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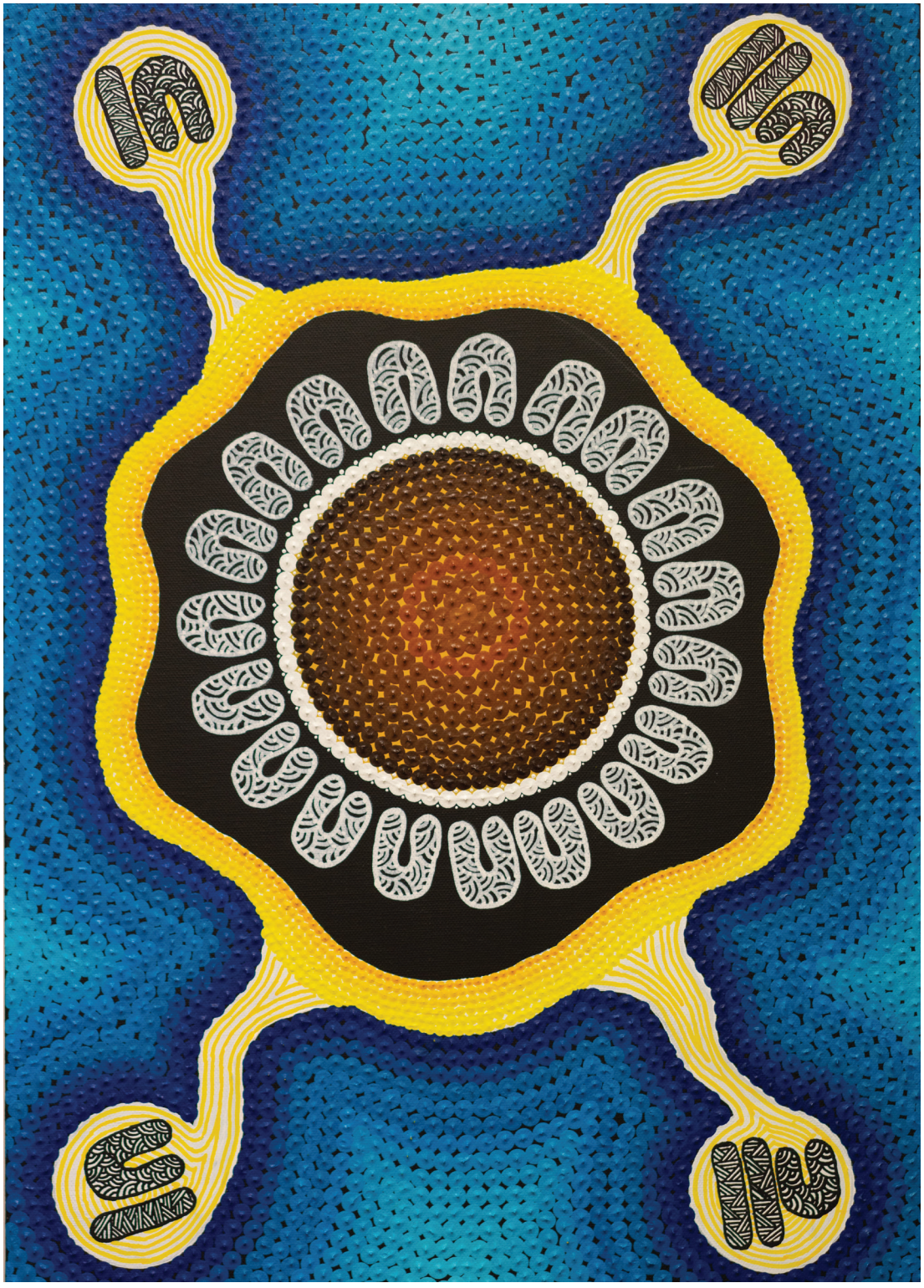

INCREASING ABORIGINAL PEOPLES' USE OF SERVICES THAT REDUCE HARMS FROM ILLICIT DRUGS PROJECT FINAL REPORT: APRIL 2021

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Corrigendum
On page 18, the original text was as follows: Currently, secondary supply is specifically legislated against in all states and territories in Australia.

The original text has now been changed to: Legislation does not specifically allow for secondary supply in all Australian states and territories.

The associated reference on page 56 has been updated.

Cover artwork by Mavis, 19 yrs female, who is Wongai, Yamaji and Torres Strait Islander.

Mavis has been painting for 3 years and has found her passion in creating pieces symbolic of connection and non-judgement, encouraging Aboriginal people to work through feelings of shame and seek support to be able to reconnect with others.

This piece is unnamed and encompasses concepts of sharing without shame.
A safe space. A yarning circle.
The colours represent sands and water, a transitional environment inclusive of different lands.
The symbols in the corners represent women and men coming together to share without judgement.

Report layout by Smith and Brown Design: smithandbrown.com.au

ACKNOWLEDGEMENTS

The *Increasing Aboriginal Peoples' Use Of Services That Reduce Harms From Illicit Drugs* project was funded by Healthway (project 32924). The research team is grateful for the generous involvement of the Aboriginal people who inject drug community and the wider community that support them, including needle and syringe program staff and volunteers. This project would not have been possible without the leadership of the Aboriginal Advisory Group and the contributions of the Co-Design Working Group and Project Advisors.

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The project team acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. We acknowledge the wisdom of Aboriginal Elders both past and present and pay respect to Aboriginal communities of today.

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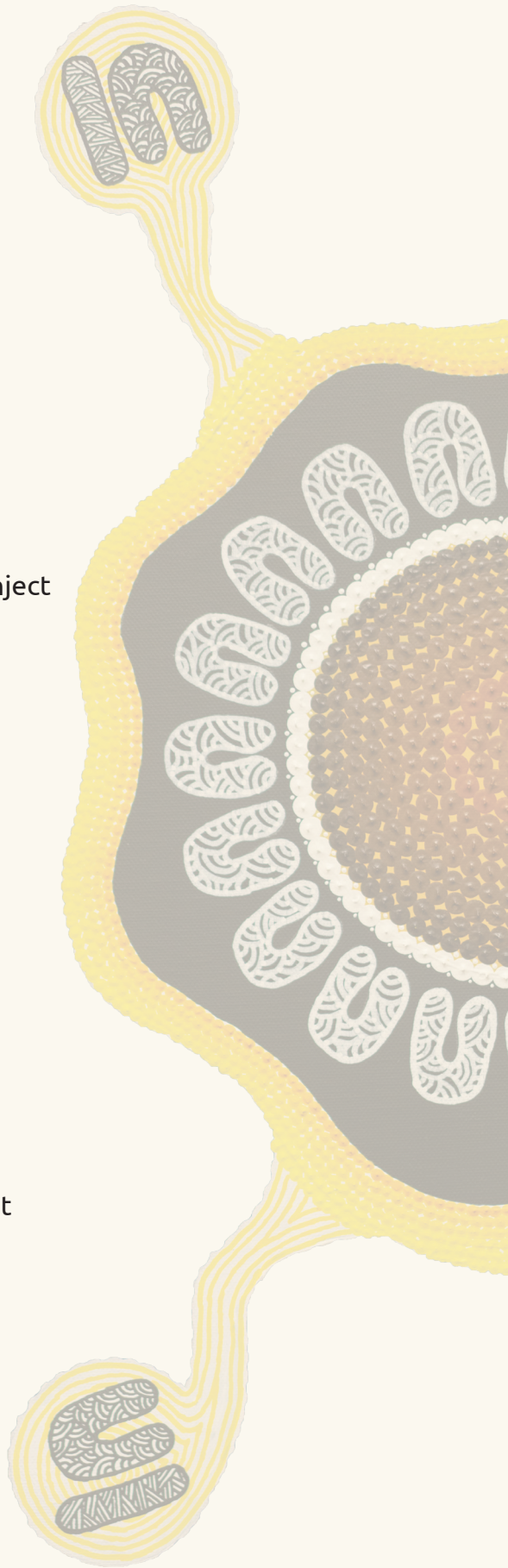

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ABBREVIATIONS

ACRONYM	DESCRIPTION
AAG	Aboriginal Advisory Group
AHCWA	Aboriginal Health Council of Western Australia
AIVL	Australian Injecting and Illicit Drug Users League
AMS	Aboriginal Medical Service(s)
ANSPS	Australian Needle and Syringe Program Survey
BBV	Blood-borne Virus
CAS	Centre for Aboriginal Studies
CDWG	Co-Design Working Group
DYHS	Derbarl Yerrigan Health Service
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDRS	Illicit Drug Reporting System
NSEP	Needle and Syringe Exchange Program
NSP	Needle and Syringe Program
PAR	Participatory Action Research
PWID	People Who Inject Drugs
SHBBVP	Sexual Health and Blood-borne Virus Program, Department of Health, WA
SIREN	Sexual Health and Blood-borne Virus Applied Research and Evaluation Network
STI	Sexually Transmitted Infection
WANADA	Western Australian Network of Alcohol and other Drug Agencies

Harm reduction, in the context of illicit drug use, focuses on working with people without judgement or discrimination, or requiring that people stop using drugs to access support.[1]

> *"I can go in and get freshies because it is healthy for you and makes you feel better in yourself that you're being clean." [consumer]*

The *Increasing Aboriginal Peoples' Use Of Services That Reduce Harms From Illicit Drugs* project brought together stakeholders from 14 organisations in Western Australia (WA), to explore the needs and experiences of Aboriginal and Torres Strait Islander peoples (referred to hereafter as Aboriginal people) who inject drugs (PWID) including access to needle and syringe programs and needle and syringe exchange programs (collectively referred to as NSPs). NSPs are known to reduce harm from illicit drugs, such as the transmission of hepatitis C or Human Immunodeficiency Virus (HIV) through the supply and/or exchange of sterile injecting equipment.[2]

An analysis of trends over 25 years of the Australian Needle and Syringe Program Survey, held at NSPs nationally, showed the proportion of respondents to the annual survey that reported an Aboriginal background increased significantly from 5% in 1995 to 22% in 2019.[3] The factors influencing Aboriginal PWID to utilise NSP services remain unclear and were investigated through this exploratory research.

The spirit of the project was that of 'positive change', giving a voice to Aboriginal PWID, a group so often silenced by stigma and discrimination, and ultimately, to improve health outcomes for the WA Aboriginal PWID community.

> *"A lot of them are shame. They're ashamed of people knowing their business. They're ashamed because they're Aboriginal and Aboriginal people have a lot of shameness in them." [consumer]"*

A major strength of the project was the leadership and involvement of an Aboriginal Advisory Group (AAG) consisting of four Elders and two younger Aboriginal community members and establishing a Co-Design Working Group (CDWG). Members of the CDWG were the Elders, five Aboriginal PWID (consumers), researchers, government policymakers, service providers of NSPs, and peak bodies supporting Aboriginal people, Aboriginal PWID, and NSP services.

This research was conducted in WA between June 2019 to March 2021. NSP staff facilitated yarning sessions with Aboriginal adults aged over 18 years, living in WA, who currently inject or had injected drugs in the past 12 months ('consumers'). For consumers who attended NSP services, the yarning guide explored consumers' awareness of NSP services, their understanding of safe injecting practices and risk behaviours related to injecting drugs, and the features that encourage or discourage the use of NSP services by Aboriginal PWID, acknowledging the interconnectedness of factors influencing drug use. The needs and activities of Aboriginal PWID who were secondary suppliers of injecting equipment, also known as secondary exchange providers or peer supply, were also explored.

EXECUTIVE SUMMARY

> *"I like coming in here because you know my face. You know me, not personally know me but you know my face… You're not here to judge." [consumer]*

NSP staff and staff associated with organisations involved in the CDWG, facilitated yarns with consumers who did not access NSP services. The features that encourage or discourage the use of NSP services were explored.

Key stakeholders within the Aboriginal community also participated in yarning sessions, facilitated by an Aboriginal Elder, to explore attitudes and concerns about injecting drug use in the WA Aboriginal community. The research team conducted yarning sessions with NSP staff and volunteers to understand barriers and enablers for Aboriginal consumers to access NSPs.

