dealing with risk

a multidisciplinary study of injecting drug use, hepatitis C and other blood-borne viruses in Australia
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Australian National Council on Drugs 2003
Foreword

Hepatitis C and other blood-borne viruses and diseases are a significant public health concern, not only within Australia, but also internationally. Whilst the past successes of Australia’s approach to controlling the spread of HIV/AIDS have been duly recognised, the significant number of people being diagnosed with hepatitis C is a genuine public health problem and a real warning against complacency. Indeed, there are some clear warning signs and evidence that the rate of HIV/AIDS infection is beginning to rise again in Australia.

It is against this background that the Australian National Council on Drugs (ANCD) and the Australian National Council on AIDS, Hepatitis and Related Diseases (ANCAHRD) have jointly commissioned a project that closely examines some of the factors that contribute to the risk of blood-borne virus transmission, particularly within the population of injecting drug users.

A fundamentally important ingredient for Australia’s enviable record to date in controlling or addressing drug and blood-borne virus issues has been bi-partisan political support of policies and associated funding decisions. These decisions are influenced by the weight of evidence that is offered through research and other advice, establishing a persuasive case for programs that are developed with, and for, particular target groups. Partnerships are essential if progress is to be made; that is, cooperation and concerted efforts between individuals, community groups, advisory bodies, decision makers and governments.

_Dealing with Risk_ is a report that some may find challenging. It provides a case for thinking about risks in a more sophisticated way, which in turn suggests a need for more sophisticated responses. Above all, this report provides an excellent basis for increased dialogue and thoughtful consideration of how the Australian community can best prevent more HIV/AIDS, hepatitis C and other infection amongst its injecting drug user, and thus the broader, population.

It is with some degree of pride that, as Chairs of the principal advisory bodies to government on drugs and on blood-borne viruses, we have been able to work together to present such a report. It is more than symbolic, and the ANCD and ANCAHRD look forward to further opportunities to work together on these very important health issues.

Accordingly, it is with great pleasure that the ANCD and ANCAHRD commend this report. It is a pioneering and substantial report and our gratitude is extended to the research team for their work. Particular thanks must also be paid to members of both Councils, who have worked to develop, support and oversight this endeavour.

Yours sincerely,

Major Brian Watters AO
Chair
Australian National Council on Drugs

Mr Chris Puplick AM
Chair
Australian National Council on AIDS, Hepatitis C and Related Diseases

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Jo Kimber & Carolyn Day

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Acknowledgements

The authors wish to acknowledge the following organisations, staff and others for their assistance with our research. We thank the Australian National Council on Drugs (ANCD) and the Australian National Council on AIDS, Hepatitis and Related Diseases (ANCAHRD) for funding the research and the Council members who provided helpful feedback on drafts. In particular, we thank Professor Margaret Hamilton and Associate Professor Robert Ali of the ANCD and Professor Bob Batey, Dr Susan Caruthers and Ms Jude Byrne of the ANCAHRD. We wish to acknowledge the support of Council chairs, Major Brian Watters and Mr Chris Puplick, in jointly commissioning the work. We also thank Karen Price and Gino Vumbaca of the ANCD for their assistance throughout the project.

We are grateful to staff at the Kirketon Road Centre, Darlinghurst; New South Wales Users and AIDS Association (NUAA); Biala NSP, Brisbane; WA Substance Users Association (WASUA); South Australian Voice for IV Education (SAVIVE); Youth Link, Cairns; Wayside Chapel, Kings Cross.

We also wish to thank the key informants for this study and especially the many participants who gave their time and shared their stories so generously.

Finally, we acknowledge others who assisted us: Ms Emma Black, Ms Julie Hodge, Ms Lyn Lordi, Mr Stuart Loveday, Dr Kathryn Owler and Ms Clare Thetford.

Shortly before the release of this report, the ANCD and ANCAHRD were saddened to hear of the passing of Dr Margaret MacDonald. Dr MacDonald made some significant contributions to this report, and her research in the area of injecting drug use, needle and syringe programs, and blood-borne viral infections is highly regarded. Members of the ANCD and ANCAHRD extend their sympathies to those close to Dr MacDonald.
Preface

Dealing with Risk has been a project long envisioned and carefully developed by many people. In one sense, this research evolved in a way that is not so unusual; a conversation between colleagues expressing real concern about what it is we ‘aren’t getting’ about blood-borne virus (BBV) transmission among injecting drug users, and what to do about it.

In another sense, the development of this project is quite distinctive in that two ministerially appointed advisory bodies — the Australian National Council on Drugs (ANCD) and the Australian National Council on AIDS, Hepatitis and Related Diseases (ANCAHRD) — have combined to commission research to inform advice on reducing the incidence of BBV transmission among injecting drug users.

As one of the people involved in the development and oversight of this initiative, I am pleased to provide this preface to a report that offers some insight into injecting drug users’ experience and interpretations of ‘risk’, as well as data on their knowledge and drug using practices.

The report includes new data and re-presents other related information. It powerfully demonstrates that risk taking must be understood in the context of the environment of drug use and life circumstances of drug users. It tells us that we have not yet got it right — we are not delivering clear information or messages and we don’t sufficiently recognise the imperatives in some injecting drug users’ daily lives.

These insights have been made possible through generous cooperation and contributions from injecting drug users who agreed to allow researchers access to their experiences. Their experience provides a compelling context for understanding these data.

Unlike me, the injecting drug users studied are economically and socially marginalised. They nevertheless share core values with me in that they care about their health, their family and their other relationships, and they want to minimise risks to themselves, those close to them, and others.

These findings offer important opportunities to intervene and change the course of the hepatitis C epidemic among injecting drug users.

The two case study locations, Kings Cross (Sydney) and Fortitude Valley (Brisbane), have distinct characteristics. The messages nevertheless resonate with the findings of the focus groups conducted in other locations, and thus can help inform both specific, and more general, national responses.
Strategies to reduce the risks of BBV transmission among injecting drug users must be designed on the basis of evidence, using messages and methods that work for injecting drug users; not for scientists, researchers or public health officials. The ANCD and ANCAHRD commissioned this report to further understanding and responses to prevent the spread of BBV infection. To achieve this aim, this report must be carefully considered and not read as a curious, voyeuristic account of the day-to-day lives of a particularly marginalised group. It is our responsibility to apply the knowledge gained to future public health efforts to work with injecting drug users to reduce risk.

Finally, I would like to thank the participants in the study and congratulate the research team. The report reflects a high degree of professionalism and methodological diligence. This is quality research conducted by a group of dedicated people, whom I have been pleased to work with.

I hope that this report inspires some creative thinking and courageous policy development.

Professor Margaret Hamilton
Executive Member
Australian National Council on Drugs
## Abbreviations

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<tr>
<td>ANCD</td>
<td>Australian National Council on Drugs</td>
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<td>ANCAHRD</td>
<td>Australian National Council on AIDS, Hepatitis and Related Diseases</td>
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<tr>
<td>BBVI</td>
<td>blood-borne viral infection</td>
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<tr>
<td>CDIR</td>
<td>commercial drug injecting room(s)</td>
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<tr>
<td>HCV</td>
<td>hepatitis C virus</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>IDU(s)</td>
<td>injecting drug user(s)</td>
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<tr>
<td>KRC</td>
<td>Kirketon Road Centre, Kings Cross</td>
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<tr>
<td>LAAM</td>
<td>levo-alpha-acetylmethadol</td>
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<td>MMT</td>
<td>methadone maintenance treatment</td>
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<tr>
<td>MSIC</td>
<td>Medically Supervised Injecting Centre</td>
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<td>NSP</td>
<td>needle and syringe program</td>
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<tr>
<td>P–S–GI routine</td>
<td>pooling–scoring–group injecting routine</td>
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<tr>
<td>QoL</td>
<td>quality of life</td>
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<td>ROI</td>
<td>Risks of Injecting study (this study)</td>
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This report presents findings from a multidisciplinary project on risks for blood-borne viral infection (BBVI) among injecting drug users (IDUs) in two Australian contexts. The project aimed to examine the context of injecting and identify particularly ‘high risk’ groups.

Qualitative research was carried out in two locations: Kings Cross, Sydney, and the Fortitude Valley/New Farm area of Brisbane. A series of focus groups with current IDUs were also conducted nationally. The qualitative research was conducted toward the end of a substantial decrease in heroin availability (the ‘heroin drought’), resulting in behaviours such as higher levels of cocaine and other psychostimulant use. This affected some areas (Fortitude Valley/New Farm) more than others (Kings Cross). However, the data presented in this report cannot be seen as an aberration due to this phenomenon, as heroin availability had stabilised in Kings Cross by the time the research was conducted and the Fortitude Valley research focused on amphetamine use, traditionally the dominant drug in that area.

Quantitative research was carried out using the national needle and syringe program (NSP) survey. A pilot study of a quality of life (QoL) instrument designed specifically for IDUs was trialled to examine the impact of BBVI on IDUs’ quality of life.

The process of interpreting findings was collaborative, with the entire research team involved in building the overall picture. Qualitative and quantitative researchers and health educators worked in a dialogic fashion to collect, analyse and interpret data. The collaborative nature of this project served to focus the research team on ethical and practical issues, thus enhancing the development of research questions and augmenting the validity of findings and recommendations.

HCV and HIV among Australian IDUs

The prevalence and incidence of hepatitis C virus (HCV) are high among Australian IDUs, around 50 per cent and 20 per cent respectively. Conversely, the prevalence and incidence of HIV among Australian IDUs have remained low.

There are a number of reasons for the different rates of HIV and HCV among IDUs. HIV prevalence was low when harm reduction strategies were introduced, whereas HCV prevalence was already very high. Furthermore, HCV is a more robust virus than HIV and more easily transmitted. Therefore, transmission is likely via injecting paraphernalia such as spoons and filters as well as via needles and syringes.

Needle and syringe sharing, the primary mode of HIV and HCV transmission for IDUs, has decreased significantly since harm reduction strategies were introduced. Prevalence of recent needle and syringe sharing halved between 1995 and 1997 in the needle and syringe program (NSP) survey, a finding supported by other Australian research.

National needle and syringe program survey

Cross-sectional surveys have been carried out annually at selected NSPs to monitor HIV, HCV and related risk behaviour since 1995. Data about injecting risk behaviour obtained in the survey were used to obtain a quantitative context of the prevalence of risk practices nationally and highlight subgroups of injectors most at risk of acquiring blood-borne viruses.
Re-use of someone else’s syringe in the past one and six months was reported by 13 per cent and 19 per cent of participants respectively. The last sharing occasion generally occurred at the participant’s or a friend’s home. Participants most likely to report re-using someone else’s syringe in the month preceding interview were those aged less than 20 years, Indigenous Australians, those who had been in prison in the previous year, those who self-reported being HCV positive, those who had injected outdoors and those who were injected by another person.

Kings Cross case study

A socio-cultural approach was used to document and interpret risks for BBV transmission among injecting drug users in Kings Cross, Sydney’s foremost red light district. Technical aspects of risk practice were identified and situated in the context of everyday life.

Known IDUs or people within their injecting networks were approached by guides to participate in the study. Guides were chosen for their long-standing knowledge of the area, rapport with the researcher, an understanding of and interest in the research, and street credentials. The interviews were conducted in a variety of locations usually around the social centre of participants’ injecting lifestyle.

Interviews were conducted with severely marginalised IDUs, representing the extreme end of problematic injecting drug use. Nonetheless, the study found that most IDUs preferred not to take risks and attempted to minimise risk. Circumstances related to social and economic situations, group membership, power relations, the physical environment, health, policing and housing policy and service provision constrained participants’ ability to reduce risk. The majority of participants were concerned about contracting and transmitting HCV, but this was one of many concerns in everyday life.

Obtaining money to purchase drugs was the most difficult task of the day for study participants and their friends, and therefore was attended to first. Accessing injecting equipment was seen as the easiest task and therefore was last. These priorities are influenced by both drug dependence and poverty. Such priorities set into action a pooling-scoring-group injecting routine, which has profound implications for risk.

The ‘gift economy’, i.e. offers of free drugs between the IDUs, which are later reciprocated, operated in the networks investigated. The practice of reciprocity reinforced social ties between IDUs, serving as protection against the harsh environment of the injecting lifestyle of Kings Cross.

The contingent nature of the pooling-scoring-injecting routine, based on the gift economy, often results in group injecting episodes. Situations such as drawing up the drug from a communal spoon heighten the risk of BBV transmission if group members’ needles and syringes are not new. Group injecting was often outdoors and hurried. IDUs tended to rely on visual rather than verbal checks to determine whether new equipment was being used.

If a member of a group did not have their own injecting equipment, group negotiation over equipment occurred. Typically, couples are expected to share a syringe in such situations. The level of risk associated with injecting with another was also assessed on appearance; those who looked ‘clean’ or well groomed were considered to be a lower risk than those who appeared dishevelled.
An important finding to emerge from the Kings Cross case study was participants’ poor understanding of the clinical meaning of being diagnosed with HCV. Participants were unclear about what it meant to have ‘antibodies’, with many participants believing this meant they had cleared the virus. A number of participants believed that they need only seek HCV testing if and when they experience jaundice.

There was also confusion around transmission, hygiene and blood messages. Although many participants had good technical knowledge about the BBVI risk from sharing injecting equipment, there was a common belief that hepatitis C could be contracted from unhygienic practices, such as using toilet water to inject with or wash in or using a very ‘old’ syringe.

The everyday concerns of finding money, acquiring drugs, avoiding street and domestic violence, maintaining injecting relationships with partners and friends, and, for many, finding somewhere safe to sleep take priority over transmission of BBV. The physical and perceived need to inject and the expense of obtaining the drug (dependency and poverty) are the major focus of daily life for marginalised IDUs in Kings Cross. Many of the IDUs in this study were uncertain of their status; hence their potential to transmit the virus to others. IDUs’ understanding of hepatitis C warrants further research and standardised education programs need to be implemented and evaluated.

This analysis of risk sought to provide a window into other people’s worlds so that the public health response to BBVI transmission takes into account factors such as the routines of daily life, the meanings and processes of reciprocity, and group identity.

Brisbane case study

Qualitative interviews, focus groups and observational fieldwork were conducted in the Fortitude Valley/New Farm area of Brisbane, a scene dominated by youth and clubbing culture. The social nature of the injecting culture meant that injection was often carried out in the company of non-injectors, resulting in rushed injections as the non-injectors were impatient to return to the clubs.

The fieldwork took place at a time of intense police surveillance. Laws associated with the possession of injecting equipment and self-administration have been recognised for a considerable period of time as matters that need to be reviewed in order to enhance public health practices.

Other observed practices that enhance BBV transmission were the squirting of old injectable material from discarded syringes and stashing of syringes for re-use. These risky practices were exacerbated by the unhygienic and dimly lit sites where public injecting tended to occur. More involvement of younger users in terms of peer education and health promotion, in conjunction with cooperation from the larger clubs, would seem to be critical in addressing many of the risks identified in this report.

National focus groups

A series of focus groups with IDUs were conducted nationally to access IDUs from outside the case study sites, which were well-established drug markets with high concentrations of IDUs and BBVI prevention services. The purpose of the focus groups was to investigate a broad range of injecting practices and behaviours. Focus groups were conducted in Melbourne, Perth, Adelaide, Brisbane, Sydney and Cairns. Focus groups
were facilitated by members of the research team, generally with the assistance of staff from the centres where the focus group convened.

Recruitment to the focus groups encouraged IDUs with a broad range of injecting experiences and knowledge of BBV. Seven key themes emerged, and many were salient across all focus groups. The themes were: injecting and using drugs with others, the gift economy, trust between IDUs, injecting practices, injecting experience, risk situation and policing. Other issues included anonymity, overdose and sex work. Issues around hepatitis C awareness and education also emerged. The themes were often consistent with the case study data.

Risks in prison were considered to be different from risks taken outside — high-risk behaviour was an accepted practice in prison. However, the behaviours and practices established in prison do not carry over to the outside. Participants assumed that those with HIV would disclose their status and therefore the risk of sharing a syringe with a HIV positive inmate, and consequently contracting the virus, was minimal. Conversely, it was assumed that everyone was hepatitis C positive. All participants agreed that something was needed to reduce the risks associated with injecting drugs in prison.

Quality of life

Interviews with 42 IDUs, recruited through national focus groups and the Kings Cross case study, were used to assess participants’ quality of life (QoL). Two-thirds (68 per cent) reported they were hepatitis C positive and one reported being HIV positive. At the beginning of the interview, participants were asked to rate their quality of life on a scale of 0 (worst imaginable) to 10 (best imaginable). The mean rating was 5 (range 2–10).

Two-thirds of participants reported that their health was among the five life areas they believed most determined their quality of life at the time of interview (71 per cent). Other life areas chosen by more than half of participants were family (60 per cent), housing (57 per cent) and money (52 per cent).

Hepatitis C positive participants had significantly lower mean QoL scores compared with hepatitis C negative participants. The study provides an important insight into the life areas perceived as the most meaningful in determining the study participants’ quality of life, and complements the findings of the broader study relating to the raft of health, welfare and social concerns and consequent priorities in the lives of economically and socially marginalised individuals.

Conclusion

This research indicates that risky injecting is as much a social practice as an individual behaviour. Risk is embedded in daily routines and mundane and intimate social relations. Risk is influenced by individual, group, cultural, subcultural, environmental, political, legal, historical and economic dynamics. ‘Risk’ is the sum of these dynamics, not a simple transparent concept, and will therefore be defined differently by health professionals and IDUs.

Finally, the high rating given to health in the QoL data indicates the central place health issues hold in IDUs’ lives. This centrality provides, and should continue to provide, a window of opportunity for interventions and health education aimed at preventing blood-borne virus infection.
1. Introduction

Erica Southgate¹, Carolyn Day² and Kate Dolan³

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²National Drug and Alcohol Research Centre, University of New South Wales

This report presents findings from a multi-disciplinary project on risks for blood-borne viral infection (BBVI) among injecting drug users (IDUs) in the Australian context. The Risks of Injecting (ROI) project, as it became known, was jointly funded by the Australian National Council on Drugs (ANCD) and the Australian National Council on AIDS, Hepatitis and Related Diseases (ANCAHRD). The project explored the range and contexts of risks for BBVI among various groups of IDUs. It did this by ‘piggy-backing’ onto an existing research and by conducting a number of new studies in 2001 and 2002.

The multidisciplinary nature of the ROI project produced a number of data sets. However, while each separate study generated its own discrete data set — something akin to a piece of a jigsaw puzzle — the process of interpreting findings was collaborative, with the entire research team involved in putting the pieces together. This collaborative process was enhanced by the composition of the research team, whose members came not only from various academic disciplines but also from backgrounds in health promotion and injecting drug user advocacy. The expertise of experienced HIV and hepatitis C educators was combined with the research skills and theoretical interests of academics from the disciplines of psychology, education, epidemiology and sociology. Qualitative and quantitative researchers and health educators worked in a dialogic fashion to collect, analyse and interpret data. Despite recent critiques of multidisciplinary drug research (Bourgois 1999; Moore 2002; cf. Bammer 1997), the collaborative nature of this project served to focus the research team on ethical and practical issues, thus enhancing the development of research questions and augmenting the validity of findings and recommendations.

This report is essentially a series of chapters written by different authors. Each chapter describes a discrete piece of research on risk for BBVI. The report is structured so that it can be read in the traditional way, from front to back, or alternatively so that the reader can delve into specific chapters of interest. Common themes and overall implications of the project are discussed in the concluding chapter (Chapter 8) and in the Executive Summary.

The report begins in Chapter 2 by presenting the ‘big picture’ — an overview of the epidemiology of hepatitis C and HIV among Australian injecting drug users. This chapter outlines differences between the HIV and HCV epidemics in Australia, the prevalence of needle and syringe sharing among IDUs, and concludes with a brief discussion of social factors influencing risk behaviour.

Chapter 3 highlights findings from the national needle and syringe program survey, a major annual survey that has been carried out since 1995. The survey is designed to monitor HIV, HCV and related risk behaviour among needle and syringe program attendees throughout Australia. This chapter reports specifically on findings from the 2001 survey where two questions were added to provide background data for the ROI project. These questions were designed to determine time since re-use of someone else’s syringe and the place where that last episode occurred.
Chapter 4 reports on findings from the first of two qualitative case studies. The Kings Cross case study was the major qualitative contribution to the ROI project. It began in mid-2001 and concluded in early 2002. Theoretically, this study explores various ways of conceptualising public health’s most popular term, ‘risk’. The Kings Cross case study aimed to explore, using qualitative methods such as in-depth interviews and targeted participant observation, the way risk is situated in the everyday lives of marginalised IDUs. This socio-cultural approach provided a window into other people’s worlds (Hendry 1999) by documenting and analysing everyday risk scenarios as they are described, understood and lived by injectors in Kings Cross. This chapter includes a discussion of the links between daily routines and risk, the gift economy and risk, identity and risk, environmental factors facilitating BBVI, folk harm reduction strategies, and lay understandings of the hepatitis C virus and HCV infection among participants in the study.

A smaller qualitative case study was conducted in Brisbane’s Fortitude Valley and New Farm areas. Chapter 5 reports on findings from the Brisbane case study. Although this case study received less financial resources than the Kings Cross case study, it did nevertheless produce interesting observations on injecting risk in the Brisbane drug scene. In particular, this chapter concentrates on amphetamine injecting among young people in the Brisbane and New Farm areas. The chapter combines participant observation and focus group data to explore themes such as scoring, group injecting, sex work and the impact of policing.

Chapter 6 conveys findings from a series of focus groups held with IDUs in capital cities and regional areas around Australia. Focus groups were conducted in Melbourne, Adelaide, Perth, Brisbane, Cairns and Sydney. As well as these mixed groups, a focus group with recently released prisoners was held in Sydney. The focus group methodology aimed to provide a richer insight into data collected by the national needle and syringe program survey; to highlight common concerns among IDUs; and, where applicable, to provide a snapshot of injecting issues in regard to geographic difference. Some of the themes discussed in this chapter are group injecting, risky situations, the heroin shortage, policing, sex work and prisons.

Chapter 7 describes a pilot study undertaken to measure quality of life (QoL) among injecting drug users who took part in the Melbourne, Cairns, Adelaide and Perth focus groups and among IDUs recruited in Kings Cross. Using a QoL instrument designed specifically for IDU populations (Brogley et al. 2002), this study provides a unique insight into the life areas that IDUs themselves consider most important. Significantly, ‘health’ was chosen by over 70 per cent of participants as the chief life area for improving quality of life. This chapter discusses quantitative and qualitative findings.

Chapter 8 synthesises the findings from the previous chapters, emphasising the need for an ecological or holistic approach to BBVI prevention. Following this chapter are key recommendations emerging from an analysis of the data sets as a whole.
2. Epidemiology of hepatitis C and HIV among Australian injecting drug users: a brief overview

Carolyn Day

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This chapter reviews the epidemiological literature on the hepatitis C virus (HCV) and the human immunodeficiency virus (HIV) among Australian injecting drug users (IDUs). An overview of the prevalence and incidence of HCV and HIV is provided, followed by a brief account of the prevalence of needle and syringe sharing. Reasons for the discrepancy between the rates of the two viruses are discussed. The chapter concludes with a brief discussion of social factors that influence risk behaviours.

### 2.1 Hepatitis C and Australian injecting drug users

The hepatitis C virus was first identified in 1988 (Alter et al. 1989). It was quickly recognised as the most prevalent blood-borne viral infection (BBVI) among Australian IDUs. The prevalence of HCV among Australian IDUs has been continually high, varying from almost 90 per cent to just under 50 per cent, depending on the population (Table 2.1).

Similarly, the incidence of HCV among IDUs in Australia is also high, at about 10 per 100 person years (Table 2.2). There is increasing evidence that the incidence is substantially higher among those aged less than 20 years, with one study reporting a rate of 76 per 100 person years (van Beek et al. 1998). More recent preliminary data from Maher et al. (2002) show a high prevalence of risk behaviours among recent-onset injectors and a

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
<th>Year</th>
<th>No.</th>
<th>HCV+</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australia</td>
<td>MMT clients</td>
<td>1992–1993</td>
<td>94</td>
<td>87</td>
<td>Gaughwin et al. 1994</td>
</tr>
<tr>
<td>National</td>
<td>Field</td>
<td>1994</td>
<td>778</td>
<td>55</td>
<td>Loxley et al. 1995</td>
</tr>
<tr>
<td>Sydney</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>NSP attendees</td>
<td>2001</td>
<td>2342</td>
<td>58</td>
<td>NCHECR 2002</td>
</tr>
<tr>
<td>NSW</td>
<td>Field</td>
<td>1999–2002</td>
<td>595</td>
<td>31</td>
<td>Maher et al. 2002</td>
</tr>
</tbody>
</table>
### Table 2.2: Incidence of HCV among Australian injecting drug users

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
<th>Year</th>
<th>No. sero-conversions</th>
<th>Rate (*/100PY)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney</td>
<td>Primary health clinic attendees</td>
<td>2001</td>
<td>8</td>
<td>26.9</td>
<td>NCHECR 2002</td>
</tr>
</tbody>
</table>

* Preliminary data only

### Table 2.3: Prevalence of HIV among Australian injecting drug users

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
<th>Year</th>
<th>No.</th>
<th>% HIV+</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney</td>
<td>MMT, filed(^1) AIDS clinics</td>
<td>1987</td>
<td>152</td>
<td>12</td>
<td>Wolk et al. 1990</td>
</tr>
<tr>
<td>National</td>
<td>Field</td>
<td>1994</td>
<td>832</td>
<td>3</td>
<td>Loxley et al. 1995; Rutter et al. 1996</td>
</tr>
<tr>
<td>Sydney</td>
<td>Field</td>
<td>1994</td>
<td>212</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Melbourne</td>
<td></td>
<td></td>
<td>205</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Adelaide</td>
<td></td>
<td></td>
<td>202</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Perth</td>
<td></td>
<td></td>
<td>213</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>NSP attendees</td>
<td>1995</td>
<td>1005</td>
<td>2</td>
<td>MacDonald et al. 1997</td>
</tr>
<tr>
<td>National</td>
<td>NSP attendees</td>
<td>2001</td>
<td>2342</td>
<td>0.9</td>
<td>NCHECR 2002</td>
</tr>
</tbody>
</table>

\(^1\)Includes IDUs recruited through outreach, street intercept and snowballing (word of mouth)
HCV incidence of 39.7 per 100 person years. The prevalence of HCV among IDUs aged less than 25 years attending sentinel NSPs has also increased: from 22 per cent in 1997 to 41 per cent in 2001 (Zhou et al. 2002).

