)
- increasing support and counselling for clients who wish to gradually reduce their methadone dose
- increasing drug treatment options by evaluating the efficacy of alternative pharmacotherapies, particularly buprenorphine
- conducting a trial maintenance treatment program for amphetamine dependent people.

12. Investigate creative harm reduction options, with a particular focus on strategies that have proven successful elsewhere, such as:

- options other than custodial sentences for Aboriginal people who commit drug related crimes (including property crime)
- prescription heroin or morphine as an alternative to methadone, particularly for those who are not suited to methadone
- supervised injecting facilities to reduce the incidence of overdose
- decriminalising drug use to reduce the harms associated with injecting drugs of unknown quality and purity, and to reduce the stigma of injecting drug use.

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Appendix 1a

Aboriginal and Torres Strait Islander People as a percentage of the total Adelaide population (Census 1996)

Aboriginal and Torres Strait Islander people

As a percentage of the total population



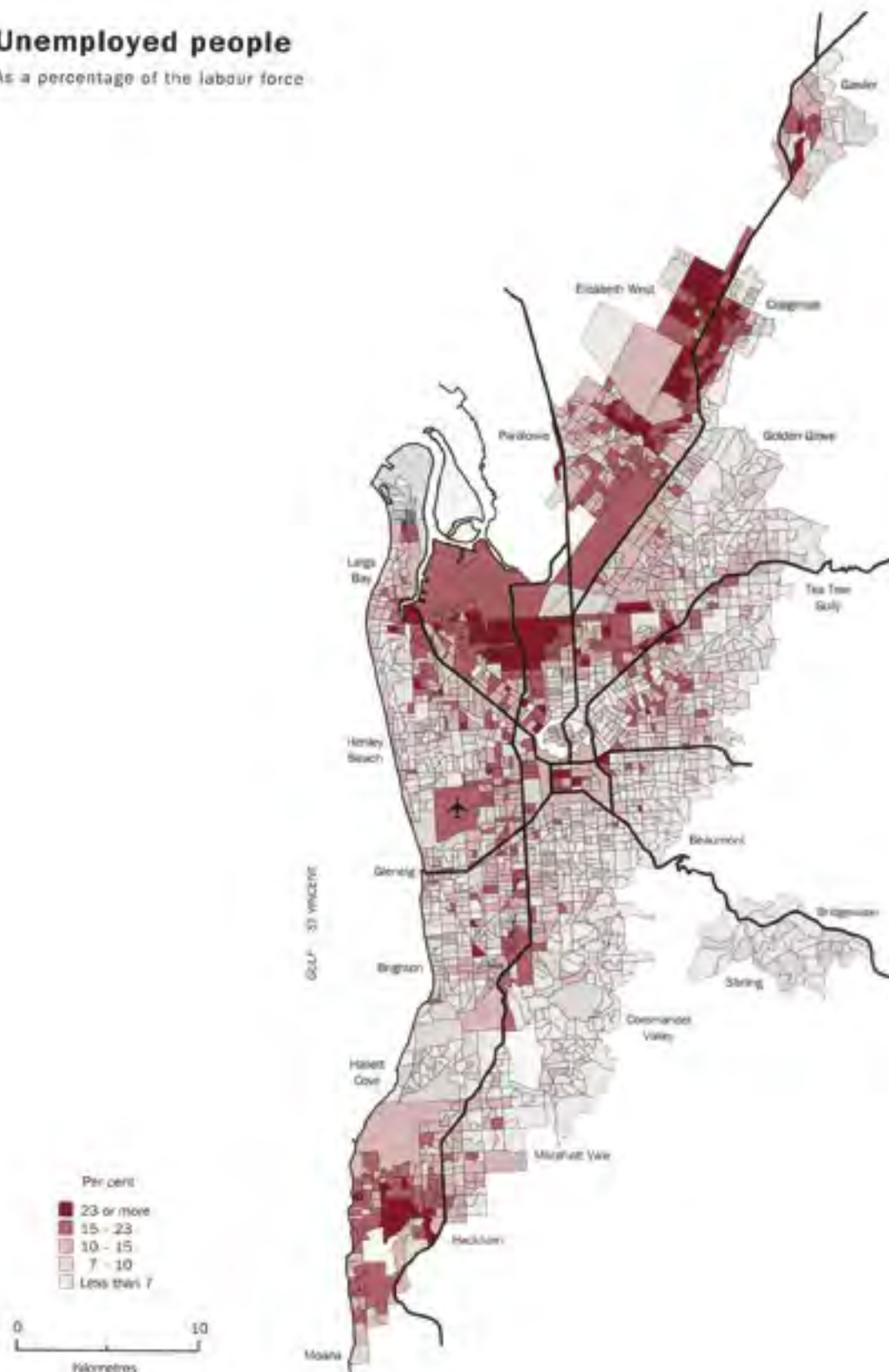


Appendix 1b

Unemployed People as a percentage of the Adelaide labour force (Census 1996)

Unemployed people

As a percentage of the labour force





Appendix 2

BLOOD BORNE VIRUSES: INFORMATION ON TESTING AND RESULTS

	NU-HIT Client Survey Adelaide SA 1993	University of QLD Brisbane QLD 1996	HINT Snapshot II Darwin NT Aug 1998	HINT Snapshot III Darwin NT Dec 1998	HINT Snapshot IV Darwin NT 1999	ADAC /NCETA/LMNC Murray Bridge SA 1998	NDARC IDRS SA/NSW/VIC 1999
HIV Information	48% had HIV test	69% had HIV test	88.88% HIV test 5.55% HIV +ve	100% HIV test 12.5% HIV +ve	100% HIV test 6.25% HIV +ve	96% HIV tested 0 positive	1.5% HIV +ve22
HCV Information	N/A	65% had HCV test	94.44% HCV test 66.66% HCV +ve	93.75% HCV test 37.5% HCV +ve	88.3% HCV test 50% HCV +ve	92% HCV test 36% HCV +ve	49% HCV +ve 66.66% HCV +ve if using for over 6 years23
HBV Information	N/A	N/A	88.88% HBV test 22.22% HBV +ve	43.75% HBV vacc 6.25% HBV +ve	43.75% HBV vac 6.25% HBV +ve	96% HBV test 16% HBV +ve 32% HBV vacc	N/A

APPENDIX 3 GENERAL PROJECT FLYER





APPENDIX 4

RESEARCH PROJECT

USING RAPID ASSESSMENT PROCEDURES TO INVESTIGATE THE IMPACT OF IDU AMONGST INDIGENOUS AUSTRALIANS IN METROPOLITAN ADELAIDE

A Collaborative Project between the Aboriginal Drug and Alcohol Council (ADAC) and the National Centre for Education and Training on Addiction (NCETA)

KEY CONSULTANT INFORMATION SHEET

You are invited to take part in a research project that will be looking at injecting drug use within Indigenous communities in metropolitan Adelaide. This project aims to gather information on Indigenous peoples' levels of injecting drug use, on the ways in which drugs are used, Indigenous users' knowledge of the risks associated with injecting drug use, Indigenous users' knowledge of and access to services, and the impact of injecting drug use on the Indigenous community.