Qualitative data from all participants were combined for thematic analysis. Similarities and differences in the data collected from Aboriginal consumers, NSP staff/volunteers, and key informants were identified.

KEY FINDINGS

Yarning Session Participants

- Thirty-two Aboriginal consumers who access NSPs from three metropolitan NSPs.
- Four consumers who were not accessing NSP service from one metropolitan NSP and one metropolitan Aboriginal Community Controlled Organisation.
- Nine NSP staff and two NSP volunteers from three metropolitan NSPs.
- Seven NSP staff from five regional NSPs.
- Seven key informants, six of whom identified as Aboriginal or Torres Strait Islander.
- Not all consumers were asked to provide their demographic information. Of those asked, consumer participants' ages ranged from 24 to 55 years, with 16 consumers identifying as female, and 16 as male. Though not asked specifically, 12 consumers identified as being street present.
- Consumers in regional areas could not be recruited due to Covid-19 restrictions and impacts on NSPs during the data collection period.

Language Used for Injecting Equipment and Drugs

- Great diversity in the language used with more than 19 terms for drugs, 21 terms for NSPs, and 19 terms for needles or syringes.
- Commonly used words for needles include 'freshies', 'darts', 'weapons'.

Barriers and Motivators for Aboriginal Consumers to Accessing NSP Services

- Multiple reasons for not accessing NSPs were expressed by consumers, NSP staff, and key informants. These included:
  - shame (internalised and/or cultural)
  - stigma (of being a PWID and overlapping with shame)
  - lack of anonymity
  - confidentiality concerns
  - obtaining equipment from other consumers
  - locations (hard to access without a car, near Police station or Aboriginal Legal Services)
  - not knowing about NSPs
  - the potential for unwanted interactions with other consumers
  - opening hours.
- Only consumers mentioned health issues or impatience as a barrier to accessing NSPs.
- Motivators for accessing NSPs expressed by both consumers and NSP staff included:
  - rapport with staff
  - cultural security
  - incentives such as care packs and water
  - location (close to services for street present people, accessible train)
  - support from staff.
- Only consumers mentioned a desire to use sterile equipment, free equipment, referrals by friends or family, and obtaining injecting information as motivators or enablers to accessing NSPs.

Key Informant Feedback

- Improved cultural safety and security of NSP services is essential.
- Offer Aboriginal-led harm minimisation services with Elder involvement, cultural healing, and a holistic approach with a move away from individual focus.
- Awareness-raising in Aboriginal community of issues facing Aboriginal PWID and philosophies of harm reduction utilising radio or educational resources.

NSP Needs for Street Present Consumers

- Being street present had some additional challenges for accessing NSPs but overall, the barriers and enablers were the same as for non-street present people.
- A barrier unique to this group was difficulty in carrying multiple or large amounts of used or sterile equipment on one's person.

Feedback from Consumers Who Do Not Access NSPs

- Similar barriers to accessing NSPs as suggested by consumers who do access NSPs, and staff, especially shame.
- Word of mouth by peers to vouch for the benefits of NSPs suggested as a way to encourage access of NSPs.

Ways in Which Aboriginal People Who Inject Drugs Access and Engage with Testing and Treatment Services for Blood-borne Viruses (BBVs)

- Just under half (40%) of consumers who accessed NSPs were aware of the BBV testing and treatment available through NSPs.
- Prior negative experiences from health services were expressed and may be a barrier to accessing health promotion services available at NSPs.
- Lack of English proficiency was reported as a potential barrier to accessing pathways to testing and treatment.
- Staff mentioned it takes time to build trust and rapport with consumers and "picking the right moment on the right day" to discuss clinical services is essential.

Comparison of Data from Regional/Remote and Metropolitan NSP Services

- Overall, reported barriers and motivators for Aboriginal consumers accessing NSPs were similar in regional/remote and metropolitan services.
- Many consumers who travelled regionally commented that they "stocked up" on sterile equipment before heading regionally or preferred to travel to another regional location to access sterile equipment to avoid being recognised by community members.

Gender Differences in Awareness of NSP Health Services

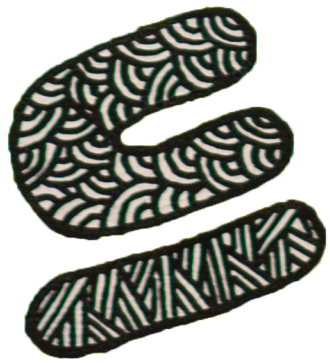
- Awareness of the health services available at NSPs, such as screening for hepatitis C and sexually transmitted infections (STIs) was more common among female consumers who access NSPs (50%) than male consumers who access NSPs (13%).

Re-using Own or Sharing Own Used Injecting Equipment

- Re-using their own syringes was extremely common with 75% (n=24) of consumers stating they re-used their own syringe
- Overall, 34% (n=11) of consumers said they shared their own used injecting equipment (someone used it after them), and 31% (n=10) used someone else's used injecting equipment. This sharing was mainly with friends or family. This may be under-reported due to shame or concerns disclosing such information face to face.

Secondary Supply of Sterile Equipment

- Not all consumers were asked if they were a secondary supplier.
- Of those asked, most consumers (68%; n=17) identified as being a secondary supplier, supplying sterile injecting equipment to their family and friends.
- The main motivator to be a secondary supplier appeared to be a desire to help others.
- Noting the barriers to accessing NSPs, NSP staff were overwhelmingly in support of secondary supply laws being reviewed to lawfully enable the distribution of injecting equipment more widely than through NSPs.



Ways to Increase Access to NSPs for Aboriginal PWID

The Co-Design Working Group discussed the research findings and agreed on five main areas of intervention for increasing access to NSPs for Aboriginal PWID.

1 **Increasing cultural security of NSPs.** Findings from the research indicated enhancing the cultural security of NSPs could improve access to these services for Aboriginal PWID.

2 **Community education and awareness campaign about harm reduction.** Research participants indicated that if the wider Aboriginal community had a better understanding of the importance of NSPs, more community support may follow, which could also contribute to reducing the shame and stigma experienced by people who inject drugs.

3 **Peer referral program pilot.** Findings indicated peers play an important role in access to sterile injecting equipment. A trained Aboriginal Peer Worker coordinating Aboriginal PWID trained as peer educators to share harm reduction knowledge and raise awareness of NSPs with other Aboriginal consumers would be beneficial.

4 **More holistic harm reduction service models.** The service system for Aboriginal consumers with complex needs is not well integrated and established referral pathways are required.

5 **Exploring the feasibility of increasing NSP service availability.** Findings from this research indicated demand for increased NSP service availability. Existing available data should be examined, including service user demographics, service user evaluations, equipment distribution, notification data for blood-borne viruses, and costs associated with providing NSP services, to investigate the feasibility of additional mobile, outreach, and after-hours services.

OUTCOMES OF THE CO-DESIGN APPROACH

In addition to the key findings outlined above, important outcomes were evident in the co-design process itself which are likely to have ongoing benefits into the future, independently of any interventions.

The leadership and support from the Aboriginal Advisory Group and Co-Design Working Group, which included Aboriginal PWID, were critical in achieving the outcomes of this exploratory research. For example, participants were not recruited by researchers but through existing, trusted relationships between Elders and key informants or relationships between NSP staff and consumers.

'The co-design process offered Working Group members a unique opportunity to meet and learn from other organisations, in Perth and regionally, who are working to improve outcomes for Aboriginal PWID. Existing relationships between NSP organisations were strengthened and new connections and awareness of other services were established. This is an important outcome to support a more integrated service system for Aboriginal consumers and will provide a solid foundation for the planned interventions arising from the research findings.'

The co-design process offered Working Group members a unique opportunity to meet and learn from other organisations, in Perth and regionally, who are working to improve outcomes for Aboriginal PWID. Existing relationships between NSP organisations were strengthened and new connections and awareness of other services were established. This is an important outcome to support a more integrated service system for Aboriginal consumers and will provide a solid foundation for the planned interventions arising from the research findings.

Service providers and consumers were also able to build capacity in research skills, improving the rigour of this current project, and future projects. NSP staff valued the opportunity to engage with consumers accessing NSPs for the purposes of research. The yarning discussions have further strengthened the relationships between NSP staff and some consumers.

Finally, the culturally safe involvement of Aboriginal consumers in the co-design process was a particularly important outcome of this research. Consumers were able to offer their insights and feedback one-to-one with NSP staff they knew and trusted. One consumer also participated in the yarning sessions conducted by the NSP staff with other consumers. The NSP staff felt having a consumer assist with recruitment meant they were able to recruit more participants than planned, and also found the support from the consumer to conduct the yarning sessions was invaluable.

Participation in the research was reported as a highly positive experience by these consumers and provides evidence that actively engaging members of a marginalised population in conducting sensitive research is important and achievable.

The *Increasing Aboriginal Peoples' Use of Services That Reduce Harms from Illicit Drugs* project sought to build on the effective engagement by NSPs with Aboriginal consumers in WA. Funding has been requested to trial the recommendations for interventions informed by this research.

Aboriginal and/or Torres Strait Islander peoples (respectfully referred to hereafter as Aboriginal peoples) are disproportionately affected by health and social harms relating to injecting drug use, including hepatitis C and HIV, due to unsafe injecting (sharing and re-using equipment). Injecting drug use may impact or be impacted by alcohol use, homelessness, and poor mental and physical health outcomes.[4] A significantly higher proportion of HIV transmission is attributed to injecting drug use among Aboriginal populations than non-Aboriginal populations.[5] Needle and syringe programs (NSPs) are known to reduce harms from illicit drugs through the supply and/or exchange of sterile injecting equipment.[2]

An analysis of trends over 25 years of the Australian Needle and Syringe Program Survey, held at NSPs nationally, showed the proportion of survey respondents that reported an Aboriginal background increased significantly from 5% in 1995 to 22% in 2019.[3] The factors influencing Aboriginal PWID to utilise these NSP services or ways to increase Aboriginal PWID engagement with NSP services are unclear.

Since 2009 in Australia, the HIV notification rate has been higher in Aboriginal people than in the non-Aboriginal, Australian-born population.[4] In addition, the rate of newly acquired hepatitis C virus (HCV) was 13.7 times higher than in the non- Aboriginal and Torres Strait Islander population in 2018.[4] The higher rate of hepatitis C may be related to risk behaviours associated with injecting drug use, and difficulty in accessing NSPs.[5] These injecting risk behaviours include receptive syringe sharing, with 26% (n= 120) of respondents in the 2017 Australian Needle and Syringe Program Survey who identified as Aboriginal or Torres Strait Islander reporting sharing syringes.[4] Young Aboriginal people have also been identified in the literature as being more vulnerable to riskier injecting practices due to shame, disempowerment, and marginalisation.[6] As with any statistics involving illicit activities, injecting practices, the prevalence of hepatitis C, and to a lesser extent HIV, are likely under-reported, especially for people who do not access services.[1]

The Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmitted Infections Strategy includes the goals of significantly reducing the transmission of blood-borne viruses (BBVs) among Aboriginal peoples, and reducing morbidity and mortality associated with BBVs.[5]

BARRIERS AND MOTIVATORS FOR ABORIGINAL PWID ACCESSING NSPs

The most common barrier to NSP access discussed by participants in a 2008 report by the Australian Department of Health was shame about being an Aboriginal injecting drug user.[7] Multiple reports have also highlighted stigma and discrimination as barriers to NSP access, not exclusive to Aboriginal PWID.[7-10]

Limited opening times of NSPs have been noted as a barrier to NSP access and longer opening hours a facilitator to NSP access.[7-9 10, 11] Multiple studies raised the point that drug use often occurs at night, on public holidays and weekends, when the majority of NSPs are not operating.[7, 8]

The location of NSPs was also a barrier to NSP access in multiple studies, not specific to Aboriginal consumers.[7, 8, 10, 11] Accessibility was improved if the NSP was accessible by bus, train, tram, or within walking distance.[7, 8, 11]

