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**Review Of Literature On Injecting Drug Use Within Urban
Indigenous Communities**

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Review of Literature on Injecting Drug Use Within Urban Indigenous Communities

INTRODUCTION

In 1997 a collaborative project between the Aboriginal Drug and Alcohol Council (ADAC), the Lower Murray Nungas Club and the National Centre for Education and Training on Addiction (NCETA) commenced. This project used a specific methodological tool, Rapid Assessment Methodology (RAM), to examine the impact of and harms associated with injecting drug use in the Aboriginal Community in Murray Bridge, South Australia. Based on the success of the Murray Bridge (or Lower Murray) project, in addition to the research findings, ADAC will be conducting research into injecting drug use in urban Aboriginal communities in metropolitan Adelaide, also using RAM as a tool.

Although there is some acknowledgement that drug use is taking place within Indigenous communities, the issue is often put into the 'too hard basket' for many reasons. Some reasons may be: the difficulty of accessing the Indigenous community and Indigenous drug users; injecting drug use may not be regarded as a priority issue; a belief that alcohol is the most problematic drug in Indigenous communities; and community members' denial of the extent of injecting drug use in Indigenous communities. Although injecting drug use is believed to be a relatively new practice within Aboriginal communities, injecting drug use by Aborigines is increasing and illicit drug use currently affects nearly all Indigenous communities to some extent, particularly urban communities.

Despite the evidence supporting the prevalence of illicit drug use in Aboriginal communities, there is very little research into the practice of Indigenous IDU to support this. A contributing factor to the lack of services for Indigenous injectors is the fact that information on injecting drug use within Indigenous communities is based largely on anecdotal evidence. Governments require hard data and statistical evidence before funding services and the lack of appropriate consultation and research into Indigenous IDU translates into a lack of culturally appropriate services. Anecdotal evidence indicates that Hepatitis C may be highly prevalent among Indigenous injectors; there appears to be a high rate of overdose among Indigenous injectors; and Indigenous injectors do not appear to be accessing Needle and Syringe Programs. Clearly many Indigenous injectors are not benefiting from national and state harm reduction strategies.

IDU IN AN INDIGENOUS CONTEXT

The most recent population statistics recorded 20,422 Aboriginal people living in South Australia, one third of them living in the northern or western suburbs of Adelaide. Almost one fifth (19%) of the SA Aboriginal population at the time of the survey were aged between 15 and 24 years old (SAPOL 1999). Aboriginal people in general have poorer health than non-Aboriginal people and the 1994 National Aboriginal Health Strategy indicates that life expectancy for Aboriginal women is 62 and Aboriginal men is 57, almost 20 years less than the national average (Dunlop and Ezard 1997).

Statistics from the *National Drug Strategy Household Survey Urban Aboriginal and Torres Strait Islander Supplement 1994* indicate that 3% of respondents had ever injected drugs compared to 2% in the general population. In addition, 2% of survey respondents were current injectors compared to 0.5% of the general population (Correll et al 2000). A survey of Aboriginal people in NSW recorded that 6% of the sample had ever used heroin, compared to the national average of less than 3% (Dunlop and Ezard 1997).

There is evidence that in some Aboriginal communities, every family has been touched in some way by IDU (Lehmann and Frances 1998, Edwards et al 1999). There are still many misconceptions in the community about harm reduction, denial about injecting drug use, and shame – not only for the user but also for the user's family. Consultations with the Aboriginal community have identified conflicting attitudes toward harm reduction, where the community can see the need for protecting the health of users while continuing to promote a drug free lifestyle and respecting those who don't use or want their families to use (Edwards et al 1999).

One of the consequences of harmful drug use is the over representation of Aboriginal people in the criminal justice system for drug related crimes (Edwards et al 1999). Although Indigenous people make up just 2% of the Australian population, the percentage of Indigenous people in prison has been estimated at 10% (Correll et al 2000). A NSW study found that 25% of the prison population was Indigenous (Arabena 2000).

Communities are concerned that they do not have enough knowledge about drug use issues (ie treatment, overdose) to be able support those in their community who use injectable drugs (Smith and Newton 1997, Edwards et al 1999). There is evidence that most Indigenous users are not accessing either mainstream or Indigenous services for drug related issues. Nevertheless, the few projects for Indigenous injectors that do exist have been shown to have a positive impact not only on the community by raising awareness of drug issues, but on the self esteem of injectors involved in the project (Lane 1993).

OVERVIEW OF LITERATURE

There are very few studies that give concrete data on Indigenous injecting drug use and these studies have only been able to access small samples. In the last decade there has been research undertaken in only 3 states (South Australia, Queensland, and Victoria) that specifically look at Indigenous injecting drug use¹. Other studies have looked at a range of drug use within Indigenous communities² or have identified Indigenous injectors within surveys of injectors³.

¹ These include: SA – NU-HIT Report (Lane 1993), *Using RAM to Examine IDU in an Aboriginal Community Final Report* (Shoobridge et al 1998); QLD – *IDU Working Papers # 2* (Larson 1996), *IDU Working Paper # 4* (Eldridge 1997); and VIC – *Community Report IDU Project* (Lehmann and Frances 1998).

² *The Prevalence of Drug Use in Urban Aboriginal Communities* (Perkins et al 1994).

³ Including: *Snapshot 2* (Roberts Aug 1998), *Snapshot 3* (Roberts Dec 1998) and *Snapshot 4* (Roberts 1999); and Australian NSP Surveys data recorded in *Hep C Infection in Indigenous Communities in Australia* (Correll et al 2000)

In 1993 the first project set up for Indigenous injectors, NU-HIT, published *The NU-HIT Evaluation Report* (Lane 1993) which included a section based on data compiled from a small representative group of 31 Aboriginal injectors. Throughout the 11 months that NU-HIT was based at the AIDS Council in South Australia, the project had contact with 124 Indigenous injectors and accessed indirectly a further 450. By bringing Indigenous injecting drug use into the open, NU-HIT paved the way for discussion of IDU issues within the Aboriginal community.

The University of Queensland published 4 papers on drug use by Indigenous people residing in Brisbane, entitled IDU Working Papers 1-4. Paper number 1 provides an overview of service providers' perspectives of drug use by Indigenous people, paper number 3 examines use of tobacco, alcohol and other drugs by young Indigenous people and paper number 4 examines findings from discussions with young Indigenous Injectors. Only IDU Working Paper #2, *What Injectors Say About Drug use: Preliminary Findings From a Survey of Indigenous Drug Users* (Larson 1996), includes statistical data on Indigenous injectors. For this survey interviews were conducted with 77 Indigenous people living in Brisbane who had injected drugs at least once in the past 12 months. Participants consisted of 53 males and 24 females, with ages ranging from 13 to 44 with a median age of 21.