Your participation in the study will help to provide us with more detailed information on how drugs are being used and will help us to look at how the Indigenous community can respond to problems associated with injecting drug use. In addition, we hope that the community and ADAC will be able to use this information to develop programs to assist people who are having problems with their drug use.

Your participation as a consultant in this project will involve taking part in an interview with the researcher involved in the project. There is a range of different experiences and your story will be added to others' experiences to form a picture of IDU in Indigenous communities in SA. The interviewer's role is to listen and record your story or experiences for the purposes of the research. This session will take about 3/4 to 1 hour. The researcher interviewing you is familiar with injecting drug use and will ask questions about a wide range of issues associated with injecting drug use. These may include questions about illegal activities.

Please note that your involvement in the study is entirely voluntary, and you may withdraw from the interview at any time. You only need to answer the questions that you feel you have knowledge about. Additionally, if you choose, you may decline to answer any of the questions during the interview. All of the information collected in the interview will remain anonymous. Names will not be recorded, and there will be no information released which could identify you. Only those persons directly involved in the research will have access to the interview data.

A report of the results of this research can be provided to you once the study is completed, at your request.

If you require further information about the research project at any time, you may contact Scott Wilson on 0410419915

This project has been approved by the Aboriginal Health Council Research Ethics Committee. If you wish to discuss the study with someone who is not directly involved you may contact the Chairperson of this committee.



APPENDIX 5

RESEARCH PROJECT

USING RAPID ASSESSMENT PROCEDURES TO INVESTIGATE THE IMPACT OF IDU AMONGST INDIGENOUS AUSTRALIANS IN METROPOLITAN ADELAIDE

Screening Instrument:

The ADAC IDU Project is aimed at collecting and analysing information about injecting practices and needs of Indigenous injecting drug users in metropolitan Adelaide. ADAC will use the results of the research to assist the Adelaide Indigenous community to develop services and interventions for Aboriginal injecting drug users and their families.

We would like to discuss a range of issues, and are interested in knowledge that you may have about patterns of use, any risks that people are taking in relation to drug use, what users know about safe using and HIV/ Hepatitis C, that sort of thing. Anything that you tell the interviewer will remain anonymous. Information will be recorded (written) throughout the interview and you can ask for any information to not be recorded, if required.

Notes will be taken throughout the session and, if possible, we would like to record the interviews on a tape recorder. The use of a tape recorder will be discussed at the beginning of the session, and only used if you give your complete agreement. The tape recording will be used to verify notes taken during the interview. The tape recording will only be accessed by ADAC project staff, and will be kept in a safe place until the required information is obtained.

If you have any objections to the use of a tape recorder please indicate below.

Are you interested in participating in the study? Y/N

If NO, please write your reasons for this below, or state any concerns that you have

Would you be willing to recommend anyone else who we may be able to contact that may also provide us with information about injecting drug use among Indigenous people in metropolitan Adelaide? Y/N

If you are interested in participating in the interview please proceed to answer the following questions:



APPENDIX 6

Date / /

G = M / F

Time _____

CONSULTANT SURVEY

BACKGROUND INFORMATION



CONSULTANT QUESTIONNAIRE BACKGROUND INFORMATION

Please circle the number that best answers your situation

1. Do you identify your background as

- | | |
|------------------------|---|
| Aboriginal | 1 |
| Torres Strait Islander | 2 |
| Non-Aboriginal | 3 |

2. How did you find out about this study?

- | | |
|---|---|
| Interviewer contact (Carol told you about it) | 1 |
| Contact with a member of the Advisory Committee | 2 |
| Contact with a member of ADAC | 3 |
| Contact with someone who has already been involved in the project | 4 |
| Was passing through a service when the researcher was there | 5 |
| Contact with one of the peer interviewers | 6 |
| Other means (please describe)_____ | 7 |

3. Where does your knowledge about injecting drug use among Aboriginal residents of the Adelaide metropolitan area come from? (as many as apply)

- | | |
|--|---|
| Through your work as a professional | 1 |
| Through another agency or health centre
(state which one)_____ | 2 |
| Through your involvement in the community
(ie as a committee member, volunteer etc) | 3 |
| As an acquaintance of someone who uses | 4 |
| As a friend of someone who uses | 5 |
| As a family member of someone who uses | 6 |
| Through the 'grapevine'/networking | 7 |
| Personal use | 8 |

4. If you are currently working, could you briefly describe the kind of work that you do, for example your main duties and job title. _____



5. In the last 6 months, how much contact have you had with an Aboriginal person who injects drugs?

Daily contact	1
Every couple of days	2
Weekly contact	3
Monthly contact	4
Every few months	5
Once	6
No personal contact	7
Not sure	8

6. Approximately how many Indigenous injecting drug users do you work with/have contact with? _____

7. If you have any comments regarding drug use in the Adelaide Aboriginal community that you would prefer to write down, rather than talk to the researcher about, please use the space below. Remember your name is not being used, and there are no means of identifying anyone from these comments. These comments are only available to the researchers. Please don't use any names or other details that may disclose another person's identity. You may wait until after the interview if you wish.



APPENDIX 7

Date / /

Time start _____

Time end _____

N. _____

G = **M / F**

(ie N= number of C's in interview, G= gender)

C Survey completed ()

(ie tick if handed in)

CONSULTANT INTERVIEW



CONSULTANT INTERVIEW

1. Area of Knowledge (Region/Geography)

What region of Adelaide would you say your knowledge about, or contact with, Aboriginal injecting drug users best describes (as many as apply)

All over Adelaide	1
Port Adelaide area	2
Western suburbs	3
Inner city Adelaide	4
Southern suburbs	5
Northern suburbs	6
Eastern suburbs	7

2. Patterns of use

Q1. Could you describe the broader 'scene' in....., in relation to what you know about injecting drug use among local Indigenous people.

3. Problems associated with IDU

Q1. Could you describe how drug use is affecting the Aboriginal community in metropolitan Adelaide?

Q2. Could you describe any differences between the use of alcohol, cannabis and injecting drug use in relation to how the use of these substances affect the Aboriginal community in Adelaide?

4. Risk taking behaviour

Q1. Can you tell us about what you know about injecting practices?

Q2. If users are sharing, whom are they sharing with?

Q3. From what you know of Indigenous people who use or inject drugs, what do you think is the general level of knowledge about HIV?

