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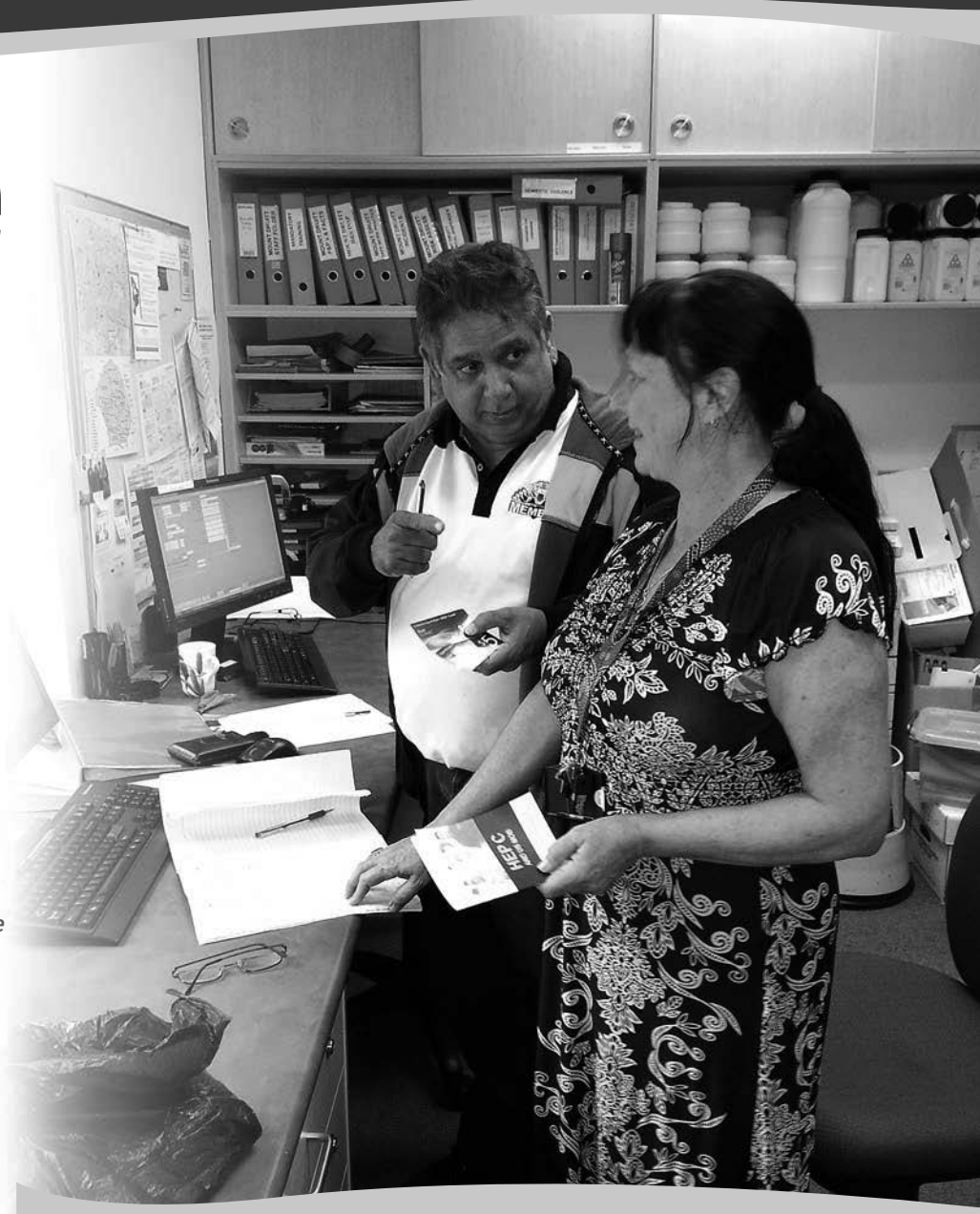
# Peers drive hepatitis yarns



*Mount Druitt in Sydney's outer west has the largest urban Aboriginal and Torres Strait Islander population in Australia, and around 30 per cent of the clients accessing the Mount Druitt Needle and Syringe Program (NSP) identify as Aboriginal and Torres Strait Islander. The DEADLY LIVER MOB project operates out of the Mt Druitt NSP, co-located with the Sexual Health Clinic. Recruitment into the project targets existing Aboriginal and Torres Strait clients, plus their family, community and drug-using networks. It is increasing access to services by populations previously unseen by the services, and is a good example of using innovative methods to increase coverage within priority populations.*

An award-winning peer-driven hepatitis intervention for Aboriginal and Torres Strait Islander people is drawing in a vast "yarning up" network stretching from Mount Druitt in Western Sydney to beyond Bourke and even into Queensland.

Aboriginal Hepatitis Worker, Kerri-Anne Smith, and Aboriginal Sexual Health Worker, David Webb, pictured right, were initially sceptical that financial incentives were an appropriate way to bring people into a health service.

But, they now support the use of incentives and are amazed that a system in which Coles vouchers are offered is seeing several generations of family members attending hepatitis education, testing and counselling based on 'seeds' established through an NSP.

David, who is a direct descendent of Maria Lock of the Boorooberongal clan of the D(h)arug peoples*, said they had noticed that some of the people attending the clinic learnt of the free testing from friends and relatives gathered for funerals hundreds of miles away.

"We ran it through the existing injecting drug users that we know, and it has just spread from there," said Kerri-Anne who is also Aboriginal.

"We have reached so many places. It is run from Mt Druitt, and most of our clients are from around here, but we also have people come from Gulargambone on the central west plains of NSW, also Moree, Inverell and Armidale in the north, Brewarrina and Bourke out west, and north coast Port Macquarie - even from Kiamba and Toowoomba in Queensland.

"People come to visit us, and tell their family. The one from Armidale, she was here for a couple of days and came back three weeks later with a couple of people [she had recruited]."

Deadly Liver Mob uses funding from NSW Health that is dedicated to improving Aboriginal and Torres Strait Islander people's access into Hep C treatment. A team effort, it was instigated by the senior Hepatitis Health Promotion Officer and former nurse, Louise Maher, along with NSP Team Leader Sasha Kaplan, and Harm Minimisation Coordinator Felicity Sheaves.

Felicity said that in 2013, around 30 per cent of NSP client interactions were with people who identified as Aboriginal and Torres Strait Islander.

She said 395 people had received the hepatitis education and more than three quarters of those were offered sexual health screening which includes hepatitis tests.

Hepatitis NSW Chief Executive Officer, Mr Stuart Loveday, said it was innovative in the way that this local-level project "directly engages Aboriginal people right at the forefront of the hep C education and prevention efforts."

Felicity said the voucher system uses Respondent Driven Sampling (RDS) is a form of peer-driven intervention which draws on the work by Professor Douglas Heckathorn and Professor Emeritus Robert Broadbent, both from the United States [see 1, 2, 3].

Felicity said that, on preliminary figures, the model was looking like it would be cost effective, with an estimated average of $43 spent on each participant.

David added: "Every penny is worth it. They are going out and spreading the word saying this is what you are going to get, and it is working."