In a 2015 study by the Australian Injecting & Illicit Drug Users League (AIVL), participants spoke of the fear of being exposed or discovered as a PWID.[8] Treloar et al also found that "being seen as a PWID"

was the main barrier to accessing NSPs.[9] Desire for anonymity was associated with not wanting to be exposed to Police as a PWID,[8, 9] and has been reported in other studies.[7, 12] This appeared to be particularly an issue for younger Aboriginal PWID, places with smaller populations, and NSPs in or near an Aboriginal service.[7, 12] The cost of equipment as a facilitator or enabler to NSP access for Aboriginal consumers has not been extensively explored in previous studies except in a report by Holly et al.[12] Staff behaviour and perceived attitude towards consumers has been reported as either a barrier or an enabler to accessing NSPs.[7, 9, 11] Unfriendly or judgemental staff (particularly noted in pharmacies) can also deter PWID from using an NSP service.[7]

Secondary Supply: Obtaining Equipment For Other Consumers

A small number of Australian studies explored secondary supply in the PWID community as a whole.[13-16] Secondary supply refers to the distribution of injecting equipment obtained from NSP services by a person who injects drugs (provider) to other injecting drug users (recipients).[17] Legislation does not specifically allow for secondary supply in all Australian states and territories.[18] However, studies show secondary supply is common, with estimates of around 40% of people attending NSPs or pharmacies for equipment reporting they had distributed equipment.[15]

Re-using Own Injecting Equipment

For this project, re-using of equipment will refer to the use of injecting equipment on a second or subsequent occasion by the original user of the equipment.[8] The risks involved with re-using own equipment are related to several variables including the condition of storage of the equipment being used and the impact on the vein health of the individual.[8] In 2019, the prevalence of re-using own syringes in the last month was 8% (n=217) of participants in the Australian Needle and Syringe Program Survey.[3]

Sharing Equipment

Sharing of equipment can be defined as the use of a needle and syringe after it has been used by another person.[8] In terms of BBV transmission, the practice with the highest risk is receptive equipment sharing.[8] In 2019, one in six participants in the Australian Needle and Syringe Program Survey, reported receptive sharing of syringes.[3] In the 2017 Australian Needle and Syringe Program Survey, 26% (n=120) of respondents who identified as Aboriginal or Torres Strait Islander reported receptive sharing of syringes, compared to 15% (n=312) in non- Aboriginal or Torres Strait Islander participants.[4] In a study of Aboriginal PWID from 1999 by Gray et al, 43% (n=32) of participants reported they 'normally' shared syringes when they injected.[19] Of these 32 participants, 14% (n=10) shared syringes distributively only, with the remaining 30% (n=22) reporting receptive and distributive sharing of syringes.[19]

OVERVIEW OF RESEARCH

This exploratory research was conducted in Western Australia (WA), between June 2019 to March 2021. It focussed on Aboriginal adults aged over 18 years, living in WA, who currently inject or had injected drugs in the past 12 months.

The study explored the target group's awareness of NSP services, their understanding/behaviours associated with safer injecting practices and risk behaviours related to injecting drugs, and the features that encourage or discourage the use of NSP services by Aboriginal people, acknowledging the interconnectedness of factors influencing drug use. In addition, the study explored the needs and activities of secondary suppliers, also known as secondary exchange providers or peer suppliers. Secondary target groups included NSP staff and volunteers to explore their perceptions of barriers and motivators for Aboriginal consumers to access NSPs, and key informant stakeholders in the Aboriginal community to explore attitudes and concerns about injecting drug use in the WA Aboriginal community.

Research aim

The overall aim of the research was to co-design intervention strategies to reduce harms from illicit drugs among Aboriginal peoples.

OBJECTIVES

For Aboriginal people who currently or have previously injected drugs, the project objectives were:

1. Provide insights into their understanding of safer injecting drug use including strategies they have used to reduce harms from illicit drugs (e.g. re-using but not sharing needles).
2. Understand the services and support required by specific groups (e.g. street present) to reduce harms from illicit drugs or to change injecting drug use behaviour.
3. Understand the needs and activities of secondary suppliers and assess opportunities to engage secondary suppliers in reducing harms from illicit drugs in Aboriginal communities.
4. Articulate common and unique features of metropolitan and regional needle and syringe programs that encourage or discourage use and engagement with NSP services.
5. Describe the ways in which Aboriginal people access and engage with NSPs, including pathways to testing and treatment of BBVs.
6. Assess attitudes and concerns of key informants within Aboriginal communities related to the utility and efficacy of NSPs as a harm reduction strategy and issues related to confidentiality and the shame and stigma of using illicit drugs.
7. Co-design recommendations for interventions to enhance the delivery of client-centred NSP services and health promotion and education initiatives including what would be required for people to adopt safer injecting practices or to reduce drug use, and consensus on relevant language to be used.

METHODOLOGY

The research utilised a co-design approach involving Aboriginal Elders; Aboriginal consumers; researchers; NSP service providers in regional and metropolitan areas; peak bodies representing Aboriginal health organisations and Western Australian drug and alcohol services; and policymakers.

Co-design as a methodology

Underpinned by the belief that collaborative and community-centred approaches lead to increased efficiencies and greater overall impacts, co-design is a method shown to deliver relevant, real-world solutions designed in part by those most affected by a problem.[20-23] Integral to the co-design process is the participation of 'end-users' in an intervention's development and not merely their consultation, requiring the researcher to move from the role of translator to that of the facilitator.[24]

Co-design is being increasingly used within the health care, public health, and health promotion sectors.[21, 25-27] Co-design methodologies and Indigenous research principles both advocate for the empowerment of target populations and view research as intervention.[28-30] Studies utilising co-design with Aboriginal populations have demonstrated the importance of Aboriginal people's meaningful involvement in research.[27]

As recommended by the Fifth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy[5] and academic literature, use of co-design ensures culturally appropriate research methodologies as determined by target populations, e.g. yarning as a data collection tool, and sustainability of interventions.

Involvement of Aboriginal PWID in research and health promotion

The published literature includes few examples of Aboriginal PWID involvement in research and health promotion. Twenty years ago, in 2001, a study conducted by Gray et al.[19] collected data from representatives of harm reduction services and Aboriginal PWID in regional and metropolitan WA.[19] The study aimed to assess the prevalence and nature of illicit drug use among Aboriginal people in WA and determine the harm reduction needs for Aboriginal PWID. Aboriginal people aged over 16 years and who had injected drugs in the previous 12 months, were recruited via the distribution of flyers by staff at NSPs and Aboriginal health services in the specified locations.[19] Additional participants were recruited through snowball sampling (i.e. asking one participant to suggest another).[31] All participants were given a $20 financial recompense in acknowledgement of their time and expertise.[32-34] Data were collected through one on one structured and semi-structured interviews. Gray et al. concluded that the involvement of Aboriginal people in the design of health promotion and harm reduction materials was critical.[19] The current exploratory research project adapted Gray et al's method of participant recruitment.

Yarning as data collection

Yarning, a form of Indigenous cultural communication[35], is both a process and an exchange by way of informal and relaxed discussion.[36,37] A valuable research tool for Aboriginal people, yarning provides a known and culturally secure environment for Aboriginal people to talk honestly and openly about their experiences, thoughts, and ideas.[37] A 2016 study exploring Aboriginal peoples' experiences with health care services in WA utilised yarning sessions to collect data.[38] The researchers concluded that the use of an Indigenous Reference Group allowed for the respectful collection of data and generated trust between 'story collectors' and participants.[38]

METHODS

HOW DID WE 'CO-DESIGN'?

The co-design process for this project began by firstly fostering and strengthening partnerships with stakeholders involved in the wellbeing of Aboriginal PWID in Western Australia, to establish an Aboriginal Advisory Group (AAG) and a Co-Design Working Group (CDWG).

ABORIGINAL ADVISORY GROUP

Based on the evidence for respectful and meaningful engagement of Aboriginal people in health interventions[39], Aboriginal people were involved in the design of this project at each step, guided by the AAG and with an Aboriginal Project Officer in the research team. Four Elders and two young Aboriginal men were recruited to form the AAG. Each Elder on the project had well-established research skills and experience, two with doctoral qualifications. The AAG guided this project at each stage. This included: assisting with the recruitment and support of an Aboriginal project officer; ensuring letters of support from Aboriginal corporations were received promptly; advising on ethical and cultural considerations for ethics; identifying key informants to be interviewed; and providing feedback and cultural guidance on methodology and intervention planning. Four AAG meetings were held over 12 months.

Using the Elders' networks, a young Aboriginal man with lived experience was recruited as an Aboriginal project officer. A second Aboriginal project officer was recruited the following year through the research team's contacts at Curtin University.

CO-DESIGN WORKING GROUP

NSP service providers were invited to participate in the CDWG. The Department of Health WA funds three organisations to provide NSPs in metropolitan Perth:

1) **Western Australian AIDS Council** – mobile needle and syringe exchange program (NSEP) van servicing Armadale, Belmont, Gosnells, Joondalup, Midland, Mirrabooka and Rockingham, postal services, fixed sites in West Perth and Fremantle.
2) **HepatitisWA** - NSP and clinic offering BBV testing and treatment in Northbridge (Perth city).
3) **Peer Based Harm Reduction WA** - NSEP and clinical services in East Perth, outreach and postal services in Perth.

Derbarl Yerrigan Health Service (DYHS) is the largest Aboriginal Medical Service (AMS) in Perth and the only AMS that provides NSP services. Derbarl Yerrigan Health Service provides NSPs in East Perth, Maddington, and Mirrabooka, funded by the Commonwealth Government.

The Hedland Well Women's Centre in the Pilbara region was also invited to participate in the CDWG to explore differences between metropolitan and regional NSP services.

Discussions with Associate Professor Michael Wright leading the 'Our Journey, Our Story: Building Bridges To Improve Aboriginal Youth Mental Health And Wellbeing' co-design project also helped to identify key stakeholders to form the CDWG, which included Elders, Aboriginal PWID, researchers, government policymakers, service providers of NSPs, and peak bodies representing the needs of Aboriginal PWID (Table 1, page 23).

Table 1: Members of the Co-Design Working Group and relevance to project

RELEVANCE TO PROJECT	ORGANISATION
Policy	Sexual Health and Blood-borne Virus Program, Department of Health, WA
Alcohol and Other Drugs Peak Body	Western Australian Network of Alcohol and other Drug Agencies
Knowledge/culture	Australian Indigenous HealthInfoNet Centre for Aboriginal Studies, Curtin University Curtin School of Occupational Therapy Telethon Kids Institute
NSP Service Providers	Hedland Well Women's Centre HepatitisWA Peer Based Harm Reduction WA WA AIDS Council
Aboriginal Community Controlled Organisations and Peak Body	Aboriginal Health Council of WA Derbarl Yerrigan Health Service Wungening Aboriginal Corporation
Clinical services	Royal Perth Hospital
Research	Curtin University Edith Cowan University Menzies School of Health Research

Co-Design Working Group meetings

Stakeholders were sent an introductory email with an overview of the project, and an invitation to attend the first co-design meeting. Five co-design meetings were held over 18 months.

Each co-design meeting had different objectives and the format of the meeting and group members' involvement varied depending on the meeting objectives, their capacity, and expertise. Meetings were held at venues with Aboriginal cultural security in mind. Venues included the board room of Wungening Aboriginal Corporation, an Aboriginal Community Controlled Organisation, and the Centre for Aboriginal Studies, Curtin University. Members of the Co-Design Working Group were invited to present at each meeting, with the research team acting as facilitators.

Table 2 (page 24) provides a summary of the co-design meetings held.