2.2 HIV and Australian injecting drug users

The situation for HIV is quite different. HIV first appeared in Australia in 1982. Studies in the 1980s identified the presence of HIV among IDUs by detecting the virus in exchanged needles and syringes (Wodak et al. 1987; Wolk et al. 1988). Shortly after this, harm reduction strategies such as needle and syringe programs were introduced and treatment for heroin dependence, particularly methadone maintenance treatment (MMT), was expanded (Wodak & Lurie 1996). It is generally accepted that the implementation of these harm reduction strategies has averted an HIV epidemic among Australian IDUs (Des Jarlais et al. 1995; Wodak & Lurie 1996; Hurley et al. 1997). As a result, the prevalence of HIV among the IDU population has remained low (Table 2.3).

The national prevalence of HIV among IDUs has not exceeded 5 per cent. Some studies conducted in Sydney have reported a higher prevalence, although this is generally due to sampling issues. For example, Wolk and colleagues (1990) reported a prevalence of 12 per cent for IDUs in Sydney, despite eight of the 27 IDUs who were HIV positive reporting homosexual or bisexual contact. Similarly, Rutter (1996) reported that HIV prevalence was only 3 per cent among heterosexual males and females.

The incidence of HIV among Australian IDUs has also remained low at less than 1 per 100 person years (Table 2.4). However, due to the large subject numbers required, it is difficult to obtain robust estimates of the incidence of HIV among IDUs in Australia. Nonetheless, vigilance is required, as HIV outbreaks among IDUs have been reported in Australia (Dolan & Wodak 1999). Furthermore, the virus can spread rapidly among IDUs if unchecked, as demonstrated by Friedman and Des Jarlais (1991).

<table>
<thead>
<tr>
<th>Site</th>
<th>Population</th>
<th>Year</th>
<th>No. sero-conversions</th>
<th>Rate (1/100PY)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Field</td>
<td>1990–1995</td>
<td>1</td>
<td>0.2</td>
<td>Crofts &amp; Aitken 1997</td>
</tr>
<tr>
<td>Sydney</td>
<td>Primary health clinic attendees</td>
<td>1992–1995</td>
<td>2</td>
<td>0.17</td>
<td>van Beek et al. 1998</td>
</tr>
<tr>
<td>National</td>
<td>NSP attendees</td>
<td>1995–1996</td>
<td>1</td>
<td>0.8</td>
<td>MacDonald et al. 1997</td>
</tr>
</tbody>
</table>
2.3 Behaviour change among injecting drug users

Needle and syringe sharing, the primary mode of HIV and HCV transmission for IDUs, continues to be reported. However, recent (in the last month) needle and syringe sharing remains low and there is evidence of a decrease in the behaviour. By analysing the available data on needle and syringe sharing among IDUs, Crofts et al. (1996) found an overall decreasing trend in the proportion of IDUs reporting the use of needles and syringes after someone else. This trend has been supported more recently by MacDonald et al. (2000), who also found a decreasing trend in IDUs reporting the use of a needle or syringe after another person in the last month – from 31 per cent in 1995 to 28 per cent in 1996 and only 15 per cent in 1997. A decrease in injecting risk behaviours among Victorian IDUs has also been documented (Crofts & Aitken 1997).

2.4 Reasons for the differences in HIV and HCV prevalence

There are a number of reasons why HCV transmission continues among Australian IDUs while HIV does not. Firstly, there is good evidence that HCV was prevalent among Australian IDUs long before harm reduction strategies were introduced, when risk behaviours such as needle and syringe sharing were likely to be common. A Victorian study examining the stored serum of IDUs hospitalised in 1971 found a HCV prevalence of 57 per cent (Moaven et al. 1993). The high prevalence of HCV among IDUs results in a very high risk of infection even if only a small number of sharing episodes occur (Kaldor et al. 2000; Crofts et al. 1999).

Secondly, it is generally accepted that HCV is more robust and more easily transmissible than HIV. This is supported by a number of studies indicating more efficient transmission of HCV in health care settings when compared to HIV (for a review, see MacDonald et al. 2001). There is also evidence that HCV is more readily transmitted via shared needles and syringes than HIV. One case study found that HCV only was transmitted from one HIV and HCV seropositive IDU to a HIV and HCV seronegative IDU, and that this occurred despite needles and syringes being rinsed with bleach or disinfectant (Bodsworth et al. 1994). A case of HCV transmission during a fistfight has also been reported (Bouliere et al. 2000).
Thirdly, there is burgeoning evidence that HCV is transmitted through means other than needle and syringe sharing. This is supported by a small but growing number of studies that have reported HCV among IDUs who deny needle and syringe sharing. Following the examination of HCV notifications, Sladden et al. (1997) found 9 per cent of the cases reporting injecting drug use denied ever sharing needles and syringes. Seventy-four per cent of a sample of New Zealand IDUs tested HCV positive, but denied ever sharing. Two Australian cohort studies have also reported seroconversions among those who reported no needle and syringe sharing. Van Beek and colleagues (1998) reported that nine (out of 31) IDUs did not share needles and syringes but seroconverted. Crofts and Aitken (1997) reported 43 HCV positive IDUs and two cases of seroconversion who did not report sharing needles and syringes. However, when interpreting risk behaviour data, it is necessary to consider that responses may have been biased by social desirability, and this may also influence the overall reduction in sharing needles and syringes (Crofts et al. 1996).

An alternative (and likely) explanation for the higher rate of HCV compared to HIV is the shared use of injecting equipment other than needles and syringes, also known as ‘indirect sharing’. As Crofts et al. (1996) point out, few studies have examined the shared use of injecting equipment other than needles and syringes. A British study reported the shared use of spoons and water containers to be more common than needle and syringe sharing among IDUs (Gossop et al. 1997), and this has also been reported among Australian IDUs (Maher et al. 1998; Maher et al. 2001; Dwyer et al. 2002). The Victorian Injecting Drug Use Cohort Study calculated an incidence rate of 4.3 per 100 person years for those who reported sharing injecting paraphernalia, but not needles and syringes (Crofts & Aitken 1997). More recently, a study from the United States found that, after controlling for syringe sharing, sharing of ‘cookers’ was the strongest predictor of seroconversion and carried a relative risk of 3.5 (Thorpe et al. 2002).

Poor injecting practices may also contribute to the spread of HCV. Ethnographic research has been instrumental in highlighting these poor injecting practices. For example, Maher et al. (1998) described behaviours and environments conducive to blood-borne viral transmission, such as rapid and furious jabbing at veins, resulting in multiple blood spills. Photographic and video evidence of actual injecting episodes has also demonstrated the lack of general hygienic practice. This includes contact with injecting sites and the inappropriate disposal of injecting paraphernalia (Carruthers 1997).

In a recent study of IDUs in Melbourne, Sydney and Perth, blood exposure risk during injecting was found to be high (Dwyer et al. 2002). One-third of the participants reported having handled another person’s used needle or syringe while they had cuts or lesions on their fingers or hands in the last month. Other practices that increase the risk of blood exposure, such as having injected a drug that had come into contact with another person’s needle/syringe in the preceding month, were also reported by a quarter of participants (Dwyer et al. 2002).
Very poor injecting practices which would normally result in opportunities for blood–blood transmission have been observed at the Medically Supervised Injecting Centre in Sydney (MSIC Evaluation Committee 2003). Similarly, supervised injecting facilities in Europe have indicated that many of the injecting practices, which are part of injecting culture such as sharing filters, are inherently risky in terms of HCV transmission (Haemmig 2001).

Finally, harm reduction strategies that have been used to successfully prevent HIV transmission may not be as efficacious for HCV. There is good evidence that methadone maintenance treatment (MMT) is associated with lower rates of HIV (Ward et al. 1998). However, there is little evidence of a similar relationship between MMT and HCV. One reason for this is that MMT clients tend to be older and in a more advanced stage of their injecting career. Therefore, they are more likely to have already been exposed to HCV (Ward et al. 1998). MMT reduces risk behaviour by reducing the number of injections, thereby reducing the number of opportunities for risky injection (Caplehorn & Ross 1995). Given the very high prevalence of HCV, this is unlikely to be sufficient to decrease the rate of HCV transmission. Indeed, Crofts et al. (1997) found an incidence rate of 22 per 100 person years for those currently enrolled in MMT, and this did not differ significantly from that of the general IDU population.

Likewise, although needle and syringe programs (NSPs) have been effective against HIV (for a review of the evidence, see Rouen & Dolan 2000), they have been less successful against HCV. The main reason for this is almost certainly due to the higher prevalence of HCV and the more efficient transmission of the virus (Crofts et al. 1999), as outlined above. These factors are further impeded by issues surrounding the availability of needles and syringes. The two national studies of HIV and injecting drug use, the Australian National AIDS and Injecting Drug Use Study and the Australian Study of HIV and Injecting Drug Use, both identified lack of availability of needles and syringes as a problem (Loxley et al. 1995; Ross et al. 1994). This issue has been identified more recently by Maher et al. (1998).

A number of social factors have been found to predict risky injecting practices. Psycho-social determinants such as depression, suicide attempts and non-consensual sex have also been found to predict risk behaviours (Strathdee et al. 1997a). Strathdee et al. (1997b) noted unstable housing and low education levels to be associated with IDUs who were HIV positive. These psycho-social aspects of IDUs’ lives impact on quality of life (QoL); yet little is currently known about the relationship between blood-borne virus risk behaviours and IDUs’ quality of life. The relationship between social factors and blood-borne viral infection among IDUs is addressed in more detail in the following chapters.

HCV is highly prevalent among IDUs in Australia and continues to be transmitted. HIV, however, has remained low among IDUs in Australia. The reasons for the disparity between the rates of HCV and HIV are related to the higher prevalence of HCV among IDUs, in addition to HCV being more easily transmissible than HIV. These factors may be exacerbated by poor injecting practices and inappropriate injecting conditions. Such factors are also influenced by a variety of psycho-social determinants which will be further explored throughout the report.
3. National needle and syringe program survey

Margaret MacDonald, Julian Zhou and Megan Buddle

National Centre in HIV Epidemiology and Clinical Research, University of New South Wales

3.1 Introduction

Cross-sectional surveys have been carried out annually at selected needle and syringe programs (NSPs) throughout Australia since 1995 to monitor HIV, hepatitis C and related risk behaviour among injecting drug users. Behavioural change is an efficient and pragmatic way to prevent transmission of blood-borne viruses among people who inject drugs. However, even under optimal conditions, people who inject drugs can and do get into situations where clean injecting conditions and sterile equipment are unavailable or where blood contact with another occurs.

Establishing the frequency with which injecting equipment is shared and the determinants of shared syringe use helps target prevention programs to achieve maximum effectiveness and reduce transmission of infection. This chapter reports the findings of the 2001 Australian NSP survey with regard to injecting behaviour, particularly injecting behaviour in the month before survey, with the purpose of providing a quantitative context of the prevalence of risk practices nationally and highlighting those groups of IDUs most at risk.

3.2 Methodological comment

Using data obtained in the NSP surveys, Chapter 3 aims to determine:

- time since and place of last episode of re-use of someone else’s used syringe
- extent of re-use of someone else’s syringe in the month before survey among participants
  - a) aged less than 20 years
  - b) identifying as Asian or Aboriginal and Torres Strait Islander
  - c) reporting methadone or other pharmacological treatment for drug use
  - d) reporting paid sex in the last month
  - e) reporting imprisonment in the calendar year before survey
  - f) according to the type of drug last injected
  - g) reporting any outdoor injection in the past month
  - h) from Kings Cross
  - i) from Brisbane, and
  - j) from Cairns
- predictors of re-use of someone else’s syringe in the last month
- relationship to people after whom syringe was re-used last month
- extent of re-use of injecting equipment other than syringes last month, and
- the extent of being injected second by someone else in the last month.
In the NSP surveys, staff at participating sites asked all clients attending during one week in October 2001 to complete a brief questionnaire and provide a finger-prick blood sample for HIV and hepatitis C antibody testing (MacDonald et al. 1997; MacDonald et al. 2000).

Standard information is routinely collected on demographic characteristics and injecting behaviour in the NSP surveys. Two extra questions were added to the standard questionnaire in the 2001 survey at all sites, except those in Adelaide and Kings Cross, to determine time since re-use of someone else’s syringe and the place where that last episode occurred. In addition, the number of sites in Queensland was greatly enhanced to increase regional coverage in that State. Re-use of someone else’s syringe in the month before survey is described according to specific geographic locations; that is, Kings Cross, Brisbane or Cairns, to complement the localities where qualitative research was undertaken.

3.3 Results

There were 2738 participants from 54 sites in the 2001 NSP survey (Table 3.1). Survey sites were in the capital cities in most States and Territories except Queensland and New South Wales. Last episode and place of last injection with another’s used syringe were reported by 2126 participants at 45 sites (see 3.3.1).

3.3.1 Time since and place of last injection with another’s used syringe

More than half the participants (57 per cent) reported that they had never re-used someone else’s syringe (data not available for Adelaide and Kings Cross). Re-use of someone else’s syringe in the past month was reported by 13 per cent and re-use in the past six months by 19 per cent of participants.

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>No. of sites</th>
<th>No. of participants</th>
<th>% response</th>
<th>No. of capital city sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>1</td>
<td>44</td>
<td>40</td>
<td>1</td>
</tr>
<tr>
<td>NSW</td>
<td>14</td>
<td>691</td>
<td>40</td>
<td>13</td>
</tr>
<tr>
<td>NT</td>
<td>2</td>
<td>94</td>
<td>57</td>
<td>1</td>
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<td>1101</td>
<td>48</td>
<td>5</td>
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<tr>
<td>WA</td>
<td>3</td>
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<td>57</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>2738</td>
<td>45</td>
<td>34</td>
</tr>
</tbody>
</table>
Among the 904 participants who reported that they had re-used someone else’s syringe in the past, 86 per cent also reported the place where the episode occurred, 5 per cent reported more than one location and 9 per cent did not report on location. The most frequently reported location for the last injection with someone else’s used syringe in the past month, past 2–6 months or more than six months ago, respectively, were the participant’s home (45, 43 and 31 per cent) or a friend’s home (23, 26 and 31 per cent; Table 3.2).

Last re-use of someone else’s syringe when injecting in a car or on the street in the past month was reported by 12 per cent and 7 per cent of participants respectively. There were slightly more participants aged less than 20 years (n = 59) who reported re-use of someone else’s syringe when injecting on the street in the last month than participants aged 20 years or more (19 vs 9 per cent, p = 0.1); the latter were more likely to report re-use in a car in the last month (14 vs 4 per cent, p = 0.1).

Last re-use of someone else’s syringe on the street in the past month was more likely to be reported by participants reporting being paid for sex in the last month (16 vs 9 per cent, p = 0.03), and participants reporting imprisonment in the last calendar year (14 vs 8 per cent, p = 0.03).

Participants who reported Asian descent, as indicated by the main language spoken at home by their parents, were more likely than other participants to report their last episode of re-use of someone else’s syringe when injecting as at ‘the flats’ (car parks or stairwells of apartment blocks, Maher et al. 1998) in the last month (15 vs 0.4 per cent, p<0.001), in the past 2–6 months (25 vs 0 per cent, p<0.001), and more than six months ago (25 vs 0 per cent, p<0.001).
### Table 3.2: Number and percentage of participants reporting re-use of someone else’s syringe in the last month, by State and area

<table>
<thead>
<tr>
<th>State / area</th>
<th>No. injected last month</th>
<th>No. shared* last month (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2342</td>
<td>337 (16)</td>
<td></td>
</tr>
<tr>
<td><strong>Australian Capital Territory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canberra</td>
<td>40</td>
<td>12 (30)</td>
<td></td>
</tr>
<tr>
<td><strong>New South Wales</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>61</td>
<td>12 (20)</td>
<td></td>
</tr>
<tr>
<td>Kings Cross</td>
<td>176</td>
<td>32 (18)</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>26</td>
<td>3 (12)</td>
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<tr>
<td>South Eastern</td>
<td>81</td>
<td>10 (12)</td>
<td></td>
</tr>
<tr>
<td>South Western</td>
<td>89</td>
<td>23 (26)</td>
<td></td>
</tr>
<tr>
<td>Western &amp; Far West</td>
<td>84</td>
<td>6 (7)</td>
<td></td>
</tr>
<tr>
<td>Northern Rivers</td>
<td>55</td>
<td>5 (9)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>572</td>
<td>91 (16)</td>
<td>0.03</td>
</tr>
<tr>
<td><strong>Northern Territory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darwin and Alice Springs</td>
<td>83</td>
<td>10 (12)</td>
<td></td>
</tr>
<tr>
<td><strong>Queensland</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brisbane</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biala</td>
<td>289</td>
<td>49 (17)</td>
<td></td>
</tr>
<tr>
<td>QuiVAA</td>
<td>127</td>
<td>24 (19)</td>
<td></td>
</tr>
<tr>
<td>Logan Youth</td>
<td>68</td>
<td>17 (25)</td>
<td></td>
</tr>
<tr>
<td>Outer</td>
<td>135</td>
<td>21 (16)</td>
<td></td>
</tr>
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<td>Far North Qld</td>
<td>119</td>
<td>14 (12)</td>
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<td>Mid North Qld</td>
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<td>18 (19)</td>
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<tr>
<td>South West Qld</td>
<td>91</td>
<td>17 (19)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td>160 (17)</td>
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</tr>
<tr>
<td>Adelaide</td>
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</tr>
<tr>
<td><strong>Tasmania</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hobart</td>
<td>25</td>
<td>2 (8)</td>
<td></td>
</tr>
</tbody>
</table>
3.3.2 Re-use of someone else’s syringe in the month before survey

Re-use of someone else’s syringe in the last month was reported by 16 per cent of participants reporting injection in the past month from all survey sites (n = 2342, from 54 sites). Similar proportions of male and female participants reported re-use of someone else’s syringe in the last month (16 vs 16 per cent, p = 0.8).

Male participants who reported less than three years (14 per cent) or more than five years (18 per cent) of drug injection were more likely than males who reported 3–5 years to report re-use of someone else’s syringe in the last month (10 per cent, p = 0.003). Among female participants, those reporting less than three years (18 per cent), or 3–5 years (20 per cent) of drug injection were more likely than those reporting more than five years of injection to report re-use of someone else’s syringe in the last month (14 per cent, p = 0.2).

Participants reporting daily or more frequent drug injecting in the past month were more likely to report re-use of someone else’s syringe in the last month than those reporting less frequent drug injecting (20 vs 12 per cent, p<0.001).

Participants from the Australian Capital Territory (30 per cent), Western Australia (26 per cent), Queensland (17 per cent) and New South Wales (16 per cent) were more likely than participants from the Northern Territory (12 per cent), South Australia (12 per cent) and Victoria (11 per cent) to report re-use of someone else’s syringe in the month before survey (p = 0.001; Table 3.2). In Sydney, participants from south-western Sydney (26 per cent), Central Sydney (20 per cent) and Kings Cross (18 per cent) were more likely than those from other areas to report re-use of someone else’s syringe (8 vs 12 per cent, p = 0.03). In Brisbane, high rates of syringe re-use were reported from participants at Logan (25 per cent). Low rates were reported from Collingwood and Footscray in Melbourne (6 and 7 per cent respectively).

<table>
<thead>
<tr>
<th>State / area</th>
<th>No. injected last month</th>
<th>No. shared* last month (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melbourne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collingwood</td>
<td>32</td>
<td>2 (6)</td>
<td></td>
</tr>
<tr>
<td>Dandenong</td>
<td>61</td>
<td>12 (20)</td>
<td></td>
</tr>
<tr>
<td>Footscray</td>
<td>88</td>
<td>6 (7)</td>
<td></td>
</tr>
<tr>
<td>St Kilda</td>
<td>109</td>
<td>13 (12)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>33 (11)</td>
<td>0.08</td>
</tr>
<tr>
<td>Western Australia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perth</td>
<td>146</td>
<td>38 (26)</td>
<td></td>
</tr>
</tbody>
</table>

*‘Shared last month’ refers to re-use of someone else’s used syringes in the last month.
3.3.3a Youth

Median duration of drug injection among participants aged less than 20 years was three years (range: <1–12 years). Participants aged less than 20 years (n = 163) were more likely than those aged 20 years or more to report re-use of someone else’s syringe in the past month (25 vs 15 per cent, p = 0.002). Female participants aged less than 20 years (n = 71) were also more likely than young males (n = 90) to report re-use of someone else’s syringe in the past month, although the difference was not statistically significant (28 vs 22 per cent, p = 0.4).

3.3.3b Asian or Aboriginal and Torres Strait Islander identity

Participants who reported Asian or Aboriginal and Torres Strait Islander origin were more likely than other participants to report re-use of someone else’s syringe in the past month (27 or 26 per cent vs 14 per cent, p<0.001). There was a trend of increased reporting of re-use of someone else’s syringe in the past month with increased duration of drug injection among participants of Asian descent (7, 26 and 36 per cent among those who had injected for less than three years, 3–5 years, and more than five years, trend p = 0.04).

In contrast, reporting of re-use of someone else’s syringe in the last month among participants of Aboriginal and Torres Strait Islander origin was similar according to duration of drug injection, although there were slightly higher rates among newer injectors (30, 34 and 25 per cent among those reporting less than three years, 3–5 years, and more than five years of drug injecting, trend p = 0.3).

3.3.3c Methadone or other pharmacological drug treatment

Participants reporting current treatment with other programs such as naltrexone, buprenorphine or LAAM were more likely than participants reporting previous and no treatment to report the re-use of someone else’s syringe in the last month (28 vs 17 and 15 per cent, p = 0.003). Participants reporting previous methadone treatment were more likely than participants reporting current or no methadone treatment to report re-use of someone else’s syringe in the last month (18 vs 14 and 13 per cent, p = 0.03). Participants aged less than 20 years who reported previous methadone treatment were more likely than older participants to report re-use of someone else’s syringe in the last month (40 vs 14 per cent, p = 0.004).

3.3.3d Paid sex in last month

Participants who reported engaging in paid sex in the past month were also more likely than other participants to report the re-use of someone else’s syringe in the past month (24 vs 15 per cent, p = 0.002). Among those reporting sex work in the past month, participants aged less than 20 years were more likely than older participants to report the re-use of someone else’s syringe in the past month (39 vs 21 per cent, p = 0.03) and more likely to report engaging in paid sex in the past month (21 vs 9 per cent, p<0.001). Participants reporting sex work in the last month were also more likely than other participants to report the re-use of their casual sex partners’ syringes (15 vs 6 per cent, p = 0.05).
3.3.3e Recent imprisonment

Participants reporting imprisonment in the calendar year before survey were more likely than others to report re-use of someone else’s syringe in the past month (25 vs 14 per cent, p<0.001). Similar proportions of reporting re-use of someone else’s syringe were found among participants reporting imprisonment in the last year, regardless of their sex, age and duration of drug use.

Among participants reporting imprisonment in the last year, participants of Asian or Aboriginal and Torres Strait Islander origin were more likely than others to report re-use of someone else’s syringe (39, 33 vs 21 per cent, p = 0.01). Participants who reported Asian (40 per cent) or Aboriginal and Torres Strait Islander (30 per cent) origin were also more likely to report recent imprisonment, compared to 16 per cent among those of other ethnic backgrounds (p<0.001).

Participants reporting imprisonment in the last year were more likely than others to report re-use of someone else’s spoon (40 vs 26 per cent, p<0.001), filter (24 vs 15 per cent, p<0.001) and water (31 vs 19 per cent, p<0.001).

3.3.3f Type of drug last injected

Participants reporting more than one drug (29 per cent), cocaine (alone or with heroin or other drugs, 24 per cent) and heroin (17 per cent) as the type of drug last injected were more likely than participants reporting amphetamine (13 per cent) to report re-use of someone else’s syringe last month (p<0.001).

Among participants reporting heroin as the type of drug last injected, those who reported daily or more frequent injection in the last month were more likely than participants reporting less frequent injection to report re-use of someone else’s syringe (21 vs 12 per cent, p = 0.001). A similar increased rate was also found among participants reporting cocaine as the type of drug last injected and daily or more frequent injection in the last month (23 vs 12 per cent, p = 0.01), but not among participants reporting amphetamine (15 vs 12 per cent, p = 0.1).

3.3.3g Any outdoor injection in last month

Participants reporting any outdoor injection, such as on the street or in a car (23 per cent) or public toilet (17 per cent), in the last month were more likely than participants reporting injection at their own or their friends’ homes (11 per cent) to report re-use of someone else’s syringe in the last month (p<0.001). Among participants reporting injection on the street or in a car, participants of Asian (36 per cent) or Aboriginal and Torres Strait Islander (32 per cent) origin were more likely than other participants (20 per cent) to report re-use of someone else’s syringe (p = 0.001).

3.3.3h Participants from Kings Cross, New South Wales

There were 176 participants from Kings Cross who reported drug injection in the last month, of whom 18 per cent reported re-use of someone else’s syringe in the last month, a similar rate to other sites in New South Wales (15 per cent, p = 0.3). Participants aged less than 20 years (n = 12) were more likely than older participants (n = 164) to report re-use of someone else’s syringe in the last month (42 vs 16 per cent, p = 0.03).
The proportion of participants reporting paid sex in the last month (30 vs 7 per cent, \(p<0.001\)), Aboriginal and Torres Strait Islander origin (15 vs 7 per cent, \(p = 0.001\)), and cocaine injection (alone or with heroin or other drugs, 44 vs 29 per cent, \(p<0.001\)) in the last month was higher in Kings Cross than at other New South Wales sites.

### 3.3.3i Participants from Biala, Queensland

Among 289 participants from Biala who reported drug injection in the last month, 17 per cent reported re-use of someone else’s syringe in the last month. Higher rates of re-use in the last month were reported among Biala participants aged 20 years or more than among participants aged less than 20 years (35 vs 12 per cent, \(p<0.02\)), among participants reporting paid sex in last month (35 vs 15 per cent, \(p = 0.03\)) and among participants reporting imprisonment in the last year (40 vs 14 per cent, \(p<0.001\)).

Compared to other sites in Queensland, participants from Biala were younger (median age 27 years from Biala vs 30 years at other sites, trend \(p<0.001\)) and reported shorter duration of drug injection (median 7 years vs 9 years, trend \(p<0.001\)). Participants from Biala were also less likely to report imprisonment in the last year (13 vs 19 per cent, \(p = 0.02\)) and being of Aboriginal or Torres Strait Islander origin (4 vs 10 per cent, \(p = 0.001\)).

### 3.3.3j Participants from Cairns (Cairns NSP and Cairns Youth Link), Queensland

There were 95 participants from Cairns who reported drug injection in the last month, of whom 11 per cent reported re-use of someone else’s syringe in the last month. Participants reporting paid sex in the last month (3/4, 75 per cent) were more likely than other participants (7/89, 8 per cent, \(p<0.001\)) to report re-use of someone else’s syringe in the last month.