*Continued on page 4*

*This edition of the Bulletin explores ways in which some Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services are working to better service Aboriginal and Torres Strait Islander people who inject drugs.*

*More can be done to have Needle and Syringe Programs integrated throughout the Aboriginal Community Controlled Health network, which includes more than 150 member organisations.*

*As our stories from the frontline show, there are leadership examples that provide inspiration for us all to learn from. Anex greatly appreciates the advice and guidance of Torres Strait Islander Professor Kerry Arabena and Aboriginal Scott Wilson in the development of this special edition. However, any errors made are those of Anex.*

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Anex's vision is for a society in which all individuals and communities enjoy good health and wellbeing, free from drug-related harm. A community-based, not-for-profit organisation, Anex promotes and supports Needle and Syringe Programs (NSPs) and the evidence-based approach of harm reduction. We strive for a supported and effectively resourced NSP sector that is perceived as being part of the solution to drug-related issues.

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*In this edition the term 'Aboriginal and Torres Strait Islander people' is used to refer to and recognise the two unique Indigenous populations in Australia. However, there are instances where Aboriginal is used by itself because that is the preference of those people being referred to and/or is the established terminology used by the services or service areas in question.*

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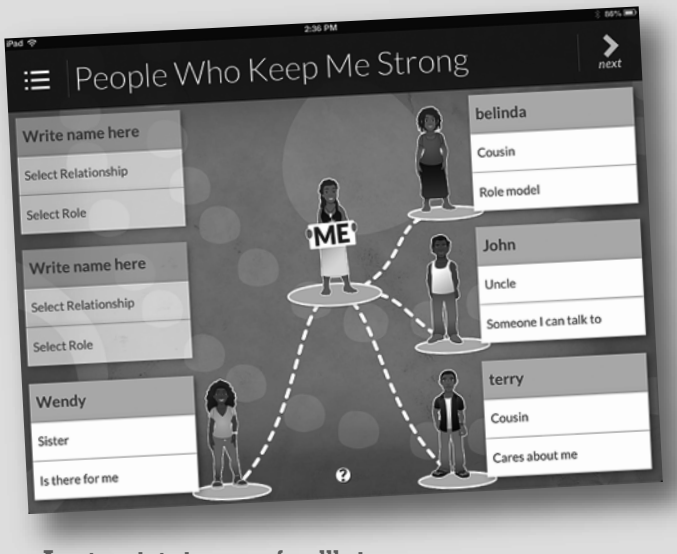
# Briefs




## App taps into images of wellbeing

An iPad app to gauge mental wellbeing developed by and for Indigenous Australians aims to deliver effective, low-cost substance misuse and mental health interventions. It is an example of how innovative use of technology platforms may become part of health promotion strategies to assist the health workforce engage people with co-morbidities, which would logically include many NSP clients.

The app, which is being trialled, has an engaging graphic interface and a question-and-answer format, which it is hoped will bridge cross-cultural and literacy gaps, especially in remote communities.

Developed and funded by the Menzies School of Health Research in partnership with the Queensland University of Technology, the Stay Strong app aims to help health staff assist clients conduct a stock-take of the positives and negatives in their lives and set goals for their self-improvement.

Aboriginal and Torres Strait Islander people are exposed to complex stress factors like the deaths of a family members or friends, alcohol or drug problems, trouble with the police and violence and Australian Bureau of Statistics data shows them to be two-and-a-half times more likely to die from "intentional self-harm" [37].

Menzies Associate Professor Tricia Nagel said the AIMhi (Australian Integrated Mental Health Initiative) Stay Strong App will help service a range of health workers and clients.

"It's important to remember that mental health is more than just treating mental illnesses; it is about our overall emotional wellbeing, which is so important for positive health and life outcomes," she said in a statement.

Clients are first asked to identify the people in their life who help keep them strong, their relationships and the role they play. They are then asked to identify their strengths in four areas of their life and this is represented graphically as leaves on a tree. As they add more strengths, the leaves grow stronger and healthier. Similarly, clients are asked to identify areas of their life that diminish their strength. As they add worries, the leaves on the tree wilt and change colour.

"Clients are then left with a visual representation of the areas in their life where they are strong and the areas in their life where they are not as strong," Associate Professor Nagel said.

The app is designed to devise and suggest avenues for improvements and a summary of the resulting Stay Strong Plan to improve wellbeing can be emailed and printed to keep a record of the session.

Menzies and QUT are currently trialling the app with selected health service providers and the final product is expected to be publically available later this year.

*See At A Glance box on Page 7.*

## Indigenous people as proportion of NSP clients

There are six Aboriginal Community Controlled Health Organisations/Services in New South Wales and five in Victoria that are registered NSPs. There are about four in Queensland, three in Tasmania, two in South Australia one in the ACT and Western Australia.

The most recent published data from the national NSP annual survey found that nationally, 12 per cent of NSP clients identified as Aboriginal and Torres Strait Islander [4]. Only one Aboriginal health service that provides NSP services participates in that survey.

In 2012, the jurisdictions with the highest proportion of Aboriginal and Torres Strait Islander clients recorded in the annual NSP survey was the Northern Territory (24 per cent) measured across three NSP sites, followed by Victoria (14 per cent measured at six NSP sites), Tasmania at 13.3 per cent and New South Wales at 12.6 per cent [4].

It should be borne in mind that the annual NSP survey is, generally speaking, carried out in large-volume primary NSPs and most sites are in capital cities or some large regional centres.

According to the 2011 Queensland NSP minimum dataset, eight per cent of the 183,623 recorded service occasions in 2011 were with people who identified as an Aboriginal and Torres Strait Islander person. The report noted, however, that it may be an under-representation due to inconsistencies in data collection for Indigenous status across programs and missing data [5]. The ratio was also eight per cent (but a higher number) in the 2012 minimum data set report [6].

Not all jurisdictions routinely collect such data. One of the main findings of the Australian National Council on Drugs report into drug injection and harms within Aboriginal and Torres Strait Islander populations was that there should be better data collection systems so that a true measure of the depth of Aboriginal and Torres Strait Islander injecting drug use, and associated harms, may be available to funding bodies and service providers [7].

Peter Waples-Crowe from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) said it would be helpful if NSP services routinely collected information that would enable a better understanding of how common it was for Aboriginal and Torres Strait Islander people who inject drugs to access mainstream health services as well as the relatively small number of ACCHOs that provide NSP.

"This is a missing piece of the jigsaw," said Peter. "This data would help our advocacy for better services for Aboriginal people who used drugs, as well as promoting the need for closer partnerships between mainstream health services and ACCHOs."

## 'If they don't come here, where do they go?'

Wathaurong Aboriginal Cooperative in Geelong is taking a different approach to NSP provision by moving away from an over-the-front counter model.

Health worker, Kit-e Kline told the Bulletin that it was difficult for injecting drug users to ask for injecting equipment across the reception desk because people may know each other directly, or know of each other through kinship and social networks.

Furthermore, noted Kit-e, the physical layout of the service made confidentiality difficult, said Kit-e.

Kit-e said the co-op had placed information packs and boxes of sterile injecting equipment throughout the health service sites, including the maternal child health rooms.

She explained that this was that this is so that when a client who was an injector was engaging with the service on routine health matters the issues around injection could be raised at appropriate times.

The boxes are visible in the rooms.

"We are a close-knit community, and there are issues around the shame factor and of confidentiality," Kit-e said. "This way the service can be more discreet and more confidential."

Few clients were utilising the NSP option, she said. "If they aren't accessing here, where are they accessing?" she wondered.

"We are looking at doing some research for a month at one of the regular NSP outlets to help us understand how many Aboriginals in our community are accessing NSPs," Kit-e said.

# High but falling youth jail rates

Studies have shown again and again why young Indigenous people in particular must be priority targets for innovative justice programs.