Table 2: Summary of Co-Design Working Group Meetings

DATE	AGENDA ITEMS	NUMBER OF PARTICIPANTS	LOCATION
Meeting One June 4th 2019	• Project overview and introduction of each member of the CDWG, including the AAG • Guest speaker Associate Professor Michael Wright on the principles of co-design, and a case study involving the *Looking Forward Building Bridges* project • Discussion by each NSP service provider of observations of current engagement with Aboriginal consumers • Open discussion of questions about the study including enablers, challenges, and ethical considerations	22	Wungening Aboriginal Corporation
Meeting Two July 17th 2019	• Progress report • Workshop three questions then feedback as a group: - How do we develop a culturally secure framework for the project recruitment and data collection? - How do we involve consumers in the co-design process? - How do we reach consumers who are not accessing the services? • Whole group discussion: What do we want to ask consumers?	13	Centre for Aboriginal Studies, Curtin
Meeting Three March 4th 2020	• Progress report • Experiences from engaging consumers in co-design: presentation by four staff from NSPs • Extra findings from Consumer Co-Design Working Group • Key informant interview progress and discussion • Discussion on data analysis • Going forward: intervention design and grant applications	16	Wungening Aboriginal Corporation
Meeting Four July 7th 2020	• Progress report • Open discussion	11	Online via Microsoft Teams
Meeting Five December 14th 2020	• Discuss summary report • Going forward: outstanding activities, outreach event, yarning with Aboriginal PWID who do not access NSPs, collecting data from Peer Based Harm Reduction WA, keeping CDWG engaged • Identifying stakeholders for knowledge translation • Discussion of suitable dissemination for each stakeholder group	6	Centre for Aboriginal Studies, Curtin

The introductory co-design meeting provided an opportunity for group members to get to know one another and learn about the project. The second meeting was more activity focussed. The AAG suggested collaborating on the discussion questions by splitting the large group into three smaller groups, each with a facilitator who explained the discussion questions and desired outcomes and documented responses. Facilitators rotated between the three groups, allowing all groups to consider the three discussion questions: how to develop a culturally secure framework for the project recruitment and data collection; how to involve consumers in the co-design process; and how to reach consumers who are not accessing needle and syringe programs. The smaller groups then re-joined to discuss what interview questions would be asked of our participants in the form of yarning guides, and any ethical issues.

With the information gathered, the research team devised the project's recruitment strategy including appropriate remuneration for consumers and interview questions.

Subsequently, service providers helped recruit consumers to the CDWG to provide feedback on the research methods and interview questions. Co-design participants were recruited by staff from HepatitisWA and Peer Based Harm Reduction WA. Consumer participants were asked if they would like to take part in a yarn where a $40 incentive was offered.

There was a significant break between CDWG meetings two and three, due to the ethics review process. During this time, the project team focussed on preparing service providers for data collection. Meeting three focussed on early findings, experiences of service providers on engaging consumers in the CDWG with a presentation by four staff from NSPs, and a discussion on data analysis.

Due to COVID-19 safety precautions meeting four was held online. This meeting was used as a project update only, and not a forum for the CDWG to make project decisions. Meeting five was held in person and focussed on ways to overcome challenges experienced in collecting data from Aboriginal PWID who do not access NSPs. Ways to disseminate the project's findings to consumers were also discussed.

PARTICIPANT RECRUITMENT

Consumer recruitment

Staff and a consumer from Peer Based Harm Reduction WA; the NSP officer and staff from HepatitisWA, staff from the WA AIDS Council and staff from Wungening Aboriginal Corporation recruited consumers for the study. An information sheet was provided to participants who were required to provide verbal consent that they agreed to participate and have the yarn either recorded or notes made on their responses.

NSP staff and volunteer recruitment

The project officer sent emails to the Chief Executive Officers from the WA AIDS Council, HepatitisWA, and Peer Based Harm Reduction WA providing information about the project and requesting the contact details of staff and volunteers who would be appropriate to be invited to be interviewed for the project.

Potential participants were then invited to participate in an interview via email. The email explained the aim of the project and requested a response with the preferred date for the interview within the proceeding two weeks. An information sheet and consent form were provided to participants who were required to sign and return the consent form before the interview took place.

Key informants

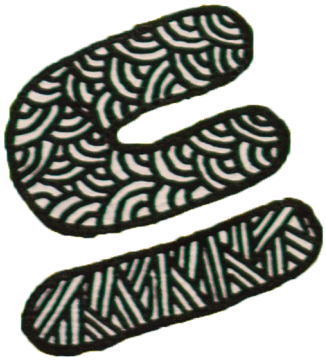
To recruit key informant participants, in late March 2020 one of the Elders identified several Aboriginal people in their network who worked for community organisations and had some knowledge and experience of Aboriginal PWID. They contacted them by phone initially and sent a follow-up email with project information. An information sheet and consent form were provided to participants who were required to sign and return the consent form before the interview took place.

Aboriginal PWID who do not access NSPs

Planned outreach events to engage consumers who did not access NSPs were cancelled due to Covid-19. In May 2020, one of the Elders contacted 12 Aboriginal organisations to seek participants. No potential participants contacted the researcher. An outreach event with the aid of a consumer member of the CDWG was planned for December 2020, to attempt again to access Aboriginal PWID who do not access NSPs. This event did not go ahead due to the consumer not being available. One interview with an Aboriginal consumer who did not access NSPs was conducted by an NSP worker during an outreach foot patrol.

Feedback from the CDWG stated the length of the yarning guides and having the yarns recorded may be a barrier to some consumers participating. As such, the yarning guide was reduced to seven questions covering the project's main themes, which could be completed in approximately two minutes.

The Wungening Alcohol and Other Drugs (AOD) team, Manager of Research, Evaluation and Impact, and Chief Executive Officer met with the project team to discuss the project and data collection. The Wungening AOD team offered to ask some of their clients during counselling sessions if they would consent to participating in the research. It was agreed that a $25 Coles voucher would be appropriate remuneration for participants. The Wungening AOD team subsequently recruited and interviewed three consumers who do not access NSPs.



DATA COLLECTION

This project adopted a similar approach to Wain et al (2016) using yarning sessions to collect data from consumers, staff and volunteers from NSPs and key informants.[38] Questions asked in the yarns differed based on who was being interviewed. Six yarning guides were developed – two for consumers who access NSPs (a longer and shorter version), two for consumers who do not access NSPs (a longer and shorter version), one for staff and volunteers from NSPs, and one for key informants.

Feedback from the CDWG had noted that when working in a mobile NSP van situation, or alone in an NSP, it was not always feasible to be unavailable to other consumers for 10 minutes to conduct a yarn. The shorter yarning guide increased the success rate of recruiting participants for one of the NSP service providers that had found the length of the yarning guides a barrier to participation. However, the lack of uniformity in the questions asked of consumers created some limitations in data analysis. This included being able to comment on the trends involving secondary supply, consumers visiting multiple NSPs and awareness of health clinics and services available at NSPs.

The yarning sessions were used to elicit conversations regarding general themes around the awareness of safer injecting practices and risk behaviours (e.g. sharing/re-using syringes), NSP locations and services available within NSPs, access to and engagement with NSP services (e.g., obtaining sterile equipment for consumers themselves or others in their community), features of NSPs that increase cultural security and encourage or discourage use, and engagement with health promotion and clinical services. The yarning guides aimed to extract the necessary information to answer the research objectives within two to 10 minutes for consumers, and 30-45 minutes for NSP staff, NSP volunteers, and key informants. This was considered important to minimise the time burden on participants and NSP service providers who conducted the yarning sessions with consumers. However, if yarning session participants had the time or wished to speak for longer, there was an opportunity to do so. Yarning sessions were continued until data saturation was achieved.

Consumer involvement

The research team developed the structured yarning guides for consumers in consultation with the CDWG. Consumers from the CDWG were invited to provide feedback on the yarning guide to be used with their peers and received between $20-40 cash reimbursement for their time, with the reimbursement fee at the discretion of the service provider. This consumer feedback resulted in adjustment of some of the language used in the guide to be more suitable to the target audience. NSP staff conducted yarning sessions with consumers in a quiet place at NSP services. One of the co-design consumer participants assisted to recruit 16 consumers and co-facilitated the yarns with these consumers, alongside a NSP staff member.

All consumers who were interested in participating in the yarning sessions were provided or read an information sheet and verbal consent was requested to participate in and record the yarn, or have their responses recorded manually by the interviewer. Consumers who accessed NSPs received $10 cash as a reimbursement for their time. This cash amount was agreed upon by the CDWG, based on current and previous research, the current reimbursement rates for surveys involving Aboriginal PWID, and from feedback from consumers and peer workers concerning possible data quality issues attached with offering a cash reimbursement higher than $10. Consumers who did not access NSPs were offered a higher remuneration amount in voucher form (a $25 Coles voucher), consistent with the consumer remuneration policy of the organisation that conducted the interviews with consumers who do not access NSPs.

NSP staff and volunteers

The research team developed the structured yarning guide for NSP staff and volunteers in consultation with the CDWG. Two members of the research team conducted yarning sessions with staff and volunteers at NSPs. Interviews took place either face to face at the participants' workplaces, or via telephone. Yarning sessions were audio-recorded with participants' written consent. After the initial yarning sessions, the interviewers reconvened to provide feedback on the yarning guide. Consequently, the yarning guide was shortened, as two questions were deemed similar.

Key Informants

The research team developed the structured yarning guide for key informants in consultation with the CDWG. The AAG also provided feedback on the yarning guide. One member of the research team interviewed two key informants at their workplaces. In late March and early April 2020, a member of the AAG interviewed five Aboriginal people who consented to participate as key informants, via telephone interview. The yarns were recorded with participants' consent. Key informants each received $50 as a reimbursement for their time.

DATA ANALYSIS

Yarning data were transcribed verbatim by experienced personnel within one week of data collection, if the yarns were recorded by an electronic device. Participants were not identified in any transcripts and transcripts were independently reviewed by the research team for accuracy and to ensure identifying content had been excluded.

With the exception of consumers who do not access NSPs, yarning sessions were continued until a point of data saturation was reached, with no new themes or ideas emerging. The project team was not able to recruit a sufficient number of consumers who do not access NSPs to achieve data saturation. Thematic and content analysis to identify key themes was undertaken using NVIVO version 12 qualitative data management software. Thematic analysis involved the transcripts being read several times and points of interest to the project being noted down. Descriptive codes were then assigned to the points of interest which were subsequently grouped into categories. Two members of the research team cross-referenced analyses to ensure rigour. The emergent categories developed the overarching themes which addressed the project's objectives.

FINDINGS PRESENTED INCLUDE:

- participant demographics
- the language used by consumers for drugs, NSPs, and injecting equipment
- barriers and motivators to accessing NSP services
- secondary supply of sterile equipment
- re-using or sharing equipment
- ways to increase access to NSPs for Aboriginal PWID.

CONSUMER YARNING SESSIONS AND DEMOGRAPHICS

Purposeful sampling to obtain diverse participants (in age and gender) was utilised. Recruitment took place over twelve months, and methods varied by the service provider.

Of the participants asked (n=25), notable findings included:

- more female participants (67%) were aware of the health clinic and other services offered, compared to male participants (15%)
- 75% of participants had re-used their own used syringes in the past twelve months
- secondary supply was also very common, as 68% of participants collected 'freshies' for other people who inject drugs
- 68% of participants visited multiple NSPs, with this being more common in female participants.

Table 3 (page 31) summarises the demographics and characteristics of consumer participants who access NSPs.

Table 3: Demographics and characteristics of consumers who access NSPs, interviewed in this project

	Female (n=16)	Male (n=16)	Totals (n=32)
Ages[1]	24-55 years	28-53 years	N/A
Street present[2]	4 (25%)	8 (50%)	12 (38%)
Aware of the health clinic and services[3]	8 (50%)	2 (13%)	10 (31%)
Shared syringes in the past 12 months	5 (31%)	9 (56%)	14 (44%)
Shared syringes – used someone else's and someone used theirs in past 12 months only	2 (12%)	5 (31%)	7 (22%)
Shared syringes – used someone else's only	1 (6%)	3 (19%)	4 (13%)
Shared syringes – someone used theirs only	2 (13%)	1 (6%)	3 (9%)
Re-uses their own syringes	13 (81%)	11 (69%)	24 (75%)
Secondary supplier[4]	7 (44%)	10 (63%)	17 (53%)
Goes to multiple NSPs[5]	10 (63%)	7 (44%)	17 (53%)
Travel regionally[6]	4 (25%)	6 (38%)	10 (31%)

[1] Not all participants gave their age.

[2] Participants were not directly asked if they were street present, and there were potentially other participants who may have identified as being street present.

[3] Seven interviewees were not asked about health clinics and services, as the questions involving this topic were not included in the shorter yarning guides.

[4] Seven interviewees were not asked about secondary supply, as the questions involving this topic were not included in the shorter yarning guides.