In collecting data for the ADAC/NCETA/Lower Murray Nungas Club report, *Using Rapid Assessment Methodology to Examine Injecting Drug Use in an Aboriginal Community*, Shoobridge et al (1998) used rapid assessment methodology, a method of research that utilises a variety of tools to collect data while continually cross-checking results. The objectives of the study were to examine injecting drug use amongst Indigenous people in the Lower Murray region of South Australia. Both Indigenous injectors and other key community members were consulted to identify risk taking behaviour, assess practices and perceptions and identify issues raised by the community in relation to injecting drug use. For the survey component of the research, 25 (19 male, 6 female) local Aboriginal identifying injecting drug users were interviewed about various aspects of their drug use.

The Community Report – Injecting Drug Use Project (Edwards et al 1999) is a report published by the Victorian Aboriginal Health Service Co-operative documenting results from interviews with 30 Indigenous injectors and 30 other community members. The research was undertaken as a response to Aboriginal Health Workers in Victoria noticing an increase in drug use within the Aboriginal community and concerns from friends and families of Indigenous injectors about transmission of blood borne communicable diseases. In addition to interviews the researchers involved Aboriginal Health Workers, service providers, doctors, Indigenous users, and Indigenous users' families in group discussions (Edwards et al 1999).

The research paper, *Hepatitis C Infection in Indigenous Communities*, examines and analyses 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 NSPs between 1995 and 1998. A total of 395 (5.4%) respondents self-identified as Indigenous. This is more than double the 1998 Australian

Bureau of Statistics (ABS) figure of 2.1% of the general population who self-identify as Indigenous (Correll et al 2000).

Prevalence of Drug Use in Urban Aboriginal Communities (Perkins et al 1994) looks at a random sample of 531 Aboriginal people living within the geographical boundary of NSW Aboriginal Medical Services. A separate questionnaire was used for illicit drug use which was far from comprehensive⁴ but gave the researchers some idea of the prevalence of drug use in the Aboriginal community.

The Northern Territory AIDS Council has produced a series of reports, *Snapshots I-IV* (Roberts 1998,1999), tabling results of surveys of injecting drug users in Darwin. The surveys of clients accessing the Needle Exchange in Darwin include data on Indigenous injectors. The reports give an overview of characteristics of needle exchange clients in Darwin and provide a comparison between responses during the wet and dry seasons. *Snapshot II: The Dry* (Roberts, Aug 1998) includes responses from 129 injectors, 18 of whom identified as Aboriginal or Torres Strait Islander. *Snapshot III: The 1998 Wet* (Roberts, Dec 1998) covers 121 responses, including 16 ATSI identifying injectors. *Snapshot IV: The 1999 Wet* (Roberts 1999) includes responses from 104 injectors, including 16 injectors who identified as Aboriginal or Torres Strait Islander.

The Aboriginal Drug and Alcohol Council's *Statewide Substance Misuse/Injecting Drug Use Report* (Smith and Newton 1997) examines the educational needs of the South Australian Aboriginal community in regard to injecting drug use and blood borne communicable diseases. The researchers consulted 254 community members, not necessarily users, and came up with 60 recommendations from 53 identified issues.

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

⁴ For example the only question that participants were asked for each drug was whether they had ever used it or not

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. 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), and unemployment, stolen generation issues, poor health and inequality (Dunlop & Ezard 1997, Lehmann and Frances 1998) have been cited by community consultants and injectors as some of the causes of the emotional pain experienced by Indigenous people. Boredom, through lack of employment or meaningful activity, is widely believed to contribute to drug use, particularly by young people (Gray and Morfitt 1996, Eldridge 1997, Shoobridge et al 1998, Edwards et al 1999). Both lack of role models (Eldridge 1997, Shoobridge et al 1998) and a need to belong/peer pressure (Edwards et al 1999, Shoobridge et al 1998) are perceived to be contributing factors to the increase in youth drug use.

TYPES OF DRUGS USED

Heroin and amphetamine (speed) are the drugs most frequently injected by Indigenous users (Lane 1993, Edwards et al 1999, Shoobridge et al 1998, Larson et al 1999). Statistics vary on whether amphetamines or opiates are the preferred or most frequently used drug, although there is a trend in more recent surveys toward increased heroin use. There appears to be more polydrug use (use of more than one drug) among Indigenous injectors than in the general IDU population. 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).

Heroin was the drug of choice for 36% of the Lower Murray sample (Shoobridge et al 1998) and for over 50% of Darwin Indigenous injectors (Roberts August 1998, 1999). A high 68% of the Lower Murray injectors had used heroin in the 12 months prior to the survey (Shoobridge et al 1998). Sixty six percent of the Brisbane sample had used heroin at least once, with heroin being the most recent drug used for 27% of the sample (Larson 1996). Heroin was the drug used most recently by 43% of the NSP survey Indigenous participants (Correll et al 2000). Although less than 10% of participants in the Darwin surveys identified Morphine as their drug of choice, it was the most recent drug used for between approximately 56% (Snapshot 4) and 93% (Snapshot 3) of Indigenous users in Darwin (Roberts August 1998, December 1998, 1999). Pharmaceutical Morphine is the most commonly used opiate in Darwin among injectors in general.

Amphetamines (speed) were the first drug used by 83% of the Brisbane sample and the most recent drug used by 73% of the sample. Younger users in the sample tended to inject speed at first use while older users used other methods before injecting. Speed was the most recent drug used by 56% of the Brisbane sample (Larson 1996), compared to only 15% of the NSP sample (Correll et al 2000). Twenty five percent or less of Darwin Indigenous injectors reported speed as their drug of choice, although it was the most recent drug used for 25% of the sample in 1999 compared to less than 10% of the two

1998 samples (Roberts August 1998, December 1998, 1999). The increased use may be a result of a recent increase in availability of speed in Darwin, or there may be other factors contributing to the increase. Shoobridge et al (1998) found that although speed was the first drug of choice for only 8% of participants, 76% had used speed in the last 12 months. Lane (1993) points out that speed use tends to be more problematic and over half of the speed users in the NU-HIT survey had experienced long term problems associated with speed use.

Cocaine use amongst Indigenous injectors appears to be occurring less frequently than among the general IDU population. Cocaine was used by only 4 (16%) of the Lower Murray participants in the 12 months before the survey (Shoobridge et al 1998) and was not common as a drug of choice amongst the Victoria sample (Edwards et al 1999). All of the 4 Lower Murray participants who had used cocaine had spent time in NSW and only one of them was ever a regular user, using while living in Sydney (Shoobridge et al 1998). Much higher rates of recent cocaine use (67-94%) were reported in the IDRS survey of the general IDU population (McKetin et al 2000).