Q4. From what you know of Indigenous people who use or inject drugs, what do you think is the general level of knowledge about hepatitis, particularly hepatitis C?

Q5. Is overdose an issue for the Indigenous users that you know of?

5. Services for Indigenous Injectors

Q1. (for service providers only) What services does your organization provide to Indigenous people who inject drugs?



Q2. What do you see as the main needs of Indigenous people who inject drugs?

Q3. What services are you aware of that provide support for Indigenous people who use illicit drugs?

Q4. What services are you aware of that do a reasonable or good job of meeting the needs of Indigenous people who inject drugs?

Q5. Please explain some of the reasons why you think Indigenous users may not access services?

Q6. How could existing services (Indigenous and non-Indigenous) offer a better service for Indigenous people who use illicit drugs?

6. Methadone Questions

Q1. Can you describe your experience or knowledge of methadone programs?

Q2. In your experience, has methadone provided benefits for Indigenous opiate users?

Q3. (a) What are some of the things that make it difficult access methadone?

(b) What are some of the things that make it difficult to stay on methadone?

Q4. What could be done to improve existing methadone services for Indigenous opiate users?

Q5. What do you know about other programs to assist those dependent on opiates?

Q6. What might be the alternatives to methadone and other maintenance treatment for opiate users?

7. Other Interventions

Q1. How could the community in general help organisations like ADAC respond to drug related issues?

Q2. How could the community assist other organisations, for example non-Indigenous organisations such as DASC, to improve their responses to Indigenous drug use?

Q3. What do you think needs to happen to best respond to drug related problems in the Indigenous community?



APPENDIX 8

RESEARCHER INFORMATION

Consultant's name/alias.....

Contact number/place.....

1. Type of consultant

Drug and Alcohol worker	1
Youth worker	2
Family/friend of user	3
User/ex-user	4
ATSI worker/representative	5
Social worker/counsellor	6
Health worker	7
Other (specify)	8

2. Impression of level of knowledge

Excellent	1
Good	2
Fair/average	3
Limited	4

3. Interested in participation in a focus group

Yes	1
No	2

4. Was there any particularly interesting/outstanding aspect of the interview or information given?



APPENDIX 9

DATE _____

DOB _____

MOTHER'S INITIALS _____

PAID _____

TIME STARTED _____

TIME FINISHED _____

INTERVIEWER _____

ADELAIDE METROPOLITAN LIFESTYLE AND DRUG USE QUESTIONNAIRE

**INTERVIEWEE HAS INJECTED AT LEAST ONCE IN THE
LAST 6 MONTHS OR IS CURRENTLY ON METHADONE []**

**Background information**

I would like to start by asking you a few general questions:

- 1. Are you?**
- | | |
|--------|---|
| Male | 1 |
| Female | 2 |
- 2. In what year were you born?** _____
- 3. Have you lived in Adelaide for most of your life?**

- | | |
|-----|---|
| Yes | 1 |
| No | 0 |

In the last 2 years, how many months have you lived in Adelaide?

- | | |
|----------------------|---|
| Less than six months | 1 |
| Six to twelve months | 2 |
| More than 12 months | 3 |

4. What type of place are you living in at the moment?

- | | | | |
|---------------------------|---|-----------------------------|----|
| Mother's/Fathers place | 1 | Hostel | 7 |
| With another family | 2 | Housing Trust | 8 |
| Cousin's/relative's place | 3 | Refuge/Women's Shelter | 9 |
| Foster home | 4 | Renting/ buying alone | 10 |
| Squat | 5 | Renting/buying with partner | 11 |
| Share house | 6 | Other _____ | 12 |

5. What suburb do you live in? _____ **postcode** _____ **6.**

Are you still at high school?

- | | | | |
|---|----------|---------|---|
| Yes | 1 | | |
| What year are you currently in? _____ | GO TO 10 | | |
| No | 0 | | |
| How old were you when you left school? ____ yrs | | | |
| What was the highest level you completed? | | | |
| Less than grade/year 7 | 1 | Year 10 | 5 |
| Grade/year 7 | 2 | Year 11 | 6 |
| Year 8 | 3 | Year 12 | 7 |
| Year 9 | 4 | | |

7. Have you had any further education or training since you left school?

- | | | |
|--|---|---------|
| No | 0 | GO TO 8 |
| Yes | 1 | |
| Did you do: | | |
| Apprentice-ship or on the job training | | 1 |
| Qualification gained _____ | | |
| Started certificate or trade course | | 2 |
| Completed certificate or trade course | | 3 |
| Qualification gained _____ | | |
| Started university degree | | 4 |
| Finished university degree | | 5 |
| Qualification gained _____ | | |
| Other (state) _____ | | 6 |



8. How are you employed at the moment?

- | | |
|-------------------------------|---|
| Working full-time | 7 |
| Job title? _____ | |
| Working part-time | 6 |
| Job title? _____ | |
| Working with CDEP program | 5 |
| Working casually | 4 |
| Job title? _____ | |
| Student | 3 |
| Type of course? _____ | |
| Home duties | 2 |
| Looking for work/not employed | 1 |

9. If you are on a government benefit or pension, what benefit or pension are you on?

- | | |
|----------------------|---|
| Youth allowance | 1 |
| Jobstart | 2 |
| Sickness benefits | 3 |
| Disability allowance | 4 |
| Pension | 5 |
| Austudy/Abstudy | 6 |
| CDEP | 7 |
| Other _____ | 8 |
| Don't know | 9 |

10. Do you have any children?

- | | |
|----------|---|
| No | 0 |
| GO TO 14 | |
| Yes | 1 |

11. How many children do you have? _____

12. How many of these children live with you? _____

13. Who looks after your children most of the time?

- | | |
|------------------------------------|---|
| I do | 1 |
| My partner and I do | 2 |
| My ex-partner does | 3 |
| My family does (grannies, aunties) | 4 |
| They are in foster care | 5 |
| They are grown up | 6 |
| Other (state) _____ | 7 |

Social Background

For this section I am going to ask some questions about your social life:

14. Are your close friends Aboriginal?

- | | |
|--------------------------------|---|
| All or most are Aboriginal | 3 |
| About the same of each | 2 |
| All or most are non-Aboriginal | 1 |



15. Do your close friends inject drugs?

- | | |
|----------------------------------|---|
| All or most of them inject drugs | 3 |
| Half inject drugs, half don't | 2 |
| All or most do not inject | 1 |