On an average night, over half (53 per cent) of the young people in detention in Australia are Indigenous. And they are less frequently let off with a warning than non-Indigenous. Police charge Aboriginal and Torres Strait Islander young offenders at five to 10 times the rate of non-Indigenous offenders aged 10-14 years [33].

In addition studies show that Aboriginal and Torres Strait Islander people are less likely to be referred to diversion programs [34]. The reasons for this were canvassed by the AIC in a 2008 study. It found Aboriginal and Torres Strait Islander offenders were:

- less likely to make an admission of guilt - a key prerequisite for diversionary programs;
- more likely to have multiple charges;
- more likely to have previous criminal convictions (particularly for violent offences);
- more likely to have drug misuse problems outside drug diversion programs, such as alcohol and inhalants; and
- more likely to have a co-existing mental illness (Juodo 2008).

Unfortunately, just one of these issues can often exclude offenders from most diversion programs.

But there have been wins.

A report released by the Australian Institute of Health and Welfare (AIHW) in August 2012 noted a decline in Aboriginal and Torres Strait Islander youth detention rates across Australia [35].

Research bears this out. A study of young people in New South Wales, South Australia and Western Australia found that those who are diverted were less likely to reappear in the criminal justice system than those who appeared before a court [36].

# Remote clients stock up for health

*Naomi Evans at work in Cairns.*

Injecting drug users in rural Australia who do not have a needle and syringe program (NSP) just down the road are finding strategies for ensuring they and their mates have enough equipment to last extended periods between visits.

Jason Savo is a community support worker with Alcohol, Tobacco and Other Drug Services (ATODS) at the Innisfail Hospital in north Queensland dealing with Indigenous NSP clients.

Most of his clients come from outlying areas which means people must stock up for themselves and will often pick up for their friends.

In Queensland, the official limit on the number of needle and syringes a person can pick up in one encounter is 50. But, where "extenuating circumstances" apply it can be higher. Being a rural or remote service is one such extenuating service.

"We're a rural and remote NSP - we cover from Tully to Mission Beach and Babinda. We're only (formally) allowed to give out 50 needles per client, but knowing our clients travel from these more distant areas we allow a little bit more than that." This is a harm reduction strategy that is pragmatic and adjusted to the needs of remote clients.

Other NSPs that cater to wide catchment areas adopt similar approaches to clients that are known to travel in from more remote areas. For example, Cairns NSP supplies much of far north Queensland and Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander injectors alike routinely collect as much equipment as they can while in town, says Naomi Evans, from Youthlink.

"We do get regulars that just come in and get the five-packs or the 20 packs. But then people get larger numbers for farther out. A lot of it has to do with distance and generally people like to get bulk.

"If they're within the Cairns region they can get 50 max, and for rural areas we do 100 max. It can be tricky for people, especially when they're living far away. It's essential if they live four or more hours drive away and if they have to rely on others for transport," she told the Bulletin.

"They may have only borrowed a car and they may not have access (to an NSP near where they live) so that can be a bit tricky. It's better to have more (injecting equipment) than less."

Unpredictable weather, including natural disasters, can cut off small communities. This happened in Cairns "a couple of years ago", according to Naomi.

The vagaries of the weather further isolated many of her clients, and had such a dramatic effect on NSP supplies that she now has additional back-up stock to cater for natural disasters.

"When we had floods and, not only could clients not get to us (but) we couldn't get stock in for a month. So now I try and keep at least two months' supply on hand."

In order to help people qualify for as much clean equipment as possible she suggests that if they want more than the daily limit they can bring people along.

"I get people coming from Townsville and Ingham and I do get some from the (Torres Strait) islands as well. I guess with small towns there can be some concern with confidentiality, not with accessing but with being seen accessing. That's the same with people up at Cooktown. They do have access to injecting equipment but I guess it's that confidentiality thing (why they come to Cairns)."A 2008 report for the Council of Australian Governments Multilateral Group on Needle and Syringe Programs heard there were "lots of kids injecting speed on the Cape". However, clean injecting equipment was hard to come by on Cape York even though hospitals at Weipa, Lockhart River and Cooktown had NSP services.

Cairns was regarded as the best source of equipment for injecting drug users from the Cape York area. The report acknowledged that people visiting Cairns could be asked to bring back equipment for others [27].

Even in large metropolitan areas, many NSP clients, who often live in relatively small, close-knit circumstances which make privacy and anonymity difficult, can be wary about services. This anxiety can make peer distribution important in avoiding sharing or re-use of equipment.

Michael Honeysett, the Aboriginal NSP worker at Turning Point in inner-city Melbourne, said many clients collected injecting equipment for a group to avoid making too many trips to the service.

"(Peer distribution) happens across the board, but it does happen more with my mob," Michael told the Bulletin. Except he has to be very alert to the possibility his being Aboriginal may equally drive away young Aboriginal injectors.

"Because you have a community relationship it can be a hindrance. A young bloke might come in and see 'good old Uncle Mick' (at the NSP counter) and they take off because they don't want you to know what they're up to."

Jason acknowledges that being an Indigenous staff member can be a positive for some clients, for others accessing the Innisfail hospital NSP can be seen as a threat to their privacy. He was brought up in Innisfail and sometimes people enter who know him and are worried their drug use may become town gossip. He takes care to let them know "whatever happens in the NSP stays in the NSP".

"You have to build up a rapport so that when they come in they know you. Our service is a voluntary service so if they want help we can provide it for them when they're ready. We don't force anyone," said Jason.

NSP workers and drug users report that the "underground" NSP has always existed. Nevertheless the law as it stands potentially criminalises peer-to-peer distribution.

Naomi Evans says she makes sure clients are aware of the law about secondary distribution and their rights and responsibilities regarding possession of injecting equipment.

# Outback yarns about reducing harms

Queensland Injectors Health Network is increasing its work with Aboriginal and Torres Strait Islander communities. The Bulletin spoke with a rural Aboriginal Health Worker and two QuIHN staff after they spent a week outback as part of community dreaming and planning.

This cooperation around harm reduction messages became a two-way street in learning.

Tight country town networks can be ignited to promote stronger engagement with illicit drug use problems, even amidst anonymity worries that amplify stigma.

That's a learning that Queensland Injectors Health Network (QuIHN) outreach worker Tegan Nuckey took away from a week spent with outback Cunnamulla Aboriginal Corporation for Health (CACH), where she and colleagues met with Aboriginal elders, police, the local council, schools and the full range of health services.

Cunnamulla is a town of around 1200 people roughly 700km south-west of Brisbane.

Sexual Health worker at CACH, Ann-Marie Mitchell, invited QuIHN to participate in the Unity Dreaming Festival in February.

Like most Aboriginal Community Controlled Health Services/Organisations, CACH does not have an NSP program, but works with injecting drug users as part of other health offerings. Cunnamulla Hospital is an active member of the Queensland NSP, and according to one hospital health worker, the in-service training by QuIHN during the Unity Dreaming Festival was "great".

"I asked QuIHN to come out. Also (she invited), Queensland Positive People, and two of them came out too for a couple of days. Tony Coburn from Queensland Aboriginal Islander Health came too. He is a state-wide expert on blood borne viruses," said Ann-Marie.

She said the range of drugs available in the community included speed, marijuana, ice/amphetamines and prescription opioids, as well as others.