INJECTING BEHAVIOUR: SURVEYS OF INDIGENOUS IDUs AND IDRS NATIONAL IDU SURVEY

	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
Age of Sample	16-43	13-44	N/A	N/A	N/A	19-42	av age 29.1
Sample Size	31	77	18	16	16	25	410
Gender	13 male 18 female	53 male 24 female	14 male 4 female	13 male 3 female	12 male 4 female	19 male 6 female	283 male 127 female
Age First Injected	38.7% using for over 5yrs	av age 17.8 yr 50% <16	N/A	N/A	N/A	av age 18.6 yr	av age 18.7
First Drug Injected (top 3)	N/A	83% speed	N/A	N/A	N/A	48% speed 32% heroin 12% morph	48% speed 47% heroin
Drug of Choice (top 3)	N/A	N/A	50% heroin 22.2% speed 11.1% steroid	N/A	56.25% heroin 6.25% morph 25% speed	36% cannabis 36% heroin 16% tobacco	av 74% heroin av 10.33% speed
Drug Last Used/ Currently Using (top 3)	61.3% speed 51.6% heroin 19.4% pills ⁵	73% speed 27% heroin	83.33% morph 5.55% Ritalin 11.1% steroid	93.75% morph 6.25% speed	56.25% morph 25% speed 12.5% heroin	N/A	52% heroin 21% speed 8% methadone ⁶
Frequency of Use	N/A	38% >1x day 77% >1x wk 16% >1 month ago	61.1% >1x day 27.75% 1- 6x wk 11.11% >1 m ago	75% >1x day 25% 1-6x wk	75% >1x day 12.5% 1x day 12.5% 1-2x wk	N/A	38.33% use heroin daily
Expenditure on Drugs	N/A	36% <\$100pw 40% \$100-500 pw 18% >\$1000pw	N/A	N/A	N/A	N/A	previous day 81% \$0-200 19% >\$200
Sharing Information	83.8% share 16.2% never share	18% shared past wk 21% in past month 51% in past year	N/A	N/A	N/A	72% don't share ⁷ 48% at least once 32% in last 12 m	30% reported sharing in the last month

⁵ Total of over 100% due to polydrug use

⁶ Results from 1998 NSP Survey (not from IDRS sample)

⁷ According to participants definitions of sharing (ie sharing with kin/close friends may not be considered sharing)

FREQUENCY OF DRUG USE

Opiate users tend to use more frequently than amphetamine users, most likely due to the higher rate of dependence associated with heroin use. Shoobridge et al (1998) found that amphetamine use varied in frequency from monthly or less to 2-4 times a week. Heroin use, on the other hand, ranged from monthly or less to 4 or more times a week, with 3 participants using heroin daily. The Darwin injectors reported the highest frequency of injecting (either heroin or morphine) with 87.5% of one sample injecting at least once a day and the rest injecting 1-2 times a week (Roberts 1999), and 75% of another sample injecting more than twice a day (Roberts December 1998). A little over one third of the sample of 77 Brisbane Indigenous injectors injected (drug unspecified) at least once a day and over three-quarters injected at least once a week (Larson 1996).

PROBLEMS RELATED TO INJECTING DRUG USE

Not all injectors feel guilt or shame about their using, or view their drug use as problematic. Most of the participants in Larson's study had a positive attitude toward their drug use; 84% used because it felt good, 77% considered themselves to be casual users and 54% felt that they would like to inject more often (Larson et al 1999). It is not unusual for attitudes of injectors to conflict with service providers, for example Eldridge (1997) found that service providers believed that drug use contributed to health and social problems while the users themselves believed that drug use lessened their problems.

One of the factors that contributes toward discrimination and stigmatisation of injecting drug users is the general community's inability to differentiate between 'use' and 'abuse' of drugs. Lane (1993) points out that the vast majority of drug users experience no major problems with their drug use and that social and economic factors contribute to problems associated with using. Aboriginal injectors are more at risk of harmful use because they experience on a daily basis the inequities (poor health, unemployment, dispossession and discrimination) that lead to poor self esteem, which in turn contributes to problematic drug use (Lane 1993, Dunlop and Ezard 1997).

Although many Indigenous injectors use drugs to cope with problems, the drug use itself can cause its own associated problems so that the user has to face additional issues. This puts the drug user in a continuing cycle of using where they use drugs to cope with problems but the using causes other problems which the user deals with by further drug use. Of the 77 injectors in Larson's (1996) Brisbane study, 49 used drugs to help them to cope with problems but 33 reported that their drug use had caused problems with family and/or friends and 38 reported that their drug use had caused problems at work and/or school. Indigenous injectors also experience a range of health problems that can be directly associated with injecting drug use, such as track marks, bruising, dirty hits, nausea, and constipation (Larson 1996, Shoobridge et al 1998). Additional health problems identified are sleeping problems, hot and cold sweats and lack of energy, which are usually associated with heroin withdrawal, and more heroin users experienced these problems than amphetamine users (Shoobridge et al 1998). Other physical and mental health problems reported by Indigenous injectors are mood swings, dental problems,

heart problems and depression (Larson 1996, Shoobridge et al 1998) which may be drug related but other causes should not be ruled out. Shoobridge et al (1998) point out that there are so many factors that contribute to the poor health of the Aboriginal community in general that it is difficult to identify which health problems are specifically drug related.

DEPENDENCE

The Indigenous injectors in the Lower Murray survey displayed higher levels of dependence to heroin and speed⁸ compared to dependence levels for non-Indigenous injectors (Shoobridge et al 1998). Results from the Brisbane survey found that dependence is more likely for heroin users and those who have been using long term (Larson 1996).

EXPENDITURE

Larson (1996) found that 56% of the sample of Brisbane Indigenous injectors spent \$200 per week or less on drugs; 20% spent up to \$500 per week; and almost one quarter of participants (24%) spent over \$1000 per week on drugs. The same survey found that on average the most money ever spent in one week is \$1,000, but some participants have at some time in the previous year spent over \$3,000 in a week (Larson 1996). Results from IDRS surveys (37% spent over \$100 the previous day, about 26% spent \$50-\$99 - McKetin et al 2000) suggest higher weekly expenditure among the general IDU population, assuming the amounts recorded are an indication of daily expenditure.

INJECTING IN PRISON

Approximately 20% of South Australia's prison population are Aboriginal and 86% of Aboriginal people in prison between 1994-1998 had a history of prior imprisonment, compared to 58% of non-Aboriginal prisoners (SA Police 1999). Considering the high rate of Indigenous incarceration it is not surprising that high numbers of Indigenous injectors surveyed had spent time in prison or juvenile detention centres, ranging from 50% of participants under 21 and 36% of participants over 18 (Larson 1996), to 84% of total participants (Shoobridge et al 1998). Over 50% (11) of the 21 in Larson's (1996) sample who had been to prison had injected in prison and 57% of Shoobridge et al's (1998) sample had injected while in prison.