16. Are you currently in a relationship?

- | | | |
|-----|---|----------|
| No | 0 | GO TO 20 |
| Yes | 1 | |

17. Is your partner?

- | | |
|----------------|---|
| Aboriginal | 2 |
| Non-Aboriginal | 1 |

18. Does your current partner also inject drugs?

- | | | |
|-----|---|----------|
| No | 1 | GO TO 20 |
| Yes | 2 | |

19. Is your partner using any services or receiving support for drug use issues (e.g.methadone,counselling)

- | | |
|-----|---|
| Yes | 1 |
| No | 2 |

20. How much of the last 6 months have you been living with anyone who injects?

- | | |
|------------------|---|
| All of the time | 1 |
| Most of the time | 2 |
| Half of the time | 3 |
| Some of the time | 4 |
| None of the time | 5 |

Drug Use

The next lot of questions are about your use of drugs:

21. What is your drug of choice? (What is the drug you would choose to use if you could?)

- | | |
|--|----|
| Marijuana (Yarndi) | 1 |
| Amphetamines | 2 |
| Other stimulants (eg Ephedrine, Duromine, Ritalin)
specify | 3 |
| Cocaine (including crack, ice, shabu) | 4 |
| Benzodiazepines (eg Serepax, Valium, Mogadon,
Temazepam, Rohypnol) (specify)..... | 5 |
| Inhalants (eg Amyl, glue, petrol, butane, thinners)
(specify)..... | 6 |
| Designer drugs (eg. Ecstasy, PMA)
(specify)..... | 7 |
| Heroin | 8 |
| Methadone | 9 |
| Other opiates (eg. codeine, morphine, etc)
(specify)..... | 10 |
| Hallucinogens (eg. LSD, magic mushrooms)
(specify)..... | 11 |
| Other drug(specify)..... | 12 |

The following questions are about drugs that you may have used in the last 6 months:

22. Have you used the following drugs?

Drug Type	Ever Tried	Ever Injected	Last used	>2-3 times a day	2-3 times a day	Once a day	Every 2nd day	Twice a week	Once a week	Once a fortnight	Once a month	<3x in lat 6 mth
Heroin				1	2	3	4	5	6	7	8	9
Methadone				1	2	3	4	5	6	7	8	9
Other opiates (morphine, codeine etc)				1	2	3	4	5	6	7	8	9
Amphetamines (speed)				1	2	3	4	5	6	7	8	9
Alcohol				1	2	3	4	5	6	7	8	9
Tobacco				1	2	3	4	5	6	7	8	9
Cocaine				1	2	3	4	5	6	7	8	9
Other stimulants (ritalin, ephedrine etc).....				1	2	3	4	5	6	7	8	9
Hallucinogens (LSD, mushrooms etc).....				1	2	3	4	5	6	7	8	9
Marijuana (Yarndi)				1	2	3	4	5	6	7	8	9
Benzodiazapines (serapax, valium rohypnol etc).....				1	2	3	4	5	6	7	8	9
Inhalants (petrol, glue, amyl, nitrous etc).....				1	2	3	4	5	6	7	8	9
Designer Drugs (ecstasy, PMA, ketaminr etc).....				1	2	3	4	5	6	7	8	9
Pituri (traditional Indigenous drug)				1	2	3	4	5	6	7	8	9
Other Drugs.....				1	2	3	4	5	6	7	8	9

23. Which drugs do you regularly use together?



Severity of Dependence Scale

24. What drug that you have used in the last 6 months has caused you most concern/worry? _____

25. These questions are about how you feel about your use of this drug in the past 6 months:

Did you think that your drug use was out of control?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

Did the prospect of missing out on a taste /hit/dose/smoke/drink make you anxious or worried?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

Did you worry about your drug use?

Not at all	0
A little	1
Quite a lot	2
A great deal	3

Did you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

How difficult did you find it to stop, or go without this drug?

Not difficult	0
Quite difficult	1
Very difficult	2
Impossible	3



Alcohol Audit

26: Now I am going to ask you some questions about your use of alcohol in the past 6 months.

How often do you have a drink containing alcohol?

Never ☐ monthly or less ☐ once a week or less ☐ 2-4 times a week ☐
>5 times a week ☐

How many drinks do you have on a typical day when you are drinking?

1 ☐ 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or more ☐

How often do you have 6 or more standard drinks on one occasion?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

How often during the last year have you found that you were not able to stop drinking once you had started?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

How often during the last year have you failed to do what was normally expected of you because of your drinking?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

How often during the last year have you had a feeling of guilt or shame after drinking?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

Have you or someone else been injured as a result of your drinking?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or
almost daily ☐

Has a friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

Never ☐ less than monthly ☐ monthly ☐ weekly ☐
daily or almost daily ☐

AUDIT Score []



Physical and Mental Health

This section is about your physical and mental health and well-being. These questions are about your drug use and whether you think that your drug use has had affected your health:

27. Have you ever had any of the following physical health problems in the last 6 months that you think may be related to your drug use?

Heart problems	Yes	1	No	2
Stomach problems	Yes	1	No	2
Teeth/dental problems	Yes	1	No	2
Liver problems	Yes	1	No	2
Skin problems	Yes	1	No	2
Hot and cold sweats	Yes	1	No	2
Aching muscles or limbs	Yes	1	No	2
Headaches	Yes	1	No	2
Lack of energy	Yes	1	No	2
Lack of appetite	Yes	1	No	2
Problems breathing/coughing	Yes	1	No	2
Nausea (feeling sick)	Yes	1	No	2
Vruses/infections	Yes	1	No	2
Other problems: Specify_____	Yes	1	No	2

28. Have you ever had any of the following mental health problems in the last 6 months that you think may be related to your drug use?

Mood swings	Yes	1	No	2
Depression	Yes	1	No	2
Seeing/hearing things	Yes	1	No	2
Sleeping problems	Yes	1	No	2
Anxiety/bad nerves	Yes	1	No	2
Paranoia	Yes	1	No	2
Bad dreams	Yes	1	No	2
Other problems: Specify_____	Yes	1	No	2



29. Have you had any of the following problems in the last 6 months that you think may be associated directly with injecting/caused by a hit?