[5] Fourteen interviewees were not asked if they go to multiple NSPs, as the questions involving this topic were not included in the shorter yarning guides.

[6] Fourteen interviewees were not asked about their regional travel.

Table 4 summarises the characteristics of consumers who do not access NSPs, interviewed in this project using the shorter yarning guide.

Table 4: Demographics and characteristics of consumers who do not access NSPs

	Total (n= 4)
Aware of NSPs	3 (75%)
Shared syringes– used someone else's and someone used theirs in past 12 months only	2 (50%)
Shared syringes– used someone else's only	0
Shared syringes – someone used theirs only	0
Re-used their own syringes	4 (100%)

NSP STAFF AND VOLUNTEERS YARNING SESSIONS AND DEMOGRAPHICS

Sixteen NSP staff and two volunteers participated in one on one yarns with a member of the research team.

Table 5 summarises the location and roles of NSP staff who participated in yarning sessions.

Table 5: Location and roles of NSP staff and volunteer yarning session participants

TYPE OF NSP	NUMBER OF PARTICIPANTS (n=18)	ROLES
Metropolitan fixed, outreach, or mobile NSP (3 sites)	9 staff 2 volunteers	NSP coordinator Volunteer coordinator NSP volunteer Peer NSP worker Outreach co-ordinator
Regional, fixed, or outreach NSP (5 sites) Regions covered: Great Southern Goldfields Kimberley Pilbara	7	NSP Coordinator Aboriginal Sexual Health Promotions Officer Outreach Co-Ordinator

KEY INFORMANT YARNING SESSIONS AND DEMOGRAPHICS

Seven key informants participated in one on one yarns. Six key informants identified as Aboriginal or Torres Strait Islander. Key informants had a variety of professional roles past or present, including an academic with previous involvement in Aboriginal alcohol and other drug research, a Chief Executive Officer of an NSP, senior management in Aboriginal Community Controlled Organisations or Aboriginal corporations, and a senior officer at the Department of Child Protection.

LANGUAGE USED FOR DRUGS OR EQUIPMENT

Consumers were asked which words, in Aboriginal language (acknowledging the fact there are many Aboriginal languages, and not a single entity) or English, they used for drugs, NSPs, and injecting equipment.

Table 6 summarises the responses.

Table 6: Language used by consumers for drugs, NSPs, and needles and syringes

LANGUAGE USED FOR DRUGS	LANGUAGE USED FOR NSPs	LANGUAGE USED FOR NEEDLES AND SYRINGES
Amphetamines	Drug Centre	Barrels
Dart	Exchange	Cleanies
Dang	Exchange Centre	Darts
Ding ding	Fit Exchange	Fighters
Food	Fit-Pack Place	Fits
Gateway	Fit Place	Fit Pack
Gear	Freshie Place	Fresh Darts
Icicles	Fit Shop	Freshies
Meth	Health Service	Guns
Narbis	Hep-C Place	My tools
Poor pickle	Hot Shot Place	Nubs
Rock	My Support Group	Old Faithful
Shoon	Needle Exchange	Packets
Shoonal	Needle Exchange Place	Pick
Smack	Needle Exchange Program	Shotguns
Speed	Needle Outlet	Spears
The H	PNE (Perth Needle Exchange)	Syringe Guns
Upper	Swap Centre	Trigger
Yum yum	Syringe Exchange	Weapons
	Uptown	
	Yum Yum Shop	

BARRIERS OR REASONS FOR NOT ACCESSING NSP SERVICES

Reasons for not accessing NSPs suggested by consumers currently accessing NSP services, NSP staff/volunteers and key informants included: shame, lack of anonymity, obtaining equipment from other consumers, locations, and opening hours. Motivators for accessing NSPs included wanting to use sterile equipment, rapport with staff, referral by friends or family, incentives, free equipment, information, and support.

Shame

Shame was a major barrier to consumers accessing NSPs as expressed by both consumers and NSP staff. The source of shame varied, from internalised shame (including about being a user of illicit drugs), culture-related shame, or shame perceived from others.

Some examples of shame were shown in these quotes:

> *"They think that they're then going to talk about them and they don't want people finding out that they use." [consumer]*

> *"Shame's a big thing, I know." [consumer peer researcher]*
> *"Yes, it still is, but between us it's not, but it is outside our circle." [consumer]*

> *"A lot of them are shame. They're ashamed of people knowing their business. They're ashamed because they're Aboriginal and Aboriginal people have a lot of shameness in them." [consumer]*

Perceptions from staff of shame were mentioned often.

> *"I think that for some people it's shame. There are all sorts of different levels of that. There could be community shame, there could be that there's shame in their family. There's the whole self-thing, they don't want to admit that they've got a problem with substance use. "I don't want to go in there," and what have you. Maybe their friend goes in for them, or what have you. We see a lot of that." [NSP staff]*

Key informants were asked to expand on the concept of 'shame' and how it may affect access to harm reduction services such as NSPs. Opinions expressed focussed around the concept of shame often leading to a PWID withdrawing from their community and friends, and not feeling empowered to access services.

> *"I think shame is sometimes this aggressive voice in your head, it's almost a colonial voice that's planted in there. "You are a problem, you need to stay out of-- You need to just get out of the way, not be seen. You're a burden."" [Key Informant]*

> *"Shame and discrimination, that's going to really anchor a person. They're going to stay right where they are indoors. They're going to prison themselves. Society is just too weird and just too hard to get back into, and their own self-*

judgment prohibits them from seeking help. That makes services work twice as hard. It just keeps them in, it takes a little bit of poison to create a prison." [Key Informant]

Lack of Anonymity

A lack of anonymity, particularly from fellow community members, when accessing NSPs was discussed as a major barrier by consumers and validated by responses from staff and some key informants. Also, the idea of news travelling down the 'bush grapevine' was commonly discussed.

"Getting off the train, walking past here (NSP), other people might see. Other family members like an uncle or aunty might see and then tell mum and dad and then the grapevine creates a massive thing." [consumer]

Family on staff was reported as a barrier to accessing NSPs at AMS or regional hospitals by multiple consumers and staff.

"If you got a drug problem and you go in there, and your aunty's in there working, you don't want to go in there. [chuckles] We have really extended family, which is our immediate family, so there's the shame in that. The Aboriginal network is very tight-knit. Word of mouth goes faster than the internet for Aboriginal people. Yes, I reckon there's a massive amount of shame because obviously when that person comes in, it's not like … a doctor and a patient." [Key informant]

One staff member told a story about a group of Aboriginal PWID who preferred to break into safe disposal units in a park, to gain access to used syringes, than to access sterile syringes from the hospital next door to the park.

"They were breaking into the units to access the equipment and the reason for that, although there was an NSP on the other side of the park, equidistant to the toilets that they were breaking in to use the equipment. We saw that they didn't want to go into the hospitals and be identified as injecting drug users. Under those circumstances, so right outside an NSP, they would rather go into the toilet block and use another person's used piece of equipment than get something sterile from the NSP." [NSP staff]

Consumers and staff both noted that tension between peers could lead to an avoidance of certain NSPs.

"The other thing is that they're liaising with other drug users, dealers, customers things like that. That's another thing. I'll have someone here and then they look in the courtyard and see someone coming and they just leave really fast." [NSP staff]

Similarly, staff also noticed trends of their Aboriginal consumers prioritising anonymity.

"I've noticed certain Indigenous people, they'll scout to see who's in here first

because they might not want to be recognised by another person that's already in here. They will check when they're leaving, who's outside. … they don't want to see this person or they don't want to see that person." (NSP staff)

Staff also discussed some issues with health workers upholding patient confidentiality and thus deterring consumers from accessing NSPs. This was more common in the regions.

"We do have people saying things like they can't go to their local hospital to get equipment because their aunty works there. Health workers are supposed to be confidential but that doesn't mean that people have confidence in that. That's a significant issue." [NSP staff]

Locations

The location of an NSP was a barrier for some consumers to access NSPs. Barriers mentioned by consumers included living in a suburb not serviced by a mobile van; not having transport to an NSP; or an NSP being located in an area of town that the consumer did not want to go to.

"They need to get a shot, a fit, but they're in a suburb… No one's going to loan their car to drive them here because they don't have a licence." [consumer]

Other location-related barriers included consumers not being aware of an NSP location due to it being relatively discreet and/or lacking signage, or an NSP being located near a service or organisation that does not feel 'safe' for some Aboriginal PWID. Examples given included being close to a Police station or where Police patrol, or close to Aboriginal Legal Services.

"I know because [the NSP is] located close to the vicinity of the Perth Watchhouse which is the police station up in Northbridge and because when they do their rounds-- when you've got your whatever drugs it is and you want to get your fits you're scared that the cops will pull you over." [consumer]

NSP staff also mentioned similar barriers, with transport and distance being mentioned multiple times. One regional NSP was purposely located next door to an Aboriginal Health Service. As the NSP is relatively new, the staff member was unsure if the location served as a barrier or motivator to attracting Aboriginal consumers.

"I think one of the main reasons we're based in this building is for that purpose of making ourselves visible and welcoming for Aboriginal people." [NSP regional staff]

A different regional NSP had the idea of being co-located with an AMS vetoed by the consumers in the community, due to the perceived lack of confidentiality.

Service availability

Multiple consumers and staff mentioned opening hours of NSPs as a barrier to accessing sterile equipment.

"Well, then you'd have to come up with some money to go to a chemist. Well,

that's when you fall back, you start using your own fit again, and there's no other way around it if you haven't got a clean one, well you haven't got it." [consumer]

Consumer attitudes

A common theme discussed by consumers was that their peers would not visit an NSP due to a perceived "don't care enough" attitude. The reasons for this attitude appear to be complex.

"A lot of people are just lazy. They just hurry up when they get it (drugs) and then go and have it straight away." [consumer]

"When I feel lazy and I know you guys are open and I can't be bothered getting on the train, so laziness and impatience is a big one for me. Like that day I shared with my friend, we were right near a train station when you guys were open, so, impatience." [consumer]

Rely on peers for sterile equipment

Consumers commonly discussed having peers who relied on others to get their equipment and thus felt no need to visit the NSP themselves. Some staff also shared this view. Some consumers mentioned drug dealers being a source of sterile equipment. It was apparent, however, that consumers have alternate sources of equipment other than NSPs, such as a reliance on peers for sterile injecting equipment. Opening hours were mentioned by consumers often indirectly, in discussions about secondary supply where "NSPs not being open" was a reason often given to why people liked/accessed secondary supply.

"When you see them, I don't know why, but they seem to ask people off the street. "Got any fits? Any fits?" But they won't come and see you guys." [consumer]

"They have people that have just always come in. They collect from people and then come in, and they might do a thousand exchange." [NSP metropolitan staff]

Not wanting to carry equipment and authority issues

For some members of the study's target demographic, not wanting to carry used or sterile equipment was a barrier to accessing NSPs. If one did not want to have more than one needle on them at one time, the perceived importance of obtaining multiple needles from an NSP was most likely not very high. One consumer who was street present explained that they felt it was not safe to have equipment on them, used or otherwise. Discussions around Aboriginal people being a target for Police or rail security were also common. For context, the Public Transport Authority Act 2003, section 21B states "A person, other than an authorised person, a security officer or a member of the Police Force in the proper exercise of his or her duties, who, without lawful excuse, possesses any one or more of the following things on or in Authority property commits an offence —a syringe other than a syringe for the administration by or for a person of a medication obtained by prescription".[47]

"Because we're on the streets and sometimes police officers, I hear that they are actually charging people [for having equipment on them]. They charge people if they have them." [consumer]

Some staff also discussed storing equipment or having equipment on one's body as a barrier to accessing NSPs.

"An Aboriginal person, just by being Aboriginal is significantly more likely to be picked up by law enforcement. If you're significantly more likely to be picked up by law enforcement, then you're not going to want to carry high volumes of equipment. You're going to be more likely to re-use equipment that you have access to…I've seen cases with Aboriginal consumers where they will prefer to, in some cases, stab a needle into a tree to come back and use later, than carry a sterile syringe on them." [NSP metropolitan staff]

MOTIVATORS FOR ACCESSING NSPS

Motivators for accessing NSPs discussed included: incentives other than obtaining injecting equipment; a positive attitude towards sterile equipment; price of, and quantities of equipment allowed to be obtained at NSPs; opening hours and location of NSPs; rapport with staff and referral by friends or family.