Many Indigenous injectors reported that they used for the first time in prison (Lane 1993, Larson 1996, Shoobridge et al 1998). Reasons given by those who injected drugs for the first time in prison were that it helped them to cope with being in jail and made the time pass more quickly (Edwards et al 1999). In prison, even those who are informed about safe using and transmission of blood borne communicable diseases have no suitable alternative to sharing syringes. Indigenous injectors with a prison history state that

⁸ 81% (16) of the 21 participants rated as dependent using the Severity of Dependence Scale. The rate of dependence of Indigenous injectors to Amphetamines (speed) is 66% and Heroin 62%

syringes are reused multiple times, with estimates of 50 or more prisoners using one syringe (Edwards et al 1999). Aboriginal community members have told of syringes being cleaned in prison with bleach, alcohol, detergent, soap, water and even coca cola (Shoobridge et al 1998), showing that most Indigenous prisoners are attempting to use as safely as they can under the circumstances. Prison courses have provided support and information to Indigenous prisoners but there is a need for support programs and services such as rehabilitation programs, counselling and HIV/HCV testing for newly released prisoners (Smith and Newton 1997, Lehmann 1998, SAPOL 1999). Newly released prisoners who may have made the decision to stop using drugs are at risk of recommencing their drug use without post-release followup and support (SAPOL 1999).

SHARING INJECTING EQUIPMENT

There are high rates of sharing (lending and borrowing) syringes and other injecting equipment amongst Indigenous injectors. NSP survey results recorded a higher rate of sharing among Indigenous injectors than in the general IDU population (Correll et al 2000). Larson (1996) recorded 50-60% of Indigenous injectors in the study shared syringes in the last 12 months and Shoobridge et al (1998) report 48% of Aboriginal injectors interviewed had shared syringes at least once. Results of a variety of questions on sharing injecting equipment suggest that half of the participants in the Brisbane survey share syringes (Larson 1996). The highest rates of sharing are recorded in Larson and Currie (1995) where 70% of Indigenous injectors interviewed by QUIVAA shared on occasion. These statistics are much higher than the general IDU population where the rate of needle sharing (20% in 1999 compared to 29% in 1995) is decreasing (McKetin et al 2000).

Sharing is the norm in Indigenous culture and the ritual of sharing injecting equipment is an extent of this (Lane 1993, Larson et al 1999). Larson et al (1999) point out that Indigenous injectors may have a different concept of sharing to non-Indigenous injectors and that sharing with family/kin or those of the same HIV or HCV status may not be considered sharing. This is supported by Lower Murray statistics where, although 72% (18 out of 25) of participants indicated that they did not share, 2 people did not consider borrowing a used syringe from another user's stash to be sharing; 2 people did not consider it to be sharing if it was with a close relative or partner; and 3 people did not perceive it to be sharing if the other user was someone of the same HIV/HCV status (Shoobridge et al 1998). Over half (56%) of the Lower Murray injectors shared filters, spoons, tourniquets etc (Shoobridge et al 1998), placing them at risk of HCV transmission.

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 BCCDs as a 'whiteman's disease' (Shoobridge 1998, Junga-Williams 1998).

It is clear that Indigenous injectors are not getting the information needed to make safe choices regarding their injecting drug use. Of 40 Indigenous injectors interviewed by QUIVAA, 6 did not know how to inject safely and 12 did not understand what safe

injecting was (Larson and Currie 1995). Although lack of information on safe using is a major contributing factor to needle sharing amongst injectors, Larson and Currie (1995) suggest that poor literacy skills, need for immediate use/not being able to wait, shame of obtaining injecting equipment, living on the street, desire to join in, or having a special relationship with another injector are other reasons that contribute to unsafe practice

INITIATION INTO INJECTING

There is evidence that use of drugs by young people is on the increase (Lane 1993, McKetin et al 2000) and Aboriginal youth are commencing drug use at an even younger age than non-Aboriginal youth (Larson et al 1999). Research shows evidence of increasing Indigenous youth drug use with 50% of participants commencing at age 16 or younger and 55% of participants who commenced using within the past 2 years were between 12 and 15 at initiation (Larson 1996). The mean age of initiation for Indigenous injectors has been recorded as low as 17.8 years (Larson 1996). This is approximately 1 year younger than the 18.7 years recorded for the general IDU population (McKetin et al 1999).

Injecting drug users are usually initiated into injecting by trusted people such as friends or relations, and not by dealers, as is widely believed in the general community. For the majority (58%) of the Indigenous injectors involved in the Brisbane study, the first 'hit' was not planned but just happened and, of a total of 77 injectors, 39 reported that it was their own idea to start and 31 reported that it was a combination of their own idea and somebody else's (Larson et al 1999). Coercion was not a factor in the participants commencement of injecting drugs, and in fact curiosity was cited by 90% of the Brisbane participants as the reason they started injecting (Larson et al 1999). Research indicates that over half of Indigenous injectors were initiated into using by other Indigenous people (Shoobridge et al 1998, Larson et al 1999).

OVERDOSE

Indigenous injectors experience a much higher overdose rate than non-Indigenous users, with nearly every family being affected in some way by overdose (personal communication, Norvill 2000). Larson (1996) found that 52% of heroin users (those whose last drug used was heroin) had experienced their own or someone else's overdose. Out of 11 of the sample who had experienced an overdose themselves, 2 had been left by friends and 3 were alone at the time (6 had been given either mouth to mouth or other assistance). The high numbers of injectors who usually or sometimes inject alone (Larson 1996, Shoobridge et al 1998) increases the potential for fatal overdose.

Although there is a greater risk of overdose during times of feeling depressed or low, particularly if the injector is using to cope with emotional pain, overdose is believed to be mostly unintentional. A community worker discussing Indigenous injectors stated "They don't actually sit down as often and say, "I am going to kill myself" and take the drug to do that. That's less common. But I think people do sit down and say "I'm going to take this dose and I don't care if I die of it" (Edwards et al 1999).

SUICIDE AND SELF- HARM

Indigenous Australians have the highest rate of youth suicide in the world and almost 3/4 (73 %) of Indigenous Australians have contemplated suicide (Junga-Williams 1998). Shoobridge et al (1998) recognise a link between suicide/self harm and intoxication by Indigenous people, adding that intoxication often facilitated the decision to go through with a suicide attempt. More than half (52%) of the Lower Murray injectors had attempted suicide at least twice, and 92% of those reported being intoxicated for at least one of the attempts (Shoobridge et al 1998).

FAMILY AND SOCIAL NETWORKS

Community members have reported that parents often blame themselves for their children's drug use and older Aboriginal people have little or no understanding of the issues involved. Often Indigenous users will stay away from their families because of the shame and stigma attached to IV drug use. This leads to further hardship by being unable to access their support system. Often when a person stops using there is a need to avoid other users. In some cases family members are users, so that both social networks and support networks are unavailable at a time when the user is most vulnerable (Edwards 1999).

One issue that affects families is family shame (Shoobridge et al 1998, Edwards et al 1999), where the drug using member brings shame upon their family and the families of IDUs lose respect in the community and become ostracised. Some of the community believe that families are too supportive and rather than rescuing the user they should be taking a stronger stance, forcing the user to face up to their responsibilities (Shoobridge et al 1998).

Fifty two percent of the Lower Murray Aboriginal injectors interviewed were in a relationship at the time of the interview and 20% of participants had a non-Aboriginal partner at the time. Of those in a relationship, 16% had partners who were also injecting drug users, which appears to be a smaller percentage than in the general IDU population where most users have partners who also use. More than half of the participants had children, although in the majority of cases the caring was done by previous partners, extended family or previous partners' extended family (Shoobridge et al 1998).