### 3.3.4 Predictors of re-use of someone else’s syringe in the last month

Factors independently associated with re-use of someone else’s syringe in the last month included: age less than 20 years and 20–24 years compared to 25 years or more; being injected second by someone else after they had injected themselves or someone else in the last month; Asian or Aboriginal and Torres Strait Islander identity; any outdoor injection within the past month; sharing any injecting equipment such as spoon, filter, water, tourniquet or drug mix; self-reporting of positive hepatitis C test compared to a negative result or not tested; and imprisonment in the last year (Table 3.3).

Among participants reporting re-use of someone else’s syringe in the last month, 46 per cent reported sharing with their regular sex partners, 7 per cent with casual sex partners, 27 per cent with friends and 13 per cent with acquaintances.
3.4 Discussion

The survey found that just over half the sample reported never having re-used someone else’s syringe. However, one in six participants reported such re-use in the last month. Factors associated with re-use of another’s syringe in the past month were daily or more frequent injection in the previous month, age less than 25 years, Asian or Aboriginal and Torres Strait Islander identity, any outdoor injection in the past month, re-use of injecting equipment other than syringes or being injected second by someone else last month, self-reported hepatitis C infection, and imprisonment in the previous year.

There are several limitations associated with surveys of this type that need to be considered when interpreting the results. Participants self-selected to attend survey sites. They also self-selected to participate in the survey. Consequently, the survey results are not generalisable to all injectors or all injectors attending NSPs. The survey results were also based on self-report data. Recall bias was minimised by asking participants about more recent rather than distant events. Social desirability bias was minimised by the self-report design and assuring confidentiality.

The most frequently reported place of last episode of re-use of someone else’s syringe was at the participant’s own home or at a friend’s house. Participants aged less than 20 years, participants reporting sex work in the past month and those reporting imprisonment in the calendar year before the survey were more likely to report outdoor locations as the place of their last episode.

Participants reporting Asian identity were more likely than other participants to report flats as the place of their last re-use episode. It is likely that flats represent outdoor injecting scenarios such as car parks or stairwells of apartment blocks (Maher et al. 1998).

Participants reporting Asian identity and those reporting Aboriginal and Torres Strait Islander identity were also more likely than other participants to report re-use of another’s syringe in the past month. Participants reporting Asian or Aboriginal and Torres Strait Islander identity were also more likely to report recent imprisonment.

The survey found similar rates of re-use of another’s syringe between males and females. Several other Australian studies have also reported similar rates between males and females (Loxley et al. 1995; Hando & Darke 1998), although more studies have reported females more likely to re-use another’s syringe than males (Darke et al. 1990, 1998; Lenton & Tan-Quigley 1997; Lucas & Easthope 1996; Maher et al. 1998). Among survey participants aged less than 20, females were more likely than males to report re-use of another’s syringe in the past month.

The survey also found that participants with hepatitis C infection were more likely to report re-use of someone else’s syringe than those without or those who had never been tested. It is possible that people with hepatitis C intentionally went last to prevent transmission to their injecting partners. The concept of negotiated safety has previously been identified in studies of sexual behaviour among gay men with HIV infection (Crawford et al. 2001).
Table 3.3: Reported re-use of someone else’s syringe in the last month (% shared) by demographic characteristics and injecting behaviour, and multivariate logistic regression analysis

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No. surveyed</th>
<th>% shared*</th>
<th>Adj. OR</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
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<td><strong>Total</strong></td>
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</tr>
<tr>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25+ years</td>
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<tr>
<td>20–24 years</td>
<td>462</td>
<td>19</td>
<td>1.2</td>
<td>0.8–1.7</td>
<td>0.4</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>163</td>
<td>25</td>
<td>1.9</td>
<td>1.1–3.2</td>
<td>0.02</td>
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<td>14</td>
<td>1.0</td>
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<td>26</td>
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<td>1.1–2.6</td>
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<td></td>
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<tr>
<td>Daily or more</td>
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<td>1.2</td>
<td>0.9–1.7</td>
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<td>Current</td>
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<tr>
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<td>1155</td>
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<td><strong>Other pharmacological treatment</strong></td>
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<tr>
<td>Current</td>
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<td>Previous</td>
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<td>1.0–1.9</td>
<td>0.06</td>
</tr>
<tr>
<td>Characteristics</td>
<td>No. surveyed</td>
<td>% shared*</td>
<td>Adj. OR</td>
<td>95% CI</td>
<td>p value</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Type of drug last injected</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Amphetamine</td>
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<td>13</td>
<td>—</td>
<td></td>
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</tr>
<tr>
<td>Heroin</td>
<td>675</td>
<td>17</td>
<td>—</td>
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<tr>
<td>Cocaine**</td>
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<td>20</td>
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</tr>
<tr>
<td>More than one drug</td>
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<td>Morphine</td>
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<td>—</td>
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<tr>
<td>Other</td>
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<td>15</td>
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<td><strong>Outdoor injection</strong></td>
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<td>23</td>
<td>1.8</td>
<td>1.3–2.4</td>
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<td></td>
<td></td>
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<td>Kings Cross, NSW</td>
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<td>18</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biala, Qld</td>
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<td>17</td>
<td>—</td>
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<td></td>
</tr>
<tr>
<td>Cairns, Qld</td>
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<td><strong>Re-used injecting equipment other than syringes</strong></td>
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<td><strong>Injected second by someone else after injecting themselves or others</strong></td>
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<td>2.4–4.5</td>
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<tr>
<td>Negative</td>
<td>949</td>
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</tr>
<tr>
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<td>1.7</td>
<td>1.2–2.3</td>
<td>0.002</td>
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<td>19</td>
<td>1.1</td>
<td>0.6–2.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

*‘Shared last month’ refers to re-use of someone else’s used syringes in the last month.

** Alone or with heroin or other drugs.
4. Sydney case study: Kings Cross

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You get lost in the bush, you learn how to survive quick smart. You’ll start eating leaves, whatever the fuck you have to do to survive. But the thing is people will adapt. They’ll improvise. They’ll overcome. That’s exactly the same on the street. You have to adapt. You have to improvise and you overcome it.

(Clive, a 29-year-old Kings Cross injector)

4.1 Introduction

4.1.1 The concept of risk

The meaning of the term ‘risk’ differs considerably across time and place. For example, in sixteenth-century Western Europe ‘risk’ was linked with natural disasters rather than human action (Luhmann 1993). By the nineteenth century, the term ‘risk’ encompassed good risks and bad risks (Ewald 1991). In this context, risk was a neutral concept: it involved the possibility of gains as well as losses (Lupton 1999a). By the end of the twentieth century, risk was primarily associated with the idea of hazard or danger.¹ In the public health arena, notions of risk have become increasingly central to policy, research and practice (Gabe 1995; Lupton 1999a). In popular and public health discourse, risk is most often associated with harm, danger, threat or hazard. As Mary Douglas (1992: 24) notes, ‘the word risk now means danger; high risk means a lot of danger’ (original emphasis). Furthermore, while risk was once connected with natural disaster beyond human control, it is currently understood in terms of the responsibility of each individual to prevent or limit harm to self and others (Petersen & Lupton 1996).

There are two main approaches to risk within the arena of public health.² These are the technico-scientific approach and the socio-cultural approach. The technico-scientific approach seeks to calculate the probability of risk, identify the size of at-risk populations, quantify and predict risk behaviour, and measure the seriousness of risk at an individual and public level. This approach treats risk as a pre-existing thing to be identified through scientific measurement and calculation (Lupton 1999a: 18). Sometimes this approach has ‘an ill-masked contempt for lay people’s lack of what is deemed to be “appropriate” or “correct” knowledge about risk’ (Lupton 1999a: 19). The technico-scientific approach privileges expert knowledge over folk understandings of risk. Moreover, risk is viewed in terms of individual judgement with research concentrating on why rational expert information on risk is rejected in favour of ‘irrational’ decision making (Loxley & Davidson 1998; Kemshall 2002).

The health belief model, an influential theory in the field of health promotion, reflects a technico-scientific approach to risk. Within this model, individuals who avoid risk or enact protective behaviours are considered rational, while those who take risks are deemed irrational (Bloor 1995; Loxley & Davidson 1998). Such a model places an ‘unintended emphasis on

¹ Lupton (1999a) offers an excellent overview of the socio-historical relativity of the concept of risk and contemporary social theorists on the topic.
² Lupton (1999a: 35) provides the framework for understanding these approaches.
perceptual pathology’ (Douglas 1985: 3). It is predicated on the notion that there is a linear relationship between knowledge of a risk, developing protective behaviour and the prevention of risk. Risk is situated at the level of the individual who has complete freedom in decision making. There is scant regard for the social processes people use to make meaning of their world or of the many factors that impinge on or facilitate decision making in everyday life.¹

A different approach to risk contends that it is a ‘social product’ (Thompson & Wildavsky 1982: 148). This socio-cultural position views risk as a social construction. The socio-cultural perspective examines how knowledge about particular risks is established at different historical and social junctures, including expert and institutional knowledge of risk. This perspective investigates conflicts between expert-mediated knowledge, and between lay and expert understandings of risk.⁴

A socio-cultural approach asks different questions from a technico-scientific one. For example, key questions in the technico-scientific approach are: ‘What risks exist?’ and ‘How do individuals cognitively respond to risk (as defined by experts)?’ The socio-cultural approach poses different questions: ‘What do people themselves consider risky?’; ‘What are the contexts of risk?’; ‘How do people understand these contexts as risky?’; ‘How do people cope with risk in their everyday lives?’ and ‘What social processes as well as individual factors affect risk practice?’ Rosengarten et al. (2000) capture the socio-cultural approach when they write:

Individuals do make decisions and ... their accounts are valid as a source of insight into the way [epidemics are] lived at this point in time; ... decisions are historically informed by the cultural context in which they are located, their own personal history and the lived experience of [illness and epidemics].

This chapter primarily uses a socio-cultural approach to document and interpret risks for blood-borne virus transmission among injecting drug users in Kings Cross, Sydney, Australia. Our approach identifies technical aspects of risk practice, while seeking to situate the concept of ‘risk’ within the everyday lives of those who inject drugs illicitly. This involves both the application of expert knowledge to identify and document risks for transmission of blood-borne viral infections (for example, syringe sharing) and a critical examination of everyday risk scenarios as they are described, understood and lived by participants in the study (Koester 1994).³ Our analysis seeks to provide a window into other people’s worlds (Hendry 1999) so that the public health response to blood-borne viral infection (BBVI) transmission takes into account factors such as the routines of daily life, the meanings and

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¹ This approach is evident in cognitive science research and is sometimes referred to as behaviourist.

⁴ For the range of epistemological stances evident in the social constructionist approach, see Lupton (1999a: 24–35) and Fox (1999).

⁵ In the Australian context there are a number of qualitative studies, including ethnographies, that have taken a similar approach to the documentation and analysis of risk in drug injecting cultures. These include Maher et al. (1997, 1998; Maher & Dixon 2002); Loxley and Ovenden (1995); Crofts et al. (1996); Fitzgerald and colleagues (Fitzgerald 2000; Fitzgerald & Hamilton 2000; Dovey, Fitzgerald, Choi 2001); Carruthers (1999); Moore (1992a, 1992b, 1993); Higgs et al. (2001); Sharp et al. (1991); Ireland et al. (1999); Southgate and colleagues (Southgate & Hopwood 1999, 2001; Southgate et al. 2000; Southgate in press); and Denton (2001).
processes of reciprocity, group identity and environmental risk factors. Furthermore, we seek to examine the interplay between expert knowledge of risk for BBVI transmission as delivered by health professionals and the situated logics employed by injecting drug users to gauge levels of risk.

4.1.2 Kings Cross

Kings Cross (also known as ‘the Cross’) is situated in inner east Sydney, approximately 1 kilometre east of the Central Business District. It is bordered by a naval base to the north, the wealthy eastern suburbs to the east and the gay precinct of Oxford Street to the south. The Cross is Australia’s most infamous red light district. Darlinghurst Road, its main thoroughfare, offers cafes, bars and pubs, low-budget hotels, strip clubs, nightclubs and sex clubs and an array of shops catering for tourists and locals. A number of side streets and laneways intersect and run parallel to Darlinghurst Road. The bustle of Darlinghurst Road contrasts with the quiet of these back streets. The population of Kings Cross is dense and the space, designed in the late nineteenth century for the wealthy citizens of Sydney, comprises a myriad of terrace houses, small and large apartment blocks and houses, and moderately sized parks. Sandstone stairs and walls link lower streets to the higher ground of Darlinghurst Road. Plane trees line back streets, giving an airy, shady feel. William Street, the main road running from Sydney’s city centre to the heart of the Cross, is the setting for street-based sex work (although Darlinghurst Road also proves popular, particularly with male sex workers). Brothels occupy the side streets off Darlinghurst Road and William Street. There are also two safe houses, room-for-rent abodes that cater for brief sex work liaisons. The following description, from a tourism web site, captures the mood of the Cross:

Kings Cross has for a long time been known to most Australians as the drugs and red light capital of Australia. Most Australians who have visited Sydney at one time or another have wandered through the Cross, if only for a look at how the ‘other half’ live and play. In recent years, however, this sleazy pocket of Sydney has started to evolve, albeit ever so slowly, into a richly vibrant part of the city. The strip clubs, topless waitresses, adult bookshops and tacky nightclubs are still there, but small, trendy cafes have sprung up on the fringes of the Cross that are attracting a different type of visitor. The Cross is most sleazy at night, when the bright lights come on and the action heats up. During the day it can look a lot less threatening. Visitors to the area should be careful, especially at night, as people do get mugged here ... You will see some pretty strange sights around the Cross, an area frequented by people from all walks of life, and although generally it is OK to look, don’t stare or make snide remarks as this could land you in trouble. (www.sydney.com.au/kingsx.htm)

Heroin was introduced to Kings Cross in the early 1970s by American and Australian servicemen on recreation leave from the Vietnam war (McCoy 1980). The excitement of the Cross, combined with a thriving open-air drug market, attracts local and out-of-town injecting drug users, sex workers, young people, a nightclub crowd, backpackers and an array of tourists and visitors. The drug market offers opportunities for small-time and large-scale drug dealing in heroin and, since 1997, cocaine. A range of other drugs

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6 See reports from the Wood Royal Commission for a picture of the thriving drug market and concomitant police corruption in Kings Cross during the 1970s–80s (Wood 1997).
such as ecstasy, ice (methamphetamine) and speed (amphetamine) are also dealt. Public injecting is common, with 32 per cent of residents surveyed in Kings Cross reporting that they have seen one public injection episode in the prior month (MacDonald et al. 1999).

Kings Cross provides an interesting site for the study of risks for BBVI transmission for a number of reasons. First, the dynamic open-air nature of the drug market means that changes in the drug economy have an immediate, visible impact. This visibility factor facilitates monitoring of change. For example, the introduction and increased popularity of cocaine since the heroin shortage have been observed by researchers and health care workers alike (van Beek et al. 2001; Day et al. 2003). This is not to say that all aspects of drug culture are visible and easy to monitor. The public nature of the drug market does, however, facilitate certain aspects of fieldwork including observation, the identification of local ‘guides’ and a heightened awareness of issues among health workers (which in turn translate into research questions).

Another reason for choosing Kings Cross relates to the density and diversity of networks of injecting drug users who live in or frequent the area. Drug user networks include professional and opportunistic sex workers, long-time locals known as ‘Crossies’ (some of whom are homeless or itinerant), young people, Indigenous people, visitors such as backpackers, tourists, nightclubbers and the clients of sex workers, as well as an assortment of drug dealers and runners. Some of these networks constitute tight-knit social groups or ‘tribes’, while others are more fluid in composition.

The density and relative visibility of different networks in Kings Cross allow for the development of insights into the relationship between social disadvantage, marginalisation and high-risk practice. This relationship has been explored here and abroad (Bourgois et al. 1997; Bourgois 1998; Maher et al. 1998; Friedman et al. 1999). Kings Cross provides a case study in the connection between severe social marginalisation based on fragile income-generating strategies and increased risk for the transmission of BBVIs (Singer 1994; Bourgois 1998).

Lastly, numerous health and welfare services, many of which directly target injecting drug users, operate in the Kings Cross area. For example, the Kirketon Road Centre operates two fixed outlets (Kirketon Road Centre and K2) and an outreach bus. Both the Kirketon Road Centre (KRC) and K2 operate needle and syringe programs, with KRC also offering primary health care and methadone maintenance treatment. Two syringe vending machines operate in or near the heart of the Cross. Australia’s only supervised injecting facility to date, the Medically Supervised Injecting Centre (MSIC), commenced operation in May 2001 on a trial basis and is situated on Darlinghurst Road. It provides a clinically supervised injecting environment, vein care advice, overdose management and a client needle and syringe program. The final MSIC evaluation report has been publicly available since April 2003 (MSIC Evaluation Committee 2002).

7 We would contrast this with the invisible world of the suburban injecting drug user, particularly in areas where there is no shopfront needle and syringe program and the problem this poses for research (see Southgate et al. 2000).
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A number of other specialist drug and alcohol services are located within a few kilometres of the Cross. These include drug and alcohol counselling, opioid maintenance treatment and detoxification programs offered by St Vincent’s Hospital and the Langton Centre. The Sex Worker Outreach Project (SWOP) runs an outreach needle and syringe program and offers referrals and education, while the New South Wales Users and AIDS Association (NUAA) periodically funds peer education projects. In addition, there are church-operated and independent welfare services offering accommodation, food, counselling and referrals. Many of Kings Cross’s health services have acquired a reputation for excellence in regard to harm reduction initiatives.\(^8\)

No other area in Australia boasts so many services targeting injecting drug users in one locale, coupled with the long history of health initiatives aimed at preventing BBVI transmission, since the advent of the AIDS epidemic in the 1980s. While the availability of sterile injecting equipment and targeted education initiatives were key factors in stemming an AIDS epidemic among Australian injecting drug users (Des Jarlais et al. 1995; Wodak & Lurie 1996; Hurley et al. 1997), the rate of new hepatitis C infection among injectors is still considerable (see Chapter 2 for the epidemiology of the HCV epidemic). The Kings Cross case study posed questions regarding the continuation of risk practice in an environment where free, sterile injecting equipment is fairly available and education about BBVI transmission is constantly being ‘put out there’ by health care workers. Kings Cross juxtaposes excellence in health care and education with high-risk injecting practices and environments.

4.2 Method

4.2.1 Qualitative methods

Three methods were used to collect data:

- ongoing contact with two key informants and a local guide
- observational fieldwork
- in-depth semi-structured interviews.

Ongoing contact with two key informants and a local guide employed specifically for the study allowed for up-to-date detailed information about the state of the Kings Cross drug market to be recorded. The role played by the guide was particularly important (Power et al. 1995). In order to facilitate entry into IDU networks, the researchers asked service providers to identify a person to act as a guide. The guide escorted the researcher through a variety of injecting locations, introduced the researcher to a range of local identities and assisted in the selection of participants for in-depth interviews. The guide also helped in identifying people who would act as key informants; that is, people who were opinion leaders within their injecting networks (Watters & Biernacki 1989). The guide assisted in maintaining researcher safety by providing the reassurance of a familiar face, by warning about unsafe places to conduct interviews and by providing frank assessments of potential interview participants. The guide and key informants acted as sounding boards for the researcher’s ideas and helped to verify the accuracy of information as it emerged during the course of the study. The guide requested that his interview data be treated as ordinary participant data in order to best preserve anonymity. For this reason

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\(^8\) Harm reduction acknowledges that drug use takes place, and attempts to reduce the harm associated with drug taking. Needle and syringe programs are an example of a harm reduction strategy. Harm reduction is one component of the National Drug Strategy.
the guide’s profile has not been singled out in this chapter or in the participant profile appendix to this report (Appendix A). The two key informants did not undertake tape-recorded interviews. Rather, conversations with them were written in field note form. The guide, key informants and local service providers were instrumental in identifying sites and networks. In addition, limited observations of in-situ injecting were documented in field note form.

Observational fieldwork was conducted intensively for four months (November 2001–February 2002). Fieldwork involved mapping injecting locations. This involved finding and visiting a range of popular injecting locations within the Kings Cross area, including public and semi-public sites (stairwells, alleys, parks, toilets) and commercial drug injecting rooms (hotel rooms and safe houses). Locations were visited at different times of day to gauge levels of use. Locations were marked on a map and detailed descriptions of sites were written in field note form. Mapping of physical locations was complemented by the mapping of networks of injecting drug users who frequented certain sites (for example, street-based sex workers frequented safe houses). The mapping exercise informed the recruitment of injecting drug users from a range of networks for in-depth interviews. Many of the people in the sample spanned several networks. Most interview participants were recruited through the guide or by chain referral, that is, via other participants. On a couple of occasions participants approached the researcher on the street in the absence of a guide. The Human Research Ethics Committee of the University of New South Wales approved the study. This approval mandated that information about the study and the rights of participants be fully explained in oral and written form prior to data collection. Participants were required to sign a consent form. Participants received up to $30 as reimbursement for their time.

Interviews were conducted in a rented room at a local welfare agency, in cafes and in public locations. Interviews lasted between 30 and 90 minutes. Twenty-six interviews were tape-recorded; however, two of these proved inaudible and could not be transcribed (this is a hazard of interviewing in busy streets). The final data set comprised 24 transcribed interviews: 14 from men, and 10 from women. Participants’ ages ranged from 19 to 47 with most in their thirties. One participant was HIV positive. It was difficult to assess, on self-report, the HCV status of participants as there was confusion regarding their current status (see 4.3.8 of this chapter). A profile of participants is included as an appendix to this report (Appendix A).
An interview schedule guided the process. The schedule was developed from issues raised during the fieldwork, key informant interviews and existing literature (Appendix B). It comprised areas for discussion with ‘kick-start’ questions inserted to prompt discussion. These included the topic of public and private injecting and the circumstances that govern decisions about using particular spaces; the networks in which people inject; the impact of policing and services on injecting practices; participants’ overall health and living situation; and understandings of BBVIs. Time was allowed for participants to discuss concerns outside of the schedule. Referrals were made for participants requiring information or assistance on health or welfare matters. Transcripts were ‘cleaned’ of identifiers that might prompt recognition of the participant. Cleaning included the use of pseudonyms for the names of the participants and others mentioned in the interview and for certain locations.

4.2.2 Analysis

Field notes and transcripts were analysed according to a dual epistemological approach. First, in line with a technico-scientific approach, a list of risk practices for the transmission of BBVIs was compiled. This list included information drawn from researcher observation and participants’ own identification of risky injecting practice. Interview data were analysed for descriptions of risky practice that may not have been recognised by participants themselves but have been documented in the national and international literature. Second, an analysis of participants’ own understanding of risk and infection was conducted. This type of analysis accords with a socio-cultural approach in which categories such as ‘risk’ and ‘risk groups’ are viewed as social constructs which are continually in the process of being interpreted and acted upon by individuals and groups of people. Using a socio-cultural lens, we analysed the data for group understandings of or common discourses on ‘risk’, ‘risk event’, ‘risk groups’, ‘infection’ and ‘infectiousness’. This type of analysis sought to uncover participants’ own understanding of categories experts often take as given, and attempted to document the folk logics of risk by situating these within observations and descriptions of everyday life. Folk interpretations were compared with findings from the national and international literature, particularly sociological and anthropological research.

A number of processes were used to assess the validity of the analysis. First, the research team read all the transcripts and field notes and analysed these data for: techniques and contexts for BBVI transmission as identified in the literature; common concerns of and discourses used by participants; similarities and disparities in network membership and environmental location for injecting; and collective and individual patterns of social action in everyday life. Other themes and key issues were noted as they arose. The authors of this chapter then re-read data noting any aspects, including disconfirming evidence, not identified during the group analysis process. This inductive approach is similar to that outlined by Glaser and Strauss (1967) where data are coded and synthesised, several times over, to create a system of thematic

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9 This is not to say that it is only the ‘ordinary’ people (those who commonly constitute the subjects of research) who construct categories of risk. Experts themselves construct categories, as indeed the authors of this chapter are doing in their analysis and writing. The constructed-ness of risk categories is nowhere more apparent than in epidemiology, where exposure to risk and at-risk categories sometimes does not reflect social practice or grouping (Glick Schiller et al. 1994; Singer 1994; Day 2000).
4.3 Results: injecting drug use in Kings Cross

4.3.1 Risk and the routines of everyday life

For many participants in this study, daily life flowed according to a set of events that were at once routine and contingent. Many participants began the day in search of money to buy drugs. Getting money for drugs was based on any number of contingent activities – from committing crime, to selling prescription pills, to finding or running into someone who owed or could lend cash. The search for money began with drug users ‘getting out and about’. This involved walking around the Cross, hanging around in the street or park, making phone calls or going to cafes to have a coffee. A morning trip to the methadone clinic could also provide a chance to catch up with somebody who would pay back or loan money or who might buy prescription pills. For some participants, getting out and about occurred in the morning. For others, it was an afternoon or evening activity. For some, getting out and about was the constant activity of daily (and nightly) life. Underlying the ‘out and about’ routine is a hierarchy of need. This is articulated by Oscar, a long-term injector and Kings Cross resident:

I don’t see the point in getting the [injecting] equipment [first] ... It’s so easy to get. [It’s] usually very close to where I’m going to use ... So equipment’s the last thing on my mind. Money first, drugs second, equipment third.

(Oscar, a 39-year-old injector)

In terms of the generalisability of our findings, it is wise to heed Carlson’s (2000) warning that each local setting has its own social dynamics and forms; searching for monolithic and undifferentiated structures or dynamic is not recommended. This point acknowledged, our findings are resonant with much of the literature on established street-level drug markets in urban Western settings.
In this hierarchy of need, the hardest item to come by (money) is privileged over the easiest item to get (injecting equipment). The folk priorities of everyday life, produced by poverty and dependence, bristle against expert health promotion messages regarding the importance of having constant access to sterile equipment. The ‘money first, drugs second, equipment third’ hierarchy does not necessarily pose a problem vis-à-vis the transmission of BBVs if, as Oscar suggests, there is a nearby NSP outlet whose opening hours coincide with the routine. Problems arise, however, if the routine is enacted late at night or in the early hours of the morning when NSP outlets are closed or if vending machines are out of order, as was commonly reported.

For many participants there are any number of problems to be overcome on a daily basis. These problems form a daily routine, reflecting a situational hierarchy of risk. Clive, a 29-year-old injector, offers this insight:

After all the shit you go through — to getting the money, to go and get on — you haven’t got time to worry about cleanliness. Cleanliness is the last thing you worry about after spending all fuckin’ day putting your arse on the line. Then spend another fuckin’ hour trying to get on. Two hours, three, four hours sometimes trying to get onto the fuckin’ dealer and then [it] fuckin’ takes two minutes to shoot it up. I mean, after all that time you’re so fuckin’ lethargic and pissed off anyway.