Incentives

A major motivator discussed by both consumers and staff to visiting an NSP was access to items other than injecting equipment. Incentives mentioned included fruit, cold water, Easter and Christmas gifts, a toy box for children, an opportunity to have a yarn, get a smile, access to basic first aid such as bandages and plasters, and soap.

"That was the first thing I noticed about when I come here. There was fruit at the table, and that was the best thing because blackfellas, we got to have our fruit." [consumer]

Wanting to use sterile equipment/attitudes to "freshies"

Consumers who felt there was a benefit to using sterile equipment spoke about this being a reason to visit NSPs.

"I use clean needles. It takes two seconds and it's simple and clean, you know?" [consumer]

"I can go in and get freshies because it is healthy for you and makes you feel better in yourself that you're being clean…. I'm a user and I like to use it in a clean way and healthy way you know what I mean." [consumer]

Free equipment

Obtaining equipment from an NSP free of charge was also discussed as an enabler to NSP access by multiple consumers and staff. At primary needle and syringe exchange programs (NSEP), such as those in the research project, 1 ml and 0.5 ml syringes with tips are free when exchanged one-for-

one. Consumers can also receive syringes free of charge, without exchanging used syringes, up to a maximum number.

At NSPs, there is no cost for needles and syringes. At NSPs, regardless of whether the premise is an exchange, items such as alcohol swabs, sterile cotton, and safe disposal bins are also given to consumers free of charge. Some more expensive equipment, such as certain filters, carry a small cost to decrease the risk of wastage.

> *"Well the best thing is that it's free." [consumer]*

> *"I think I found that there was probably more Indigenous people that came to us because it was free [instead of having to pay at a pharmacy]." [NSP regional staff]*

Quantities

Policies enabling access to relatively large quantities of sterile equipment in one transaction at an NSP were discussed by a few consumers and staff as a motivator to visit an NSP. Each NSP has a different policy for the amount of injecting equipment they can provide. Generally, there is a limit of 25 needle and syringe packs per day, per consumer. Before a long weekend, the limit may be increased to 50 needle and syringe packs. Some consumers can request 50 needles and syringes if travelling regionally.

> *"You can get them [needles and syringes] in abundance, every time you use, you can always use a clean fit." [consumer]*

> *"For me, the big one changed when I was able to get 20 [needles and syringes] as opposed to just two [needles and syringes]." [consumer]*

Staff differed in their approaches to the quantity of equipment they were willing to provide. It appears policies are in place but they may be flexible, at the staff's discretion.

> *"We're not supposed to give any more than 25 to a single person in a day. If somebody is from a regional area and we know that they're going to have a problem getting access we will give them more. If somebody is coming in on a regular basis and they're always wanting more then we'll have a brief intervention where we'll have a little bit of a chat. If somebody is just out in the car and they don't want to come in and say, "I'm just getting it from my friend," we'll usually coax them in nicely by saying, "Your friend has to come in and get them. Here's your 25. You can go and now your friend can come in. This is the way we have to do it." Sometimes that doesn't work but most of the time it does." [NSP metropolitan staff]*

Location

The location of an NSP could also be a facilitator to NSP access. For example, being close to services used by street present people made accessing an NSP quite convenient.

> *"It is convenient. It's close to a train station. When you come into the city to do*

your business like your appointments, government appointments that we have scheduled, or whatnot, we can always pop back in here close to say Tranby's where we can grab a bite to eat or something in the morning and then [after] Tranby's … You can come here and get your clean syringes." [consumer]

Accessibility by train, foot, or easy parking was also discussed as an enabler to accessing NSPs.

"A lot of the clients will get up on the bus or a lot of them access us on foot or with bikes." [NSP metropolitan staff]

Rapport with staff

Another major motivator or enabler to accessing NSPs, discussed by consumers, was good rapport with staff. The theme of 'trust', 'no judgement', and 'familiarity' came up frequently.

"I like coming in here because you know my face. You know me, not personally know me but you know my face…You're not here to judge." [consumer]

"That I'm able to walk through the door and I'm not going to be stared at or freaked out or stereotyped." [consumer]

Staff also shared similar views, when questioned about what they think works well at their service for Aboriginal consumers.

"We're not judging. I'm certainly- my face and my hair, and my composure is probably pretty crazy and pretty relaxed." [NSP regional staff]

"They have very much a respect for us because we have a respect for them." [NSP regional staff]

Staff frequently talked about consumers seeming to value the confidentiality or trust of the staff, and that the key to this was time and consistent behaviour.

"It takes a little while, I've found, for them to, when they see a new face, to be trustworthy with you, and rightly so…Once you demonstrate who you are, then actually the relationship is really quite nice. I find people coming in again and again." [NSP metropolitan staff]

"It's taken a while, but now they're comfortable with me, they know that there's no judgment or stigma." [NSP metropolitan staff]

Another theme was that "genuine concern and care" by staff seemed to be perceptively picked up on by consumers.

"They can read what sort of person you are. They know whether you're being authentic or not. They know that from the get-go, most times. If you're consistently you, then that goes a long way. ... That puts people at ease. A lot of these people, maybe this is the only interaction that they get in the daytime

where somebody is being authentic with them, or not wanting something out of them, or demanding that they be something that they're not." [NSP metropolitan staff]

Aboriginal staff

Two consumers mentioned that having Aboriginal staff working at an NSP could encourage Aboriginal PWID to access the service.

"I reckon more Indigenous of my age group working here… that would help heaps. They can communicate with you the Nyungar mob and they can help white boys too." [consumer]

One consumer mentioned some older Aboriginal people may not feel comfortable with the non-Aboriginal staff.

"A lot of the younger ones don't have something against the white people, but the older ones haven't really got, well some of them do because they were brought up that way." [consumer]

Referral by friends or family

A common theme for consumers was the idea that if a family member or friend could "*vouch*" for a service, they were more likely to attend themselves. It was also the most common way, among our consumer interviews, of becoming aware of NSPs.

"I didn't even know there were places like these until my cousin sister." [consumer]

"Friends or family, one of the two that I just followed came along the road and then I realised what it was about that you didn't have to pay anything." [consumer]

BARRIERS TO ACCESSING NSPS FOR ABORIGINAL PEOPLE WHO INJECT DRUGS AND WHO DO NOT ACCESS NSPS

Overall, the barriers to accessing NSPs expressed by consumers who do not access NSPs were very similar to those provided by consumers who do access NSPs and reasons for not accessing suggested by NSP staff. Shame was mentioned as a barrier, for reasons including "*they straight out know you're a junkie*" or being an Elder and not wanting other community members to know one is a person who injects drugs. A lack of convenience due to location was also mentioned as a barrier to access.

Unique to this group were comments that people may not access NSPs because they do not know what an NSP does or where they are located. It was suggested this may be linked to low English proficiency, particularly if a consumer is visiting Perth from a remote community.

Sources of injecting equipment

Consumers interviewed who do not access NSPs obtained injecting equipment from a diverse range of sources including chemists, peers or bins.

Re-using and sharing of injection equipment

Re-using one's own injecting equipment was very common. Awareness of the risks involved in sharing injecting equipment also seemed common.

> *"I know it's risky [sharing needles] but the need is too great, it takes over." [consumer]*

Increasing access to NSPs for Aboriginal PWID

Suggestions for increasing access to NSPs for Aboriginal PWID included having Fitpacks® be available at no cost at chemists and utilising peer word of mouth, with peers educating peers that NSPs exist, where they are and what they do.

> *"You gotta just talk to people, ask people around." [consumer]*

These suggestions were consistent with those made by consumers who do access NSPs.

REGIONAL AND REMOTE CONSUMER EXPERIENCE VERSUS METROPOLITAN

Of the 32 consumers interviewed, 10 consumers occasionally, or frequently, travelled regionally although it should be noted that not all consumers were asked if they travelled regionally. No data were able to be collected from consumers based in the regions, following several attempts. The reasons for 'no shows' at pre-arranged appointments are unknown but unsurprising given the irregular schedules of consumers. Seven staff involved in regional NSPs were interviewed. Overall, regional staff mentioned barriers and motivators to NSP engagement that were similar to responses by metropolitan staff.

Many consumers that travelled regionally commented that they "*stocked up*" on unused equipment before heading regionally. Others mentioned they did not "*use*" in their home regions, out of respect, while vending machines were mentioned as a positive of being a PWID in the country.

> *"I always made sure I packed up from down here and took it up there for myself without anybody else knowing." [consumer]*

> *"My family, they don't allow it. They all know I use drugs and everything, but I don't like them seeing me on it." [consumer]*

Others mentioned going out of their way to get equipment from a town where they were less likely to be recognised. This was corroborated by staff.

> *"When I was living in the country town, I made sure I went to the town down the road to get my fits so that in case a nurse or a doctor or a cleaner whose family works there saw me [at local NSP] because the grapevine is, "Oh my God, [consumer]'s a massive biggest dealer in town." It's like, I just walked in to get a fit pack." [consumer]*

> *"In rural regions and remote areas access is kind of patchy, and also, there are huge concerns around confidentiality in small communities and small towns.*

> *How people access in those areas is very different. We know people who drive considerable distances to get to a town where nobody knows them, to access injection equipment." [NSP metropolitan and regional staff]*

Multiple staff commented that due to the diversity of each region, there was no "*one size fits all*" model of an effective NSP service.

> *"I think it's really interesting because each region as well is completely different, in WA. That's what makes it hard as well because everywhere is so diverse." [NSP regional staff]*

Long distances to travel to an NSP were mentioned as a barrier to access, a theme that is universal to accessing services in non-metropolitan areas.[48] This issue is further exacerbated by the lack of public transport in regional or remote areas.[48] One way consumers managed to obtain equipment in the regions was secondary supply.

> *"It's quite a common thing [secondary supply]. Why would three of you come down if you lived in the same house when one of you can come down? People come down from Lancelin and Jurien Bay and these exchange high numbers [of syringes] for a community." [NSP metropolitan staff]*

Consumers relying on secondary supply for sterile needles is not unique to regional NSPs. Studies currently show secondary supply is most common among people who inject heroin or stimulants, receive methadone equipment, are young, relatively "new" injecting drug users, or are isolated from services. [35]

SECONDARY SUPPLY

In the current study, 25 (78%) consumers who access NSPs interviewed were asked if they identified as a secondary supplier. Sixty-eight percent (n=17) of consumers asked identified as being a secondary supplier, supplying "*freshies*" to their family and friends. Due to the illicit nature of both injecting illicit substances, and providing injecting equipment to others, the frequency of secondary supply is most likely significantly higher.

Who are the recipients of secondary supply of equipment?

Consistent with previous Australian studies, secondary supply was reported to usually occur among small networks of social groups, friends, and intimate partners.[40] Most participants distributed to family and friends.

> *"It's just the little circle that I'm in or whatever." (consumer)*

Motivations for secondary supply

The main motivator for secondary supply appeared to be a desire to help others. It was commonly mentioned that drug dealers often supply their clients with sterile injecting equipment, though motivations for this were not discussed.

> *"We have had a few Aboriginal family members come in and collect on behalf of their nieces and nephews or cousins, from what we can tell from what those people will tell us. The person who's coming in isn't necessarily an NSP*

consumer but they're collecting on behalf of the people whose behaviours they're very worried about. They worry about people who have very high-risk injecting behaviours." [NSP regional staff]

"I get freshies for others as well because I find that if you use a needle more than once or twice you're going to get some sort of disease so I give my friends the freshies all the time and myself." [consumer]

One staff member commented that she had noticed some consumers 'bargain' with each other and exchange 'shots' for sterile equipment.

Method of secondary supply

Most consumers and staff reported that secondary supply is usually not done formally, but alongside drug-using day-to-day activity, and on a small scale among friends and family. Secondary suppliers usually obtained more equipment than needed for personal use and distributed any extra equipment.