Participants in the Lower Murray survey had contact with/knew a median of 24 other Indigenous injectors, numbers similar to participants in the NU-HIT survey (Shoobridge et al 1998). Peers appear to be a factor that contributes to a young Indigenous person commencing injecting. Seventy two percent of the Lower Murray injectors stated that half or more of their friends used drugs, while 60% stated that more than half of their friends used IV drugs. Most of the participants (80%) injected with other people most or all of the time. Peer groups were not restricted to Aboriginal friends but range from Aboriginal only, mixed, mostly non-Aboriginal, related and not related (Shoobridge et al 1998).

RACIAL ISSUES

Many Aboriginal people live in multiracial areas and face associated issues such as conflicts caused by underlying racial tension although this is often not discussed or brought into the open. Young Indigenous users in Brisbane spoke of seeing people from Asian backgrounds with houses, jobs and 'flash cars' and feel that the Asian "refugees" are in a position of privilege, while they themselves have nothing (Eldridge 1997).

Community members identified fair skinned Aboriginal youth and children to be at particular risk as they often don't fit in either the Anglo or Aboriginal community (Shoobridge et al 1998).

POVERTY AND UNEMPLOYMENT

Perkins (1994) recognized a relationship between unemployment and substance use in the Aboriginal community due to the Aboriginal community having a higher rate of unemployment and substance use than the general population. Using drugs can be a distraction from the limited opportunities that are associated with living in a low socioeconomic area (Eldridge 1997).

The Aboriginal injectors in the report by Shoobridge et al (1998) showed a high rate of unemployment and low income, with only 3 (12%) of the participants in full time employment and 88% in receipt of a government benefit. Two thirds of Indigenous injectors in a Brisbane study had never been employed (Larson 1996). Forty six percent of participants in the Lower Murray survey had an annual income of less than \$10,000 and 72% had an income of less than \$15,000 per annum (Shoobridge et al 1998).

ACCOMMODATION

A number of Aboriginal injectors have unstable accommodation, living in a number of different residences in a given period. Nine (36%) of the Lower Murray sample had lived in 3 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). Forty percent of the Brisbane sample had lived in 5 or more places in the previous 12 months (Larson 1996). Over half of the Lower Murray sample were dissatisfied with their current living conditions and a number of participants were living in short term accommodation such as rehab centres and support accommodation (Shoobridge et al 1998).

Homelessness as an issue is often overlooked because there is an assumption that the supportive family structure of Indigenous Australians ensures accommodation for young people who are unable to live at home. One Brisbane service provider states "You don't see many ATSI homeless youth because they have always got somewhere to go, like a family member or a friend's house if they are having trouble at home" (Eldridge 1997). In addition to the direct impact that homelessness has on a person's life there is the added disadvantage of having little or no structure to life, making it difficult to attend scheduled

appointments, and existing outside of the system therefore being unable to receive social security benefits.

EDUCATION

The 1991 ABS Census data shows that less than 60% of Aboriginal people left school before the age of 16, compared with 80% of the Aboriginal IDU who participated in the Lower Murray survey. This indicates a connection between leaving school early and IDU although further study needs to be undertaken to find out if there is a correlation between the two. More than half (52%) of the Lower Murray participants completed year 10, but 16% left before completing year 9 and only 8% completed year 12. A high proportion (88%) of the sample had commenced or completed tertiary study but there is a marked gender difference (6 males, 1 female) in those who gained tertiary qualifications (Shoobridge et al 1998).

The average school leaving age of the Indigenous injectors interviewed in Brisbane is 15 years but 10 participants left school at aged 13 or younger and 15 participants left school at 14. Approximately 40% (31) of the sample had commenced either TAFE or university and 20% (16) had undertaken an apprenticeship or on-the-job training (Larson 1996).

INVOLMENT IN CRIME AND DEALING

Many Indigenous injecting drug users are on a government benefit, which is generally insufficient to pay for use of drugs. Service providers and community members report that Indigenous IDUs sometimes engage in sex work to pay for drugs (Larson 1995, Edwards et al 1999, Junga-Williams 1998) although more research is needed to get a better picture of numbers. Almost all of the Brisbane sample had engaged in illegal activities (including stealing, gambling, break and enters, stealing cars, sex work and dealing) to pay for drugs, reporting an average of four types of criminal activities ever undertaken. A little over half of the sample scored from dealers and about 42% bought their drugs from friends⁹. Only 2 participants stated that they got their drugs from an Indigenous dealer (Larson 1996).

It is not unusual for injecting drug users to support their using by 'dealing' and Victorian research found that most of the Indigenous IDUs surveyed dealt on some level, usually by splitting a deal and selling a portion of it to another user. This research also found that dealing is a way of supporting the family economy in some cases, making it difficult for other family members to speak out against a practice that was easing financial strain (Lehmann and Frances 1998).

Researchers found that there was a perception in the Aboriginal community that dealing of marijuana ('yarndi') was acceptable but dealing of IV drugs was not. Some of the youth interviewed believed that this was sending a confusing message and stated that it was hard to respect their elders if they were dealing (Edwards et al 1999).

⁹ The researcher suggests that if the user knows the dealer well, they may be categorised as friend (Larson 1996)

YOUTH INJECTING DRUG USE

Service providers report that the age of initiation into injecting drug use has dropped and more young people are using drugs than in the past (Larson and Currie 1995, Larson 1996). One study of Indigenous injectors showed that half of the participants were 16 or younger when they first injected drugs (Larson 1996). It appears that young injectors are engaging in riskier behaviour than older users. The Brisbane survey recorded a 63% rate of recent needle sharing by Indigenous users under 20, almost twice the rate of older users (Larson et al 1996).

Studies of young Aboriginal injectors have identified strong relationships¹⁰ between being cautioned by police and drug use (Larson et al 1997) and associations between offending and use of 'softer' drugs (marijuana, alcohol) in young Indigenous males aged between 14-17 years (SAPOL 1999).

Young injectors tend to fall into 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. Research in Brisbane specifically targeted young Indigenous males who inject¹¹ to discover reasons for not accessing services. Participants stated concerns that Drug and Alcohol Services were linked to the police or government in some way and there needed to be assurance that services wouldn't "dob them in" to the police or the community before they would access the services. The young men also feared discrimination ('userphobia'), and reported negative experiences when they attempted to overcome barriers and use the service (Eldridge 1997)

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 to detoxify (Edwards et al 1999).

PEER EDUCATION

In the last decade peer education has proven to be the most effective and credible method of imparting harm reduction messages to injecting drug users. Peer education can be a useful tool for educating Indigenous injectors in safe drug use but is often misunderstood by the Aboriginal community. The NU-HIT project initially encountered hostile reactions from community members who perceived the project to be encouraging drug use rather than abstention (Lane 1993).