Tegan was accompanied by her QuIHN co-worker, Scott Dodd, who returned home to Brisbane, humbled by the way in which local Aboriginals' "dreaming" for a healthy and vibrant community brought young and old people together.

"I felt like they've got a plan and a dream for what's going to happen in the future, for 2015, 2020, 2030 etcetera. It's a long-distance future that they are dreaming; it's for a healthy and vibrant community," said Scott.

Ann-Marie said: "When they (Tegan and Scott) did (one of) their presentations, they did with the school kids, other services were there and elders were there too. They did a really good job. I think the elders learned a lot. Tegan is a really interactive person and it was well received."

Tegan said she began to feel comfortable in the yarn circle after "I introduced myself to the elders and shared my story. Afterwards a few came up and yarned with me more. It was great."

Scott said he felt like he was "welcomed in, by the people we met there not just those who invited us in. And we really got to see how important some of the stuff we are doing is, because there are some big gaps out there," said Scott.

Ann-Marie said: "It's always good to have the city mob come out here and share experiences because they tend to see a lot more of illicit drug use than us and have more access to specialist knowledge.

"We can learn a lot. In turn, they take away new insights into the difficulties faced in the rural areas where access to services is less, and there is far greater fear amongst drug users about being exposed," said Ann-Marie.

Scott said that apart from specific in-service trainings with organisations, such as police and council, "the drug use stuff was touched on a number of different times".

This included being invited into "the yarning circle. Sitting around, we talked more about hepatitis, BBVs and a bit about safer disposal, needle stick injury. And we were available for people to talk to as well."

Scott said he and Tegan were timid when speaking with elders. "It was slowly, but that's the way it goes in those smaller communities ... we got to say some stuff in the yarning circle. So at that level we engaged with the elders."

Anne-Marie said: "Even though this is a sensitive area, if we handle it culturally appropriately we can find space to share ideas and break down some barriers."

*Continued on page 6*

# A tale of complex local sensitivities

*Needle and Syringe Programs can sometimes entail complex stakeholder management, especially where local residents believe, incorrectly, that such programs attract drug activity. Redfern is an example of an inner city community where there are divergent views which sometimes spill out into open public debate.*

Redfern has been the spiritual home of radical Aboriginal politics since at least the 1970s. The Redfern Black Power movement was the epicentre of Aboriginal politics during the 1970s and '80s and a beacon of hope for young progressives. However the hopes of the local Aboriginal community soured in the 1990s when Redfern became one of Sydney's biggest street drug markets alongside, Kings Cross and parts of Cabramatta.

Health authorities responded in 1993 with a mobile Needle and Syringe Program (NSP) van that would park in appropriate locations during the week. Unfortunately in the midst of rampant drug use, with street heroin dealing and injecting in the open, some locals and community leaders came to see the van and its provision of clean needles and syringes as part of the problem.

The intervening years have done little to dissipate the tension between the supporters of harm reduction and its opponents in the Redfern community.

In 1999 The Sun-Herald newspaper published a front-page photograph of a 16-year-old boy being injected by another person in a syringe-littered Redfern gutter close by the mobile NSP as part of a series of articles about young people using kits from the service to shoot heroin. Health Minister Dr Andrew Refshauge immediately suspended the Redfern NSP program [8].

Kirketon Road Centre's (KRC) Dr Ingrid Van Beek recalls that the NSP was soon restored.

"The NSP was only suspended for a few days in the Block back in 1999 – KRC's outreach bus was contracted in to replace the local van service the day before the front page story after a tip-off. The bus provided primary health care advice etcetera without NSP for several days until we refused to continue this on the basis of having a duty of care to provide NSP, which was heeded within a few days," Ingrid told the Bulletin.

In 2004 Redfern captured the national headlines when it erupted in a riot during which more than 50 police and local residents were injured and the railway station was set on fire.

The violence led to extensive soul-searching over community dysfunction, and the role of NSPwas on the agenda. The New South Wales parliamentary inquiry on the riot heard local Aboriginal leaders vent their frustration at crime and drug use. And in their minds the neighbourhood NSP was both a symbol of and catalyst for a crumbling social order.

NSP services have been present in Redfern for over 20 years, with some changes from time to time in management structure and specific location.

However, local leader Mick Mundine said the NSP "was like a honeypot for drug addicts and dealers" and that it promoted a culture of tolerance of illicit drugs.

He said the NSP had contributed to Redfern's reputation as a centre for injecting drug use and its presence was negating the community's attempts to eradicate drug use in the area.

Mr Mundine is Chief Executive Officer of the Aboriginal Housing Company (AHC), which has administered The Block, a group of 41 houses, since their purchase by the Federal Government in 1973 to protect longstanding Aboriginal residents. The purchase and its symbolism as the first successful native land rights claim drew many more.

Mr Mundine told the parliamentary inquiry on the riots that he had tried to get the NSP closed for years and the service had "undermined every effort the AHC has made to remove the drug industry from The Block".

Mr Mundine's opposition to NSP is consistent with the views of some prominent Indigenous figures including Noel Pearson, who has applauded the Redfern campaign against the needle exchange service [9]. In a column in the Australian last year Mr Pearson described the fight against the NSP as "a huge ideological and political struggle".

Mr Pearson laid out his criticisms of harm reduction in his 2001 Charles Perkins Memorial Oration "On the human right to misery, mass incarceration and early death" in which he said addressing substance misuse was the key to eliminating Indigenous disadvantage [10].

"We solve grog and drugs, we will solve everything else, or at least be on our way to solving them," he said.

The Redfern mobile NSP was suspended and reinstated and moved several times. It was finally closed in October 2004. In announcing the van's closure Premier Bob Carr said he understood public feelings were running high about needle and syringe programs.

"While I understand some peoples' reservations about the needle and syringe program, as a community we must recognise that this program has resulted in Australia having some of the lowest HIV and hepatitis C rates in the world," Mr Carr said at the time.

"Authoritative studies show that Australia's early adoption of needle exchange programs has prevented more than 25,000 HIV infections and 21,000 cases of hepatitis C between 1991 and 2000.

"We cannot turn our backs on the evidence which tells us these programs help prevent the spread of these diseases," Mr Carr said.

### *10 years later opposition remains*

The opposition to NSP in Redfern has not waned with the intervening years.

In 2008 a syringe dispensing machine (SDM) was proposed for the former court house when it was being converted to a community health centre. A total of 20 community consultations were held throughout 2012.

Some Aboriginal leaders voiced their disapproval. Long-time resident and head of the Wyanga Elders Group, Millie Ingram, said she was worried the machine would attract people to Redfern solely for drugs. Mark Spinks, coordinator of Babana Man's Group, said he was concerned about the disposal of used syringes [11].

Nevertheless, the outcome of the consultation saw the installation of the SDM in front of the Redfern Community Health Centre in February 2013.

Kate Reakes, manager of the Harm Minimisation Program for the Sydney Area Health District said the SDM was part of the campaign to combat "unacceptably high levels of HIV and hepatitis C infections among injecting drug users in the Redfern area" [12].

The SDM will be subject to a 12-month evaluation by the University of Sydney.

Kirekton Road Centre Director, Dr Ingrid Van Beek, said that "while community voices have not been unanimous in support of the [NSP] service, its continuity reflects the public health recognition that if people inject drugs, regardless whether they are Aboriginal or non-Aboriginal, it is better that they at least avoid the risk of life-threatening infections by using clean equipment".