The routines of everyday life are profoundly implicated in risk taking. When participants get ‘out and about’, they commonly run into friends and acquaintances. These meetings can result in a decision to pool money and share a drug deal. The pooling of money to buy drugs is borne of financial necessity, as Lisa, a 31-year-old injector, explains:

[A] lot of the people who use together [in the Cross], they’re not friends. They’re just acquaintances a lot of the time. So they run into each other and maybe someone’s got $25 and they need another $25 to get on [get drugs], so they hook up together like that but they hardly know each other and so they really don’t care.

Sometimes the pooling of money is planned, especially among core members of a network. If an injecting event is planned, then arrangements are usually made to have enough sterile injecting equipment on hand. However, when money is opportunistically pooled, access to new injecting equipment is less likely. Pooling money to buy drugs is a social norm imbued with specific meanings (Murphy 1987; Page et al. 1990; Bourgois 1998; Dwyer et al. 2002; Hahn et al. 2002). The opportunistic pooling of money marks the beginning of a collective routine: participants in this study invariably pooled their money, scored together and injected as a group (the pooling–scoring–group injecting routine is hereafter abbreviated to P–S–GI routine).

Trust plays a key role in the P–S–GI routine. While some participants were committed to the practice of carrying around new and used injecting equipment on the chance that it would be needed, others, like Oscar, did not see it as a priority. If the opportunistic P–S–GI routine occurred within the confines of a close friendship network, participants were more likely to trust their friends with their share of the drug deal while they went to obtain sterile equipment (trust was sometimes difficult even within this scenario). However, if the routine involved acquaintances or strangers, the likelihood of a participant leaving the person or group to get sterile equipment was slim (Zule 1992). The following scenario, supplied by James, a 35-year-old long-term injector, illustrates this point:
I was using with [three] people the other day ... and there wasn’t enough fits. I had my old one. She had her old one and the other guy had nothing ... [He discovered he didn’t have a fit and he went, ‘Oh, I’ll use hers’ ... I said what about cross-infection and he said, ‘Oh, she just got hep C and I’ve got that anyway’ and she said, ‘Yeah, yeah, that’s right’ ... If he had to go and look for a fit, it would have taken him half an hour. Even if it would have taken him five minutes, he didn’t feel comfortable that his share would be there when he returned.

This scenario raises a number of pertinent issues, including understandings of HCV infection and the place of HCV in the lives of users (to be discussed shortly). In terms of accessing sterile injecting equipment, James’ tale is a common one. In this story, the person without a syringe will not leave the group as he does not ‘feel comfortable’ leaving his share with James and the woman. He would rather re-use her syringe than risk losing his share of the deal. While the issue of HCV infection appears moot as both injectors have the virus, the story exposes the social dynamics of the P–S–GI routine as it is implicated in producing risks for the transmission of BBVIs. (Indeed, the story offers a warning vis-à-vis the potential for HIV transmission and HCV superinfection.) The account is indicative of the reluctance of injectors to leave to obtain sterile injecting equipment once the P–S–GI routine is set into play.

4.3.2 The gift economy and risk

Getting ‘out and about’, whether it be a once-a-day or full-time activity, brings with it the possibility that a friend, acquaintance or stranger will offer free heroin or cocaine. A gift economy operates in and between networks of injecting drug users in the Cross. The gift economy and the practices of reciprocity it entails are an extension of broader social relations among drug users (Grund 1993; Power et al. 1995; Maher et al. 1998). Gift-giving and practices of reciprocity reinforce social ties (Hendry 1999). In an environment permeated with uncertainty, violence and stigma, gift-giving is a social support mechanism (Zule 1992; Bourgois 1998; Southgate & Hopwood 1999). However, gift-giving can also serve to heighten risks for transmission of BBVIs (Bourgois 1998). Mauss (1970: 1) describes a gift economy as one involving a set of phenomena: gifts which in theory are voluntary, disinterested and spontaneous do in fact involve a series of obligations; namely, the obligation to give, receive and very often to repay. Michelle, a 35-year-old injector, sums up the gift economy when she explains that the attitude in Kings Cross is: ‘I’ll lay a shot on you and you can pay me back’. Participants give a number of accounts of the gift economy in drugs, of which this one is indicative:

There’s been the odd occasion when I’m sitting in the park ... and this guy comes running up and ... he said, ‘Oh, come on, I’ve got some dope. Let’s go and do it’ ... I did know who he was and there was another guy there too and we sat in the park, and I hate doing it in the park. You know it just freaks me out. I’m always scared I’m going to be busted. And he had some clean fits and I was watching what he was doing and it was all fine so [I shot up] ... I think people like using with others and it’s pretty boring using by yourself, so
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Lisa, a 31-year-old injector

The contingent nature of the gift economy serves to heighten risky practice. As Lisa’s account illustrates, when a gift of free drugs is offered, it is an immediate gift. There is little possibility of postponing it or holding up the imminent injection episode by dashing off to find sterile injecting equipment. Lisa was fortunate in that the person who offered the gift also offered sterile equipment. In many situations this is not the case, with users deciding to share fits or pick up discarded syringes from public places. On occasion, the gift economy extends to helping others inject. In this case, the gift involves the use of technical expertise (a knowledge of injecting procedure) to assist friends, acquaintances and even strangers. Users may ask others to inject them if their veins are in a poor condition or if the person chooses not to learn to inject or if they are neophytes. Ralph, a 47-year-old injector, tells the following story in which he lends a helping hand:

You have this other group of addicts that use daily and didn’t inject themselves. They get somebody else to do it. [Because it’s the place they inject or ...?] No, because they don’t want to ... I actually know these three Asians that are like that. They’re using daily and they don’t want to do it themselves. They have somebody else do it. They don’t even do the three of them. You know, like I’ll do you and you’ll do me. I actually took my dog for a walk [and] he was sitting in the park, one of these little Asian guys, and he got me to do it in the park. So that just says to me they can ask anyone. [Anyone?] He only met me once before.

To inject friends, acquaintances and even strangers is an act of solidarity, derived from the social obligations many users feel towards each other. The obligation to lend a helping hand exists even though the direct social ties between the two men are weak; after all, the men had met only once before. Relying on others to inject you brings with it several risks. There is the possibility that the injecting procedure of the person who injects is poor. There is also no way of knowing if the injector’s hands are completely blood-free. In an environment like Kings Cross where injecting drug users constantly circulate, meet up and inject together, hands may bear traces of blood. Indeed, helping others to inject brings with it the risk of contaminating one’s own hands with blood. The lack of facilities for hand washing in public and semi-public injecting settings, such as the one described by Ralph, enhances this risk.

For many injectors, helping someone out, by assisting them to inject or by sharing drugs, provides an opportunity for favours to be returned. It would be easy to account for the reluctance of injectors to reject a drug gift solely in terms of drug dependence (although this certainly is a key factor for some participants in the study). For many participants, it is the social aspects of the gift economy that make it a routine that is difficult to disrupt. The gift economy reinforces social ties through a shared understanding of reciprocal practice and obligation (Grund 1993). It creates interludes of group support and is a survival mechanism for tough times — when money or drugs are difficult to come by, it is possible to call in a favour. These factors, coupled with the sociability of group
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The link between risky practice and the rhythms of everyday life is nowhere more apparent than in the lives of those IDUs who begin their daily routine at night. Relatively easy access to free sterile injecting equipment occurs during the day and into mid-evening when several NSPs operate. For pre-planned injecting, opening hours such as these are adequate. However, during late night/early hours injecting episodes, access to sterile injecting equipment is often impossible. Although Kings Cross is serviced by a number of NSPs, access, as Maher et al. (1998) point out, must be distinguished from availability. Options for accessing sterile needles late at night or during the early hours are limited. If a participant has money, he or she might use the needle vending machine located at the Kirketon Road Centre or buy a needle from a friend, acquaintance or stranger. However, participants often reported that the vending machine was broken and that they had to resort to buying fits from people who charged $2 per needle (these needles were usually sealed in packets and were assumed to be new). For those without money to purchase fits, borrowing or foraging for needles was the only option available. In some cases, participants kept an old fit to re-use, although many were reluctant to carry these because they feared being targeted by police. All these factors contributed to risky injecting.

4.3.3 The dynamics of group injecting episodes

The gift economy and the pooling–scoring routine are fundamental to the pervasiveness of group injecting. Risks for BBVI transmission in group injecting episodes are well documented (Grund 1993; Bourgois 1998; Maher et al. 1998). An examination of injecting procedure indicates numerous points in which transmission may occur. Injecting procedure begins by adding cocaine, heroin or amphetamine powder to a dry spoon. A measure of water is added, using a syringe. Water can be taken from various sources, including sterile water ampoules supplied by NSPs, bottled water, tap water or water from public toilets and gutters. The amount of water is noted so that the drug mix can be divided into equal portions. It is considered more equitable to divide the drug in mix rather than powder form (Koester et al. 1990). The drug mix is generally stirred using the plunger from the syringe or the cap from the needle. A small piece of cotton wool is pulled out of a bigger ball of cotton, usually supplied by needle and syringe programs. This piece of cotton is compacted using fingers and put into the spoon containing the drug mix. The syringe is placed on the cotton filter and the mix is drawn up through the syringe. The same procedure can also apply to small plastic bags in which amphetamine is sold. In this case, the plastic bag acts as the mix container instead of a spoon.

11 Field notes document spontaneous acts of kindness among users where reciprocity is not a concern. For example, the researcher observed the main guide employed in the study putting cigarettes next to a homeless woman who slept in the grounds of a local church. The researcher commented that ‘this appears to be the essence of using in the Cross. [Certain] social networks of drug users ... support people who would otherwise be stuck out alone in Housing Commission flats in the suburbs or in gaol.’
In group injecting episodes, the risks for transmission of BBVIs are manifold. For example, the syringe used to draw up the water to add to the spoon may not be sterile. Similarly, the spoon or container used to mix the drug in may have already been used and may therefore contain traces of blood. It is possible that a person or people drawing up the mix from the single spoon or container may use old needles, thus infecting the mix with their blood. In addition, in some home-based or semi-private settings, a common container filled with water is used to rinse syringes. Rinsing containers serve a dual purpose. First, they are used to rinse old fits to ensure that any blockages are cleared before injecting. Second, fits are placed in the container after injecting. In this situation, fits are given a quick rinse-out in order to ensure that blood and other material do not cause a blockage. Fits are rinsed in the likelihood that they will need to be re-used. Use of a common rinse cup represents a high-risk practice for the transmission of BBVIs. The common container used to rinse fits before and/or after an injection will be contaminated with blood. Even if each member of the group has a new fit, the action of rinsing used needles in a common container of water afterwards increases the chance of BBVI transmission (Koester et al. 1990; Gaskin et al. 2000; Hagan et al. 2001). Finally, there is always the possibility that blood from hands and injecting paraphernalia will be passed on to others through contact or when injecting paraphernalia is laid down on surfaces commonly used by injectors.

Group injecting can be a hectic business. This is especially true when there is pressure to inject, as in public settings where there is a fear of being caught by the public or police. Pressure may also be induced by ‘stand-over merchants’ who rob other users or demand a share of the drug mix, and by people who are severely ‘hanging out’ (suffering withdrawal).

Participants tend to check visually rather than verbally whether the injecting equipment is new or not. The visual checking of needles is a relatively safe strategy if one views a new needle being extracted from a sealed packet. Spoons, however, do not come in sealed packets, making their status more difficult to detect. The strategy of visually checking injecting equipment fails when the bustle of group injecting is considered. As participants noted, it is difficult to watch all members of a group to ensure that they are using new needles. It is impossible to see everything and everyone at once. During the action a member of the group can introduce a used needle with relative ease. As Ralph, a 47-year-old injector, explains: ‘Someone could use their old fit and you wouldn’t see where it came from. It just appears in their hand.’ Even if others are verbally challenged, the pressure to inject quickly can override safety considerations. Clive, a 29-year-old injector, points out that the fear of being ‘ripped off’ by the people you are injecting with necessitates a concentration on the practice of dividing the drug mix, rather than observing who has a new needle, an observation also recorded in the anthropological work of Bourgois (1998). James, a 35-year-old injector, reflects on risk and group injecting in a public context:

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12 One participant, Lisa, provided an exception to this when she stated that it was safer for women to inject in public with acquaintances who attempt to stand over females. A public setting provided a better chance for women to escape violence or have someone intercede on their behalf.
Regular users carry around things like spoons that they’ve dipped a dirty fit in. They’ll put it back in their bag. Next time they’ll pull out the spoon. ‘Oh, it’s alright, I’ve got a spoon’ [they’ll say and] everybody will mix up in it without cleaning it or using a new one … I’ve seen it hundreds, thousands of times. Someone will go, ‘Has anyone got a water [ampoule]?’ and they go, ‘Yeah, it’s clean’, and they’ve just picked it up off the ground. Yep, it’s been opened … If you look carefully you can see a rose-coloured tinge to the water and [people go], ‘Yeah, it’s clean, use that and shut up. Shut up, I’m cokin’. Some people like silence when they’re on coke ... When it comes to the crunch, which is the actual situation of injecting drugs [like] making sure you’ve got your share, ... getting the drugs, that becomes the priority and other things can fall away.

James’ account highlights how social dynamics affect risk practice. Some regular users are in the habit of carrying around used spoons in the event they may need them. While James is aware of the risks of re-using spoons, others are not as knowledgeable or as concerned. While it may be difficult to tell if a spoon has been used, the description of the blood-tinged water ampoule indicates that the use of sterile paraphernalia can be a low priority in group injecting episodes. In this story, there is pressure to inject quickly and silently. The only priority is ‘making sure you’ve got your share’.

The dynamics of group injecting have an impact on needle sharing. If a member of the group does not have a syringe (new or used), then a negotiation process occurs. This sometimes involved a discussion of hepatitis C status in which a HCV negative person is given a needle to use before a HCV positive person. A person without their own fit might decide to pick up a used fit from the ground or to get one from a nearby ‘stash’ of clean or used needles kept at the home of a friend or secreted in a public place. Fits can be bought or borrowed from people on the street. If time permits and other pressures are not great, attempts are made to flush the used fit with water or bleach. Ken, a 22-year-old injector, provides the following account, which encapsulates both the contingent nature of group injecting and the risk calculations employed by users who share syringes:

I’d asked the dealer for credit ... I’d cleared it on the phone, which is something you should do. You shouldn’t just turn up and ask for credit. [When I] went to see him he said, ‘No, I can’t do it’ ... I’d come all this way hanging out, and luckily two friends walk by [and they have drugs] ... [They are] both quite young, like really young, like three or four years younger than me. They are probably about [17 and 19] ... [My friends] are extremely clean, clean kind of people, always dressed up neatly. Kinda that kind of person ... There was a brand new fit. I let her use it once and then I cleaned it and then used it once ... I was hanging out so bad ... She’s got the less chance of having anything, you know ... They’re very off-and-on users and always got their own gear. Very low risk ... I know the person and she doesn’t sleep around on her boyfriend.

The issue of verbal and non-verbal communication, especially negotiation and disclosure techniques, during injecting episodes requires further investigation. Furthermore, the practice of being silent while injecting cocaine provides an interesting instance where verbal discussion of risk is considered totally inappropriate. We have documented an instance in the field where an injector told the researcher to shut up while he injected cocaine. The researcher had been talking about hygiene.
Ken’s story demonstrates how some users calculate risk and attempt to minimise harm. In this story, Ken describes how he attempts to reduce harm by negotiating the injecting order and cleaning of the fit (unfortunately we did not ask how). In group injecting episodes, risk calculation is based as much on who is injecting as what is going on (Hughes 1999). Ken takes a risk because he is ‘hanging out’ (suffering withdrawal) and because his injecting partner is a friend. For Ken, risk is minimised because that friend is young and an infrequent injector, and because she looks and acts in a ‘clean’ way. Ken equates the girl’s reputed sexual fidelity with cleanliness. Physical and sexual cleanliness equates with a lack of disease. The sharing of a needle in this instance reflects the strong social ties between Ken and his friend. In this story, both the drug and the syringe are part of the gift economy.

Some participants simultaneously ‘read’ the appearance of others and judge the reputation of their injecting partners in order to gauge the likelihood of becoming infected with a BBV. For example, injecting with known gay men was considered very risky. In this situation participants stated that they were very alert to risks for BBV transmission. Some participants described a fear of contracting HIV, or ‘the dreaded’ as it is colloquially known, from gay men and certain kinds of injectors at risk of the disease. Some participants considered it ‘dangerous’ to inject with hardcore chaotic users or ‘desperadoes’. Danger encapsulated health risks and the potential for being ‘ripped off’ or assaulted. Street-based sex workers differentiated between those who had some control over their drug use and those who were so desperate they would do anything for a shot. While some risk calculation strategies serve to minimise harm, others were of doubtful efficacy. It is impossible to tell if someone has HIV or HCV by ‘reading’ their appearance or by judging risk solely on reputation.

The importance of the ‘who’ factor in risk taking is nowhere more apparent than in situations where couples inject with others. In group injecting episodes where there are too few sterile syringes, there is an assumption that couples will share a fit:

I think there were ... about four of us ... There was only three fits. Because we were the partners, everyone sort of came to the conclusion [that] I should be the one using the second-hand fit. So yeah, I got stuck ... someone’s gotta break.

(Lisa, 31-year-old injector)

Like, I mean, the situation in [the park] the other week. [There was a] boyfriend and girlfriend and me ... We had two fits. I had mine. They had theirs and they just shared ... I said, ‘Don’t you worry about getting hep C?’ ... She just said, ‘Oh well, you know we have been using together for six months now. If I’ve got it, I’ve got it.’

(Ralph, a 47-year-old injector)

There is a widely held expectation that couples will share a fit if there are too few syringes available (Klee et al. 1990). In some networks, this expectation translates into normative injecting etiquette. In other words, it is considered proper (and normal) for couples, who share other intimacies, to share needles and other injecting paraphernalia. Furthermore, there is an overall benefit to the group if couples share a fit. As one participant pointed out, couples who share ‘free up’ scarce resources, thus reducing the need for others who are not intimately connected to share. In this case, couples are obligated to enact a protective strategy that will benefit the group rather than themselves.
Some couples are unconcerned about this practice, as Ralph’s story illustrates. The woman in Ralph’s account is not worried about sharing a syringe because sharing with her partner has become a normalised activity over time. Syringe sharing, in these contexts, is simply one practice of reciprocity (among many) that underpins a loving relationship. Ralph’s account indicates a connection between intimacy and fatalism. The danger, as Klee et al. (1990: 144) note, is that it is difficult for couples to break strong normative patterns of sharing, as it can jeopardise the relationship. Refusing to share a partner’s syringe can be equated with a lack of trust (Sterk 2000).

The who factor, with its attendant aspects of obligation, trust and intimacy, impacts upon risk practices between friends and relatives. In the case of sex workers, this can extend to certain fellow sex workers who provide support and protection in the often-violent milieu of King Cross. The trust one puts in a friend, relative or fellow worker necessarily extends to situations of potential risk. The following accounts exemplify this dynamic:

I’m not sure [how I caught hep C] because I’ve never shared a needle ... [I was] staying with a girl over at [Y suburb] and she went and scored for me and instead of coming back with the speed, she came back with the fit [preloaded with a speed mix]. She probably already used the fit. Stupid, I trusted her ... She really pissed me off when she did that. She usually would come back with the half gram of speed. (Diane, a 29-year-old injector)

I caught hep C off my brother. He’s doing a life sentence in gaol. Because he was my brother I did not think ... Not thinking I used his [needle] and caught hep C off him ... It was about five, six years ago. He told me he had it. I said, ‘You know you’re my brother. It’s not going to do anything to me.’ (Maritsa, a 34-year-old injector)

The first account illustrates the amount of trust some injectors place in close friends. In this story Diane trusts that her friend will take her money, score the speed and return to the house to inject. Instead, Diane’s friend arrives with a pre-loaded syringe. A pre-loaded syringe is one in which the drug is already mixed up in the syringe ready to inject (Bourgois et al. 1997). The problem, as Diane points out, is that a person cannot know whether pre-loaded syringes have been previously used. Diane implicitly trusts her friend, indicated by her willingness to give the friend money to buy drugs. Trust is extended to using the pre-loaded syringe even though Diane knows the risks. In retrospect, Diane finds this ‘stupid’: at the time it is a natural extension of a trusting friendship.

14 This connection can also manifest itself in the unwillingness of couples to use condoms (Klee et al. 1990).
Maritsa’s story exemplifies a dynamic of absolute trust. Maritsa is unconcerned about acquiring hepatitis C from her brother because she feels that nothing her brother has, or could do, will harm her. Maritsa’s story indicates the operation of an insider/outsider dichotomy. Underpinning this dichotomy is the notion of Otherness. Otherness entails a distinction between the self and a group of people who are considered fundamentally different from the self (Douglas 1992). The Other is considered a threat, provoking anxiety and concern. Notions of danger and risk are associated with the Other, while ideas of purity and safety are linked to those who are not different from the self (Douglas 1992).

In broader societal terms, the illicit drug user is frequently considered an Other: illicit drug users are represented as criminal, diseased, sick and morally reprehensible (Conrad & Schneider 1980; Manderson 1993; Elliot & Chapman 2000). If broader societal discourses rarely differentiate between illicit drug users, subcultural discourses certainly do. Maritsa’s story exemplifies the way injecting drug users themselves construct insider/outsider boundaries which affect how risk calculations occur. Maritsa thinks that she is in little danger of becoming infected with hepatitis C because the person she shares a needle with is not an Other. Similarly, Diane accepts a pre-loaded syringe, another potentially high-risk activity, because her friend supplies it. Friends are those who necessarily have strong bonds with the self: they are not Others. Similarly, being a couple involves creating a social unit. Danger lies outside the unit, not within it (Loxley & Davidson 1998; Hughes 1999).

Risk is differentiated and calculated according to the logic of Otherness. Insider/outsider dichotomies produce a form of situated rationality (Rhodes 1997). This rationality dictates that the degree of risk is tempered by the status of the person or persons present. If the person is a friend, partner or relative, then the sense of risk is lessened or negated. By extension, the things used by the insider person (for example, syringes, cottons, spoons and water ampoules) are less likely to cause harm. Moreover, the bodily stuff of insiders, such as blood, semen or vaginal fluids, is viewed as less dangerous. Not all blood is the same. Not all used needles are equally risky. Situated rationalities based on insider/outsider dichotomies bristle against expert knowledge and generalist public health messages. For example, the hepatitis C prevention message, ‘Be blood aware’, would be most effective when the blood of outsiders is present. In this situation, the message builds on a pre-existing social unease with the Other. The efficacy of the message is more doubtful if insider blood is present. The body of the insiders rarely symbolises danger, threat or impurity.\footnote{Other factors, such as gender, sexuality, geographic location and ethnicity, may impact on insider/outsider dichotomies and the symbolic meanings of blood and needles. For example, Maher et al. (1998: 34) provide an interesting account from an Indo-Chinese injector who discusses the difference between ‘Asian blood’ and ‘Aussie blood’.
4.3.4 Risk and identity

The relationship between Othering and risk practice is apparent in the way participants discuss their own and others’ identities. Participants often differentiate between themselves as ‘users’ who are aware of and reasonably committed to safe injecting practice and other injectors who undertake high-risk practice. The terms ‘desperado’ and ‘junkie’ are often used to denote the latter group. Interview transcripts are peppered with accounts of ‘desperadoes’ and ‘junkies’.

In one of these accounts a desperate man uses the blood-filled syringe of an acquaintance he knows has tuberculosis. In other stories, injectors frantically search for old needles in garden beds, toilets and streets. There are tales of people drawing up water from the gutter to inject with and of people picking up blood-tinged cotton filters and water ampoules from the street. Cocaine dependency, in particular, is thought to be a sign of the ‘desperado’. Diane, a 29-year-old sex worker, delivers two tales in which desperate ‘junkies’ figure:

I don’t see myself as a junkie. Drug user, yeah, drug addict [even], but not a junkie. I reckon there’s a difference [How do you think?] Oh, [there’s] a big difference. I’ve seen them out there. [For example,] we chucked in and went halves and some girls [will] try anywhere to [inject] themselves. [This girl] went to the toilet. It took her a good half-hour to try and get [inject] herself and there’s blood running down here and everywhere, all over the floor ... and as soon as she pulled her hand off the jack she washes it ... in the toilet bowl...[Was she trying not to drip blood?] Oh no, there was blood everywhere. She didn’t care ... Once I left my fit on my lap. [It] had the wash-down with blood in it and this girl came up to me and asked for a cigarette. So while I was getting a cigarette, she snatched it up and had it. I told her it’s still full of blood. She [still] ... had it.

Diane differentiates herself from the Other, in this case ‘junkies’. She does this by telling two stories about fellow sex workers who are unconcerned with their health or the health of others. In the first story, the girl is unconcerned about spreading blood in the toilet. Nor is she worried about washing her arm in the toilet bowl. In the second instance, a fellow sex worker snatches up Diane’s fit, which is filled with a combination of the wash-down and blood. An individual will sometimes have a second injection, known as a wash-down. The wash-down is the residual drug left in the cotton filter. The filter is rinsed with water and squeezed out into the spoon. The original fit is then used for a second injection. In Diane’s story, the sex worker appears unconcerned that she is using Diane’s fit. As a ‘junkie’ she is concerned only with injecting the drug, not potential harm.

Diane’s reticence to identify as a ‘junkie’ is echoed in the stories of many participants. Indeed, for the guide employed in the study, the junkie identity was so abhorrent that he refused to keep new or used needles on him or at his house. He reasoned that doing so signalled the inevitability of injecting and the lifestyle that accompanied it. As the field diary notes: ‘The guide admitted that the thought of keeping syringes for the future meant you had every intention of using in the future. Each day he thought he might stop using, even though he had been using for 20 years with one break of four years in between.’
While few participants identified themselves as desperadoes or junkies, some like Phil, a 32-year-old injector, readily described the reality of risk taking:

Some girl ripped me off in the Cross and, instead of getting me drugs, I think she went to the dealer and got a whole bunch of swabs [filters] that might have had small amounts of drugs left in them and mixed them up ... I don't know if it's true if you can get hep C from old equipment like swabs and things like that, but if I didn't get it from her, I got it from the bloke who had blood in the syringe ... If you're a junkie long enough, no matter what people say, you will use old syringes, washed out or not. If you're sick and you know you might have done a serious crime to get hold of the money to buy them, you're not going to give a shit.

Phil alludes to the difficulty of talking about risk practice in relation to the self. When injecting drug users talk about risk in relation to themselves rather than other people, they are involved in an enterprise that threatens to cast them as ‘bad and/or mad’. Risk is not a morally neutral topic (Douglas 1992; Lupton 1993, 1999b). The moral meanings of risk ‘reach deep into the individual’s identity ... Injecting drug users, no less than the rest of the population, are attuned to the implications of the worth of self in admitting risky behaviour’ (Plumridge & Chetwynd 1999: 330–331). It is therefore not surprising that some users are more comfortable telling ‘horror stories’ about other people rather than themselves. Talking about certain subjects is taboo. For example, participants are reluctant to discuss initiating other people into injecting, although they are willing to discuss their own initiation experience and give accounts of helping experienced injectors to shoot up.