Track marks/bruising/scarring	Yes	1	No	2
Vein problems	Yes	1	No	2
Dirty hit	Yes	1	No	2
Virus/infection	Yes	1	No	2
Hurting yourself while out of it	Yes	1	No	2
Abscesses/sores	Yes	1	No	2
Nausea (feeling sick)	Yes	1	No	2
Headaches	Yes	1	No	2
Feeling shaky/shivering	Yes	1	No	2
Other problems:	Yes	1	No	2

Specify _____

30. Has your injecting drug use caused you any problems in any of the following areas in the last 6 months?

With your partner	Yes	1	No	2
With members of your family	Yes	1	No	2
With your friends	Yes	1	No	2
With other people	Yes	1	No	2
At work	Yes	1	No	2
Money problems	Yes	1	No	2
Accidents	Yes	1	No	2
At school/uni/course	Yes	1	No	2
Legal problems	Yes	1	No	2
Lack of concentration	Yes	1	No	2
Not enjoying things you used to	Yes	1	No	2
Lack of enthusiasm	Yes	1	No	2
Bad memory/forgetting things	Yes	1	No	2
Other problems:	Yes	1	No	2

Specify _____

This question is about any medication that you are on, only answer if you feel okay about answering:

31. Are you currently prescribed medication for any health problems? Do not include methadone

No	0	GO TO 33
Yes	1	Type of medications

32. What is this/these medication/s for? _____



HIV/AIDS and Hepatitis

The following statements are about HIV/AIDS and Hepatitis:

33. My chance of becoming infected with the HIV (AIDS) virus is

- | | |
|-----------|---|
| Very low | 1 |
| Low | 2 |
| Medium | 3 |
| High | 4 |
| Very high | 5 |

34. Why do you think this? _____

35. My chance of becoming infected with the Hepatitis B virus is

- | | |
|-----------|---|
| Very low | 1 |
| Low | 2 |
| Medium | 3 |
| High | 4 |
| Very high | 5 |

36. Why do you think this? _____

37. My chance of becoming infected with the Hepatitis C virus is

- | | |
|-----------|---|
| Very low | 1 |
| Low | 2 |
| Medium | 3 |
| High | 4 |
| Very high | 5 |

38. Why do you think this? _____

39. Have you ever been tested for the following viruses?

- | | | | |
|-------------|-----|-----|----------|
| HIV/AIDS | Yes | No | Not sure |
| Hepatitis B | Yes | No | Not sure |
| Hepatitis C | Yes | No | Not sure |
| | (1) | (3) | (2) |

40. Have you been tested for any of these in the last six months?

- | | | | |
|-------------|-----|-----|----------|
| HIV/AIDS | Yes | No | Not sure |
| Hepatitis B | Yes | No | Not sure |
| Hepatitis C | Yes | No | Not sure |
| | (1) | (3) | (2) |

41. Have you been vaccinated against any of these viruses?

- | | | | |
|-------------|-----|-----|----------|
| Hepatitis A | Yes | No | Not sure |
| Hepatitis B | Yes | No | Not sure |
| | (3) | (1) | (2) |

If person has volunteered that they are Hepatitis C positive tick this box [](do not ask directly)



Injecting History

For these questions you may have to think back to when you first injected:

42. How old were you when you first injected a drug?

_____ years

43. What was the first drug that you injected?

- | | |
|----------------------------------|---|
| Heroin | 1 |
| Methadone | 2 |
| Speed | 3 |
| Ecstasy | 4 |
| Benzodiazepines (rohies, Valium) | 5 |
| Trips/LSD | 6 |
| Cocaine | 7 |
| Other (specify) _____ | 8 |

44. How did you use this drug the first time?

- | | |
|--------------------------------|---|
| Snorted | 1 |
| Swallowed | 2 |
| Smoked | 3 |
| Injected on the first occasion | 4 |
| Other (Specify) _____ | 5 |

45. The first time you injected, did someone else inject you, or did you do it yourself?

- | | |
|---------------------------------------|------------|
| Someone else injected me | 3 |
| I did it myself | 2 GO TO 48 |
| Someone helped me but I did it myself | 1 |

46. Was this person also Aboriginal?

- | | |
|-----|---|
| Yes | 1 |
| No | 2 |

47. What was your relationship with this person?

- | | |
|--------------------------|---|
| Partner | 1 |
| Relative | 2 |
| Friend | 3 |
| Dealer | 4 |
| Someone you know | 5 |
| Someone you met recently | 6 |
| Other _____ | 7 |

Injecting Practices

This section is about your recent injecting drug use (in the last 6 months) and the things you usually do when you inject:

48. When did you last inject? (eg yesterday, last week, 2 months ago, etc)_____

49. Where were you the last time you injected? (eg home, cousins place, pub etc)_____

50. When you inject, how often do you use a brand new needle or syringe?

- | | |
|-----------------------|---|
| Always, for every hit | 1 |
| Almost always | 2 |
| Often | 3 |
| About half the time | 4 |
| Almost never | 5 |
| Never | 6 |



51. In the past 6 months when you have injected, have you used the same spoons, filters, mix or tourniquet as other people?

	(3) Almost always	(2) sometimes	(1) Rarely or never
spoon			
filter			
Mix/water			
tourniquet			

52. Where do you usually get water for mixing up a hit/taste?

- Tap water 1
- Boiled water 2
- Sterile water ampoules 3
- Bottled/spring water 4
- Other (state) _____ 5

53. What part of your body, and/or what injecting equipment, do you swab with alcohol swabs when you inject?

	(3) Always or mostly	(2) sometimes	(1) Never or rarely
Hands/fingers			
Spoon			
Injection site before injecting			
Injection site after injecting			
Other (state where)			

54. Do you usually wash your hands before having a hit?

- Almost always 1
- Sometimes 2
- Rarely or never 3

55. Do you usually wash your hands after having a hit?

- Almost always 1
- Sometimes 2
- Rarely or never 3

56. When did you last use a syringe/fit after someone else had used it?

- In the last 2-3 months 4
- In the last year 3
- In the last 2 years 2
- More than 2 years ago 1
- Never 0 G0 TO 58

57. The last time you shared a syringe, how many other people used the



syringe before you? _____

58. When was the last time that someone else used a syringe after you did?

- | | |
|------------------------|------------|
| In the last 2-3 months | 4 |
| In the last year | 3 |
| In the last 2 years | 2 |
| More than 2 years ago | 1 |
| Never | 0 GO TO 60 |

If never shared [] GO TO 63

59. When this happened, how many other people used the syringe after you? ____

60. Thinking about the last time that you shared a syringe with someone, (including your regular sexual partner) what were the circumstances? (Circle more than one if necessary)

- | | |
|--|------------|
| Never shared | 0 GO TO 63 |
| Didn't have another needle | 1 |
| Needle exchange/chemist was closed | 2 |
| Knew the person very well | 3 |
| Really wanted to use/hanging out | 4 |
| Didn't worry or think about sharing | 5 |
| No transport to get to chemist/needle exchange | 7 |
| In prison | 8 |
| Didn't know sharing was risky | 9 |
| Other reason _____ | 10 |

61. The last time that you shared a syringe (ie syringe was used either before or after you) how was the syringe cleaned? _____

62. If you have shared syringes in the last 6 months, have you shared with (circle) :

- | | | |
|--|---|---|
| Regular partner whose HIV/HCV status you knew | Y | N |
| Friend whose HIV/HCV status you knew | Y | N |
| Regular partner whose HIV/HCV status you didn't know | Y | N |
| Friend whose HIV/HCV status you didn't know | Y | N |
| Someone else whose HIV/HCV status you didn't know | Y | N |
| Someone else whose HIV/HCV status you knew | Y | N |