"If I've got more than enough equipment on me, I'll help out other people." [consumer]

A common theme was that "*people just knew who to ask*" when it came to who would distribute sterile equipment. Drug dealers were mentioned by multiple participants as distributors of sterile equipment.

"People will go – if they've got to go to the dealer's house, they'll ask, "Have you got a clean?" A lot of times they do. That's where they get it from, from the dealer." [consumer]

"By the end of the day, there's 10 people who have asked me [for a needle]." [consumer]

"You may meet up, you might go to a park and four or five of you is waiting on the same bloke to get on, and that there, and once you get it you'll all walk off and go. "Got any fits my brother?" "Got any fits?" And then you'll go "here my brother". Give them a couple of fits." [consumer]

Staff and key informant attitudes to secondary supply

Staff were overwhelmingly in support of secondary supply laws being reviewed so that peer supply of equipment was made legal.

"I think it's awesome when people are happy to get equipment for other people. Especially, if those other people aren't willing to come to the service themselves because it does mean that people still have access to sterile injecting equipment." [NSP metropolitan staff]

I'm all for it, but I do try and get people to say, "See, it's comfortable. There's no issues here [coming to the NSP], please…" I want them to have clean equipment."[NSP metropolitan staff]

There were also some negatives to changing current laws discussed, such as consumers on-selling equipment, supplying large quantities leading to a lower return rate on used equipment, and a missed opportunity to provide health promotion or professional support to consumers.

There appeared to be, in staff responses, a balance required to their obligations to the law and ensuring consumers had access to sterile equipment.

> *"If somebody wants more than they're allowed I always say to them, and I think everyone is the same, "Is this for other people as well? Is there any reason why that person can't come in?" Suss them out." [NSP metropolitan staff]*

Staff were in support of secondary supply laws being changed so that peer supply of equipment was made legal.

> *"I don't see how there will be any harm in removing laws against secondary supply. I'm not exactly sure what they're preventing happening, and as I said, it's already happening in practice." [NSP metropolitan staff]*

> *"It's a needle and syringe to prevent blood-borne virus. You should be able to give it to your mate." [NSP metropolitan staff]*

RE-USING INJECTING EQUIPMENT

Amongst the project's consumers who accessed NSPs, re-using their own syringes was extremely common with 75% (n=24) of consumers reporting they re-used their own syringes. Re-using one's own syringes was also common among consumers who do not access NSPs. Reasons for re-using often included needing a sterile syringe when NSPs were closed, impatience to source a clean syringe to use drugs, and the aforementioned barriers to NSP access.

Risk management

Some participants discussed how they minimised the risk involved with re-using syringes. This included: cleaning used equipment, having a limit on the number of times a syringe would be re-used, or re-using a syringe that had not been re-used repeatedly.

> *"It depends on if you do know most people that will have fresh darts on them and whatnot. If not, you just go back towards your old one but I don't use my old one more than twice." [consumer]*

> *"I just go through one of my bins, pick one that almost seems fresh, one I've used once because I use them once, and chuck them." [consumer]*

One participant commented they would never share a needle, so re-using is the safer option.

> *"I won't do that. I may have used my own fit over and over again." (consumer)*

SHARING INJECTING EQUIPMENT

For this project, sharing equipment refers to sharing injecting equipment with others after using or using injecting equipment after someone else (receptive sharing).

Prevalence of sharing injecting equipment

Overall, 44% (n=14) of consumers who access NSPs, interviewed in the project, shared injecting equipment. In the sample, 22% (n=7) reported receptive equipment sharing and someone using their equipment, 9% (n=3) said someone had used their equipment only and 13% (n=4) of consumers said they had been involved in receptive equipment sharing only, over the past 12 months. Of the consumers who do not access NSPs, two of the four consumers interviewed stated they shared needles, both receptively and distributively.

People with whom consumers share injecting equipment

Consumers commented they usually only shared injecting equipment with someone they knew well, such as an intimate partner, family member, or friend.

> *"I've never done it with someone I don't know. You know what I mean?" [consumer]*

Reasons for sharing injecting equipment

The reasons for sharing injecting equipment were not extensively explored in the interviews. However, of the consumers who did comment on why they shared injecting equipment or staff who had ideas why consumers may share injecting equipment, reasons included: not having enough sterile needles available, not knowing where to get sterile needles, no access to sterile equipment in prison, sharing is part of the injecting behaviour they've been taught and trusting the people they share equipment with.

> *"[NSP metropolitan staff]: Because they can pick one up off of their brother that, until it snaps, it's still good to use.*
>
> *[Interviewer]: That's safe?*
>
> *[NSP metropolitan staff]: Yes, [they think] that's safe. We've got the same blood. They don't think of the harm. They haven't got the knowledge of the harm around it."*

To the best of our knowledge, this project is one of the few pieces of research to focus solely on Aboriginal PWID and their use of NSPs and the only qualitative research focussed solely with Aboriginal PWID in Perth and NSP access since Gray et al's (2001) study.

LANGUAGE USED FOR DRUGS, NSPS AND INJECTING EQUIPMENT

There was great diversity in the language used for drugs, NSPs and injecting equipment with more than 19 terms for drugs, 21 terms for NSPs, and 19 terms for needles or syringes. Most commonly used words for needles included 'freshies', 'darts' and 'weapons'. The large range of terms used to describe NSPs and injecting equipment is useful for the development of health promotion, education and communications interventions concerning harm reduction and accessing NSP services.

19 terms for drugs

21 terms for NSPs

19 terms for needles or syringes

REASONS FOR NOT ACCESSING NSP SERVICES

Yarns showed the most common barriers to accessing NSPs were shame, a lack of anonymity (including amongst peers and/or drug dealers), concerns confidentiality won't be upheld, location of NSP not easily accessible by foot or close to a government service where disclosure of being an injecting drug user is not desirable (Police station, government welfare or legal service), opening hours of NSPs, carrying injecting equipment, relying on peers for sterile needles, and consumer attitudes towards using sterile needles. These findings are congruent with the existing limited literature in the area, which also highlights the barriers affecting Aboriginal PWID from accessing NSPs is similar to the wider PWID population.[7, 8, 10, 12, 19, 28, 40] Less focus has been given on how consumers' attitudes can be either a barrier or motivator to accessing NSPs and warrants further qualitative exploration. The need for anonymity may also be stronger in Aboriginal PWID as opposed to non-Aboriginal PWID, though this requires further investigation.[7]

Stigma and shame

Notably, in the current research and the research focused specifically on Aboriginal PWID, the concept of shame was the most common barrier suggested by consumers, NSP staff, and key informants as a barrier to NSP access for Aboriginal PWID.[7-10] The sources of shame for participants in the current project included cultural (being seen by other Aboriginal people as an injecting drug user), self (internalised), and from the wider community, including health professionals. Shame appeared to be closely associated with stigma. These findings are in line with available literature on Aboriginal PWID. Multiple overlapping stigmas associated with the cultural concept of shame, and stigma associated with being a PWID are barriers to accessing harm reduction services.[7-10]

DISCUSSION

MOTIVATORS OR FACILITATORS FOR ACCESSING NSP SERVICES

Data from the yarns highlighted several motivators or facilitators for NSP access by Aboriginal PWID. These included incentives other than injecting equipment, a positive attitude towards sterile injecting equipment, free and large quantities of injecting equipment, location (close to links with public transport, or services for street present people), rapport with NSP staff, and referral by friends or family.

Literature focused on enablers to NSP access for Aboriginal PWID is limited, with the limited literature being more focused on barriers.[7, 8, 10, 12, 19, 28, 40] However, the available literature discussing both Aboriginal and non-Aboriginal PWID also found little to no cost, flexibility with quantities of equipment allowed per visit, location close to frequented services, easy access, and a good rapport with staff as enablers to NSP access.[7, 8, 10, 12, 19, 28, 40]

To the research team's knowledge, there is currently no literature exploring incentives such as fruit and hygiene packs as motivators for Aboriginal PWID to access NSPs, nor in the Australian literature on PWID more broadly. Provision of more holistic services as a motivator to engaging Aboriginal PWID in harm reduction services and reducing the shame and stigma of accessing services warrants further investigation.

Multiple participants consulted in the Australian Department of Health project[7] stated that NSPs needed to be culturally appropriate but it was not clear what this involved, with some participants saying an abandonment of Aboriginal cultural tradition effectively occurred once somebody became a PWID.[7] As previously mentioned, the importance of anonymity has been reported as a barrier to accessing NSPs at Aboriginal specific services.[7, 11, 15, 28] However, it was still evident that NSPs could be intimidating to Aboriginal PWID.[7, 12] Aboriginal staff, displaying relevant materials (such as the Aboriginal flag) or offering an NSP at sites that have already been established within the local Aboriginal community as "Aboriginal friendly", even if they are not an Aboriginal Community Controlled Health Organisation (ACCHO) specifically may facilitate access to NSPs for Aboriginal peoples.[7]

Overall, the current project highlights ways to make NSPs more culturally appropriate, however many of the suggestions, in the form of barriers and facilitators to accessing NSPs, could be generalisable to the wider PWID community. The research team did not ask consumers specifically if an Aboriginal flag, Aboriginal staff, or an NSP co-located in an ACCHO would facilitate NSP access. Open-ended questioning 'Is there anything that would make the service better for you or other consumers?' did not yield responses stating Aboriginal flags or similar would be an improvement, however, two consumers did express that Aboriginal staff may make an NSP more inviting. In light of the importance of anonymity for Aboriginal PWID, a balance is needed with interventions that encourage access to NSPs that allow Aboriginal PWID to feel safe and anonymous, while utilising the benefits having Aboriginal staff at an NSP can bring.

SECONDARY SUPPLY: OBTAINING EQUIPMENT FOR OR FROM OTHER CONSUMERS

The findings from this project are consistent with current literature on PWID as a broad community and secondary supply.[15-17, 41] In the current study, 68% (n=17) of consumers interviewed who were asked about secondary supply identified as being a secondary supplier. International literature reports that of NSP attendees, between 28%-75% participate in secondary supply.[15] Due to the illicit nature

of secondary supply and the substances used for injecting drug use, it is hard to estimate the true prevalence of secondary supply both in the project's sample and in the wider PWID community.

The findings from our study are also consistent with existing literature, where the primary motivation of secondary exchange providers is a desire to help others.[14, 15, 17] Consumers in this current study carried out secondary supply in an informal manner amongst their peers, or with drug dealers. This is congruent with the findings by Newland et al (2016), where 71% (n=22) of participants in the study who participated in secondary supply, did so for reasons of convenience, amongst small networks of partners and friends.[15]

These studies challenge the illegality of secondary exchange and conclude that if secondary exchange were to be legalised, NSPs may be able to harness peer networks by engaging secondary exchange providers as peer educators to reach injecting drug users who do not access NSP services.[14, 17, 39]

RE-USING SYRINGES

In the current research, consumers were asked if they had re-used their own needles in the past 12 months, with 'sharing syringes' referring to someone else using their syringe. Amongst the project's consumers who access NSPs, re-using their own syringe was extremely common with 75% (n=24) of consumers saying they re-used their own syringe. Re-using one's own syringe was also common amongst consumers who do not access NSPs interviewed for this project. These findings are considerably higher than reported in the Australian Needle Syringe Program Survey (ANSPS), where in 2019, the prevalence of re-using own syringes in the last month was 8% (n=217) of participants (Aboriginal and non-Aboriginal).[3] As this question was only asked in the context of the last month as opposed to the current project asking about re-using one's own syringe in the past 12 months, this may account for the difference in reported prevalence.

The 2019 Illicit Drug Reporting System (IDRS) report showed an increase of Aboriginal and non-Aboriginal people reporting to have re-used their own needles in the past month at 44% (n=397) compared to 37% in 2018.[42] The significantly different rates of re-using own equipment could also be accounted for due to the mode of interview/survey administration, as the ANSPS is self-administered by consumers[3], whilst the IDRS and current research are interviewer-administered.[42] The majority of consumer interviews in the current research were undertaken by peers. There is a possibility consumers felt more comfortable reporting risk behaviours to peers, and warrants further investigation.[43]

SHARING INJECTING EQUIPMENT

Prevalence

Overall, 44% (n=14) of consumers in the project who accessed NSPs shared injecting equipment either receptively only, distributively only, or both. In our sample of consumers who access NSPs, 22% (n=7) of consumers reported both receptive and distributive equipment sharing, 9% (n=3) reported distributive equipment sharing only, and 13% (n=4) of consumers said they has been involved in receptive equipment sharing only, over the past twelve months.