Most participants did not consider themselves to be desperadoes. Rather, they were users who found themselves in desperate circumstances. Desperate risk taking was generally associated with particular situations or life stages. It was not an intrinsic part of identity. Desperate actions are associated with: ‘hanging out’ or feeling withdrawal effects; contingent circumstances such as being offered an immediate gift of drugs and being forced to rush their injecting procedure; being ‘ripped off’ by those who offer pre-loaded syringe deals rather than heroin or cocaine in powder form; or being ‘stood over’ in injecting situations where intimidation precludes negotiating safer injecting.

Some participants discussed the effect of life stages or life events on risk taking. They took risks when they were younger and therefore less knowledgeable about BBV transmission. Youth was sometimes linked to diminished negotiating power in terms of both the drug market and group injecting episodes. Men, in particular, were candid about the effects of mental illness on risk-taking behaviour. Participants pinpointed specific life events, such as episodic bouts of depression or schizophrenia, as triggers for high-risk behaviour (Darke et Ross 2002). For some, alcoholism and bingeing on cocaine were viewed as contributing to high risk. Unlike the young injectors in Plumridge and Chetwynd’s (1998) study, participants in our study did not attribute their risky behaviour to forces outside of their control. Rather, they provided a wide and complex range of personal, situational and systemic factors impacting upon personal risk taking.
4.3.5 Environmental factors: injecting settings and physical conditions

Participants frequented a number of injecting settings in Kings Cross. These include public spaces, such as streets and laneways, parks and shopfronts; semi-public spaces such as the stairwells and outbuildings of apartment blocks, car parks and cars, abandoned buildings, public toilets and toilets situated in hospitals, welfare organisations, cafes and pubs; in private dwellings; the medically supervised injecting centre (MISC); and commercial drug injecting rooms (CDIRs). CDIR is a term that covers a range of private spaces rented out for short periods of time for the purposes of sex work and/or injecting. CDIRs include hotel rooms, rooms in brothels and sex-work safe houses, booths in adult bookshops and sex clubs, and rooms in strip clubs. A few participants discussed injecting in prison, a topic to be explored in Chapter 6.

In a recent study of Sydney injecting drug users, an overwhelming majority of participants had injected in a public place in the six months prior to the study (Darke et al. 2001). Almost all participants in our study, even those with their own accommodation, had recently injected in a public place, such as the street, a park or a public toilet. While those with a private abode injected less often in public places than the itinerant or homeless, the rhythm of everyday life (as exemplified by getting ‘out and about’, the pooling–scoring–group injecting routine, and the gift economy) necessitated injecting in public. For those who were itinerant or homeless, public injecting was the norm.

Research indicates that public injecting locations are associated with BBVI transmission (Des Jarlais & Friedman 1990; Ouellet et al. 1991; Bourgois 1998; Maher et al. 1998; Hien et al. 2001; Strathdee et al. 2001). The findings of MacDonald et al. in this report (Chapter 3) indicate that re-use of someone else’s syringe is associated with outdoor injection.

Injecting in public and semi-public places brings with it the risk of being discovered by members of the public, other users and the police. Many injectors attempted not to offend the general public, by keeping a distance from other people or by using ‘hiding spots’ in parks or streets. Keeping away from stand-over merchants or hostile users was also a priority. Many users were fearful of being caught by the police or sniffer dogs. If users were caught, police would conduct a search, check for warrants or squirt out drugs from syringes. For some, fear of coming into contact with the police accounted for their reluctance to carry new injecting equipment:

It’s not illegal to carry clean equipment. It’s the fact that the cops see the fit in your bag. You might not have any heroin, but they’ll drag you off and strip search you. Depending on their attitude, they’ll hassle you for half an hour.

(Oscar, a 39-year-old injector)

16 Most participants approved of the MSIC, and those who had used the facility provided positive comments. Those who did not want to attend the MSIC gave a range of reasons including a fear of police surveillance, the limited opening hours and the length of the registration procedure.
The impact of policing policy on increased injection-related risk taking is well documented (Koester 1994; Maher et al. 1997, 1998; Maher & Dixon 2002; Southgate et al. 2000). Zero-tolerance policing results in a reluctance to carry new (or used) injecting equipment and in drug users rushing their injecting procedure. As Maher and Dixon (2002: 48) point out, an overt police presence exacerbates high-risk injecting in public and semi-public settings because users are anxious to ‘get on and get out’. This often means that they will use any syringe that is available, either borrowing one or picking one up off the ground.

Health risks are increased by the unhygienic conditions in which public injecting occurs. Dirt, faeces and urine are present in many public and semi-public settings. Blood is sometimes visible. Visible blood contamination of the injecting environment is not the only concern. Injectors sometimes rinse out their syringes with water after injecting. They do this to ensure that the syringe is not blocked with blood and other debris, in the event that the syringe needs to be re-used. The presence of blood-contaminated water on the walls, floor and basins of public toilets, for example, provides a possible environmental risk for HCV transmission. It should be noted that rinsing dilutes blood left in the syringe, making it a relatively invisible source of contamination. Settings such as public toilets, stairwells and abandoned buildings are often poorly lit, making it difficult to identify blood or to rinse contaminated surfaces. The impact of strategies to manage public space and injecting requires further investigation.

Another health risk associated with injecting in public and semi-public places is the practice of ‘stashing’ needles. Homeless and itinerant participants reported hiding needles in public places such as park gardens in order to retrieve clean or used needles when needed. The problem with this practice, as Maher et al. (1998) point out, is the possibility that others will find the stash and use the needles, either putting them back in their original place or taking them with them.

Most participants considered CDIRs as a safer option than public or semi-public settings. Budget hotel rooms rented for 10–20 minute periods were considered relatively safe places to inject, particularly if the cost of the room ($10–$30) was shared among injecting partners. Some hotels supplied new needles and syringes and swabs as part of the fee. Sex workers considered safe houses to be secure injecting places. Sex workers injected with other sex workers, and sometimes with their clients. A select group of sex clubs also rented out rooms for short periods, usually supplying new needles and syringes and swabs. These rooms are used for sex work and/or injecting. The general cleanliness of CDIRs varies. The state of CDIRs ranges from frequently tidied to squalid. The following accounts describe the state of a room at a hotel and a sex club respectively:

[Do you want to tell me a little bit about the injecting rooms?] They are disgusting, dirty, horrible. Blood everywhere and, if you choose to use up there, then you have to keep everything up off the table, like on your lap.
(Gina, a 25-year-old sex worker who injects)
[The rooms at Y venue] are supposedly rented out to prostitutes for 10-minute sessions, but there's a mattress in there that's mucus- and blood-stained and semen-stained. People get their fits and they squirt their names on the wall.

*(Oscar, a 39-year-old injector)*

The physical state of many CDIRs is dependent on a number of factors, in particular who is managing and cleaning the rooms, and what time of day the rooms are accessed. Evenings are busiest. The sheer volume of customers renting rooms for sex and injecting in 10–20 minute time slots necessarily means that regular cleaning is required if rooms are to be cleared of syringes and condoms, surfaces wiped and bins emptied. While some CDIRs undertake harm reduction by supplying new needles and swabs, even the best managed operation must find it difficult to keep up with cleaning in high-demand periods (at night and on weekends). As the accounts cited above suggest, CDIRs can be sites where users risk environmental blood contamination. Users add to the danger of such contamination via practices such as squirting. Finally, while CDIRs provide a private place in which there is less need to rush injecting, they are not immune from police raids. Police raids exacerbate the 'get on and get out' attitude which leads to risky behaviour.

Private dwellings were considered the safest environments to inject in. They provided spaces away from street violence and the police, and, in general, homes were considerably cleaner than public places or CDIRs. Participants felt that they had greatest control over their injecting practice when they injected at home. Mostly this sense of control extended to the homes of close friends. A few participants told stories of unsafe injecting in private dwellings, in particular if the injecting took place in the home of an acquaintance or a dealer (who was not a close friend). For example, Carl, a 40-year-old injector, described injecting with three others at a dealer's home. While each person had their own new fit, the dealer offered the group a 'sample' of the drug they are going to purchase, from his own spoon. While Carl and the others were unsure if the spoon was new or used, they accepted the sample, drawing up the mix from the dealer's spoon. Carl's story exemplifies how risk practice occurs even in a relatively safe injecting environment where a group of injectors are committed to using new fits when injecting. Carl and the others knew it was unsafe to share the spoon. However, the offer of a free sample overrode concern about acquiring hepatitis C. In Carl's case, risk was calculated according to a situational hierarchy of need: the most important priority was to have a new fit, followed by a free 'taste' of the drug. The status of the spoon was of less concern.
From a user perspective, the concepts of risk and safety extend beyond the subject of BBVI. Risk and safety are integrated in a situational hierarchy of need. First, users often take risks to get the money to buy the drug. They risk committing crimes or risk being ‘ripped off’ by others when scoring drugs. Safety involves quickly finding a convenient place to inject, hopefully away from the public and the police. Safety means avoiding street violence and stand-over merchants. Health risks are simply one more factor to be prioritised and calculated. For some, risks for BBVI transmission may be a low priority or a circumstance that is almost impossible to avoid. For example, those who use CDIRs recognise these rooms as having the potential for hepatitis C transmission vis-à-vis environmental blood exposure. However, in their hierarchy of need, the priority is to inject the drug quickly in a setting away from the prying eyes of the public and, most importantly, the police. Many users attempt to mitigate health hazards through strategies such as not laying their injecting equipment on tables in CDIRs or minimally touching the surfaces of public toilets. Blood awareness in such contexts may be sufficient to prevent BBVI transmission. The physical condition of such places, factors such as poor lighting and the presence of a near-invisible blood–water mix squirted from syringes, make it difficult to detect, let alone avoid, blood.\(^\text{17}\)

### 4.3.6 The spoon men: a case study in marginalisation and risk

The link between social marginalisation among IDUs, high-risk practice and BBVI transmission is well established (Klee et al. 1990; McDonell et al. 1993; Klee et Morris 1995; Bourgois et al. 1997; Bourgois 1998; Friedman et al. 1999; Strathdee et al. 1997; Dwyer et al. 2002). Social marginalisation is characterised by a range of interconnecting factors, such as high levels of drug dependence, criminal recidivism, severe economic disadvantage and homelessness. In their ethnographic study of homeless heroin users in San Francisco, Bourgois and colleagues (Bourgois et al. 1997; Bourgois 1998) document how ‘fragile income-generating strategies mandate … risky practices’. Within Kings Cross, a group of homeless people known as ‘spoon men’ undertake the income- (and drug-) generating strategy of scrounging for cotton filters, spoons and bags in order to acquire a wash-down mix.\(^\text{18}\)

Needle and syringe programs in Kings Cross supply little bags of cotton wool to be used as filters during injecting. Injecting procedure involves placing a small piece of cotton wool into the spoon containing the drug mix. The syringe is placed on the cotton wool and the mix is drawn up. The same procedure applies to small plastic bags in which amphetamine is sold. Once the initial injection is complete, some individuals have a second injection, known as the wash-down (see Diane’s story cited above). Wash-down injections involve

\(^{17}\) The presence of semen and vaginal fluids on unclean mattresses and other surfaces in CDIRs could also be implicated in the spread of hepatitis B.

\(^{18}\) In Bourgois’ (1998) study these people were known as ‘cotton bandits’. The practice has also been noted among users in Frankfurt where they are named ‘filter people’ or ‘service people’. These are people who prepare other people’s shots for them, and their payment is the filter (from which they extract the residual drugs) or they simply beg/scrounge around in rubbish for filters (personal communication, Josch Steinmetz, Manager, Konsumraum Niddestrasse 49, Frankfurt, November 1999).
adding water to the cotton and squeezing out any residual drug to form a drug mix. Some users choose to inject the wash-down (and then dispense with cottons and spoons), while others discard their cottons, spoons or bags after the first injection.

‘Spoon men’ is the term used to describe homeless men who collect discarded bags, spoons and cottons, rinsing them out to form a wash-down drug mix. The wash-down mix is either used by the spoon man, or traded or sold on, sometimes in pre-loaded syringes or plastic bags. Spoon men may share a wash-down mix among themselves. Spoon men sometimes approach injectors and ask to have their drug paraphernalia directly after the injection:

[Have you lent a syringe to someone? Like someone comes up and says, ‘Can I use that one after you?’] No. [Have you seen that happen with people?] Yeah, I’ve seen the spoon guys do it … The spoon men … You know they give it a rinse-out [the] bit of cotton … There’s nothing [left] for them but getting out and hav[ing] a look for it [used cottons].

(George, a 46-year-old injector)

Many injectors who have the financial means to buy drugs accommodate spoon men. Giving spoon men used drug paraphernalia is considered an act of kindness; it is an action that accords with the logic of the gift economy of user culture. Spoon men are situated at the bottom of the user hierarchy. They have little means of generating the income needed to buy drugs, even when their meagre financial resources are pooled. They are chronically homeless, living for years on the street, and must therefore always inject in public and semi-public spaces. Their long-term homelessness and drug dependency leave them exposed to police attention, street violence and a range of health problems of which BBVI is simply one.

The income- and drug-generating strategy of the spoon men provides a considerable challenge in public health terms. From a public health perspective, using other people’s injecting paraphernalia has been linked to the transmission of HIV, HCV and HBV (Koester et al. 1990; Gaskin et al. 2000; Hagan et al. 2001). As a social and economic enterprise, sharing or selling a wash-down mix has serious implications for BBVI transmission. The case of the spoon men problematises the strategy of delivering health promotion messages concerning BBVI transmission to the extremely marginalised. Like the homeless drug users in Bourgois’ (1998) study, spoon men know they are taking risks. Health risks are, however, only one aspect of an exceedingly precarious existence.

4.3.7 Folk harm reduction strategies, lay experts and peer education

Carlson (2000) is right to point out that most injectors, given a choice, would prefer not to use somebody else’s needle. Almost two decades of BBVI education in Australia have left a significant impact on injecting practice and culture, with decreasing trends in needle sharing reported by a number of authors (Crofts et al. 1996; Crofts & Aitken 1997; MacDonald et al. 2000). Choice is not, however, a simple matter of individual volition. Social and economic circumstance, group membership, power relations, physical environments, and policy and service provision in areas such as health, policing and housing coalesce to constrain individual decision making (Singer 1994; Rhodes et al. 1999).
We would argue that participants in our study were not passive dupes who viewed infection with a BBV as inevitable. While fatalism was evident among a few individuals, most demonstrated that they had taken up BBV and overdose prevention messages. Most attempted to reduce harm by adapting their injecting practice when it was practical. Indeed, some participants actively took up the role as peer educator in their network, undertaking a range of activities from scoring drugs for the group and accessing sterile injecting equipment to organizing safe places for group injection to occur. Oscar and Margaret, a couple in their thirties, became de facto peer educators during the 'heroin drought.' The role they played in their network was many and varied, as Margaret explains:

So last year with the [heroin] drought ... we were still getting our quarters [of heroin] for $80, no worries. And so I'd help all of my friends out ... There'd be groups, ... say three couples. I'd say look I'm going to go and get myself a quarter, I'll get you one. But this only happens once a week, cause as soon as everyone finds out I've got it during the drought, you'd get inundated, you know ... [So that injecting situation when there's a lot of people, do you perceive there to be any more risk of kind of like infection with hep C just in terms of the action?] Most definitely. Like even sharing the spoon to mix up is a bad one, you know ... [And so you'd make the kind of rules?] Yeah, my house, I got the dope ... You've all got to have your own equipment ... [Tourniquets?] I don't use tourniquets. [How would that work? You don't use tourniquets?] They use their own. [And so in the group those people would have to have tourniquets. What if they say, ‘I don't have one. Can I borrow your belt or something?’] Well, they’d never get to use my belt! They can use their own belt ... The biggest compensation I’ll make is when someone’s fitting up here and they haven’t got a tourniquet, I’ll hold their arm up here, so that’s as close as I’ll go ... So yeah, I’m pretty health-conscious about the whole damn thing.

Power et al. (1995) argue that interventions should build on risk-reduction strategies that are already established among networks of drug users. This includes acknowledging the important health advocacy role undertaken by key opinion leaders and high-status individuals such as drug dealers. As Margaret’s account attests, certain people within user networks are capable of exercising their authority in a positive way to ensure risk is minimized, a phenomenon well documented in IDU research (Friedman et al. 1997, 1999; Des Jarlais et al. 1995; Neaigus et al. 1994; Latkin et al. 1996) It would be unwise, however, to uncritically embrace peer education as a ‘cure-all’ strategy. As Power et al. (1995) suggest, there may be difficulty identifying and recruiting key opinion leaders within injecting networks. Indeed, the efficacy of this model relies on the relative cohesiveness of the network.

Moreover, Southgate and Hopwood (2001) contend that, while the folk harm reduction strategies of peers may be highly efficacious in reducing drug-related harm, they are vulnerable to misinformation relayed through drug user ‘grapevines.’ If a lay expert, like Margaret, receives or formulates incorrect information on reducing harm, her entire network can be adversely affected. This point is illustrated in Margaret’s account. Margaret is extremely careful that people who inject in her house do not share spoons and she assures the researcher later in the interview that everyone must have their own needles.
By her own admission, she is ‘pretty forceful’ about imposing safe injecting rules. However, in spite of her good knowledge of how to prevent BBVI, she does describe holding the arms of friends while they inject. When asked later in the interview about hand washing after such an occasion, Margaret states that she washes her hands after she goes to the methadone clinic, as she fears contracting golden staph. Margaret’s response indicates that she is unaware of the possibility of transmitting very small amounts of blood while holding the arms of her friends. Hand washing is not an activity she equates with injecting episodes, although she has ready access to running water in her home.

We point out Margaret’s lapse in safer practice not as an exercise in demeaning her: she has a demonstrated grasp of safer injecting techniques to prevent BBVI. Rather, Margaret’s example serves to illustrate both the complex knowledge required to maintain safer practice and the relative ease with which one small lapse in practice can put people at risk of BBVI transmission. Furthermore, we would suggest that while Margaret herself was open to acquiring new knowledge and adapting her practices, challenging the knowledge of lay experts indigenous to networks can be a difficult task. As Southgate and Hopwood (2001) have argued elsewhere, ‘it is essential to think through scenarios where the information of peer educators recruited from outside of a specific network conflicts with that of the [lay expert] … native to the network ... [M]embers of a network [may] be more likely to accept the views of [an indigenous expert] over a peer educator even if the outside peer educator was better informed.’

4.3.8 What’s in a virus?
Understandings of hepatitis C transmission and infection

Quantitative research with injecting drug users commonly seeks to measure participants’ knowledge of BBVI transmission. This type of research compares participants’ knowledge against expert epidemiological and clinical knowledge in order to assess accuracy and identify gaps or misconceptions. It reflects a technico-scientific approach to knowledge, providing useful information that can inform health promotion initiatives. In accordance with a technico-scientific approach, our study sought to gauge the accuracy of participants’ knowledge of how BBVIs are transmitted. However, we also extended our investigation beyond an appraisal of the technical accuracy of participants’ knowledge to encompass an analysis of non-scientific understandings of hepatitis C and HIV infectivity and infection. The value of this socio-cultural analysis lies in its focus on the way injecting drug users collectively make meaning of clinical constructs such as ‘virus’, ‘infection’ and ‘infectiousness’, including clinical markers such as ‘antibody status’. Folk understandings of clinical concepts necessarily interface with the contexts from which they primarily emerge, namely clinical encounters involving testing and diagnosis. This section explores folk understandings of BBVIs, the clinical terms attached to these and their relationship to risk practice.

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19 I have borrowed this phrase from Dr Juliet Richters and Dr Carla Treloar.

20 Rosengarten et al. (2000) undertook a similar project in relation to gay men, sexual risk and HIV clinical markers.
For participants in our study, HIV generated significantly different meanings from hepatitis C. HIV/AIDS was colloquially referred to as ‘the dreaded’, a term encapsulating fear of infection and dire disease progression.21 HIV elicited strong reactions, in particular the desire to prevent infection by avoiding certain types of injectors considered to be at high risk, such as gay men or those individuals ‘known’ to be infected with the virus within the Kings Cross injecting scene. In contrast to HIV, the meanings attached to the hepatitis C virus were fairly diverse. While hepatitis C infection was not considered desirable, participants viewed hepatitis C as less dangerous to health and quality of life than HIV. There was little evidence of a forlorn fatalism among those who were hepatitis C negative. Infection with HCV was considered neither attractive nor inevitable. Nor did the researchers encounter anyone who wore their hepatitis C positive status as a ‘badge’ signifying their position of a ‘real user’.22 Pragmatism rather than fatalism was most obvious. If participants could avoid sharing needles (needle sharing being the focus of folk infection control), then they would. In cases where circumstances were deemed to prevent safer use, then risks would be taken.

The concentration on preventing needle sharing reflects the success of earlier AIDS prevention campaigns where the ‘new fit every hit’ message was the mainstay of drug user education. In terms of more recent campaigns, while some participants demonstrated an informed attitude regarding blood awareness messages, others were less cognisant of the dangers of sharing paraphernalia other than needles, and of the potential for hepatitis C transmission via environmental contact with blood or through touch during group injecting episodes. Some participants held the view that hepatitis C was transmitted ‘through dirt’. Having participants elucidate this view proved difficult, although it was probably a re-interpretation of official hygiene messages such as hand washing after injecting, rather than a literal reference to the virus living in soil. That participants take up and re-interpret hygiene messages is evident in Bruce’s explanation of how he contracted hepatitis C:

Well, I’m hep C positive at the moment and have been for quite a long time, and I think that came about when I wasn’t using sterile injecting water. I was taking water out of the toilets and things like that and using that to inject and I think that’s how I got hep C. [So it wasn’t sharing needles with other people?] No, it could have been either that or finding somebody else’s blood or something in one of the packets [containing a drug deal] or something and just continuing to have what was left of the packet or something like that that caused me to get it. Or it could have been just using a very, very old syringe where the blood had gone off or something, I don’t know. [Like you picked up an old syringe from somewhere and used it?] I’ve done that in the past, yeah.

(Bruce, a 30-year-old injector)

21 This meaning injecting drug users attach to HIV differs from the meaning gay men attach to the virus. For example, the term ‘post-AIDS’ is used to denote the end of the crisis phase of the AIDS epidemic in the West (Dowsett & McInness 1996). This phase is marked by the introduction of highly active anti-retroviral therapy (HAART), which has created a situation where, for many, HIV infection has become a chronic condition rather than a deadly illness (Rosengarten et al. 2000).

22 Southgate et al. (2002) document the notion among hepatitis C service providers that some young people view their hepatitis C status as being a badge signifying their outlaw membership of a user subculture. This notion was not apparent in our study, although few young people were interviewed formally and informally. The concept deserves further consideration.
Bruce’s account is indicative of the way participants commonly associate hepatitis C transmission with unhygienic practices, as well as scientifically known transmission routes. Bruce variously suggests he may have caught hep C from toilet water; from someone else’s blood left in an old deal packet (one assumes a small plastic bag in which the deal was mixed ready for injecting); or from re-using somebody else’s ‘very, very old syringe’. Bruce demonstrates good technical knowledge when he states that hepatitis C can be transmitted through re-use of other people’s needles and through blood contamination. He also exhibits a commonly held understanding that hepatitis C transmission is somehow linked to unhygienic practice — in this case, the use of water from a toilet, and blood that has ‘gone off’ in a syringe. The hygiene factor is also apparent in a misconception, voiced by a few participants, that it was possible to infect oneself with hepatitis C via re-use of one’s own needle. In this case, the virus is not viewed as an agent external to the self; rather, hepatitis C is an infection caused by the unclean practice of re-using one’s own fits over and over again. There is the implication that one’s own blood, once it is lodged in a used syringe, is capable of changing or ‘going off’ and generating disease, rather than the virus being transmitted via someone else’s blood. The health threat is endogenous to the drug user’s body rather than exogenous (Herzlich 1973).

Many participants are understandably confused about the differences between hepatitis A, B and C. Perhaps the most obvious sign of this is the description participants gave of their own and others’ hepatitis C seroconversion illness: they stated that they knew they had contracted hepatitis C when they became jaundiced. Unlike hepatitis A and B, many people do not experience symptoms during the initial (acute) phase of hepatitis C infection (ASHM 2001). Indeed, unlike hepatitis A and B, jaundice is rarely associated with the acute phase of hepatitis C infection (ASHM 2001). The commonly held assumption that hepatitis C status could reliably be determined by the symptom of jaundice has implications for prevention. In this case, infection and infectiousness are associated with a symptom that is much more likely to occur in the acute phases of hepatitis A and B infection, not hepatitis C. Participants in our study actively read their own bodies, and the bodies of others, for signs of viral infection. As previously discussed, reading bodies for signs of infection can deliver a false impression of disease ‘cleanliness’ or negative viral status, thus contributing to the view that it is safe to share injecting equipment. This is, of course, exacerbated by the fact that the symptom of jaundice is not a reliable marker of hepatitis C infection in the acute stages. It is likely, therefore, that many users may seek hepatitis C testing only if they experience jaundice and that some may well be basing their ‘negative’ status on the fact that they have not experienced the symptom. Michelle, a 35-year-old injector, explains this logic:

23 According to ASHM (2001), approximately 10 per cent of people will be acutely ill for several weeks or months after becoming infected with hepatitis C.
I mean, touch wood, I never got AIDS or anything like that. And how I was diagnosed; I was staying in a halfway house, rehab type of thing ... Once a week we'd do groups on women, health issues and things like that and this one week was about hep C. And he [a doctor] said, ‘Hands up the people that have got it’ and everyone put their hand up except for me and I said, ‘Well, I’ve not been tested ... but I can’t remember being yellow or anything like that’ ... He said, ‘You don’t necessarily go yellow. Can you remember in the last five years having a really bad flu?’

Reading the interview data as a whole, there is the distinct impression that those who have hepatitis C are perplexed about the implications of the diagnosis. Most state that they are ‘carriers’ who have ‘cleared’ the virus or that the virus is currently ‘dormant’. Some participants state that they have ‘antibodies’, but are unsure what this means. Some participants recount the fear and distress they felt after receiving a positive hepatitis C diagnosis. The lack of adequate hepatitis C pre- and post-test counselling has been documented in other research (Gifford et al. 2001; Loxley et al. 2001). The following interview extract reveals the underlying confusion and fear that can accompany a positive hepatitis C diagnosis:

I haven’t got AIDS and I haven’t got hep B, but what I was told was that I carry the antibodies for [hep] C, which I said ‘What’s that mean?’ Apparently it’s that I might have a mild case of it and don’t have it anymore ... They still want to follow it up now at the clinic and have a biopsy — cut a piece of my liver, test my liver ... I should have went back [to the clinic] but that scared me.