¹⁰ Larson is careful not to assume causality or association that may be incorrect (ie she asks which came first, the caution or the drug use), nevertheless 45% of the participants had been cautioned by police and 32% had experienced police harassment for no reason in the 12 months prior to the survey.

⁸ 30 Indigenous male IDUs aged between 13-19 who don't access services for IDU or health

The Aboriginal Drug and Alcohol Council developed a peer education program for Aboriginal prisoners that included a component on injecting drug use. An evaluation of this project found that 95% of participants gained knowledge and skills that they were able to impart to their peers (within prison and in the Aboriginal community). Despite the success of the project, funding was not recurrent (SAPOL 1999).

One third of the Brisbane Indigenous injectors indicated that they had never received or did not remember receiving a leaflet or other printed material about safe drug use (Larson 1996), evidence that supports the need for peer education for a group who are not benefiting from mainstream education.

Peer education was only one of a variety of methods of imparting information that Aboriginal community members in Victoria listed. Diversity in presenting information (plays, music and dance), using graphics (posters, comics etc) and utilising traditional methods of information sharing were other suggestions (Edwards 1999).

ACCESS TO HARM REDUCTION PROGRAMS

Research shows that there are a number of reasons why Indigenous injectors are not accessing services for drug related issues. Cultural issues, fear of breach of confidentiality and shame of being identified as a drug user are some of the most common barriers to accessing services (Lane 1993, Larson 1996, Shoobridge et al 1998). Issues around breach of confidentiality are particularly associated with Aboriginal Health Services where there is a possibility that health workers are connected to the user's family in some way (Lane 1993, Shoobridge et al 1998).

The community consultants in the study by Shoobridge et al (1998) mentioned breach of confidentiality, being identified as an IDU, cost and fear of discrimination as barriers to buying injecting equipment from chemists. These injectors had access to one needle exchange (situated in the local hospital) but none of the participants accessed it. Lack of information about the service, fears of breach of confidentiality, and the restricted hours of operation (after hours) contributed to barriers in accessing this service (Shoobridge et al 1998).

Larson et al (1999) report that the Indigenous injectors in the Brisbane studies, particularly young injectors, are not benefiting from peer education and harm reduction programs. A high number of Indigenous IDU (69%) obtained injecting equipment from chemists, and younger or less experienced users were not accessing either chemist or needle exchanges, relying on friends for their supplies (Larson 1996). Using chemists rather than Needle Exchange Programs leaves little scope for peer education and also means that the minimum number of syringes are obtained each time so there is more chance of running out of injecting equipment. Needle exchanges (Clean Needle Programs) allow users to collect syringes in bulk, for example most users accessing NU-HIT were collecting injecting equipment for between 1 and 40 other users (Lane 1993). Shoobridge et al (1998) found that the Lower Murray injectors rarely access Drug and

Alcohol Services, reporting that 28% of participants had never accessed a service and 48% of participants had only accessed one type of service for drug related issues.

ACCESS TO TREATMENT SERVICES

Lehmann and Frances (1998) report that help is too slow coming for Aboriginal IDUs seeking treatment in Victoria and it can seem a lot easier to continue to use than to wait the days or weeks for assistance. The NU-HIT survey reported that two-thirds of the Indigenous users who wanted to detox, did not (Lane 1993).

Methadone is seen as a useful strategy to reduce drug related crime, although Aboriginal community consultants identified a need for methadone to be one of a number of choices and there needed to be more information made available on the pros and cons of methadone (Edwards et al 1999). Almost one half (48%) of the Lower Murray injectors had ever used methadone, yet only 4 of them had ever been in a registered methadone program and half (2) of those who had were dissatisfied with the 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 Aboriginal or Torres Strait Islander¹² (Shoobridge et al 1998).

Community consultations in Canberra regarding Indigenous involvement in the proposed Heroin Trials found that, although there were some concerns, more than half of the Aboriginal community leaders and service providers consulted were supportive of the trials. Ninety five percent of those consulted held the belief that existing services were inadequate (Humes et al 1993). Aboriginal communities in SA were also supportive of heroin trials and viewed heroin maintenance as viable alternative to methadone maintenance (Smith and Newton 1997).

NU-HIT clients requested Nunga specific, Nunga controlled treatment services, along with more outreach services and specialised treatment services for amphetamine users (Lane 1993). Research has identified a need for mainstream services to be made more Aboriginal friendly and accessible because there are some Aboriginal injectors who choose not to use Aboriginal services, preferring the anonymity of mainstream services (Edwards et al 1999, Arabena 2000).

One issue that all of the Indigenous users and community members are in agreement on is that treatment, detoxification and rehab services for Indigenous IDU must be culturally appropriate (Lane 1993, Perkins et al 1994, Lehmann and Frances 1998, Shoobridge 1998, Edwards et al 1999). There needs to be a wider range of treatments available, and more services tailored specifically for Indigenous injectors (Humes et al 1993, Larson 1995, Edwards et al 1999).

¹² There are now 2 services providing methadone for opiate dependent Nungas in SA (Nunkuwarrin Yunti , an Aboriginal health service, and the Parks Community Health Centre).

BLOOD BORNE COMMUNICABLE DISEASES

Although there has been Australia-wide mainstream education for IDUs, many Indigenous IDUs are still unclear or unsure about HIV/AIDS and hepatitis issues. One study found that most Indigenous users surveyed perceived themselves to be at a very low risk of HIV infection even though many of them shared needles¹³. Many of these injectors were unsure of the difference between HIV and AIDS (39 thought that being HIV positive meant that a person had AIDS); 5 thought HIV could be transmitted through kissing; and 10 thought that mosquitos could spread HIV. The study also found that 26% of participants had engaged in injecting practices that may have put them in at risk of HCV transmission through casual contact¹⁴ with infected blood (Larson 1996). The same study found that gay or bisexual identifying participants had more knowledge of HIV, as did participants who had used a treatment service (Larson 1999).

The Indigenous users interviewed in Victoria appeared knowledgeable about blood borne diseases although often the need for a hit would take priority over safe behaviour. The possibility of not showing any symptoms of HCV for many years meant that HCV related problems were too far into the future to be of concern (Edwards et al 1999).

A high proportion of Aboriginal IDUs (92%) in the Lower Murray region underwent HCV testing in the 12 months preceding interviews, although fewer numbers (72%) had been tested in the 6 months prior to being interviewed (Shoobridge et al 1998). Indigenous users from Darwin underwent similar rates of HCV testing with 15 of the 16 Indigenous participants (93.75%) having been tested for HCV (Roberts December 1998). Junga-Williams (1998) suggests that involuntary testing is a common occurrence. This could account for the high numbers of Indigenous users who have undergone HIV and HCV testing. 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 HIV and Hepatitis B& C testing.