# Peers drive hepatitis yarns

## *Vouching via vouchers: peer-driven yarning*

*Known as Peer Driven Interventions, the approach the Deadly Liver Mob used comes from what started out as a research methodology known as Respondent Driven Sampling (RDS). Felicity explained how the system, which is a bit like a form of health promotion 'pyramid selling', is working:*

*"A 'seed' for this project is an Aboriginal or Torres Strait Islander person who has accessed the NSP," said Felicity. "The Aboriginal project workers opportunistically discuss the Deadly Liver Mob project with the potential 'seed' and invite them to participate in one-on-one hepatitis education for which they will receive a $20 Coles voucher," she said.*

*"Following the education, the 'seed' is then offered the opportunity to recruit up to three other Aboriginal people from their networks, for which they will receive another $10 voucher for each recruit and up to another $10 for passing on the key hepatitis messages.*

*"The idea is to get a critical mass of hepatitis C 'yarn up' among Aboriginal networks, in order to encourage participants to educate, recruit, get tested, think about treatment and be treated.*

*"The NSP is co-located with the Sexual Health Clinic and a partnership approach provides a great way to add value to the project by offering a further $10 incentive for hepatitis C screening, hepatitis B vaccinations and opportunistic sexual health screening."*

*For a good starting point to find out about the principles of Respondent Driven Sampling, visit the website http://respondentdrivensampling.org/*

*Continued from page 1*

David explained the combined "yarning up" and medical linkages in the Deadly Liver Mob: "If a person comes in they will get a $20 voucher if they come and get educated. Kerri-Anne will sit down and explain to them all about blood borne viruses, hep C, how do you get it, how do you avoid it, how to live with it.

"That bit happens in the NSP part. Then they can come and see me and if they want, they can go to the sexual health clinic for opportunistic screening where they can get tested for hepatitis A, B and C and STIs, as well as HIV," he said.

Kerri-Anne said Pap smear tests were also available, and "not one of the women who had come through had had regular pap smears prior".

She said there were some sexual health issues that were picked up that "wouldn't have been if they didn't come through".

Kerri-Anne and David said they have been surprised that stigma and shame hasn't seemed to be the barrier they initially felt it would be.

"As you know hepatitis has been absolutely shrouded in shame and stigma, and especially in the Koori community shame is a huge thing," Kerri-Anne said. "And in 'yarning up' with them in the education, and then 'yarning up with family and friends, we feel that stigma and the shame is being broken down."

Kerri-Anne referred to "one young fella who is one of our injecting drug users. He came in and had the education, then he brought his grandmother and grandfather in, and then his auntie, with no shame at all about it being run out of an NSP clinic.

"We've found that there is no shame; no-one has said: 'My God, I'm not going to bring my family here'," said Kerri-Anne.

Interestingly, the relatively low risk of hepatitis C transmission through sharing of toothbrushes had been a recurrent theme.

"In the Koori community here, sharing is caring and sharing toothbrushes and razors is okay. ... every single person we have recruited has told us about toothbrushes and razors.

Even a 91-year-old man came through - his granddaughter brought him in, and he said: 'Oh, I'd better have the test'."

David explained how yarning up (talking) spreads the word so widely, because people moved around so much.

Almost 15 per cent of those who have come through the program are from outside the health catchment, with dozens from regional NSW and even parts of Queensland, David said.

"Someone who lives in this district has been through this project and when they have relatives visiting, or in a few cases, when they have gone to a funeral out (regional) west, they've brought their family members back and brought them into us.

"Some just happened to be coming back, some of them come back for the education and/or they know they have the virus and want to get into treatment. They travel a long way," David said.

In the case of the funeral, "I think it was from Moree. One of them in particular knew he had hep C and he came down to find out what he could do. There are not many liver specialists out in the country. So if you live out at Bourke, or Brewarrina or Lightning Ridge, you've got to travel to Dubbo or Bathurst to get treatment, and that's hundreds and hundreds of miles."

### *Endorsement of incentives*

David said he was initially sceptical of the need for using incentives, or that it would even work. "When I first started it, I thought it was wrong to do an incentive. I was not a big believer in it.

"Now it has just changed me. I am a firm believer and I think it's a way to go. It has taken us all by surprise. We envisaged it may run for six months, but we are up to nine or 10 months and it doesn't even look like slowing down. When you think it's going to be a quiet day, you might get five or six people come in to get educated. The highest was 21 in one day, and it's only run on a Monday and Friday."

David said a sense of ownership, and even a certain empowerment, was a factor too.

"I say (to clients) that it's Aboriginal money for Aboriginal people - it's yours. We are putting it back onto the community to take ownership. For them to get those vouchers, they have to go out into the community to recruit ... they are taking hold of it and they are running with it because it is their project."

He had been involved with all kinds of traditional health promotion strategies including outreach, giving speeches, health tents - "normal stuff".

"This one, we never ever promoted it. We rocked up and told a few people, and the next thing you know we were inundated. They just started coming - all by word of mouth."

* Maria was the first Aboriginal woman to be legally married to a white person, when she married Robert Lock on January 26, 1824. Maria, who proved herself to be a successful and accomplished woman, has, to this day, a Hawkesbury Hospital medical ward named after her.

## *Hepatitis NSW applauds the work*

*Hepatitis NSW Chief Executive Officer Stuart Loveday says:*

*"With higher rates of hep C and hep B than the non-Aboriginal Australian population, it's great to see Aboriginal and non-Aboriginal staff in a mainstream NSW Local Health District working directly and so effectively to help generate a more aware Aboriginal community and run a project which led directly to increased assessment for and uptake of hep C treatment among Aboriginal people in Western Sydney.*

*"Improved liver health for Aboriginal people was exactly the outcome this award winning project aimed to and actually achieved. This work deserves replication across NSW and elsewhere. Hats off to the Deadly Liver Mob team and the younger and older Aboriginal people who took part."*

*The Deadly Liver Mob project has won a Hepatitis Australia National Award for Innovation in Hepatitis Health Promotion, as well as being awarded The Western Sydney Local Health District Chairman of The Board Quality Award for Innovation.*

# Key reminders of NSP value

### *Needle and Syringe Programs do not increase injecting drug use*

Needle and Syringe Programs are established in areas where injecting drug use is already occurring. A global review indicates that illicit drug injection occurs in almost 150 countries [13].

No study has ever found that the introduction of a Needle and Syringe Program contributed to increased levels of injecting drug use. In fact, studies have reported decreases in drug use following the introduction of Needle and Syringe Programs because they can act as a referral point for clients wanting to begin drug treatment [14].

A World Health Organisation review concluded that Needle and Syringe Programs do not encourage more frequent injection of drugs or increase the recruitment of new injecting drug users. The World Health evidence found that:

> *"Specifically and after almost two decades of extensive research, there is still no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting"* [15].

Injecting drug users who attend Needle and Syringe Programs are more likely to reduce or stop injecting drugs than those who do not attend [14].

### *Referral pathways*

It is well established that NSPs are able to refer clients into drug treatment services [6]. They are often one of the few points of formal contacts with health systems where people who inject drugs feel comfortable enough to discuss their issues with professional staff. Leading United States supporters of recovery-oriented systems of care, Dr Arthur Evans and William White, have recently said:

> *"harm reduction strategies can also be viewed collectively as a platform or point of access for promoting long-term health, and, for those with severe alcohol and other drug problems, long-term personal and family recovery* [16].

Dr Evans, and his colleagues who included leading recovery writer, William White, represent a high-level endorsement from people historically not regarded as being publically supportive of NSPs. In short, even those people from a treatment perspective that places emphasis on abstinence recognise NSPs importance.