(Diane, a 29-year-old injector)

Participants sometimes used the clinical term ‘antibodies’ to describe having a resistance to hepatitis C, somewhat like a natural inoculation process. For example, Ken, a 22-year-old injector, stated: ‘I’ve been tested for hep C. Been cleared and then the doctor said, “You’ve got antibodies against it” and then he said, “There’s no sign of it in your system”’. Glen, a 30-year-old who had shared needles in gaol, thought he was ‘one of those strange people that might be able to fight it [hep C]’, thus perpetually avoiding infection. Only a few participants understood that having ‘cleared’ the virus, they were open to re-infection. Similarly, only a couple of participants demonstrated knowledge of superinfection. Confusion around diagnostic explanations such as ‘antibodies present’ and ‘virus cleared’ left participants vulnerable to hepatitis C infection. These terms gave many the false impression that they were protected from re-infection and super-infection through the presence of antibodies. There was a sense that it was impossible to ‘catch the virus again’, making it impossible to infect others.
4.4 Concluding remarks

The hepatitis C virus needs to be situated within the raft of health, welfare and social concerns experienced by marginalised injecting drug users. The majority of participants in this study experienced a range of health problems, including collapsed veins, abscesses, overdose, septicaemia and ‘dirty hits’. For some, the deterioration of veins in the arm was so pronounced that they had resorted to ‘fishing for veins’ in the fingers, toes, neck, chest and groin.

Despite having poor veins, most participants considered non-injecting routes of administration (NIROA) as unattractive. Taking drugs by NIROA was considered expensive and ‘a waste of good drugs’. In addition, NIROA did not deliver the ‘rush’ or instantaneous result that injecting did. A few participants thought that direct health harms would result from NIROA (for example, that snorting cocaine would cause ‘your face to be eaten away’). New drug-administration technologies are being developed to deliver drugs into the body at high velocity, via the outer layer of the skin without the use of a needle (see www.powderject.com). However, it is likely to be some time before these technologies have an impact, if any, on injecting options for IDUs.

Participants were also concerned about drug treatment options. While many discussed the benefits of undergoing methadone treatment, they continued to inject stimulants, particularly cocaine, regularly. Access to pharmacotherapies for stimulant use is extremely limited. Mental health issues such as depression and schizophrenia were commonly discussed by male participants.

These numerous health concerns nested themselves within the gamut of everyday worries that accompanied being poor and drug-dependent. Everyday concerns involve finding money, drug acquisition, avoiding street and domestic violence, making it to the methadone clinic on time, maintaining relationships with partners and friends, and, for many, finding somewhere safe to sleep. This raft of health, welfare and social concerns is what Singer (1994: 933) has termed a syndemic — a ‘set of synergistic or intertwined and mutually enhancing health and social problems’.

Public health concerns about a hepatitis C epidemic should be located within the syndemic nature of the health and welfare issues facing marginalised injectors, such as the participants of this study. Within this context, ‘risk’ has myriad meanings including, but not solely focused on, risks for the transmission of hepatitis C. While the majority of participants are concerned about contracting and transmitting hepatitis C, this concern is only one of many that permeate everyday life. Hepatitis C does not have the immediacy of ‘the dreaded’ HIV. Infection with hepatitis C is common among users’ friends and acquaintances. Hepatitis C infection offers an uncertain future, but, unlike HIV, a future nevertheless. Indeed, hepatitis C could be termed ‘the uncertain virus’. For many, there is uncertainty about modes of transmission except through the sharing of needles. Participants were perplexed about the differences between the various hepatitis and the symptoms of their acute phases. Confusion accompanies a hepatitis C diagnosis and there is difficulty interpreting the clinical language and markers of diagnosis. Few participants are sure about their current hepatitis C status and its implications for infectivity.
Addressing blood-borne virus prevention within the syndemic context of the Kings Cross injecting scene is challenging. As Aggleton (n.d.) argues, there are no magic bullet solutions to be applied within the differing local contexts of epidemics. Rather, coherent health and welfare programming at several different levels is necessary to support risk reduction at a collective as well as an individual level. Similarly, Rhodes et al. (1999) contend that factors within both micro and macro environments need to be addressed in order to respond to epidemics of BBVIs. At the micro level, this includes education that makes injectors aware that the routines of their everyday life can be adjusted to include the regular ‘picking up’ of sterile injecting equipment at NSP outlets; educating about the risks of needle sharing for couples and friends; continuing to provide digestible information on the risks of sharing equipment other than needles; educating against the practice of needle squirting in CDIRs and public places; and enhancing health promotion via the strategy of peer education, providing that peers are appropriate to the network. Working with the managers of CDIRs to improve the conditions of premises is also important.

At a macro level, addressing the complexity of the syndemic is vital. This includes promoting early interventions to prevent homelessness and providing crisis and long-term supported accommodation when homelessness does occur. Comorbidity is a key issue. Providing health services, including outreach services that address both mental health and substance misuse, is vital. Development of effective treatments for stimulant use is also warranted. As some participants in this study illustrate, the reality that some users will continue to inject while undertaking drug treatment needs to be acknowledged. Trials of injectable opioids should be considered for those who continue to inject while undertaking treatment. Increasing NSP access times to when users are most active – that is, late at night – would be beneficial. However, the benefits derived from increased NSP hours are likely to be offset by zero-tolerance policing, including the use of sniffer dogs. There is ample evidence that suggests this type of policing increases the potential for individual and public health harms. The ill-fit between public health initiatives and certain styles of policing deserves serious consideration at a policy and practical level.

Finally, education on the complex nature of the hepatitis virus is needed. This includes the provision of information on what ‘clearing’ the virus means, re-infection, superinfection and chronic infection. Information clarifying the common lack of a hepatitis C seroconversion illness is also required. Peer education would be advantageous in ‘spreading the word’ about these matters. Improved pre- and post-test counselling and ongoing support for people with hepatitis C are vital, if the fear and uncertainty of a positive diagnosis are to be alleviated.

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24 See the monograph edited by Teesson and Burns (2001) for an overview of comorbidity issues in Australia.

25 The topic of prescribed heroin and methadone has received international attention. For example, see Uchtenhagen et al. (1997) and Strang et al. (2000).
5. Brisbane case study: Fortitude Valley / New Farm

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5.1 Introduction

This case study focused on amphetamine use in Brisbane and Fortitude Valley. Incidental data on heroin use are footnoted, given the prevalence of amphetamine use in the area (Topp et al. 2001) and that the heroin ‘drought’ was current at the time of the study (Day et al. 2003; Topp et al. 2003).

On the northern edge of Brisbane’s Central Business District, Fortitude Valley (commonly called ‘the Valley’) is now the major centre of night entertainment in Brisbane. Its rich history is briefly outlined here: by the 1980s, the Valley was identified by business and real-estate interests as a run-down inner-city area whose development was being held back by the obvious presence of poverty. The area rose to prominence during this decade as the centre of vice and corruption in Brisbane, singled out for attention in the Fitzgerald Inquiry and linked with the drug trade. In the late 1980s, Fortitude Valley was clearly targeted for redevelopment, and Brisbane City Council secured Federal Government funds under the Building Better Cities Program to redevelop and revitalise the area (DSAS 2000: 12).

Significant amounts of government urban renewal funds and corporate interest in revitalising inner-city precincts during the last decade have rapidly ushered in a young, professional working population — indeed, the massive population increase in the last decade is reflected in Census figures, with a resident population of 1693 at the 1996 Census skyrocketing to 10,562 in 2001. However, the area also remains a haven for the disenfranchised and disadvantaged, with the bulk of community services in inner Brisbane located in the Valley, including two major NSPs, the peak injecting drug user (IDU) advocacy organisation, Queensland Intravenous and AIDS Association (QuIVAA), and the Brisbane Youth Service.

A report, Drug Use and Safety in Fortitude Valley: A community response, published in July 2000 (DSAS 2000), identified several relevant features (at p. 13) as characteristic of the area, including the fact that

[t]he use of police move-on powers in the area has disrupted many sections of Fortitude Valley’s traditional community, for example homeless people and sex workers. While these powers may be used successfully to move people on from public spaces in the area, they do not address where people go after being moved on, or the consequences of moving on people who feel themselves strongly connected to the area.

Long renowned for its highly visible sex industry, the Valley’s demographic changes have impacted not only on that industry but more specifically on the patterns of injecting drug use. While sex work remains prominent, the sex-work using scene is now clearly intermingled with various amphetamine using scenes, especially that associated with the proliferation of nightclubs in the area. Over 25 licensed premises in the Valley/New Farm area operate until 5am most nights of the week. Some of the implications for this trend are drawn out through participants’ comments below. The dynamic, open-air nature of the drug market means that changes in the drug economy have an immediate, visible impact, as evidenced in 2001 when, if there was any obvious impact of the so-called ‘heroin drought’ (Day et al. 2003), it was most noticeable in the Valley.
The Drug Use and Safety report summarised the situation by stating that, while it is generally acknowledged that the drug usage patterns that occur in the Valley are not necessarily distinct from broader trends occurring at both national and Queensland levels, ‘the distinguishing feature about drug use in Fortitude Valley is not so much its character but its prevalence, which is due to the fact that it is both concentrated and visible. This claim is made in the context of a number of additional factors such as social, economic, cultural (both ethnic and historic) and spatial issues that impact directly on the status of drug use in the Fortitude Valley area’ (Drug Safety and Awareness Subcommittee 2000: 28).

The same report, in its comprehensive review of all available evidence of injecting drug use in the Valley and surrounding areas at that time, noted (at p. 28) that an increase in the number of overdoses in the public space of Fortitude Valley, coupled with an escalating concern about increased public injecting in the Valley and surrounding areas, confirmed that injection in a public place was a major risk factor for both fatal and non-fatal overdose. Along with the high levels of heroin use, throughout most age ranges, opportunistic drug use was also seen to be common among homeless young people in the Valley. Furthermore, there was growing evidence of increases in the illicit drug consumption repertoire (polydrug use) of most dependent and recreational drug users who lived around and/or visited the Valley. Interestingly, this was accompanied not by visibly active levels of dealing but rather predominantly dependent users supporting their own drug ‘habits’. The most prescient observation was of the dramatic increase in the injection of amphetamines (especially ‘base’) throughout the Valley, where initiation into injecting was rising through an increase in the use of ‘base’ along with an increase in problematic behaviour (violence and crime).

In sum, the user profile to a large extent represented a typical microcosm of inner urban injecting drug use in Australia, with the notable exception of the considerably high levels of amphetamine injecting (Topp et al. 2001). The high rates of heroin use and overdosing noted in the report were characteristic of injecting drug use in the Valley through 1999–2001, but the heroin ‘drought’ had already had a noticeable effect on the prevalence of users identified in the Valley from 2001 through the period of observation.
5.2 Methodology

5.2.1 Method

An experienced injecting drug user educator was invited to conduct the fieldwork for the Brisbane fieldwork study, a much shorter and less resourced study than that conducted in Kings Cross. The location selected was the Valley/New Farm area long noted for its highly visible injecting drug use scene. Although clearly there are similarities between the Cross and the Valley, the site was chosen more on the pragmatic grounds of ensuring the safety of the fieldworker and, to a lesser extent, as the means by which to compare and contrast contributions from Brisbane members of the focus groups summarised in the following chapter.

Observational fieldwork was conducted intensively for four months (April 2002–August 2002). Fieldwork involved mapping injecting locations. This involved finding out about and visiting a range of popular injecting locations within the Valley area, including public and semi-public sites (stairwells, alleys, parks, toilets and clubs). Locations were visited at different times of the evening to gauge levels of use. Descriptions of sites were written in field note form. Describing physical locations was complemented by noting networks of injecting drug users who frequented certain sites (for example, regular ‘clubbers’ who frequented various popular entertainment venues).

In-depth semi-structured interviews were conducted with people who were injecting and utilising the Brisbane Harm Reduction Centre (commonly known as Biala), whose injecting equipment distribution figures in recent years have exceeded any other single venue in Australia (Topp et al. 2001). A few participants did reside and/or inject in the Valley but the sample was primarily recruited to provide some more qualitative understandings of injecting drug use in Brisbane. The sample comprised young people (under 25), homeless people, women, sex workers and truck drivers. Many of the people in the sample spanned several networks.

5.2.2 Recruitment

Most interview participants were recruited through the advertising of the project at Biala or by chain referral; that is, via other participants. Each participant was required to sign a consent form and received up to A$30 as reimbursement for their time.

Interviews were conducted in a locked interview room at Biala. Interviews lasted between 45 and 90 minutes. The Brisbane interviews, analysed for their relevance to amphetamine use in the Valley, comprised two individual interviews and four focus groups, ranging from three to nine participants. The final set of transcribed interviews comprised contributions from 13 men and seven women. Participants’ ages ranged from 18 to 55, with most in their thirties.

The interview schedule that guided the process was identical to that described for use with the Kings Cross sample. Transcripts were ‘cleaned’ of identifiers that might prompt recognition of the participant.

5.2.3 Ethics

The Valley fieldwork and semi-structured interviews received ethics approval from the relevant Queensland Health district authority, namely the Prince Charles Hospital Health Service District Human Ethics Research Committee. Time was allowed for participants to discuss concerns outside of the schedule and a referral process was established should participants require information or assistance on health or welfare issues.
5.2.4 Analysis

Field notes and transcripts were analysed according to a grounded theory approach. Very similar to the Kings Cross analysis described above, the initial analysis focused on information drawn from researcher observation and participants’ own identification of risky injecting practice. Data were also analysed for descriptions of risky practice that may not have been recognised by participants themselves but which have been documented in the national and international literature. Secondly, an analysis of participants’ own understanding of risk and infection was conducted. This analysis sought to uncover participants’ own understanding of categories that experts often take as given and attempted to document the dynamics of risk by situating it within observations and descriptions of everyday life. Once again, interpretations were compared with findings from the national and international literature, particularly sociological and anthropological research. This inductive approach is similar to that outlined by Glaser and Strauss (1967) where data were coded and synthesised, several times over, to create a system of thematic classification. Further, a process of theoretical validity was undertaken to ensure that the units of classification (themes, issues, concepts) were sensitive to the accounts supplied by participants and to the views of the field researcher.

5.2.5 Limitations of study

The fieldworker was employed simultaneously by the Brisbane City Council in an outreach educator role working weeknight and weekend evenings in the Fortitude Valley/New Farm area. It was a reasonably smooth transition for the fieldworker from this role into the fieldwork requirements. The fieldworker allocated those nights that she was not employed as an educator to conduct the study, basing her observations principally in the eastern end of the Valley to the intersection with New Farm.

Like the Kings Cross study, the educator kept a daily journal of observations and activities and then produced a brief summary report at the conclusion of her period with the project. An honest appraisal of the fieldworker’s efforts would attest to the difficulties experienced in separating the role of an educator vis-à-vis that of the dispassionate observer, and even more so with respect to the writing-up of observations. This would only seem to underscore the immense challenge that confronts any research reliant on experienced outreach-based peer educators who may not necessarily possess the written and analytical skills to complement their educational abilities. As Dowsett et al. (1999) point out, learning among IDU peer educators is predominantly oral-based and reiterates the need for educators and researchers to work more closely together.

The following observations are a synthesis of journal records and the regular conversations between the fieldworker and the Brisbane study investigator over the period April–July 2002. The material is also supplemented by contributions from focus group and individual interviews conducted in Brisbane where users spoke of their experiences in the Valley/New Farm area.
5.3 Results

5.3.1 Usage patterns

Some distinctive features about injecting drug use in the Valley during the period of observation were:

- participants used in a variety of public spaces, car parks, alleyways, stairwells, toilets, back streets, abandoned buildings, building sites etc; and

- a police ‘crackdown’, including a massive increase in surveillance, especially in May 2002, dramatically decreased visibility of street use and dealing.

5.3.2 Scoring dynamics

The importance of circumstances surrounding the ‘art’ of scoring or acquiring drugs to inject was evident in the participant interviews, focus groups and fieldwork. The vast majority of scoring in the Valley happens in B Street. Though this sounds like a highly public area, its actual position close to the centre of the Mall means that it is still well away from the limelight of activity at the northern end where dining and entertainment establishments are based. It is clearly a gathering point for young people in the Valley and close to the railway line, attracting a large influx of young people from the suburbs over the weekend. It is not surprising then that the more visible dealers were the young amphetamine dealers.

Sex workers were far less likely to score in such a public place, and instead organised among their networks to arrange supply at appropriate locations. A typical scenario is described by the fieldworker:

Caught up with Jade [a sex worker] again tonight about 12:30am on R St, she had a male friend with her, BJ. They were hanging around trying to make some money so they could get on. Jade went off to do a job and came back about 20 minutes later with some money. Within five minutes her dealer rang and she arranged to meet him down the block. She wouldn’t let me go with her but BJ stayed behind with me and waited for her to come back. She was only gone for about five minutes and came back with a pink balloon, which is a quarter gram. She said a quarter costs between $120 and $150 depending on the quality ... I asked them what the deal was with the balloons and Jade explained that each colour represented a different weight. Yellow equals a fifty piece, Blue a hundred piece, and Pink is a quarter.

Another sex worker spoke in an interview of how most of the older Valley sex workers were highly organised in arranging their score, typically with a regular dealer, and the importance of then injecting privately:

So it is getting the money ... or if you have the money, um, stick to one person who I have known for a long time. I have been lucky that way and it’s just in out and I don’t want to socialise with friends. I go home, I am always watching in my rear vision mirror, you know.

Interestingly, several of the focus groups conducted during the fieldwork period spoke unanimously of the substantial risks associated with attempting to score in the Valley, most attributing the dramatically increased police presence in the area during this period as the principal reason for dealers preferring to arrange private, one-on-one transactions — ‘There is heaps of them [dealers] there, but they walk off now, they just don’t do it there anymore’.
Dealing with risk

The more experienced users appeared to have adapted scoring rituals that enabled them to avoid the public glare of the Valley. Those with long-term dealers typically spoke of how pick-up points for scoring had moved to more discrete locations and expressed confidence in the perceived mutual level of trust:

I ring my dealer, um, arrange to score, I go and meet him somewhere and get the gear and pay for it. Ultimate credit. If you have got credit, they’re not chasing you and trying to break your legs and shit like that, so that’s one way to avoid a lot of trouble. Um, quick, discreet, I know. I know my dealer is going to have good gear, because he looks after me and he makes money off me. It’s that simple.

Although the fieldwork period coincided with a markedly increased police presence that significantly reduced instances of publicly visible scoring, the fieldworker did note that younger using groups, especially amphetamine users, tended to ‘colonise’ areas to protect scoring safety. This was most evident in those groups who would score in close proximity to their preferred nightclubs, but only when there was sufficient activity and people movement just outside the nightclub to enable the score to be completed discreetly. Some of these users expressed their concerns about how scoring would periodically increase at the more popular venues as word got around and how they in turn would seek to discourage the more casual dealers from exacerbating this ‘honey pot’ effect.

The fieldworker suggests that this scenario is typical. One of the interviewed users spoke about how he now scores and then injects at the same public toilet in the Valley ‘80 per cent of the time’ because he simply could not continue to face what he perceived to be substantial risks involved when only one person would score for a larger group:

It could be that, ah, one person can only go and score and dividing the gear up might go into a pick [needle], you know, that you have not seen, you know like a raffle. So you don’t know if they have used the pick, if it’s a dirty one or not, and even if their intentions are really good. It’s just the nature of the junkie in desperate times that you will lie to your flatmate or your best mate or whatever about a dirty fit because it is just the desperate situation that you get into.

This capacity to take some control of the scoring ‘moment’ to reduce risk was more noticeable among older users than the groups of younger, recreational amphetamine users. The fieldworker’s notes regularly cited unsafe group injecting practices among the latter, attributing some of this to the often arbitrary and rushed processes of scoring, because ‘for the recreational users it was a matter of getting off and getting back to the party’.

5.3.3 Group injecting

Group injecting typically occurs close to the clubs, and fairly quickly, as captured in the fieldworker notes below:

One of the other guys pulled out a five pack [of syringes] and John handed them all a bag (I didn’t understand why he didn’t just get weight instead of points, it would have been a better deal). They all mixed up their own hits in their bags but shared one sterile water even though they had three ampoules. Two of them were freaked out by me watching and went off to the other end of the lot. John and the other two sat on a step and booted up [injected] while I watched. They all used their own fits and filters. No one touched or helped each other. It was all very antisocial behaviour really. When they were finished, they chucked their fits under the stairs and I got
up them for doing so and made them pick them up and put them in the fit bin that they got with their pack. I don’t know what the other two did with theirs.

The impression gained, not only from the incident above but from a number of other group injecting occasions witnessed by the fieldworker, confirmed that the primary intention of injecting together was to finish injecting all at the same time and head immediately to the clubs.

However, alliances among young IDUs injecting in groups were not confined to fellow IDUs, thus further adding to the eagerness to rush through group injecting rituals. Typically exiting briefly from a nightclub or dance venue to inject nearby, young users would often be accompanied by friends not injecting but wishing to stay with the group. The fieldworker observed on several occasions that the non-injectors were clearly impatient to return inside the club and hurried the process of injecting.

Group injecting appeared to be almost entirely the province of amphetamine users, with heroin in short supply.1

Older users injecting in groups spoke of how these occasions tended to be organised in advance and coincided with end-of-week partying and pay days to increase the quality of the injecting:

You never can plan really a group unless, you know, say like it was pay day. Well, we might, um, make plans and say let’s get together, such and such will get on; we have done that many times, where we have [pooled] the money together ... so that we could buy bigger amounts ... the more money you can chip in, the better deal you get.

However, even where these occasions involved heading directly to the Valley to party immediately after injecting, older users stressed that the injecting would still be planned to occur at someone’s home nearby.

5.3.4 High-risk incidences

Several high-risk use occasions were witnessed by the fieldworker where there were clearly flawed injecting techniques in most occasions where group injecting was occurring and with younger ‘unsupervised’ users:

She held the mirror up so she could see her neck and inserted the needle through the abscess and searched for the vein, she drew back on the plunger and waited for blood to enter the fit so she could tell if she had her vein or not. She did not get it at first, she dug around a bit looking for it, drew back on the plunger again, this time blood entered the fit and she injected the drug and removed the fit. She placed her fingers over the injection site to stop the bleeding. She did not clean her fingers when she removed them other than licking the blood from her fingers. She also did not clean her hands before mixing up or injecting. She drew water up into the fit and squirted it into her mouth. I asked her why she was doing that and she said she did not like to leave any trace of her blood in the fits.

Participants in the focus groups confirmed these observations, one claiming that public group injecting of heroin was almost invisible in the Valley with the risks too high:

But when you are using certain drugs, like heroin specifically, when you go on the nod, then you are more susceptible to be robbed. And, um, I am not saying that all junkies do, but you do see it enough to watch out next time.
The fieldworker was particularly surprised at the extent of how much unsafe using she witnessed on a regular basis, her notes recording that:

There seems to be ignorance with recreational injectors in regards to the risks associated with sharing of injecting equipment and the re-using of one’s own equipment. Those that are dependent users who are using in public spaces seem to know these risks but for one reason or another do not take many precautions, if any at all. Most of these places that people were injecting in were extremely littered with various bits of furniture and discarded garbage, the stench of urine and in some instances human faeces. Even the well-dressed young males who were just out for the night to party didn’t seem to be concerned at all with the environment that they were using in. It was not commonplace to be concerned with swabbing hands or using sterile water, and often just used fits were stored for later use without concern for cleanliness, the risks of confusing whose syringe was whose or the fact that it was no longer sterile.

Focus group participants further confirmed that the high-risk moments of injecting in the Valley occurred when it was not possible to avoid public injecting and that the increased police presence only exacerbated the risk. One user recounted one of his riskier incidents as follows:

Usually you try, especially if you are hanging out, you try and make the point from when you get your gear to when you get it in your arm as short as possible. So you like jump straight in your car and pull up around the corner and throw your shit together anywhere or you will just go and have it straight away, you know, lock the doors. Like I have been like having a shot in the car and we have said it ourselves and gone, you know, there is cops over there or whatever. They come over, I am putting this away before, they’re not getting in before I put it away.

The fieldworker also observed a young amphetamine user over several weeks who had quickly developed a large habit, fed by increasing amounts of dealing, interspersed with hurried injecting moments. The user frequently told the fieldworker that he would take more time to safely inject if he did not have to be so concerned about the heavy presence of uniformed and undercover police. One of these occasions is vividly described:

We walked to the back to a dark and grubby corner, it is littered with shopping trolleys and boring graffiti, it looks like a seriously down-market kid's cubby house, with a chicken-wire fence separating it from the train line and another world. He rummaged through a pile of discarded trash and pulled out a used fit pack, an open ampoule of what was once sterile water and began to mix up in the cap of the yellow fit bin that comes with a 10 or 20 pack. He drew up into a used fit, not using a filter, nor swabbing his injection site or hands (which are filthy). I asked him if it was his fit he was re-using, he said it was. He booted his hit, withdrew the needle, licked the blood from the injection site and put the fit and water back where he got it. When he was satisfied he was not going to be found by anyone else, we headed back for the mall.
There certainly seems to be little doubt among service providers and IDUs that the increased police presence in the Valley has dispersed illicit drug use into broader, often more suburban areas. Such a dispersal effect – perceived or real – is causing greater harms through increased crime and discarded used syringes to suburban communities.

Policing pressures resulted in some street-level dealers storing drugs in their mouths. While the fieldworker did not directly witness such instances, she received evidence from other outreach workers that street-level dealers are resorting to methods of drug storage that can increase the risk of infections and the transmission of blood-borne viruses, a trend observed elsewhere (Wood 1999; Maher & Dixon 2002). While risks for BBV are slim, risk of overdose is increased through the storage of ‘caps’ of heroin in the mouths of drug users. In the Valley, fieldwork accounts from Davey and Davies (2000) suggest that injecting drug users swallow drugs stored in their mouths to avoid police detection. Risk of overdose is also made worse by reluctance to go to hospital for fear of being arrested.

5.4 Discussion

Some of the key aspects surrounding injecting drug use in the Valley/New Farm area were highlighted in the fieldwork and focus groups. Perhaps the clearest conclusion to be drawn from the period of observation was the seemingly significant impact of the increased police surveillance.

It is widely recognised that policing illicit drug use within a harm minimisation framework incurs a range of tensions and problems for the police, policymakers, health workers and injecting drug users. Recent work in the area by Maher and Dixon (2002) highlights the range of health risks that may be exacerbated by street-level policing and crackdowns in high drug use areas like Fortitude Valley.

An additional consequence of greater surveillance and increased police presence in high drug use areas like the Valley is that injecting drug users are less likely to carry any injecting equipment. Under these circumstances, injecting drug users are more likely to risk using unclean syringes, pick up used syringes from the street and risk vascular damage through rushed and dangerous injecting practices. Again, the fieldworker not only frequently observed these tendencies, she was also aware of several agencies describing clients increasingly reporting with these problems.