63. How do you usually dispose of syringes after you have used them?

- | | |
|--|---|
| In a sharps disposal | 1 |
| In a container (plastic bottle/fitpack), then in the bin | 2 |
| Straight into bin | 3 |
| Keep for later use | 4 |
| Leave them at home | 5 |
| Leave them with friends | 6 |
| Leave/throw outside (street etc) | 7 |
| Give them to someone else to use | 8 |
| Other (state) _____ | 9 |



OVERDOSE

This section is about your experiences with overdose. When we say overdose, we mean any occasion when someone lost consciousness after using drugs and needed assistance to come around:

64. In the past 6 months when you have injected, have you injected: (Tick the boxes)

	Always (4)	Most of the time (3)	Sometimes (2)	Only once or twice (1)	Never (0)
On your own					
With other people					

65. Have you ever overdosed after injecting drugs?

Yes 1
No 2 GO TO 71
Don't know 3 Never

66. If yes, when was the last (most recent) time that you overdosed?

In the last week 1
In the last 1-4 weeks 2
In the last 1-3 months 3
In the last 3-6 months 4
In the last 6-12 months 5
Over 12 months ago 6

67. How many times have you overdosed? _____

68. Which drug/s were you using when you last overdosed? _____

69. Why you think you overdosed? _____

70. What happened the last time you overdosed? (Describe what happened; where, who was there; police or ambulance involved; hospital; who helped you recover) _____

71. Have you ever been with someone when they overdosed?

Yes 1
No 2 GO TO 73
Don't know 3

72. What happened the last time someone you were with overdosed? (Describe what happened; where, who was there; police or ambulance involved; hospital; who helped them to recover) _____

73. When do you think police might attend an overdose? _____

74. What do you think you would do if you were with someone when they overdosed? _____



75. Have you ever overdosed on purpose, for example deliberately taken a bigger amount of a drug or drugs than you knew was safe?

No 1 GO TO 77
Yes 2

76. If yes, what were the circumstances that led to this? _____

INJECTING IN PRISON

These questions are about injecting in prison. I would like to remind you that your answers will remain anonymous and only answer the questions that you feel okay about:

77. Have you ever been in prison or detention centre?

Yes 1 No 2 GO TO 85

78. Have you ever injected while in prison/detention centre?

Yes 1 No 2 GO TO 84

79. Were you in a prison/detention centre the first time you injected?

Yes 1
No 0

80. Which drug/s did you usually inject in prison/detention ?

Heroin 1
Benzos 2
Speed 3
Methadone 4
Other 5

81. Did you share syringes in prison?

Every time 3
Most times 2
Not many times 1
Never 0 GO TO 85

82. How often were the syringes cleaned while you were in prison (either before or after you used them)?

Every time 4
Most times 3
Not many times 2
Never 1 GO TO 85
Unsure 0

83. If the needles were cleaned in any way before being re-used, how were they cleaned?

Bleach used 1
Detergent/disinfectant used 2
Rinsing in cold water 3
Rinsing, then filling with bleach and
Shaking for 30 seconds 6x (new recommended method) 4
Rinsing in hot water 5
Other _____ 6
No, not cleaned at all 7
2x2x2 8

84. What was the reason/s that you did not inject in prison? _____



Needle Exchange

85. Where do you usually get your clean needles/syringes and other clean equipment? (as many as apply)

- | | |
|---|----|
| A Nunga friend or relative gives them to me | 1 |
| A non-Aboriginal friend gives them to me | 2 |
| A dealer gives them to me | 3 |
| Get them from _____ needle exchange | 4 |
| Buy from the chemist | 5 |
| Outreach worker | 8 |
| Other (specify) _____ | 10 |

86. About how many syringes do you usually collect each time?

- | | |
|-----------------|---|
| 1-3 | 1 |
| 4-5 | 2 |
| 6-10 | 3 |
| 11-20 | 4 |
| 21-50 | 5 |
| 51-99 | 6 |
| Box of 100 | 7 |
| More than 1 box | 8 |

87. About how many people do you usually collect for?

- | | |
|--------------------------------|---|
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4-5 | 4 |
| 6-10 | 5 |
| More than 10 (how many?) _____ | 6 |

88. Are there places where you wouldn't go to get needles and syringes? Why?

- | | |
|-----|---|
| No | 1 |
| Yes | 2 |

If yes why? _____

Drug and Alcohol Services

89. Where do you usually go for general health problems? (eg checkups, colds and flus, children's illness, sickness etc)

- | | |
|------------------------------|------------|
| Local doctor (GP) | 1 |
| Aboriginal Medical Service | 2 |
| Community Health Centre | 3 |
| Hospital | 4 |
| Other _____ | 5 |
| Don't seek medical attention | 6 GO TO 91 |

90. Do the health workers/doctors at the service you go to for general health issues know that you use?

- | | |
|-------------------------------|---|
| Yes, I have told them | 1 |
| Yes, they know through gossip | 2 |
| No, they don't know | 3 |
| Unsure | 4 |



91. Have you ever been in contact with any of the following because of your drug use? (as many as apply)

Local doctor/GP	1
Hospital(include for OD)	2
Counselling	3
Drug treatment service _____	4
Emergency housing	5
Detox	6
Rehab/therapeutic community	7
Police	8
Welfare services	9
Other	10
No contact	11

92. Which services have you used in the last 6 months for drug related issues?

If no services used go to 95 _____

93. What was the main reason that you went to this/these service/s? (as many as apply)

Legal problems	1
Family problems	2
Reduce drug use	3
Stop drug use	4
Have a break from drug use	5
Methadone	6
Needle exchange	7
Health reasons	8
Other reason (specify) _____	9

94. Of the services that you have used, which one do you think has helped you the most with your drug use? Can you tell me why? _____

95. Have you ever wanted to use a service for a drug related issue and been unable to?

Yes 1 No 2 GO TO 97

96. Why was this? _____

The next section is about opiates (heroin, morphine etc) and methadone. If you have not used opiates or methadone in the last 6 months your interview is complete. (Go to comments page at end of survey and ask if they have any comments)

METHADONE MAINTENANCE TREATMENT: A

The following questions only for opiate users * (remember from the table)

97. What is the longest time that you have used heroin without a break of more than one week?

months _____

If you have used heroin in the last 6 months (if not GO TO 100):



98. How much heroin do you usually use in one hit? (ie \$50)

\$ _____

99. About how much do you usually spend on heroin in a week?

\$ _____

100. What is the main reason you decided/would decide to go on methadone?

101. Have you ever bought or been given methadone to help you with withdrawals (hanging out) that was not prescribed for you? Eg, been given methadone by a friend who is on the program.