### *Blood borne virus prevention*

It has been demonstrated by leading Australian researchers that more than 32,000 cases of HIV and close to 100,000 hepatitis C transmissions were prevented through NSP programs in Australia between 2000-2009 [17].

The HIV rate amongst drug injectors surveyed in the annual NSP surveillance survey puts it at less than one per cent overall. This compares with rates at well past 50 per cent in some parts of the world where NSP programs are non-existent or were very slow to begin [13,18,19].

- A very good resource that addresses questions concerning the value of NSPs is available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-kit-ques
- The Anex Factsheet which highlights the outstanding financial value of NSPs is at: http://www.anex.org.au/wp-content/uploads/2010/10/Fact_Sheet_NSP_Return_On_Investment.pdf

# Outback yarns about reducing harms

*Continued from page 3*

QuIHN Senior Program Manager, Health Promotion, Nick Alexander, said QuIHN was increasing work with Aboriginal and Torres Strait Islander populations, particularly those in remote areas. "We are doing this up to Weipa shortly, out to Mt Isa, out to Townsville in a rehab centre. We are racking the miles," Nick said.

"Our aim is to build on these networks. I think we could go out there bi-annually to start with, and do rural loops through a week. Hopefully, with more outreach like this we will see greater linkages and understanding of the value of helping drug users.

"The end goal is greater access to not just needle and syringe programs for blood borne virus prevention, but all the key health messages including overdose prevention, safe disposal, needle stick injury prevention and support for people seeking treatment."

Scott saw the close-knit community as having strengths, but "if there's discrimination there it's amplified. Things like confidentiality are more difficult when everyone sees everyone else."

He said that as he listened to people describe a vision for a healthier community, he "spontaneously" re-framed regular harm reduction messages to fit within the narrative he was immersed in.

"It's a long-distance future that they are dreaming," said Scott. "What we do as harm reduction, for me, it's more a part of the interim in particular, in getting from here to there.

"We can offer ways to help us look out for each other to deal with what is here now while they are still dreaming for whatever future they want ... we fit in this context.

"If people are left behind it won't be a well functioning community (in future) ... from a harm reduction point of view, people can be brought along to be a part of dreaming for the future," he said.

For Tegan, who had not done a similar rural outreach before, this was a major learning experience about how city-based services could do more rural outreach: "I think it is really important for city organisations to get out and support our rural communities. These communities are there and they should be offered the same support as the bigger populated areas.

"I think it's important to be asking rural communities what they need and try and work alongside them in a culturally appropriate way. It is important that the community and elders be involved and asked about what they feel the community needs. These communities are strong and need to be listened to."

# Queensland NSP clients uniformly disadvantaged

Being one of the first studies of injecting drug use with a high proportion of Aboriginal and Torres Strait Islander participants, the Queensland Injecting Drugs Survey (QuIDS) has uncovered important parallels between different communities. It shows Aboriginal and Torres Strait Islander Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander injecting drug users are burdened by similar levels of social disadvantage. But, from the perspective of protective factors, they may have a form of advantage over non-Indigenous people because of the very strong kinship networks. This can be borne in mind by NSP workers when managing Aboriginal or Torres Strait Islander clients.

The most recently published national NSP survey (2008-12) found that 12 per cent of all injecting drug users surveyed identified as Aboriginal and Torres Strait Islander [4] while the figures for Queensland was also 12 per cent. Indigenous Australians account for 2.5 per cent of the general population

The Queensland Injecting Drug Survey (QuIDS) recruited 294 Aboriginal and Torres Strait Islander and 275 non- Aboriginal and Torres Strait Islander injectors in 10 urban and regional centres across Queensland through NSPs.

The study found that Aboriginal and Torres Strait Islander injectors were found to have significantly greater social capital, an important factor when considering the potential for a drug user to make changes to his/her life lives. Aboriginal and Torres Strait Islander were less likely to have slept rough (63.6 per cent vs 73.3 per cent) and almost three times more likely to be living with other people (89.2 per cent vs 69.5 per cent) which points to them staying with family if not being in a relationship.

The researchers found that on employment, income and imprisonment history, Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander injectors were similar. For instance, two thirds of both groups were on less than $400 a week, three quarters were out of work and half had been imprisoned. Both groups reported that they were18-19 years old when they first used drugs.

On health many parallels were again found between the two groups. Similar levels of mental ill-health were found, with over 70 per cent having been diagnosed with a mental illness. Both groups reported similar levels of physical illness (68.8 per cent Indigenous vs 68.7 per cent) and trauma experienced in the previous year (83.4 per cent Indigenous vs 78.2 per cent).

Aboriginal and Torres Strait Islander respondents were more likely to have shared injecting equipment in the month previous (35.6 per cent vs 18.9 per cent), but the hepatitis C prevalence amongst Aboriginal and Torres Strait Islander people who had shared was 58.1 per cent compared with 67.5 per cent amongst non- Aboriginal and Torres Strait Islanders.

# Diversion programs promised top-tier support

Indigenous Australians are 15 times more likely to be imprisoned than non-Indigenous [20]8, Last year 27 per cent of all Australia's prisoners were Indigenous, a demographic which represents just three per cent of the population [21]. Drug injection in prison is common and Indigenous prisoners are among those who are initiated while incarcerated, and places where there are high levels of needle sharing [22-24].

Reducing the disparity in the prison rate was declared a priority by the Royal Commission into Aboriginal Deaths in Custody final report in 1991.

Keeping people out of prison spares people being exposed to the harsh effects of incarceration, such as social stigmatisation, poor health and limited job prospects [25]. Diversion schemes work at various levels across all jurisdictions and range from police cautions for minor offences to pre- and post-sentencing arrangements and dedicated Indigenous courts.

The Indigenous courts are the form of diversion with the most Indigenous community involvement, offering the greatest level of cultural empowerment. However, there are mixed views regarding both the appropriateness of Indigenous courts and their effectiveness compared with the mainstream court system.

The first Indigenous urban court was convened in Port Adelaide, South Australia in 1999 and was eventually called the Nunga Court. Based on this model in 2002 Victoria set up the Koori Court, Queensland the Murri Court and circle sentencing courts opened in New South Wales.

Although details differ in each jurisdiction, informality is a key to Indigenous courts, sentencing is collaborative and culturally more inclusive.

However, the value of Indigenous courts has come into question in some jurisdictions.

Evaluations of circle sentencing in NSW [26], Queensland's Murri Court [27], Western Australia's Kalgoorlie Court [28] and Victoria's Adult Koori Court [29] have all been conducted. The authors said the courts work, but none could unequivocally say they met the primary goals of reducing either the seriousness or the rate of reoffending except for the Koori Court, which has reportedly helped reduce recidivism.

The NSW evaluation of the circle sentencing court found defendants reoffended at the same rate as defendants in mainstream courts.

Report author Jacqueline Fitzgerald said the evaluation suggested circle sentencing had "no effect on the frequency, timing or seriousness of offending".

Similarly the Queensland Murri Court evaluation found no short-term impact upon the rate of Indigenous reoffending.

After the Liberal National Party (LNP) won government in Queensland it ceased funding for the Murri, Drug and Special Circumstances courts in December 2012. The Queensland Attorney-General and Minister for Justice, Jarrod Bleijie, said the court program was ineffective and did not justify the amount spent to keep it operating [30].