Drawing from current patterns of increased risk behaviours occurring in other inner urban areas of Australia, like the Drug Use and Safety report, ‘it can be predicted that surveillance and policing strategies designed to deter illicit drug use and street level sex work from the Fortitude Valley area may have a paradoxical effect’ (Drug Safety and Awareness Subcommittee 2000: 34). These strategies are likely to result in a greater risk of overdose, increased unsafe disposal of used syringes in a broader area (significant indications of this are already evident in areas surrounding Fortitude...
Valley) and increased transmission of blood-borne viruses (HIV/AIDS and HCV), as well as increasing the necessity to commit crime (for example, break and enters and armed robberies) in Fortitude Valley and surrounding areas in order to support dependent illicit drug use. Most youth agencies in the area, notably the Brisbane Youth Service, continue to report increasing incidence of hepatitis C infection among young people engaged in street-level drug use.

In short, it would appear obvious that increased police surveillance in and of itself will not necessarily deter illicit drug dealing or injecting drug use in Fortitude Valley. Indeed the experience of other areas suggests that increased surveillance in the Valley may actually disperse illicit drug use into areas that are currently experiencing low levels of street dealing and public injecting. Where injecting drug use is forced away from support services through increased surveillance strategies, it may result in an array of harms, such as those outlined above.

The other stand-out feature of the period of observation was the pervasiveness of the youth and clubbing culture in the Valley, and in particular the sociability and associated risk in relation to injecting in this culture. The fieldworker did not witness any group injecting scenes where safety was paramount, and noted how often non-injecting friends were rushing injectors to return to clubs. Associated practices of risk such as squirting old injectable material from discarded syringes and stashing of syringes for re-use were common in this often ‘frenzied’ culture, especially over weekend periods. These risky practices were exacerbated by the unhygienic and dimly lit sites where public injecting tended to occur and the fact that no safe injecting facility exists in the area remains a concern for many service providers. Several of the local non-government services responding to injecting drug use issues have run brief educational campaigns focusing on safeamphetamine use but these have tended to concentrate more on broader preventive measures than on addressing injecting risks. Another factor possibly hampering peer-based educational campaigns directed at amphetamine injectors is the predominance of current and ex-heroin users in peer-based non-government agencies responsible for developing and implementing most campaigns. More involvement of younger users in conjunction with cooperation from the larger clubs and their proprietors would seem to be critical in addressing many of the risks described above.

There would appear to be substantial room then for establishing a more coordinated approach to effective education and prevention for IDUs in the Valley. Recently a Drug Safety and Awareness Subcommittee (DSAS) emerged as a group from an initiative called the Fortitude Valley Police Consultative Committee in late 1999 and continues to meet regularly to explore strategies that would respond to community concern about the impacts of drug use and community safety in the Valley. However, the outcomes thus far have focused more on treatment options for all substance abuse-affected clients of services in the Valley rather than on broader prevention and education initiatives.

Of course, there is no simple solution to what is still regarded as a significant ‘problem’ in the Valley with regard to injecting drug use. Research continues to track patterns of drug use through services and agency data and more sophisticated tracking of overdose incidence data also assists. However, the more elusive and invariably qualitative elements of injecting drug use remain difficult to account for unless there is a commitment to the type of research carried out, albeit briefly, in the above fieldwork and analysis.
6. National focus groups

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6.1 Introduction

A series of national focus groups was conducted to obtain national data to complement the more detailed fieldwork carried out in the case study sites: Kings Cross in Sydney, and Fortitude Valley/New Farm in Brisbane. The focus groups were also intended to gain a richer insight into the data collected by the NSP survey. Focus groups, therefore, provided a snapshot of the injecting situation in that city/region. Focus groups were not intended to be representative of the injecting drug user (IDU) population but rather sample a range of people who provided in-depth information on the risks of injecting that they encounter as an IDU.

6.2 Method

A series of focus groups were conducted in capital cities. Focus groups were facilitated by members of the research team, generally with the assistance of staff from the centres where the focus groups were convened.

6.2.1 Settings

Focus groups were conducted on the premises of NSPs or user group organisations. All NSPs and users groups where focus groups took place were also included in the national NSP survey (Chapter 3). Focus groups were conducted in Brisbane, Melbourne, Adelaide, Perth, Cairns and Sydney. The number and composition of focus groups are shown in Table 6.1.

<table>
<thead>
<tr>
<th>Location</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney</td>
<td>1 x recently released male prisoners</td>
</tr>
<tr>
<td>Melbourne</td>
<td>2 x mixed gender</td>
</tr>
<tr>
<td>Perth</td>
<td>1 x mixed gender</td>
</tr>
<tr>
<td>Adelaide</td>
<td>1 x mixed gender</td>
</tr>
<tr>
<td>Brisbane</td>
<td>3 x mixed gender</td>
</tr>
<tr>
<td></td>
<td>1 x male truck drivers</td>
</tr>
<tr>
<td></td>
<td>1 x female sex workers</td>
</tr>
<tr>
<td></td>
<td>1 x primary amphetamine users, mixed gender</td>
</tr>
</tbody>
</table>

Table 6.1: Location and composition of focus groups

Total 11
6.2.2 Recruitment and inclusion criteria

IDUs who used NSP services were invited by the NSP staff to take part in the focus group. To obtain a mixed sample of IDUs, participants were asked to bring along an IDU friend who did not use the NSP services. In practice, this did not always happen; the researchers ended up with very little control over the composition of the groups. Nonetheless a range of IDUs were interviewed. In Sydney a group of recently released prisoners also took part in a focus group.

In Brisbane, even though the interviewing occurred through NSP venues, the project team deliberately set out to attract groupings traditionally reluctant to identify as IDUs, including steroid users, Central Business District-based professionals and truck drivers.

Focus groups comprised between four and 10 participants. Each participant was required to sign a consent form and received A$30 as recompense for their time. The number and composition of focus groups are shown in Table 6.1.

6.2.3 Schedule

The focus group/key stakeholder interview schedule (Appendix C) was drafted at the outset of the project and proved to be a useful tool in eliciting in-depth responses pinpointing at-risk situations and contexts. In Brisbane, some of the concepts documented during the fieldwork were also discussed in focus groups to document geographic variation and similarity among IDUs.

6.2.4 Analysis

Focus groups were audio taped and transcribed. Transcripts from the focus groups were analysed primarily by two of the research team (GW, CD). The transcripts were then analysed for thematic content, based on grounded theory (Glaser & Strauss 1967) and the analysis process outlined in Chapter 4.

Focus group data are presented in the form of quotes taken from transcripts. One of the advantages of using focus groups is that the participants can discuss the issues among themselves. This can allow for a fuller discussion of issues that may otherwise be considered socially undesirable (Kitzinger 1995). This method proved beneficial during a number of discussions, and thus dialogue between participants is presented where applicable. This dialogue between participants is presented using a new line for each speaker, with each speaker nominated an arbitrary number. An example is provided below:

Participant 1: ‘The majority in there have got hep C.’

Participant 2: ‘And most outside have got it.’

Participant 3: ‘I’ve got hep B and hep C.’

Individual dialogue is presented as a quote unto itself without the participant numbered pretext. For example:

And it’s heroin that you want to take, it doesn’t matter if there is someone there or not, as long as you get the gear.
6.3 Results

The focus groups included a range of IDUs with different experiences and knowledge of blood-borne viral infections (BBVI). Seven key themes emerged and many were salient across all focus groups. These were injecting and using drugs with others, the gift economy, trust between IDUs, injecting practices, injecting experience, risk situation and policing. Other issues included the impact of the heroin shortage, anonymity, the impact of overdose and sex work. Issues around hepatitis C awareness and education also emerged. Some detailed descriptions of the experience of injecting in prison were obtained. These themes are discussed below.

6.3.1 Injecting and using drugs with others

Participants varied in their response as to whether they preferred to use alone or with others. While some participants in the focus groups clearly preferred to use alone, many preferred to use with at least one other person present. There were a number of reasons for this, but the central reason identified by most participants was with regard to overdose — ensuring at least one other person was present to give assistance if an overdose occurred.

I prefer to inject on my own. [Why is that?] I don’t know, I just find my drug use is a personal thing and I don’t like people watching me do it. It’s like sex or something, you know, like it’s just a private thing.
(Melbourne focus group)

I use by myself if I can.
(Melbourne focus group)

Yeah, I would like to have someone there injecting in case, you know, I didn’t drop or something. If there is another person there, they can always ring an ambulance, or help.
(Melbourne focus group)

I always do it with my mates.
(Cairns focus group)

Others did not make a conscious decision whether to inject alone or with another person. As the discussions unfolded, participants were more able to elaborate on their own experiences and, for some, irrespective of their preference, they considered getting the drug to be important and any consideration about whom to use the drug with was secondary.

It don’t matter, I will use with someone else or I’ll use by myself.
(Melbourne focus group)

Participant 1: ‘Yeah, that’s it.’
Participant 2: ‘And it’s heroin that you are on and you want to take, it doesn’t matter if someone is there or not as long as you get the gear [heroin].’
(Adelaide focus group)

Indeed, in some of the smaller sites such as Perth, participants believed that they knew most of the other IDUs and that it was a large nebulous network with smaller groups who might use together.

Another factor influencing participants’ decision to inject alone or with others was the drug being injected. Typically, amphetamine was seen as a ‘party drug’ to be taken in the presence of others, while heroin was seen as a more singular experience; even if it was injected in a group, it was a more of an individual act.
Dealing with risk

With different drugs it is a different scene, like with speed it is a party thing. I would not take speed on my own ... but with a group of people.
(Melbourne focus group)

I think so, I think if you are on heroin you sort of get greedy mate in a way and you do with speed, but you are more likely to use in a group with speed than heroin.
(Melbourne focus group)

I normally use the gear [heroin] alone.
(Adelaide focus group)

Looking after each other

One outcome evident in a number of focus groups was that the more experienced the group of IDUs, the greater likelihood of them engaging in reciprocal arrangements. This was especially noticeable in a focus group with several sex workers, for example:

[And, Sharon, you will get organised with the equipment so when...] Yeah, yeah, yeah, I get it all. I get it all. Get the wipes out, you know, 26-gauge needles, whatever, and um, Belinda she just comes home and whack, whack.
(Brisbane focus group)

On Monday I will shout my friends and then right on the Friday they will shout me back and that’s the routine for every fortnight.
(Melbourne focus group)

The first quote illustrates the coordination of injecting equipment by one IDU. The second quote is illustrative of typical gift routine. As outlined in Chapter 4, this level of organisation and routine often serves to minimise risk.

Dealing and scoring — keeping it safe

The interviewees spent some time focusing on the act of scoring and, in particular, whether there were any specific issues involved in scoring that then affected a user’s decision to inject with others and safely. A fairly typical response from the groups follows:

Ah, I ring my dealer, um arrange to score. I go and meet him somewhere and get the gear and pay for it. Ultimate credit. If you have not got credit, they’re not chasing you and trying to break your legs and shit like that, so that’s one way to avoid a lot of trouble. Um, quick, discreet, I know. I know my dealer is going to have good gear because he looks after me and he makes money off me. It’s that simple ... if he doesn’t look after me, he does not make any money, so it’s in his best interests to look after me. He makes sure that the gear is good and the deals are right, um, go from there usually. Go from there to wherever I want to go and have a shot ... go back to a friend’s place, you know, if it’s a friend of mine that’s scoring at the time or I am scoring myself.
(Brisbane focus group)
6.3.2 Gift economy
The ‘gift economy’ was one of the major themes to emerge from the Kings Cross case study (see Chapter 4). The gift economy was also apparent in a number of the focus groups.

Participant 1: ‘It is true, it’s very true if you got $20, another person that you don’t even know … you know what I mean, you meet the street lad and you will go halves with it, it doesn’t matter you have not got permanent drugs.’

[Is that true for others?]
Participant 2: ‘Yeah, it’s true for me anyway.’
(Melbourne focus group)

... and usually I would not go with anyone’s opinion or try something new that I just did not know, but for some reason this day I did. Now I did not know him that well, but I figured that he was OK.
(Brisbane focus group)

After some discussions within the groups many participants identified situations in which they had inadvertently ended up using drugs and/or accepting free drugs from other IDUs. Participants’ statements outlined above demonstrate how ubiquitous the ‘gift economy’ is in the IDU culture. These situations can easily lead to risk taking and injecting situations that IDUs might otherwise have avoided or have sought greater control over. This point was illustrated by a member of the Adelaide focus group and resonates with similar situations described in the Kings Cross case study (Chapter 4).

Just someone is giving you something for nothing, and it’s a good drug and it is already mixed and it seems OK if you take it.
(Adelaide focus group)

These discussions, however, also highlighted some positive or protective practices; some focus group participants trusted that a syringe was sterile only if they saw it come from the wrapping, such as illustrated below:

... we knew he had hep C, he told us right from the start. And every time we would go over there, we say, ‘Have you got any cleanies [sterile syringes]?’ He says, ‘Yeah’. He would grab six fits from the drawer but they would not be wrapped up. I’d say, ‘These aren’t cleanies’ and he would say, ‘Yeah, these are cleanies’, and we would say no.
(Adelaide focus group)

6.3.3 Trust
Trust was another theme to emerge from discussions around group injecting. Many participants were quick to point out that injecting in groups was a matter of ‘trust’ and ‘knowing’ the person (or people) with whom they were injecting. Trust was deemed necessary for a number of reasons, overdose being the most common — participants needed to trust that the injecting partner would call for help in the event of an overdose and not rob them while they were unconscious:

You have got to trust each other.
(Melbourne focus group)

I have [shared syringes] with my boy- friend. I would not do it with anyone else cause I trust him, yeah.
(Cairns focus group)
I definitely use with someone I trust cause I don’t want to use with just anyone, cause shit they can roll you too.

(Melbourne focus group)

And you would not be injecting ... too often with a stranger cause you go into secluded places to inject so, you know, not in the public eye they will end up robbing you, mate. That is how it is getting; it is getting pretty bad these days.

(Melbourne focus group)

Generally trust was attributed to partners or close friends, but sometimes it also meant trusting unacquainted people and was based on a loose, once-over assessment of potential injecting partners. Those who appear dishevelled or ‘dirty’ were not typically trusted and no other information needed to be sought. Conversely, people who present well or, as described by one participant, are attractive gain trust more easily.

Somewhere and you just find that you follow up the people visually, um, you use certain builds. You kind of look at them, ah, they, ah, got dirty hands, they’re sweating, they’re snoozing off, they are kind of feral or something, and you decide that you are not going to use in that space with them or that you are not going to use that spoon when they say, ‘Here you are, you can use [this].

(Adelaide focus group)

You suddenly drop your guard if you find someone attractive.

(Adelaide focus group)

6.3.4 Poor injecting practices

The group injecting situation is exacerbated by poor injecting practices and chronic vein problems. Many of the experienced and older IDUs had difficulty injecting for these reasons:

Even I still miss and stuff, they’re not, not perfect. My technique can’t be 100 per cent, but even I still miss.

(Melbourne focus group)

Once out of ten times or something I have to do it again.

(Melbourne focus group)

The other theme to emerge around the issue of group injecting was that of injecting others or needing to be injected by others. This phenomenon has been documented previously (e.g. Ross et al. 1994), and was a salient issue for some focus group participants. One participant was quite adamant about whom she would allow to inject her — her boyfriend or another female — deeming other males to be unsuitable injectors in this case. Conversely, another participant was willing to let anyone inject her.

I won’t let a boy do me, but I let any chick.

(Cairns focus group)

If I don’t know, I don’t even know some of the girls that have whacked me up.

(Cairns focus group)

Once again the discussion was enhanced by the focus group methodology and this is evident in the interaction between the participants as shown below:

Participant 1: ‘When I was not that good with injecting myself, um, I let other people do it, but no, those people that I trust.’

Participant 2: ‘Anybody?’
Participant 1: ‘No, not anybody, someone who I knew was good at it.’

Participant 2: ‘Ah, so right, you would not let anyone do it then?’

Participant 1: ‘No, someone that I knew that was good at it, someone that I knew I could approach.’

Participant 3: ‘What if you were in a situation in a ring with us two, say you don’t know us, would you trust us to whack you or what?’

Participant 4: ‘So what if they said, “Yeah, I can do you” and they were not that good?’

Participant 1: ‘A lot of people do say that.’

(Adelaide focus group)

6.3.5 Injecting experience

Another sub-theme not deliberately pursued in this study but that clearly emerged was the distinction between younger and older users in terms of safer injecting. This is not to distinguish age as a particular factor in a user’s propensity to inject safely every time, but rather to highlight that older users were likely to be in a more stable injecting environment.

Well, there is more risk involved if … you go to a chemist and you fuckin’ pull your morph, or fuckin’ whatever you are pulling, um, and you go back to the car and you’re mixing up in the car and that, that should be … I don’t know about risks but there is more chance of maybe a dirty prick [needle] or something on the needle or something. You know what I mean?’

(Brisbane focus group)

Recreational IDUs, i.e. those who engage in injecting only sporadically, were seen as taking more risks, were generally less experienced, unaware of the dangers of injecting and more apathetic toward the process.

And they were really sloppy. They were just there practising of, you know, they would do it all together. They did not give a shit what they were doing. They were doing it purely for recreational use, and they would use so much that they would then just sit around like this.

(Cairns focus group)

Intervening with initiates/inexperienced

A clear but perhaps less predictable outcome from the focus groups was the reluctance of experienced users to assist younger, inexperienced IDUs and/or initiates to inject more safely. It was commonly argued that all users needed to find their own levels of safety and that intervening to help strangers was inappropriate:

So you made a bit of a point of intervening, you know. You say, ‘I’ll show you how to do it?’

(Brisbane focus group)

No, he asked me first, the other bloke say, you know, it’s like, ‘Can someone friggin’ doctor me?’ and this bloke has said, ‘Oh, I can do it’. And I sort of like, ‘Yeah, all right mate, I haven’t seen you have a shot before, so mate I’ll do it, you know.’

(Brisbane focus group)
Dealing with risk

Influence of first experience

Another theme that emerged from the focus groups was the lack of individual ‘mentoring’ or technical ‘tutoring’ regarding safe injecting occurring among IDUs. This finding is consistent with the reluctance to pinpoint any seminal influences, including first experiences of using, that might have had an influence and continue to impact on safe using.

Like my friend done it for me the first time and then we got on together again and then he says, ‘No, I’m not doing it. If you want it, do it yourself.’
(Brisbane focus group)

6.3.6 Recalling risky situations

Focus groups are not always the setting most conducive to eliciting honest and accurate recollections of when users had been personally involved in risky injecting situations. Nevertheless, a range of different scenarios were identified.

As with the Kings Cross data (Chapter 4) and other research (e.g. Maher et al. 1998), risky situations were likely to occur when one was ‘hanging out’ (experiencing withdrawal). In the scenario below, the IDU in question had recently been released from prison and was presumably hepatitis C or HIV positive, as he ‘had pretty much whatever’, so his risk was reduced.

He did not even care about washing it out. He just mixed up straight away and had a shot. He did not care cause he just recently got out of gaol, he had pretty much whatever and, um, he just did not care. He just, just hanging out bad for a shot, he did not care as long as he got that shot. He did not care about anything else.
(Brisbane focus group)

Known serostatus

It was very rare in any of the focus groups for HIV or HCV status of fellow users to influence the capacity of IDUs to inject safely. For most IDUs, injecting with others rarely involved anyone unknown to the group, and thus serostatus was thought to be common knowledge. However, this did not prevent some instances of overt discrimination among peers being recalled:

[S]o I tend not to get involved too much group-wise but sometimes there is no choice ... a freebie is being laid on you, whatever, you know. Like the other day, um, I said to somebody I had the dreaded [HIV], you know what I mean. That’s no drama, I did not think the person was going to say nothing, but four or five days later I mix up a couple of morph tabs, and ah a lot of people will like to have another crack at morph tabs after the first rinse right, and ah I was not actually in the room after I had mine. I left the spoon there right and another girl said to the person who was there, ‘Dave, can I have [interviewee’s] wash?’ He said, ‘Yeah, just make sure there is no blood in it; he has the dreaded [HIV].’ Now anybody in his fuckin’ brains knows that when you go for a wash, you don’t put blood back in your wash. It’s just common sense, mate, and I only found this out a few days later. And I seen him yesterday and he knows, mate, he knows I just, you know what I mean. He said something to me and I said, ‘What is the point in talking about it. Don’t talk to me, you fuckin’ dog’, in front of five or six girls and two of his mates.
(Brisbane focus group)
Sharing equipment

Sharing needles and syringes is a taboo topic and one not readily discussed, particularly in the group situation. However, there was some consensus among focus group participants that sharing was indeed sometimes a necessity; in such a situation, sharing with partners was acceptable and considered ‘safe’. It is also interesting to note that in these situations other precautions such as the use of bleach were not taken.

If it’s my partner’s, I know that’s as safe as gold. [Yeah?] But no one else … That’s why we keep each other’s syringes, but we don’t do that very often. [Only when you have to?] Yeah. [Do you rinse them or do you bleach them?] I don’t bleach them.

(Adelaide focus group)

Participants in the study were also cognisant of the dangers associated with sharing water and injecting equipment other than needles and syringes.

When I use with other people, I don’t share equipment, just they have got their stuff and I have got my stuff and you just have a hit together, but we don’t share.

(Melbourne focus group)

Participant 1: ‘Yeah, I’ll go second, thirds in water. It’s all in the container clean as long as there is the gear and fit, I’m in.’

Participant 2: ‘Yeah, that’s right.’

Participant 1: ‘There’s got to be clean fits.’

Participant 2: ‘As long as no one used and gone back into the water again.’

(Cairns focus group)

However, for some this could be difficult to manage. The example below also illustrates the importance of group injecting and the increased risk associated with such episodes, especially in environments with high hepatitis C prevalence among the group.

But if you dirty [the] clean water, then you have dirty water. Whoever uses after that gets the hep C.

(Cairns focus group)
6.3.7 The heroin shortage

The recruitment period was exacerbated by a heroin shortage which had commenced in early 2001 (Day et al. 2003b), the effects of which were still being felt some 12 months later. As is common with IDUs in Australia, many of the focus group participants were polydrug users (Darke & Hall 1995; Darke & Ross 1997) and were willing to use other drugs, such as cocaine and benzodiazepines, in the absence of heroin.

One of the most concerning trends following the heroin shortage was found in Perth, where the most popular form of opiate reported by participants was ‘homebake’ (an opioid manufactured from over-the-counter opioids such as codeine) being sold in liquid form in pre-loaded syringes. As discussed in Chapter 4, the selling of drugs in pre-loaded syringes poses a serious threat to BBVI prevention efforts, and this was acknowledged by the group.

You are relying on the altruism of the people who bake [manufacture opioids] to use clean fits.

(Perth focus group)

Increased use of benzodiazepines was also reported by participants in Cairns. This is consistent with findings of increased tranquiliser use during the heroin shortage which was experienced elsewhere (Topp et al. 2003). However, participants did not attribute this to the heroin shortage experienced elsewhere in Australia, instead ascribing the change to policing activities. The heroin shortage remains a phenomenon not yet fully explained (Topp et al. 2003).

There are a lot of better drugs getting hammered [seized] by the police and that, so they are turning to alternatives.

(Cairns focus group)

The increased use of benzodiazepines is problematic and the harms associated with injecting benzodiazepine are well documented (Ross et al. 1997; Ross & Darke 2000; Aitken & Higgs 2002). These include increased blood-borne virus risk behaviours, vascular problems, increased polydrug use and risk of overdose (Ross et al. 1997; Aitken & Higgs 2002).

6.3.8 Policing

The issue of policing was raised during the focus groups. Maher et al. (1998) have outlined the consequences of heavy policing of IDUs on public health and safety. They argue it increases risk by dispersing the problem, resulting in high-risk, clandestine injecting episodes. These findings have been supported more recently in Melbourne (Aitken et al. 2002). This was also found in focus groups, and was evident across the various sites.

Participant 1: ‘The aim for them is to catch you red-handed. It would not matter. They pull you in and spit you out if they want to.’

Participant 2: ‘Yeah, you know.’

Participant 1: ‘It doesn’t really matter, you just want to be safe and if you are going to do it in the street, everyone is going to get attacked.’

(Melbourne focus group)

Especially in the city and stuff, if you are using around the city. Like a number of times it has happened to me [Yeah?] I was doing my thing, you know, jacks [police] would creep past you and like the only reason you don’t get pinched is because you duck right behind a bin or something, and you have to be still as and quiet otherwise you are going to get charged, and...
there that’s the risk of using. [Yeah, so have you been in a situation where you can’t duck behind a bin?] Yeah, you just whack it up your arm.

(Melbourne focus group)

In some sites, it was pointed out that police will not confiscate syringes, but will take names and addresses, which are later followed up by a house raid. In some jurisdictions it was thought the police were inconsistent about how they treated people found with used syringes, creating an atmosphere of uncertainty and fear in terms of carrying syringes. This can also impede the safe disposal of syringes, with IDUs reluctant to return used syringes to the NSP for disposal.

While virtually all participants thought it was best to inject at home or in the car, few were in a position to manage this every time. In Perth, home was not considered ‘safer’ for injecting in terms of possible police interference, but was thought to be safer than doing it in a public place.

No, I prefer to use like somewhere else, you know, in a house or something.

There is no such thing as a safe place to inject, mate, to tell you the truth, I don’t reckon there is. Maybe if you have got a squat that you have used, you know, or something like that, but even if, how safe is that? I don’t think there is no safe thing mate.

No, as long as there are no videos around ... as long as there is no big guys around.

For those still involved in some public group injecting, the most consistent response to this question was to identify the presence of police as posing the biggest threat to safe injecting.

6.3.9 Anonymity and discrimination

Anonymity was of particular concern to some IDUs, especially professionals. There were few of such IDUs in the focus group but, for those who were, maintaining confidentiality with regard to their drug use was important. The participant below describes it as a ‘Jekyll and Hyde thing’ — he is a hard worker with a professional partner who ‘gets on with life’, while at the same time injecting drugs. In his case, drugs are not associated with recreation or relaxation but rather with work. In such cases the practices of injecting may differ from those of users who ‘associate drugs with parties’. Health messages and the delivery of such messages may also need to be delivered differently to those who do associate drugs with parties.

See, I associate drugs with work basically. I have always worked and I have always taken drugs and they just go together. A lot of people associate drugs with parties, drugs with relaxation. My association is with work ... because I have got the Jekyll and Hyde thing where, you know, I’ve a working professional life, I have got a relationship with someone who is clean and is in a management position, and that I am very family-orientated and get on with life [but] where I am also in problems with sort of shooting up.