Yes 1

No 2

102. Are you currently on a methadone program?

Yes 1

No 2 GO TO END OF QUESTIONNAIRE

METHADONE MAINTENANCE TREATMENT : B

The following questions are only for people who are currently on the methadone program:

103. How many times have you been on methadone? _____ times

104. How long have you been on methadone this time? _____

105. What is your current dose?

_____ mg

106. What is/was your highest dose?

_____ mg

107. Are you on a private or public methadone program?

Private

1

Public

2

108. What services do you receive from your methadone prescriber? (eg counselling) _____

109. Do you receive any take-away doses?

Y N

If yes, how many per week? _____

110. Was entering the methadone program a difficult decision to make? Why?

111. Please tell me the good things about being on the methadone program. _____

112. Please tell me the not so good things about being on the methadone program. (eg daily pick up). _____

113. Are there any people you wouldn't want to know that you were on methadone? If so, why? _____

114. Is there anything that could be done to help you and others on the methadone program? _____

115. How could the methadone program be improved? _____

116. Are there any other comments you would like to make about methadone and other treatment options for heroin use? _____

[illegible]



APPENDIX 10

CAN YOU HELP

WE WOULD LIKE TO TALK TO ABORIGINAL PEOPLE WHO HAVE INJECTED DRUGS

If you are an Aboriginal person and live in the Southern suburbs and you inject drugs then you can help us

We are conducting research into injecting drug use among Nungas who live in suburbs in and around Adelaide. We need to interview Nungas who know about the issues for people who inject drugs. The research will be used to increase information about injecting drug use in the Aboriginal community, and increase services to drug users and their families.

If you talk to us about your injecting drug use, the information that you give us will be anonymous. We do not need to know your name or anything else that will identify you or anyone else.

You will be given \$35 for the time that you spend at the interview. This is to compensate you for your time and as an acknowledgement of your assistance in the research.

You can meet with our interviewer at a location that suits you.

Please call Jenny on 0415978575
or Carol on 83620395 to arrange an interview

This project is being undertaken by the
Aboriginal Drug and Alcohol Council (SA) inc. (ADAC) and the
National Centre for Education and Training on Addiction (NCETA)



Aboriginal
Drug and Alcohol
Council (SA) Inc.



APPENDIX 11

USING RAPID ASSESSMENT PROCEDURES TO INVESTIGATE THE IMPACT OF IDU AMONGST INDIGENOUS AUSTRALIANS IN METROPOLITAN ADELAIDE

A Collaborative Project between the Aboriginal Drug and Alcohol Council (ADAC) and the National Centre for Education and Training on Addiction (NCETA)

INFORMATION SHEET

ADELAIDE METROPOLITAN LIFESTYLE AND DRUG USE QUESTIONNAIRE

You are invited to take part in a research project that will be looking at injecting drug use within Indigenous communities in metropolitan Adelaide. This project aims to gather information on Indigenous peoples' levels of injecting drug use, on the ways in which drugs are used, Indigenous users' knowledge of the risks associated with injecting drug use, Indigenous users' knowledge of and access to services, and the impact of injecting drug use on the Indigenous community.

Your participation in the study will help to provide us with more detailed information on how drugs are being used and will help us to look at how the Indigenous community can respond to problems associated with injecting drug use. In addition, we hope that the community and ADAC will be able to use this information to develop programs to assist people who are having problems with their drug use.

Your participation the questionnaire will involve answering questions about your drug use. The person interviewing you is familiar with injecting drug use and will ask questions about a wide range of issues associated with injecting drug use. The interviewer's role is to listen and record your experiences. These may include questions about illegal activities. This session will take about 40 minutes.

Your involvement in the survey is entirely voluntary, and you may withdraw from the interview at any time. Additionally, if you choose, you may decline to answer any of the questions during the interview. All of the information collected in the interview will remain anonymous. Names will not be recorded, and there will be no information released which could identify you. Only those persons directly involved in the research will have access to the interview data.

A report of the results of this research can be provided to you once the study is completed, at your request.

If you require further information about the research project at any time, you may contact Scott Wilson on 0410419915

This project has been approved by the Aboriginal Health Council Research Ethics Committee. If you wish to discuss the study with someone who is not directly involved you may contact the Chairperson of ADAC who is also a member of the Ethics committee, Ms Isobelle Norville on 83620395



APPENDIX 12

RESEARCH PROJECT

USING RAPID ASSESSMENT PROCEDURES TO INVESTIGATE THE IMPACT OF IDU AMONGST INDIGENOUS AUSTRALIANS IN METROPOLITAN ADELAIDE

A Collaborative Project between the Aboriginal Drug and Alcohol Council (ADAC) and the National Centre for Education and Training on Addiction (NCETA)

CONSENT FORM

I, _____ agree to participate in the research project, 'Using Rapid Assessment Procedures to Investigate the Impact of IDU Amongst Indigenous Australians in Metropolitan Adelaide'.

I acknowledge that the purpose of the study, and the nature of my involvement in it, have been fully explained to my satisfaction, and my consent is given voluntarily.

I have been provided with a written information sheet on the project.

I understand that any payment made to me is simply an expression of gratitude for my assistance in this research project.

Signature of Participant _____ Date _____

Signature of Witness _____

Printed name of Witness _____



APPENDIX 13

COMMUNITY FORUM

Are you an Aboriginal person living in the Port area?

We would like to Aboriginal people (including those who inject drugs) who are interested in drug issues.

Last year the Aboriginal Drug and Alcohol Council talked to Aboriginal injecting drug users and other community people about drug issues.

We would like to talk about the issues raised, and seek your help in working out the best ways of dealing with these. Some of these issues included:

- services for drug users
- information and education
- support for families
- overdose
- methadone
- needle exchange
- young people, and more

Come along to

Port Adelaide Community Health Centre

Wednesday 6th March

2-4pm

Free: afternoon tea, child care

APPENDIX 14 Responding to the Needs of Indigenous People Who Inject Drugs

Patterns of Drug Use – Survey of Indigenous Injectors, Adelaide

Drug	When last used	%	Frequency of use (last six months)	%
Heroin	Today Yesterday In last week In last fortnight In last 3 months In last 6 months In last 12 months >12 months ago	(n=306) 30% 29% 19% 4% 3% 17% 5% 2%	>2-3 times a day 2-3times a day daily 2-3times a week weekly fortnightly monthly <3 times in last six months	(n=303) 41% 26% 19% 6% 5% 2% <1% 1%
Cannabis (Yarndi)	Today Yesterday In last week In last fortnight In last 3 months In last 6 months In last 12 months >12 months ago	(n=197) 70% 16% 7% 2% <2% <2% <1% 1%	>2-3 times a day 2-3times a day daily 2-3times a week at least monthly <3 times in last six months	(n=179) 65% 18% 7% 5% 4% 1%
Speed	Today Yesterday In last week In last fortnight In last 3 months In last 6 months In last 12 months >12 months ago	(n=222) 14% 14% 27% 7% 8% 15% <1% 4%	>2-3 times a day 2-3times a day daily every 2 days twice a week weekly fortnightly monthly <3 times in last 6 months	(n=189) 7% 14% 11% 7% 12% 17% 10% 8% 14%
Tobacco	Today Yesterday In Last week In last 6 months In last 12 months >12 months ago	(N=175) 87% 3% 4% <3% <1% 2%	daily monthly <3 times in last 6 months	(n=172) 98% <1% 1%
Alcohol	Today Yesterday In last week In last fortnight In last month In last 3 months In last 6 months In last 12 months >12 months ago	(n=231) 17% 15% 36% 4% 3% 3% 12% 1% 11%	daily every 2 days twice a week weekly fortnightly monthly <3 times in last 6 months	(n=202) 32% 6% 12% 23% 5% 15% 7%