Some Indigenous activists have also criticised the courts as being too lenient. Professor Marcia Langton, Chair of Indigenous studies at Melbourne University, said it was outrageous that men who assaulted women were given lenient sentences in Indigenous courts [31].

"For some reason these men are regarded as victims who need to be treated gently and mollycoddled by the court system," she said.

Her criticisms were echoed by other Indigenous activists, including Dr Kyllie Cripps, a law lecturer at the University of NSW, and Leanne Miller, former Chair of the Indigenous Women's Legal Resource Group in Victoria.

Federally there does remain high-level support for diversion programs to help reduce Indigenous offending and incarceration. Warren Mundine, the head of Prime Minister Tony Abbott's Indigenous Advisory Council has promised to advocate for mandatory diversionary programs to push Indigenous juvenile offenders into jobs and education.

"Send a juvenile offender to detention and in most cases you have them for life; they'll invariably be in and out of the system forever. However, put them into a diversionary program where they instead go into a job or education that they must complete instead of jail and in most cases you never see them again," Mundine told The Australian newspaper [32].

# Anex stays strong in new Penington Institute

PENINGTON INSTITUTE

Anex has been renamed the Penington Institute and maintains its workforce development roles and its strong voice for Needle and Syringe Programs.

Cutting edge thinkers joined Chief Patron Sir Gustav Nossal AC CBE at University of Melbourne Law School for the launch of Penington Institute on April 28.

Victorian Minister for Mental Health Mary Wooldridge officially launched the Institute, named after Emeritus Professor David Penington AC who led Australia's world-leading response to HIV/AIDS and is a long time campaigner for a rational approach to drugs.

Community activists and frontline service workers from Needle and Syringe Programs were there in force, reminding everyone that our communities are our greatest asset.

The audience included leaders in medical, legal and business communities, politicians and philanthropists.

Penington Institute Chief Executive Officer John Ryan said: "The Anex program stays a strong and trusted program of the Penington Institute, remaining close to its roots in the leadership of Australia's needle and syringe programs.

"Anex staff will continue to deliver training and other workforce development to this vital public health program, acknowledged for having saved tens of thousands of lives by reducing blood borne virus transmission."

*Reflecting: Sir Gustav Nossal AC CBE, David Penington AC, John Ryan, Robinvale frontline worker Lisa Taggert and Victorian Minister for Mental Health, Hon. Mary Wooldridge MP, as they listen to Professor Steve Wesselingh (inset left) at the Penington Institute launch.*

Penington Institute is committed to:

- ***Enhance awareness*** of the health, social and economic drivers of drug-related harm.
- ***Promote rational, integrated approaches*** to reduce the burden of death, disease and social problems related to problematic substance use.
- ***Build and share knowledge to empower*** individuals, families and the community to take charge of substance use issues.
- ***Better equip front-line workers*** to respond effectively to the needs of those with problematic drug use.

In his speech, Professor Penington acknowledged the important contributions made by the organisation in its earlier incarnation as Anex in national leadership of the needle and syringe program and other harm reduction strategies. These programs saved many lives over the years, and have been socially and economically productive in reducing the costly incidence of HIV and hepatitis C infection in Australia.

John Ryan thanked Professor Penington for agreeing to lend his name to the Institute.

"He inspired Australia's evidence based and world leading approach to HIV prevention, he inspired the diversion away from the criminal system for people caught with small amounts of drugs," said John.

"He inspired in me and many others a determination: to ask what are the most efficient and effective ways to manage drug problems, and then to get on and do it.

"Professor Penington has a head for the evidence AND a big heart for the suffering of people affected by problematic drug use, individuals, families and local communities. I think ultimately, he is all about finding ways to enhance human dignity," John said.



*Above: Chris Puplick AM and Dr Ingrid Van Beek AM were among the hundreds at the Penington Institute launch.*

"He inspires us to bring substance and reason to the debates we have to have about drugs policy in Australia."

With conviction and compassion, Lisa Taggert, from Robinvale and District Health Services on the Murray River, spoke about the impact of drugs on her community and how with the professional support of our staff she was able to make a difference in people's lives.

Visit www.penington.org.au

# Health and Social Indicators at a glance

Hepatitis C and B are but two of the chronic diseases which overall, as the Prime Minister's recent Closing the Gap report outlines, contribute around 70 per cent of the gap in Indigenous health outcomes. While disparities are being reduced, as the key points below show, there are real needs to see that drug injection should not be regarded as separate to broader determinants such as environmental and socio-economic factors.

- Aboriginal and Torres Strait Islander males are likely to live about 11.5 years less than non-Indigenous men (67.2 yrs vs 78.7 years) [38]. An Indigenous female born between 2005-2007 was likely to live almost 10 years less than a non-Indigenous woman (72.9 yrs vs 82.6 yrs).
- Suicide was 2.6 times more frequently the cause of death for Aboriginal and Torres Strait Islanders than for other Australians [39]. Young Indigenous men take their own lives at almost three times the rate of non-Indigenous males, and suicide is the main external cause of death among that group.
- Aboriginal and Torres Strait Islander people were 17.2 times more likely to be incarcerated than non-Aboriginal and Torres Strait Islander people (2008). The imprisonment rate for Indigenous Australians increased by 34.5 per cent between 2000 and 2008.

Aboriginal and Torres Strait Islander people comprise 27 per cent of Australia's total prison inmates while forming 3 per cent of the general population.

In the period 2007 – 2011, a higher proportion of HIV diagnoses were attributed to injecting drug use amongst Aboriginal and Torres Strait Islander people compared with non-Indigenous (16 per cent vs. 2 per cent).

Aboriginal and Torres Strait Islander people were more than twice as likely to be hospitalised for "mental and behavioural disorders" than other Australians.

In 2012, the rate of newly diagnosed hepatitis C infection in the Aboriginal and Torres Strait Islander population was 166 per 100,000, four times higher than the 40 per 100,000 in the non-Aboriginal Torres Strait Islander population [40].

Analysis of more than a decade-worth of data from the annual NSP survey reveals higher rates of some risk behaviour amongst Aboriginal and Torres Strait Island survey participants than others surveyed and tested, including receptive sharing of needle/syringes (21% vs 16%), receptive sharing of ancillary injecting equipment (38% vs 33%), having been injected by others (18% vs 13%) and injecting in public (54% vs 49%) [41].

## A pointer to guidelines on cultural competency

A professional trainer in cultural competency in the area of Aboriginal and Torres Strait Islander health said that in "plain English, cultural competence is about understanding, empathy and awareness that translates into doing. If you are culturally competent you have understood the values of the particular culture, and this leads to a change in your approaches."

National Health and Medical Research Council (NHMRC) guidelines on cultural competence describe the term as meaning "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations."

To become more culturally competent, a system needs to:

- value diversity;
- have the capacity for cultural self-assessment;
- be conscious of the dynamics that occur when cultures interact;
- institutionalise cultural knowledge; and
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures [42].

The NHMRC guidelines provide a model for cultural competency that can be applied by health systems and organisations to improve health for all. To download the guidelines, visit http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/hp19.pdf

# On the level – working with Indigenous clients

One of Robert Assam's most unnerving experiences as an Indigenous man working in the community sector was being shown around Darwin's sobering up centres.

"This European girl was showing me around and every time I'd turn around she'd be staring at me! It was one of the most terrifying days of my life," said Robert

Her direct gaze was just her way of communicating but it made Robert anxious and afraid. Robert told the Bulletin how even after 18 years in the community sector the memory is still clear and he uses the incident to train workers how to get the best out of Aboriginal and Torres Strait Islander clients and what not to do in the process.