BLOOD BORNE COMMUNICABLE DISEASES: INFORMATION ON TESTING AND RESULTS

Hepatitis C seroconversion rates amongst Indigenous injectors vary from under 40% (Larson 1996, Shoobridge et al 1998, Roberts December 1998) to over 70% (Roberts August 1998). The Indigenous injectors participating in the NSP surveys showed a mean HCV conversion rate of 56%, slightly higher than the non-Indigenous participants. However looking at younger injectors (under 25 years), the Indigenous injectors have a much higher prevalence of HCV than non-Indigenous injectors (38% compared to 23%) and HCV prevalence was also higher for Indigenous injectors who had been injecting for less than 3 years (Correll et al 2000). Rodney Junga-Williams, from the National Association of People Living With HIV/AIDS, had contact with 50 young Indigenous injectors over a 3 month period, 40 of whom were HCV positive and 5 of whom were HIV positive. Three of the 5 HIV positive young injectors were also HCV positive and identified as gay (Junga-Williams 1998).

¹³ The perception of being at a very low risk may come from the fact that most (71%) of the participants did not know anyone who was HIV positive (Larson 1996).

¹⁴ Contact with blood other than through sharing fits or through needle stick injury.

	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 +ve ¹⁵
HCV Information	N/A	65% had HCV test	94.44% HCV test 66.66% HV +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 years ¹⁶
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

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). Two Darwin surveys of injecting drug users recorded a 100% rate of HIV testing for the Indigenous participants, as well as higher rates of positive HIV results for Indigenous participants. The results from these surveys recorded 12.5% and 6.25% of Indigenous participants were HIV positive and although it must be taken into consideration that in both cases the sample was very small this is still an alarming result (Roberts December 1998, 1999). Other studies of Indigenous injectors record a zero rate of HIV amongst participants (Larson 1996, Shoobridge et al 1998). The Northern Territory appears to have higher rates of HIV among injectors in general with 8.1% of NT injectors in the IDRS survey reporting a positive HIV status compared to the IDRS national average of 1.5% (McKetin et al 2000).

SEXUAL HEALTH

Twenty eight percent of participants in the Lower Murray survey never used condoms with casual partners and 12% rarely or sometimes used condoms with casual partners. Twenty four percent stated that they always used condoms. Community consultants believed that Aboriginal people preferred not to use condoms for cultural reasons and that Aboriginal people felt that they as a race were not susceptible to BBCDs (Shoobridge et al 1998).

As part of the NU-HIT survey, participants were asked to rate their knowledge of safe sex. About 38% rated their knowledge as high, 35.5% rated their knowledge as good and 25.5% rated their knowledge as average. Participants ratings for their community's awareness of safe sex, safe drug use and HIV ranged from low to fair while the rating of their own knowledge ranged from fair (a few) to good/high (most) (Lane 1993). It is not

¹⁵ Results from 1998 NSP Survey

¹⁶ Results from 1998 NSP Survey

clear whether the community in question is the Aboriginal community or the Aboriginal IDU community.

GENDER DIFFERENCES IN DRUG USE

There is a belief by Aboriginal community leaders that there is heavy use of prescription drugs by Aboriginal women (Humes et al 1993). This belief is supported by findings from the *1996 National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement* that benzodiazapine use is greater among Indigenous women than Indigenous men (Shoobridge et al 1998). Larson's (1996) survey of Brisbane injectors found that Indigenous women scored higher on a scale of dependency than Indigenous men. Results from the same survey show that only 3 of the 19 Indigenous injectors who reported never sharing needles were women. It is possible that the small number of women who never share is related to perceptions of what constitutes sharing and cultural norms within the injecting community. In the injecting subculture, it is common for the male partner in a couple to have the first taste (Junga-Williams 1998). This could account for the difference and is somewhat supported by results from Brisbane (Larson 1996) indicating that 62% of the women who shared only shared with one other person. This person was most likely their partner.

A study of drug use amongst Aboriginal Australians in urban NSW found some marked gender differences in the use of Marijuana between Aboriginal men and women. Aboriginal men were more than twice as likely to have used marijuana or alcohol than Aboriginal women. Use of other substances showed no significant gender differences although a higher number of Aboriginal women had ever used marijuana, heroin or cocaine compared to Non-Aboriginal women (Perkins et al 1994).

USE OF OTHER DRUGS AND ALCOHOL

Results from the survey of Indigenous IDUs in the Lower Murray area show a high proportion of Indigenous injectors use tobacco and alcohol. The survey found that 72% of participants had used alcohol in the 12 months prior to the survey and 72% of those drank at levels harmful to their health. Although, by the scoring system used, those who drank at harmful levels were classified as dependent, it is suggested that it is more likely that they are binge drinkers (Shoobridge et al 1998). 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 (Shoobridge 1998). In comparison, Perkins et al (1994) found that only 57% of a general (non-IDU) sample of Indigenous people were drinkers, although many of them were also binge drinkers.

National studies¹⁷ show that smoking is more prevalent among Aboriginal people than non-Aboriginal people (Perkins et al 1994, Shoobridge et al 1998). A high percentage (96%) of Indigenous Murray Bridge injectors identified as smokers (Shoobridge et al 1998) and comparing this figure with the 50% of smokers in a random Indigenous sample (Perkins et al 1994) it appears that smoking is even more prevalent among Indigenous injecting drug users.

There is a belief by the Lower Murray Indigenous community that local Indigenous injectors use other drugs such as cannabis, prescription drugs (codeine, rohypnol, other benzos) and alcohol more than injectable drugs. Research shows that cannabis use is prevalent¹⁸ among Indigenous injectors (Shoobridge et al 1998, Larson 1997) but it is polydrug use and use of injectable drugs that has the greater impact (Shoobridge et al 1998).

The benzodiazapine, Temazepam, has been cited as a commonly used drug among Indigenous users (Edwards et al 1999). This is cause for concern, particularly if Temazepam is being injected, because of the permanent damage to veins associated with injecting Temazepam.

Although the use of petrol within urban Indigenous communities is not widespread, statistics (8% of males and 4% of females) show that petrol use is not limited to remote or rural communities (Perkins et al 1994).

¹⁷ National Heart Foundation, () Australian Bureau of Statistics(1995,1997c)and Commonwealth Dept of Human Services and Health (1996)

¹⁸ All but 1 of Shoobridge et al's (1998) study had used cannabis, 88% (22) within the past 12 months and 45%(10) reported daily use. Over 70% of Larson's (1997) sample had ever used cannabis, 25% used cannabis at least once a week.

INDIGENOUS COMMUNITY CONCERNS

There are a variety of issues related to addressing Indigenous IDU that have been raised by Aboriginal community members. One of the issues raised is a need for support groups for mothers of heroin users (Lane 1993) and support programs for families of users, addressing issues such as parenting skills, and offering crisis care (Edwards et al 1999, Smith and Newton 1997).

Many communities involved in the ADAC consultations identified the need for Indigenous Needle and Syringe Programs that provided information, education, support, counselling referrals and safe sex products in addition to needles and syringes (Smith and Newton 1997).

Communities believe that better access to grief and loss counselling should be made available for Indigenous drug users (Smith and Newton 1997, Lehmann 1998, Edwards et al 1999). Community members have identified a need for more training for Aboriginal Health Workers on the overlap between drug use and mental health problems (Lehmann 1998).