Responding to the Needs of Indigenous People Who Inject Drugs

Drug	When last used	%	Frequency of use (in last 6 months)	%
Other Stimulantes	In last fortnight In last 3 months In last 6 months In last 12 months >12 months ago	(n=17) 24% 18% 29% 5% 24%	2-3 times a day daily weekly fortnightly monthly <3 times in last 6 months	(n=12) 17% 8% 8% 25% 42%
Designer Drugs (incl. Ecstasy)	In last fortnight In last month In last 3 months In last 6 months In last 12 months 12 months or more	(n=26) 15% 12% 12% 42% 12% 7%	twice a week at least fortnightly monthly <3 times in last 6 months	(n=21) 10% 14% 5% 71%
Inhalants	In last week In last 3 months In last six months >12 months ago	(n=17) 6% 6% 53% 35%	<3 times in last 6 months	(n=8) 100%
Plturi	In last fortnight In last month > 12 months ago	(n=3) 33% 33% 33%	fortnightly	(n=1) 6% 9% 12% 73%
Other Drugs	Today Yesterday In last month >12 months ago	(n=6) 17% 33% 17% 33%	2-3 times a day or more <3 times in last 6 months	(n=4) 75% 25%

Responding to the Needs of Indigenous People Who Inject Drugs

Drug	When last used	%	Frequency of use (in last 6 months)	%
Benzodiaepines	Today In last week In last fortnight In last month In last 3 months In last 6 months 12 months or more	(n=130) 13% 29% 5% 6% 11% 25% 11%	2-3 times a day or more daily 2-3 times a week weekly fortnightly monthly <3 times in last six months	(n=105) 16% 5% 12% 10% 12% 14% 31%
Methadone	Today Yesterday In last week In last fortnight In last month In last 3 months In last 6 months 12 months or more	(n=130) 10% 14% 16% 5% 8% 12% 24% 11%	2-3 times a day daily every 2 days twice a week weekly fortnightly monthly <3 times in last six months	(n=104) 65% 18% 7% 5% 4% 1%
Other Opiates	Today Yesterday In last week In last month In last 3 months In last 6 months In last 12 months >12 months ago	(n=102) <2% <2% 13% 10% 17% 37% 6% 14%	>2-3 times a day 2-3 times a day daily 2-3 times a week weekly 2-3 times a month <3 times in last 6 months	(n=80) 5% 3% 6% 15% 9% 11% 51%
Hallucinogens	Today In last month In last 3 months In last 6 months In last 12 months >12 months ago	(n=66) 3% 11% 18% 26% <5% 38%	>2-3 times a day (or more) at least weekly at least monthly <3 times in last 6 months	(n=33) 6% 9% 12% 73%
Cocaine	In last month In last 3 months In last 6 months In last 12 months >12 months ago	(n=52) 8% 13% 29% 4% 46%	weekly or more at least monthly <3 times in last 6 months	(n=24) 12% 17% 71%



APPENDIX 15

Risks Associated with Severity of Dependence Scale (SDS) Scores

Researchers have identified that higher scores on the SDS are related to high risk behaviours, such as injecting activity, sharing injecting equipment, and high risk sexual behaviours (Gossop et al 1995).

The information from this survey was further analysed to see if the patterns presented in other research were identified here. The SDS scores were correlated (Pearson's r) with other variables to see if a relationship between the variables existed. Although a number of the findings reported here are not unexpected or unusual, the results demonstrate consistency with similar research.

Frequency of Drug Use

- Frequency of heroin use was associated with higher SDS scores ($r^2=1.55$, $p<.01$, a weak but significant relationship). This suggests that the more frequently heroin is used, the higher the dependence score.

No relationship was identified between the SDS and frequency of speed use ($r^2=1.09$, $p=.13$). This may be explained in part, by the high rate of daily heroin use amongst this sample (258 people or 84% used heroin daily), where only a third of the sample reported daily amphetamine use. Because participants were polydrug users, it may have been difficult for them to identify exactly which drug was attributed to various physical or emotional symptoms with the SDS scale.

Physical, Emotional and Social Well being

As expected, higher dependence scores were associated with a greater number of reported physical health issues ($r^2=.29$, $p<.001$), emotional health issues ($r^2=.25$, $p<.001$), social issues ($r^2=.19$, $p<.01$), and problems related to injecting activity ($r^2=.21$, $p<.001$).

- This suggests that higher dependence scores are consistent with a greater number of difficulties reported in relation to physical, social and emotional well being scales.

Injecting Behaviour

Higher SDS scores were associated with recency of using syringes *before* someone else, ($r^2=.25$, $p<.001$), and *after* someone else ($r^2=.20$, $p<.001$). No relationship was detected between SDS scores and number of people using syringes either *before* ($r^2=.04$, $p=.71$) or *after* the participant ($r^2=.03$, $p=.74$).

- This analysis suggests that higher scores on the drug dependence scale (SDS) are associated with more recently using a needle before or after another person. No relationship was detected between the number of people who may have used before or after the participant.

Higher SDS scores were weakly but positively associated with sharing of injecting equipment (spoons ($r^2=.16$, $p<.001$), filters, ($r^2=.17$, $p<.001$), tourniquets ($r^2=.15$, $p<.01$) and mix ($r^2=.14$, $p<.005$)).

- This analysis suggests that there is a relationship between higher dependence scores and sharing of injecting equipment (spoons, filters, tourniquets and mix).

Higher scores on the SDS were also associated with increased perception of risk of contracting BBV, such as HIV ($r^2=.212$, $p<.001$), hepatitis B ($r^2=.159$, $p<.01$), and hepatitis C ($r^2=.176$, $p<.01$).

This analysis suggests that with increasing drug dependence (as measured by the SDS) participants were more likely to believe that they were at increased risk of contracting BBV