"Being stared at can be very confronting. It doesn't matter how urbanised or how educated you are, as an Indigenous person that eye contact can be very confronting. When someone is staring at us, it says we are in trouble," he says.

Robert's father is a Thursday Islander and his mother is Aboriginal. Robert has found his niche training people to deal sensitively with Aboriginal and Torres Strait Islander clients. And one of the least appreciated aspects of Indigenous communication is how troubling direct eye contact can be.

"Lack of eye contact is not a sign of disrespect. If someone isn't looking at you it's easy to think they're not listening or are a bit ashamed to talk. But when my aunties look at me, it means I'm in trouble and I'm gonna cop it."

Robert currently works with Queensland Health and says he very rarely encounters overt racism. But he says that in the health sphere, where clear communication is essential there can be little appreciation of the best approach to establish a useful rapport with Indigenous clients.

He tells workers to remember that the act of going to a health service can be quite difficult for anyone, but especially so for Aboriginal and Torres Strait Islander families.

"A lot of your experience in going to a service is a negative experience. Ask anybody how hard it is to ask for help, but with health matters you've got to be there and that's hard, so you've got your guard up."

Expecting direct answers to direct questions can create obstacles. Direct questions are likely to be considered rude, he says. And analogies are frequently used to deliver information.

"Our mob tell stories. That is how we communicate, that is how we teach, that's how we learn. So when you ask sometimes you'll get an answer in a roundabout way. So be patient and wait for a reply."

Don't fill in the silences, he adds because gaps are important. And physically crowding can be as off-putting as insisting on eye contact.

"Tell a little about yourself, be aware of gender issues and get permission to proceed, Robert says.

Communicating effectively with Aboriginal and Torres Strait Islander clients can be tricky because there can be a difference in mindsets in Aboriginal and Torres Strait Islander people's world views, he says.

"For example when Europeans meet they ask about occupation to establish status. When Aboriginals meet they ask where you are from, who your family is. As an Indigenous person it's about trying to live in two worlds and we need balance to do both," he said.

Growing up in Darwin led Robert to expect high levels of multicultural awareness elsewhere, but he was unprepared for the lack of understanding he found after leaving the territory, he said.

"I am quite surprised how little people know. Darwin is very, very multicultural; we've got Vietnamese and Greek and Chinese. But coming to Brisbane I was surprised at how little they know. They'll put on the smile and the face yet just by their conduct you can see they don't. I was thinking this is the big city and they must know more."

He still notices people are wary at getting physically close to him in public, especially on public transport.

"On a train I can have two empty seats beside me while the rest of the train is packed and people are standing. I can think it's not my problem, it's yours, but if you don't have good social and emotional wellbeing you can get quite angry.

"It all comes back to your own personal social and emotional wellbeing. If that's strong you can deal with that stuff. I've got to the stage where I just think 'I don't care - I've got two seats and it's your problem, it's not my problem'.

"But a lot of our mob who don't have good strong social and emotional wellbeing, they feel this stuff and maybe the only way they can deal with it is with alcohol and drugs or they get pissed off and get a bit angry."

On the other hand some people can romanticise Robert's Indigenous status and attribute to him some primitive, mythic quality he doesn't possess. He says he's also a 21st-century city person.

"Some can go too far the other way thinking that as an Aboriginal or Thursday Island person you must have all these cultural values and beliefs and put you too far back. I love being in both worlds because you get the benefits of both. They put you back there and you say 'hold on I'm just as urbanised as you are, but I just have this extra stuff'."

# Linkages vital in bridging service gaps

Strengthening the capacity for more Aboriginal Community Controlled Health Services (ACCHS) to be effective and holistic NSP providers is no easy task, according to NSW harm minimisation worker Bonny Briggs.

Bonny is harm minimisation worker with the Aboriginal Health and Medical Research Council of NSW, (AH&MRC) the peak body for the state's ACCHSs. Part of her job involves encouraging services to consider an NSP program.

An ACCHS is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).

Forging relationships between mainstream services and ACCHS (also known as Aboriginal Medical Services in NSW) is another part of her work.

One example would be making mainstream NSP services fully aware of the aboriginal health, welfare, legal, housing and other services in the surrounding community.

It has been a decade since the harm minimisation role was established in the AH&MRC and "it's (still) a challenge to try to get the philosophy of harm minimisation to be understood and acknowledged for what it is," said Bonny.

Currently six of the 49 ACCHSs in NSW are registered NSP service providers. It would be wrong to assume that it is an easy task for services to embrace NSP, said Bonny, because of similar issues around 'myths' that are in the non Aboriginal community.

*The Bulletin asked a regional Aboriginal Community Controlled Health Organisation why it is adamant it will not be involved in sterile needle and syringe distribution. The CEO, who personally believes the service should be involved, said the Board of Management was vehemently against it. The arguments of the Board against NSP are not complicated, the CEO said. They are: "it will encourage drug use and crime" and, at times, "it would be like sticking the needle in their arm". The town in question, with a population of about 2500, had one month last year where the local hospital's NSP distributed almost 6000 needles/ syringes, and the CEO said there was a significant drug issue in the town, where around a quarter of the population is Aboriginal.*

"It's all the old arguments, the ideas, the myths surrounding it ... that giving out needles means they are going to have crime, or have police attracted to those services. It's everything that has always been said in the past, and it still continues," said Bonny.

"That makes me want to be more creative around it. My clients are the ACCHSs, all 49 of them. It makes me more determined about gathering more evidence to support NSPs. We have to work with as many services and as many service providers as we can because at the end of the day injecting, as we know it, causes great harm," she said.

However, Bonny feels sometimes it is unhelpful if established and purpose-funded NSP programs were "sticking their nose in" by trying to urge hesitant or unwilling Aboriginal health services to adopt NSP. "Why are primaries trying to dictate to other services to do NSP when they are the primaries and have been funded for it?"

The priority currently was to help strengthen the capacity of those services that already have NSP as part of their overall programs, said Bonnie.

The Bulletin spoke with a senior state government public servant, not in NSW, who said while it was always good to have more services take up NSP, it was not essential. Mainstream services generally supplied Indigenous drug injectors with sterile equipment. But it was essential each ACCHS was fully aware of those services clients could access in their local area.

Bonny said: "Don't focus on it. The issue is making sure that we get good information out there and access to that information and the injecting equipment - most ACCHSs practice harm minimisation strategies for their communities, even if they don't provide NSPs. We need to focus on places that are doing NSP and making sure that we are looking after those services. It's got to be quality."

Quality service in part meant mainstream staff being sensitive to or culturally competent enough to avoid stereotyping Indigenous clients.

"You can apply it to not assuming or presuming that because a person is Aboriginal they come from maybe the worst set of circumstances. Maybe they do, but the thing is not to throw a blanket over it. But also being competent in knowing what services there are, or the questions you may need to ask or not ask.

"Just because a person has a background in NSP doesn't mean they are going to be the best NSP worker to work with an Aboriginal person because the client brings a whole lot of cultural baggage.

"It's like people working with adults and thinking we are going to apply that rule to young people. As you know, it does not work that way because there is a culture to youth."

She said culturally competent staff would result in client-worker interactions ending up being good for both. Services can be life-changing for clients but not if they don't return.

"That could be the thing that prevents them from accessing clean new needles."