44% **Percentage of consumers who accessed NSPs and who shared injecting equipment**

22%

Percentage of consumers who accessed NSPs and who shared injecting equipment both receptively and distributively

9%

Percentage of consumers who accessed NSPs and who shared injecting equipment distributively only

13%

Percentage of consumers who accessed NSPs and who shared injecting equipment receptively only

In the 2017 Australian Needle and Syringe Program Survey, 26% (n=120) of respondents who identified as Aboriginal or Torres Strait Islander reported receptive sharing of injecting equipment, compared to 15% (n= 312) in non- Aboriginal or Torres Strait Islander participants.[4] The survey did not stratify the prevalence of distributive equipment sharing by Aboriginal status. In a study of Aboriginal PWID from 1999 by Gray et al, 43% (n=32) of participants reported they 'normally' shared injecting equipment when they injected.[19] Of these, 14% (n=10) reported distributive injecting equipment sharing only, with the remaining 22 participants reporting both receptive and distributive sharing of injecting equipment.[19]

In the month before the 2019 ANSPS survey, 17% (n=444) of consumers (Aboriginal and non-Aboriginal) reported receptive sharing of syringes (distributive sharing of injecting equipment was not reported on).[3] In the 2019 IDRS report, 8% (n=72) of consumers reported receptive syringe sharing, and 11% (n=99) reported distributive sharing of injecting equipment.[42] These findings are comparable to the results in the current study, highlighting there is still a need for harm reduction messages concerning safer injecting practices to be highlighted to consumers.

People who share injecting equipment

Consumers commented they usually only shared syringes with someone they knew well, such as an intimate partner, family member, or friend. This is consistent with findings in the study by Gray et al (1999), which reported that consumers usually only shared syringes with someone they knew well, such as an intimate partner, family member, or friend.[19] This is also supported by the current literature on the wider PWID community.[8, 44]

OUTCOMES AND STRENGTHS OF CO-DESIGN METHOD

Co-design is about bringing all members of the project along on the 'research journey'. Outcomes of the co-design process are likely to have ongoing benefits into the future, independently of any interventions.

An outcome from the co-design method utilised in this project included the opportunities provided for co-design participants to increase their awareness of other organisations providing services to Aboriginal PWID and build their knowledge of harm reduction. Existing relationships between NSP organisations were strengthened and new connections and awareness of other services were established. This is an important outcome to support a more integrated service system for Aboriginal consumers and will provide a solid foundation for the planned interventions arising from the research findings.

The involvement of NSP staff in all research activities including seeking ethics approval, study promotion, participant recruitment, designing data collection tools, conducting yarning sessions, interpreting findings, reporting, and dissemination of key findings, including at an international conference, have provided an opportunity to enhance research and evaluation capacity within NSPs and raise the profile of the work NSPs do with a wider audience. For example, some Elders and key informants involved in this project were concerned about injecting drug use in Aboriginal communities but had limited knowledge of NSPs before the research. The project provided an educational opportunity for these participants. NSP staff also valued the opportunity to engage with consumers accessing NSPs for the purpose of research. The yarning discussions have further strengthened the relationships between NSP staff and some consumers. NSP staff were also given an opportunity to further develop their research and interviewing skills.

The leadership and support from the AAG and CDWG (which included Aboriginal PWID) were critical in achieving the outcomes of this exploratory research. For example, participants were not recruited by researchers but through existing, trusted relationships between Elders and key informants or relationships between NSP staff and consumers. This included a consumer helping one service provider to recruit and have yarns with participants, as a result of the strong relationship the service provider had with the consumer. The service providers felt having a consumer assist with recruitment and the yarning sessions meant they were able to recruit more participants than planned, and found the support from the consumer to conduct the yarning sessions was invaluable.

Finally, the culturally safe involvement of Aboriginal consumers in the co-design process was a particularly important outcome and strength of this research. Consumers were able to offer their insights and feedback one-to-one with NSP staff they knew and trusted. There was no requirement to participate as part of the larger CDWG. Some of these individuals subsequently expressed their pride in assisting with the research and interest in further involvement, including with outreach activities to recruit consumers who do not currently access NSPs and with intervention planning. Participation in the research was reported as a highly positive experience for these consumers and provides evidence

that actively engaging members of a marginalised population in conducting sensitive research is important and achievable.

Challenges in the co-design method

Challenges in utilising a co-design methodology were mainly logistical. This included organising large group meetings and coordinating a meeting schedule that was convenient to the majority. Using a meeting scheduler app greatly facilitated this process.

Another challenge was determining how best to facilitate a meeting with people from different backgrounds and establishing an environment that encouraged people to speak freely. Feedback was received from one of the Aboriginal NSP workers after the first meeting concerning feeling intimidated to attend the meeting and participate, due to the agenda including all participants' official titles. This feedback was incorporated into subsequent meetings, with professional titles no longer being included on agendas or minutes.

From the researchers' point of view it was at times challenging to 'take your hand off the reins' and not be involved directly in data collection. It required trust in the co-design method, acknowledging you may not be the 'best person for the job', and being open to learning from fellow CDWG members about the most effective research methods for the target demographic and the data collection setting (NSPs). Strong, transparent communication was central to ensuring all CDWG members involved in data collection were 'on the same page' and shared the aims of the research.

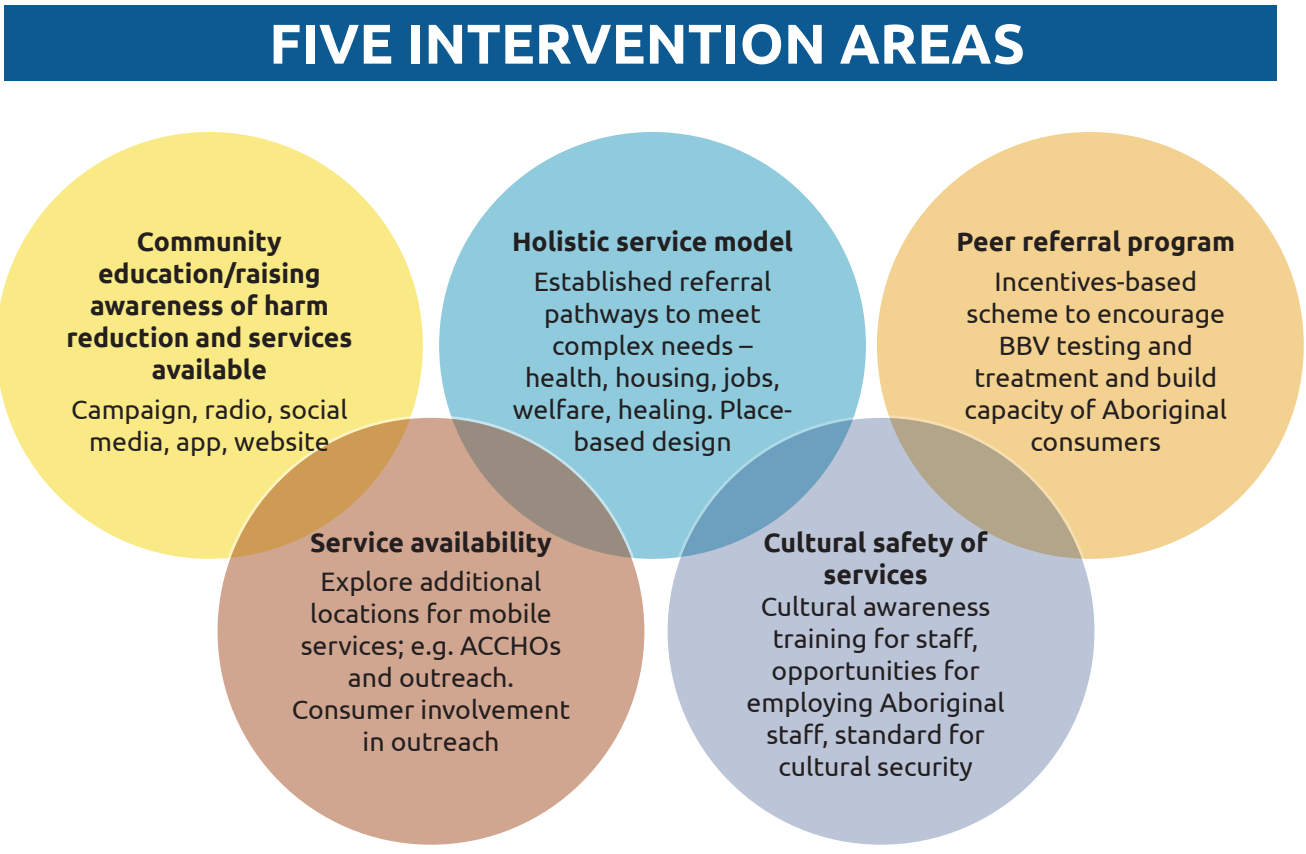
Enablers in the co-design method

Enablers included time spent building relationships with group members individually. This took the form of site visits to NSP service providers and yarns with CDWG members. Creating a safe space for all members to contribute their ideas and knowledge was essential and this was facilitated by holding the meetings in culturally secure venues, offering refreshments, and giving people plenty of time for open discussion. CDWG members could choose to participate in large or small group discussions, online, or in discussions over the phone or email. Flexibility was paramount to incorporate the needs and preferences of different members.

Overall, having an Aboriginal-led project enhanced the credibility and trustworthiness of the project. Involving Aboriginal consumers in the co-design process resulted in valuable insights to support data collection. An additional benefit of the co-design process for this project was that it provided opportunities for co-design participants to increase their awareness of other organisations providing services to Aboriginal consumers and increase their knowledge related to research methods.

Based on the project's findings, five areas of interventions were recommended for increasing access to NSPs for Aboriginal PWID (Figure 1). Best practice in Aboriginal health research suggests these interventions should be Aboriginal and consumer-led, using participatory action research (PAR).[39] Intervention planning should build on best practice guides for Aboriginal health promotion and existing initiatives for alcohol and other drug harm reduction with established identity and branding, to maximise shared resources, impact and sustainability.

Figure 1: Five intervention areas for increasing access to NSPs for Aboriginal PWID



INTERVENTION AREAS

1

Increasing cultural security of NSPs.

Findings from the research indicate enhancing the cultural security of NSPs could improve access to these services for Aboriginal PWID. A policy intervention targeting NSPs to develop a best practice guide/checklists to support services to enhance cultural security or obtain accreditation as a culturally secure organisation; and a cultural awareness training package for organisations providing services to Aboriginal consumers are recommended.

2

Community education and awareness campaign about harm reduction.

Participants indicated that if the Aboriginal community had a better understanding of the importance of NSPs, more community support may follow. A program intervention targeting the broader Aboriginal community and Aboriginal health professionals in the Perth metropolitan region to raise awareness about harm reduction and the role of NSPs would be advantageous.

3

Peer referral program pilot.

Findings indicated peers play an important role in access to sterile injecting equipment. A trained Aboriginal Peer Worker coordinating a program pilot and supervising five volunteer peer educators to share harm reduction knowledge and raise awareness of NSPs with other Aboriginal consumers should be trialled.

4

More holistic harm reduction service models.

The service system for Aboriginal consumers with complex needs is not well integrated and established referral pathways are required. Key informants highlighted the need for holistic services to meet the needs of Aboriginal PWID. An intervention to facilitate consultation between NSPs and other organisations providing services to Aboriginal consumers e.g. welfare, housing, to make recommendations towards building a more holistic, consumer-centric and integrated service system would be beneficial.

5

Exploring the feasibility of increasing NSP service availability.

Findings from this research indicated demand for increased NSP service availability. Existing available data should be examined, including service user demographics, service user evaluations, equipment distribution, notification data for blood-borne viruses, and costs associated with providing NSP services, to test the feasibility of additional mobile, outreach and after-hours services.

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