Due to the close nature of Aboriginal families, a need for treatment programs to involve family members has been identified (Shoobridge et al 1998, SAPOL 1999). Programs need to address the range of issues that contribute to Indigenous drug use using a holistic approach to treatment and be aware of the need for spiritual healing (SAPOL 1999).

Without ongoing support it is too easy for users who have stopped using drugs to return to drug use. Using drugs, particularly for a dependent user, can fill in a lot of time and the time formerly taken up by finding money, scoring and using drugs must be filled by other activities. Young urban Aborigines, in particular, may have never felt a connection to Indigenous culture and neither are they able to assimilate into mainstream Australia (Junga-Williams 1998). Community members have suggested cultural centres where Indigenous users can learn about their culture. This is part of a holistic approach that includes re-establishing links with traditional Aboriginal culture, values and spirituality and will begin the healing process and offer a replacement for drugs (Edwards et al 1999).

Consultations with Indigenous communities have identified the need for community involvement and ownership, and self determination when undertaking research with, or establishing services for, Aboriginal substance users (Larson 1999, Gray and Morfitt 1996, Edwards et al 1999, Alati 2000). In many ways injecting drug users are a community like any other and if there are any problems with the way services are presented, the information will spread very quickly throughout the Indigenous using community.

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 Indigenous IDU ownership of services, projects or programs. Appropriate intervention, services and

policies can only come about through direct involvement of Indigenous injectors (Larson 1996, Shoobridge 1998, SAPOL 1999, Arabena 2000).

HARM REDUCTION VERSUS ABSTINENCE – WHICH APPROACH?

The term harm minimisation was first officially used at the launch of the National Drug Strategy Campaign, where it was stated that the overall aim of the campaign was to minimise the harmful effects of drugs on Australian society. There is no one clear definition of harm minimisation, which has led to strategies which range from aiming to reduce harm without interfering with drug consumption to aiming to reduce harm without normalising or encouraging drug 'abuse' (Gray and Morfitt 1996). Further confusion occurs when the term harm reduction is thrown into the equation. In the mid-nineties the terms harm reduction and harm minimisation were virtually interchangeable but 'harm minimisation' has come to define the federal governments strategy of minimising harms and risks while aiming to reduce consumption of drugs/promote abstinence, while 'harm reduction' defines the strategy (supported by community based organisations, peer education projects and user groups) of reducing harms associated with risky/unsafe use while accepting that people make their own choices about drug use.

Alati (2000) states that the training of Aboriginal Health Workers in the Drug and Alcohol field has been predominantly abstinence based and strategies such as harm reduction and peer education have made little impact on Indigenous services. The Lower Murray community consultants were divided in their opinions regarding which strategies were best suited to their community. Although there was a belief that abstinence based approaches interfered with an individual's right to choose, drug and alcohol workers stated that their support of harm reduction affected their relationship with the community who mostly held traditional, abstinence based views toward drug and alcohol use (Shoobridge et al 1998). In many cases, community attitudes appear to be changing to support of harm reduction strategies (Lane 1993, Edwards et al 1999) and it is involvement in projects for Indigenous injectors that has helped to dispel inaccuracies and open dialogue on the issues (Lane 1993, Lehmann and Frances 1998).

The apparent conflict between approaches has been reconciled in the Melbourne Indigenous community where it is proposed that that strategies are put in place that protect the health of injecting drug users, their families and the community, while equally providing support and choices to people who inject and want to stop. Additionally community members have specified the need for prevention messages as a component of harm reduction strategies (Edwards et al 1999).

CONCLUSION

It has been hard to access Indigenous injecting drug users except for those in contact with services and those who are in prison or undergoing treatment. Lane (1993) suggests that due to the fact that the majority of users in contact with needle exchanges are older heroin users, there may be a large population of Indigenous amphetamine users who have never been in contact with services. Unfortunately the small sample sizes of completed research are problematic. Results may be unreliable due to not being representative, larger sample sizes allow for greater accuracy.

There is a variety of research documenting Indigenous community perceptions of injecting drug use but there appears to be blurred boundaries between perceptions based on experience or evidence and perceptions based on assumptions. This can sometimes result in disparity between what injectors report about injecting drug use and what the community are saying. Researchers need to be aware of whether participants are answering questions accurately or feeling too shamed about giving accurate answers. An example is that according to community members, young Indigenous women are doing sex work to support their drug use, but this is not supported by the surveys of injectors. The only way to really know the extent of this is by using a larger sample and research methodology that allows for cross checking of results. Additionally, using supporting data, sensitivity in conducting surveys and asking the same questions in a variety of different ways can help to ensure accuracy.

Past research on Indigenous injecting drug use has been able to provide an overview of risk taking behaviour and information, service and treatment needs. Results of research shows a need for increased education on safer injecting to reduce risk of transmission of Hepatitis C. The high rates of incarceration of Indigenous people coupled with the high rates of IDU within Indigenous communities equals increased risk of Hepatitis C and HIV (Arabena, 2000). Indigenous prisoners are tested for Hepatitis C in prison but may be released before results are available and follow-up rarely occurs. Research has also exposed a need for culturally appropriate services and peer education for Indigenous injectors, particularly regarding the practice of sharing needles/syringes.

There are a number of Indigenous IDU issues where there is little or no existing data: mental health issues and dual diagnosis; multi-racial issues; overdose and gender issues. Correll et al (2000) note the lack of evaluation of the effectiveness of services and programs for Indigenous drug users.¹⁹

When addressing injecting drug use within Aboriginal communities it needs to be acknowledged that Aboriginal communities are heterogenous, not homogenous. There are geographical and social variations, and regional differences in regard to which drugs are used and how they are used. For example, the high numbers of Darwin injectors using morphine may mean that specific resources for reducing harms related to injecting pills

¹⁹ Information from a National Drug and Alcohol Research Centre review (Hando et al 1998).

may be needed. Individual communities generally know which aspects of drug use need to be addressed in their community and which approach will work best for them.

By addressing injecting drug use within Aboriginal communities, the results of harmful using can be reduced. Edwards et al (1999) state that the key to threats to Aboriginal health is cultural wellbeing. If this is so, then programs need to address the causes of Indigenous substance abuse and not just the symptoms (Smith and Newton 1997).

GLOSSARY

ADAC: Aboriginal Drug and Alcohol Council

AIDS: Acquired Immune Deficiency Syndrome

BBCD: Blood Borne Communicable Diseases

CNP: Clean Needle Program

HBV: Hepatitis B Virus

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

IDRS: Illicit Drug Reporting Strategy

IDU: Injecting Drug Use

LMNC: Lower Murray Nungas Club

NCETA: National Centre for Education and Training on Addiction

NSP: Needle and Syringe Program

NU-HIT: Nunga Users HIV Intervention Team

RAM: Rapid Assessment Methodology

SAPOL: South Australia Police

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