(Brisbane focus group)

The issue of anonymity also arose in the smaller sites, such as Cairns. An important and, for some, real harm associated with the lack of confidentiality is the barrier it potentially creates for IDUs when they seek new injecting equipment.
You go into a pharmacy and you buy a kit which, mind you, is so expensive now. They would ring and tell your doctor. 

[Yeah?] And I actually happened to be there when this bitch rang and told my doctor. I also have maximum shots because I get quite sick. I have got a lower back problem and I am in pain quite a lot. And also they periodically give me Pethidine shots and, um, I was there when this bitch actually rang up and said to my doctor. My doctor has no idea that I am injecting the pills. But she does know that obviously I have to have the injecting equipment for the rest of it. 

(Cairns focus group)

Focus group participants in at least one area reported that NSP workers were patronising and judgemental. Once again, such attitudes can reduce IDUs’ willingness to attend the services or take advantage of the health education these services provide.

[They’re very moody over there [NSP]. I go there sometimes and they’re quite bitchy and quite discriminating against you ... How dare you [NSP staff] be so, you know, patronising. [Judgemental?] Yeah, and just get off your pedestal and give me a sharps kit. 

(Cairns focus group)

Discrimination toward IDUs by health care workers, including drug and alcohol workers, has been reported to be widespread (Ross et Darke 1992; Caplehorn et al. 1998; Day et al. 2003a). Health care workers have also been identified as one of the main discriminators against people with hepatitis C (MacCarthy et al. 1999; Anti-Discrimination Board of New South Wales 2001; Treloar et al. 2002; Day et al. 2003a). It is imperative that health care workers and educators dealing with IDUs are adequately trained in dealing with IDUs and the importance of non-judgemental service delivery. This is especially true in areas where IDUs have only limited options with regard to where they can obtain injecting equipment, as in the cases outlined above.

6.3.10 Overdose

A trigger event explored in the focus groups and interviews was the possibility that being party to and/or witnessing an overdose first-hand may have led to greater awareness of safer using. In general, most users acknowledged that being present at an overdose had a major effect at the time, but doubted its long-term capacity to effect changes in safe using behaviours. Below is a common response that recognises the need to plan group injecting occasions carefully and sensibly.

If I know someone is going to drop, I tend not to use with them because it shits me to tears. I have had people come into my house and they drop and you are trying to keep them up, you try to keep them up, and they are going back. 

(Brisbane focus group)
6.3.11 Sex work

Focus groups that included sex workers testified to some of the dangers involved in that industry while still using. These situations reiterate the severely marginalised nature of many IDUs and demonstrate the complex and dangerous nature of their everyday lives.

Locked in houses by blokes, you know. I would give them the money and half my hit and I would be locked in there and they would be like, ‘You are giving us a blow job or you are, you know, very risky.’

(Brisbane focus group)

6.3.12 Hepatitis C awareness and health education

Participants who had hepatitis C were asked whether having the virus impacted on their injecting practices. For some, having the virus made them more aware or more knowledgeable of the virus.

Yeah, made me a bit wiser about it. Like, you know, once I learnt ... about hep C and how I thought I contracted it, how I caught it, I can’t really say how I got it but ...

(Melbourne focus group)

Health messages were typically seen as beneficial and were seen as effective in making participants more aware of the risks, though there was concern in some areas that the messages were not being passed adequately from one IDU to another.

I find that the main safe practices aren’t getting talked about in the right way, getting passed on. Most of those communications between people ... No, they aren’t, not in Queensland, in New South Wales they are. But it doesn’t take long. [Why in New South Wales?] I don’t know, they have just got a better ... No, it is because of the attitude of the people down there.

(Cairns focus group)

Some participants demonstrated a good understanding of the general risk and high prevalence of hepatitis C. They knew that whether someone does or does not have hepatitis C based on their word is not a reliable way of determining the risks.

If someone says, ‘Ah, you know, you got hep?’ whatever, you know, and they say no, they don’t have a clue, mate. It is 50:50, you know; they might, they might not. Those people might not have been tested and they say no, you know.

(Cairns focus group)

Some issues that emerged were specific to the focus group. The focus groups conducted in Perth, for example, revealed issues around BBVI knowledge that were not identified in other groups and may be specific to the location. For example, it was thought that a new generation of IDUs was missing out on health messages about HIV because the intensity of health education on the issue had stopped. Some confusion had also arisen regarding the exact nature of HIV transmission.

(Cairns focus group)
Participants also demonstrated a good knowledge of the consequences of hepatitis C infection. While the participants in the focus groups typically considered hepatitis C to be a threat and understood the need to avoid contracting it, the examples below illustrate that it was seen as a condition that will not affect them for some time, a phenomenon which has impeded health promotion efforts in other areas, such as tobacco smoking (e.g. Eiser et al. 1989).

Don’t have to worry about it [hepatitis C] for another 15 years or so.  
(Melbourne focus group)

Yeah, well, you know, you can live a healthy life with hep C. You have just got to look after yourself once you get a bit older you know.  
(Melbourne focus group)

6.3.13 Prison

The different risks taken when using drugs in prison came up in some focus groups. One focus group was conducted with a group of recently released prisoners. As a result, several themes emerged that were specific to the prison setting. The following section outlines the issues discussed with these prisoners.

Risk in prison is considered differently from risk outside prison. Blood-borne virus risk behaviours, such as sharing needles and syringes, are prevalent and indeed inevitable if drugs are to be injected in prison. This is demonstrated in responses by participants from the recently released prisoners’ focus group and echoed by general focus groups.

Participant 1: ‘When you’re in gaol, you don’t care [about risks].’

Participant 2: ‘You don’t give a fuck.’

Participant 3: ‘You don’t think about it, you just want to have a shot.’

Participant 4: ‘When you got the gear [heroin], you don’t think about AIDS or anything.’

Not only is sharing syringes in prison common, it is expected. According to the participants in the ex-prisoners focus group, the demand for syringes results in a situation where all syringes are deemed communal. Thus, maintaining a syringe for the use of only one person is not feasible and, as illustrated below, can result in violence.

Well, he was running the Bay [Long Bay Prison] and there was one bloke had a clean fit and wouldn’t give it to him ... so he grabbed the bloke [who was withholding the syringe], bit his ear off and took the fit.

This situation is compounded when prisoners do not engage in other harm reduction strategies such as the use of bleach. The participants in these focus groups did not use bleach in prison for two main reasons: it was not freely available; and it was thought by participants to obstruct the plunger in the syringe.

[Do people use bleach?] You can’t get it very easily really ... We could not get bleach in the kitchen when we were there ... The thing is we got no bleach in the women’s prison, there was no bleach.

I don’t know anybody who has used bleach.

It’s just the environment that you have to live in. You are just restricted with what you can do. You can’t just get bleach from anywhere. You can’t run up the shop. You are just there. If you get caught with any of the paraphernalia, you’re gone anyway.
Dealing with risk

It [bleach] fucks up the needle.

One person tried it [bleach], but it got stuck up and grimed up the needle.

According to the group of recently released prisoners, the behaviours and practices established in prison do not carry over to the outside. Once released from prison, sterile injecting equipment is sought and greater care is taken to reduce risk.

[So in the first couple of weeks [out of prison], do you think it is hard to lose the rituals or whatever?]

Participant 1: ‘No, we do look for clean needles.’

Participant 2: ‘You’ve got a choice; you’ve got no choice in gaol. You don’t pick up bad habits in prison.’

Participant 3: ‘No’ [all nodding].

Participant 2: ‘You could be locked up for 12 months and still come out looking for a shot.’

Participant 4: ‘You go back to the way you used before.’

A number of concerning practices likely to exacerbate the spread of blood-borne virus and to create other injecting-related health problems were reported to take place in prison. Not only were safer injecting practices such as hand washing prior to injecting not performed, they were not tolerated. Hand washing was seen as a ‘pussy’ behaviour, a term used previously by the group to describe weak or effeminate behaviour, so much so that it could result in violence as demonstrated in the following excerpt:

[You are not going to be washing your hands before injecting someone else?]

All: ‘No!’ [Uproar, laughter]

Participant 1: ‘Nah.’

Participant 2 ‘Nooo’ [laughter].

Participant 3: ‘Hey, if they do that ... we gonna smash them.’

[Is it poncy? Is it a pussy thing to do?]

Participant 4: ‘Yeah.’

[You’re a pussy to wash in prison?]

All: ‘Oh, yeah!’

Another practice identified in prison and outside was licking the top of the needle before injecting. While this practice does not constitute a blood-borne virus risk, it does pose a number of other risks, including hepatitis A and possible endocarditis or septicaemia. However, a number of focus group participants were aware of the risks and attempted to educate other IDUs.

You can get a germ in your heart from licking the top of your fit. [There are] germs on your arm when you inject, and if you get that germ catching on to your heart, it can grow, like moss, you know how moss grows. Like a tumour. A lot of people down the [B...] lick the top of the fit, and I tell them not to.

One important topic to emerge from the recently released prisoner focus group was the protocol around HIV disclosure — it was assumed that those with HIV would disclose their status and therefore the risk of sharing a syringe with an HIV positive inmate was considered to be minimal by participants. However, as demonstrated in the excerpt below, although there is a firmly held belief that people will disclose their HIV positive status, there are exceptions.
Participant 1: ‘If someone has HIV, they will tell you.’

Participant 2: ‘Yeah, they would tell you.’

Participant 1: ‘And they will not give that fit.’

Participant 3: ‘If they are not arseholes.’

Participant 1: ‘They’ll tell you because they know they are dead anyways. In gaol, out of gaol, I’ve seen it all. They’ll say, “Don’t touch my fit, I’ve got that”.’

It was also revealed that it is assumed that everyone has (or at least most people have) hepatitis C, and thus there is no need for disclosure. However, according to participants, this is not the case outside prison and in that context it was assumed that people would volunteer their hepatitis C positive status.

That’s why people will tell you, ‘Don’t touch that fit, I’ve got hep C’, but in gaol it’s a different thing. Whereas outside they say, ‘I’ll give you a clean one because I’ve got hep C’.

One topic investigators were keen to explore was initiation into injecting in the prison setting. However, this proved difficult and was clearly a taboo topic. Although the participants stated that they, as individuals, were not prepared to assist someone injecting for the first time, they appeared uncomfortable with this topic. Some participants were more vocal on the topic than others.

[... a man comes into gaol and he’s really hung over and he’s sick, and he’s initiated into injecting by the other man in his cell]

Participant 1: ‘I wouldn’t do that.’

[You wouldn’t do that?]

Participant 1: ‘No.’

[What if they had money and said ...]

Participant 2: ‘I don’t give a fuck.’

If you can’t get it yourself, don’t use.

The reasons for this taboo were not clear. Although some participants quickly pointed out that they would be culpable if the initiate overdosed, the reason for the taboo appeared to be more complex than this. One possible reason for this is altruism — current IDUs do not want to see, or indeed be responsible for, someone else’s habit and all the problems that brings.

If they’ve got a heart, they wouldn’t.

The way I look at it, I wouldn’t put my worst enemy on the gear [heroin].
Participants made recommendations as to how the situation in prison could be improved. All participants agreed that some intervention was needed to reduce the risks associated with injecting drugs in the prison environment. The issue of prison-based needle and syringe programs was raised by the participants. The idea was not supported by all participants because it was felt that it could increase violence between inmates by exacerbating problems associated with drug debt. However, this concern is not supported by the experience of prison-based syringe programs in Europe, where no violent episodes have been recorded (Dolan et al. 2003). What the group suggested instead was heroin prescription. They argued that supervised monitoring of heroin consumption would reduce many of the drug-related problems in prison.

Needle exchange won’t work in gaol. You know why? Too many people [inmates] are going to get stabbed.

You’d get a lot of people using it, but when they came out [of the needle and syringe program], they’d get bashed, because if I shout you a shot, and don’t get it back, what’s gonna happen?

A needle exchange is never going to work ... it’s gotta be legal heroin in the gaol, for heroin users.

### 6.4 Conclusion

The focus groups were intended to complement the case study data by obtaining contextual data from a wide range of IDUs, including those in other parts of Australia. The data presented here suggest that, while some of the problems for IDUs may differ between geographic areas and groups, many issues are similar across the groups investigated.

One of the salient points to emerge from the focus group data is that the IDUs were generally aware that they were at risk of hepatitis C and other blood-borne viruses associated with injecting drug use, though the data do not provide evidence of technical knowledge. Yet, despite this awareness, avoiding the risks associated with BBV transmission was often not always possible. The themes that emerged from the data indicated that the IDUs in the study had to negotiate a number of risk situations such as procuring sterile injecting equipment, and finding a safe place to inject and a trustworthy injecting partner. Many of these issues are then influenced by environmental factors such as policing, changes in the drug supply and, for some, an attempt to maintain confidentiality. Similar issues emerged with both case studies.

Many of the focus group participants typically injected with people they knew. Conversely, the IDUs in Kings Cross were more likely to be in situations where they were injecting with people they barely knew. Despite this, both groups tended to assess the level of risk of injecting with a stranger based on their appearance. Moreover, those who typically injected with people they knew assumed they knew the serostatus of those they injected with.
As with the Kings Cross case study, the focus groups identified a number of discussion topics that were taboo. Initiation into injecting and assisting another drug user to inject proved difficult topics to elicit information on, especially when these occur in prison. The ex-prisoner group was unwilling to openly discuss the topic, possibly the result of social desirability. It should, however, be made clear that the topic, not necessarily the practice, is taboo. Given that the IDUs were uncomfortable discussing the topic, partly because it is socially undesirable, such a practice may be amenable to some change. Research from England has found that IDUs can be encouraged to refrain from initiating others into injecting (Hunt et al. 1998).

Prisons were identified as being a high-risk environment, where the risks of sharing injecting equipment are simply accepted, thus placing inmates at an elevated risk of BBVI transmission. The main barriers to safer injecting practices are typically structural, as IDUs cannot access sterile injecting equipment and are impeded in attempts to obtain bleach. Data from the focus group also suggested that there are some cultural barriers to safer injecting; these include negative attitudes to hand washing, and misperceptions, such as the belief that bleach blocked plungers.

One strategy to counter injecting in prison is imposing different sanctions for different drugs (Dolan 2000). Prisoners receive the same penalties for testing positive to heroin and cannabis. Yet research from the United Kingdom indicates that when mandatory drug testing was introduced, prisoners switched from smoking cannabis to injecting heroin as the window period of detection for heroin is shorter (days) than for cannabis (weeks) (Campbell 1996). The introduction of differential sanctions in prison could serve as an incentive for less risky drug use in prisons (Dolan 2001).

In sum, the data from focus groups, while outlining a number of area-specific concerns, resonate with the case study data in that many of the barriers to safer injecting practices are structural or borne out of the marginalisation of injecting drug users.
7. Quality of life

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7.1 Introduction

This chapter describes a study undertaken to measure quality of life (QoL) among participants in this study.

Quality of life is an important part of assessing and understanding the burden of disease and planning policy and evaluation (Brogly et al. 2002; Muldoon et al. 1998). Although the definition of QoL is debated, there is consensus that QoL pertains to physical, psychological and social functioning, and, more recently, that it includes abilities, relationships, perceptions, life satisfaction and well-being (Dauphinee 1999; Berzon et al. 1993).

There are two main approaches to measuring QoL: objective and subjective (Orley & Kuyken 1994). The objective approach is concerned with behaviours or observed level of functioning, and the subjective approach explores an individual’s perceived health status or well-being. The latter approach allows for the inclusion of an individual’s implicit cultural and personal values in the assessment (Anderson et al. 1995; Leplege & Hunt 1997; Lingjiang 1998; Aaronson 1991).

Studies of QoL with IDUs entering drug treatment highlight that IDUs have poorer health and psycho-social functioning compared with the general population and other chronic illness populations (Ryan & White 1996; Torrens et al. 1997). Low life satisfaction and socio-economic status have been associated with HIV risk-taking behaviour among IDUs (Kalichman et al. 1997; Donoghoe et al. 1992), while large social support networks have been associated with improved QoL (Gielen et al. 2001).

HCV infection is associated with reduced QoL compared to population norms (Miller et al. 2001; Davis et al. 1994). Knowledge of positive HCV serostatus among IDUs is associated with lower QoL compared with IDUs who are unaware of their positive HCV serostatus (Rodger et al. 1999) and diagnosis of HCV is associated with an increase in experience of life stress (Day et al., submitted). QoL in individuals with HCV also appears to be unrelated to liver histology (Coughlan et al. 2002; Miller et al. 2001). Further to this, HCV positive individuals who are current IDUs have poorer lifestyles, greater odds of being unemployed, lower mental health status and social support in comparison to past IDUs and non-IDUs (Day et al., submitted).

In recognition that QoL in IDUs had mainly been assessed using instruments developed for the general population, and that these measures may not be sensitive enough to detect changes in the QoL of IDUs, and further that their conceptualisation of QoL may exclude issues of importance to IDUs, the Injecting Drug User Quality of Life Scale (IDUQOL) was developed (Brogly et al. 2002).

The IDUQOL uses a subjective approach and, unlike most standardised QoL measures, allows for the individual to select the aspects that construct their quality of life and to weight the importance of each aspect (Brogly et al. 2002). Consistent with the qualitative approach used in the broader study, the aim of this study was to pilot the IDUQOL with a sample of Australian IDUs.
7.2 Methods

7.2.1 Participants

Participants in the QoL study were recruited from the focus groups conducted in Melbourne, Cairns and Perth (see Chapter 6) and by the study ethnographer in Kings Cross. Eligibility to participate in the study was injecting drug use in the previous six months.

7.2.2 Instrument

The Injection Drug User Quality of Life Scale (IDUQOL) was designed to measure QoL in IDU populations (Brogly et al. 2002). The authors recommend the instrument for use in needs assessment and evaluation of harm reduction interventions. A validation study of the instrument indicates that it has good psychometric properties (Brogly et al. 2002).

The IDUQOL is interviewer-administered and consists of titled picture cards depicting 14 life areas and a response form. The life areas are health, housing, partnership, family, money, resources, education, sex, friends, drugs, drug treatment, feeling good, being useful, independence and free choice, leisure activities, cure for AIDS and spirituality.

The IDUQOL has eight steps:

1. Participants are asked at the beginning of the interview to rate their overall quality of life on a scale of 0 to 10, where 0 is the worst they can imagine and 10 is the best they can imagine (Brief Life Assessment).

2. The interviewer then introduces the aim of IDUQOL.

3. Participants are then asked to describe the five areas in their life that currently most determine their quality of life (Participant Nominated Important Life Areas).

4. The participant is then shown the Life Area cards and asked to select the cards depicting their five most important areas (Card Selected Life Areas).

5. After selecting the cards, participants are asked to describe what each of these life areas means to them (Meaning of Selected Life Areas).

6. Participants are then asked to apply a weighting to each of these areas by distributing 25 chips across the five cards, according to their relative importance where more chips indicate a life area is more important (Weighting of Selected Life Areas).

7. Participants are then asked to rate these life areas according to how well each area is currently on a scale of 0 to 100 where 0 is the worst they can imagine and 100 is the best they can imagine (Rating of Life Areas).

8. The Brief Life Assessment is then repeated and the interview is concluded. The interviewer then records the time taken to complete the interview and rates on a scale of 0 to 10 the participant’s level of intoxication, how well the participant understood the method and the overall validity of the information obtained.
7.2.3 Procedure

The interviews with participants recruited from the focus groups were conducted at the focus group venues. Interviews with participants recruited in Kings Cross were conducted in an interview room at the Wayside Chapel. Participants were informed about the nature of the study and informed consent was obtained. Limited demographic information (i.e. gender, age, self-reported HCV and HIV status, last drug injected, and use of a needle or syringe after someone else in the previous month) was also collected for the interviews conducted in Kings Cross. The IDUQOL interviews were conducted by four members of the research team (GW, AW, CD and JK) and took an average of 11 minutes (5–25 minutes) to complete. Participants were paid $10 for their participation in the study.

7.2.4 Data analysis

Quantitative data were analysed descriptively using SPSS (Version 9). The IDUQOL global quality of life score was calculated from the sum of selected life area weightings multiplied by the life area rating (Brogly et al. 2002). The meanings of the life areas of health, housing and money were analysed for thematic content.

7.3 Results

Forty-two IDUQOL interviews were completed. Based on information available for 28 participants, 18 (64 per cent) were male and their mean age was 33 years (range 18–43 years). Nineteen participants (68 per cent) reported being HCV positive and one participant reported being HIV positive. The majority of participants reported heroin as the last drug they injected (56 per cent) followed by amphetamine (22 per cent). Two participants (5 per cent) reported using a needle or syringe after someone else had used it in the previous month.

Mean interviewer-rated participant intoxication during the administration of the IDUQOL was 3.7 (SD 3.2). The mean ratings of participants’ understanding of the method and the validity of the information obtained were 7.5 (SD 2.0) and 8.0 (SD 1.7) respectively.

The mean Brief Life Assessment rating at interview commencement was 5.1 (SD 2.1) and 5.3 (SD 2.6) at the end of the interview. The mean global QoL score for all participants was 47.5 (SD 22.4). Participants who reported being positive for HCV had significantly lower mean global QoL scores than HCV negative participants (41 vs 63, t25 = 2.259, p<.05).

Card Selected Life Areas (Table 7.1) chosen by more than half of participants were health (71 per cent), family (60 per cent), housing (57 per cent) and money (52 per cent). The least frequently chosen were sex (10 per cent), leisure activities (7 per cent) and cure for AIDS (7 per cent).
Meanings of health, housing and money

For participants who selected health as a life area, several themes emerged in their descriptions of what health meant to them. For example, health, both physical and mental, was described as being fundamental to one’s broader experience of life.

[Health] is everything, your whole life and being; have to respect your own health.

Got to be healthy, both body and mind, or you can’t have the rest.

Health is your wealth.

If it is good, I am reasonably content. Get depressed if I am sick.

Health is about being able to do things, mental and physical — feeling good.

Health was also described in reference to participants’ responsibilities to others:

Being alive long enough to see children grow up.

Important to have good health, so I can do things for myself, my family and others.

Need to maintain health for future generations, my children, their children.

Further, health was described explicitly with reference to drug use and blood-borne viruses:

Got to stay healthy to get a good hit.

Worries me, smoke a lot, on methadone, is main issue of quality of life.

Like to look after my health, important to use cleanly, don’t want AIDS.

Table 7.1: Life areas determining participants’ current quality of life

<table>
<thead>
<tr>
<th>Life area</th>
<th>No. selecting this life area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>30</td>
<td>71</td>
</tr>
<tr>
<td>Family</td>
<td>25</td>
<td>60</td>
</tr>
<tr>
<td>Housing</td>
<td>24</td>
<td>57</td>
</tr>
<tr>
<td>Money</td>
<td>22</td>
<td>52</td>
</tr>
<tr>
<td>Drugs</td>
<td>15</td>
<td>36</td>
</tr>
<tr>
<td>Friends</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Partnership</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Independence</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Spirituality</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Being useful</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Drug treatment</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Feeling good</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Education</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Resources</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Sex</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Cure for AIDS</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>
... have a lot to be thankful for. Am very lucky I don’t have hep C.

To get off drugs and get treatment for hep C.

For participants who selected housing as a life area, the main theme that emerged in their descriptions of what housing meant to them was a sense of personal security, safety and stability, and wanting to create and sustain a type of environment for their families.

Security, feeling of looking after yourself, safety.

Stability, home base, somewhere to branch from.

Gives sense of security, somewhere to go, other people can come and stay.

To make a home for myself and my son that is safe and happy.

Roof over my head, stable, be able to do things that need stability, like education.

Stability, home, settle down, be comfortable.

Stability for my granddaughter.

Another prominent meaning of housing was in relation to being independent and meeting the requirements for custody of their children.

Don’t want to rely on Department of Housing, want to rely on myself.

To get back into stable unsupported housing.

Really need it to get my children back, settle down, being able to look after the children.

Need to have decent housing to have my kids.

The meanings given for money were not dissimilar to those described for housing, specifically stability, independence, choice and meeting family responsibilities.

Helps get housing, health, drugs. Need it to get what you want, otherwise on streets and no one wants that.

To get a roof over your head and the bills paid, anything left over is a bonus.

Without it [money] hard to have housing, get around, lots of things revolve around it, bills being paid.

Need money to live and have security and stability.

Independence and freedom of choice.

Don’t want to rely on Centrelink, want own money to give daughter what she needs.

Additionally the practical aspects of affording the expenditures of day-to-day living, paying bills and buying drugs were described.

Buys drugs, keep a family, does a lot.

To afford drugs and see daughter.

So I am not sick, that is I can afford to buy drugs.

I need the cash only because it can get you drugs.
7.4 Discussion

The pilot of the IDUQOL was encouraging. Interviewers found the instrument easy and quick to administer, the method was well understood by the majority of participants and the information obtained appeared to be valid.

The global QoL of IDU in this study was on average less than 50 per cent and, notably, QoL for HCV positive IDUs was significantly lower than that for HCV negative IDUs. This is consistent with HCV seropositive individuals having lower QoL scores compared to individuals who were unaware of their HCV serostatus and who were no different in socio-demographic variables or risk history (Rodger et al. 1999).

The life areas that were most important to IDUs in this study were health, family, housing and money respectively, with health being selected by almost three-quarters of the sample as a life area that most determined their quality of life. The three main themes that emerged in relation to health were health as fundamental to life in general, health in relation to one’s responsibilities to others especially dependent children, and health in relation to drug use and blood-borne viruses. The prominent meanings given to housing and money related to obtaining or maintaining safety, security, stability and meeting family responsibilities.

Due to the pilot nature of this study, it is limited to a small sample of IDUs and little additional demographic or behavioural information was collected. Future investigation of IDU QoL may be complemented by the use of a general population QoL measure to allow comparison and discussion within the broader literature. As the psychometric properties of the instrument allow for the removal or addition of life areas, the inclusion of a Life Area Card on HCV may make it more sensitive to subjective QoL relating to HCV.

This study gives an important insight into the determinants of IDUs’ quality of life, and serves to complement the findings of the broader study relating to the raft of health, welfare and social concerns and consequent priorities in the lives of economically and socially marginalised individuals and the syndemic nature of risk (see Chapter 4). The specific meanings of life areas important to IDUs, such as health and housing, may inform the tailoring of policy and service provision and serve to increase their relevance to this population.
8. Conclusions: dealing with risk — a synthesis of findings from this report

Arguably, the holy grail of public health research is the answer to the question: ‘Why do people take risks with their health?’ Much of the research effort in the area of illicit drug use seeks to find an answer to this question. The question of injecting risk is complicated and enriched by the variety of disciplinary perspectives on the topic. There are those who focus on factors unique to the individual, others who situate risk taking within social networks and environments, and some who seek to explore ‘big picture’ structural determinants such as the impact of policy, trends in global drug markets and entrenched poverty. Moreover, as a number of commentators (Douglas 1992; Bloor 1995; Lupton 1999) have demonstrated, there are innumerable tensions between the way public health professionals define risk behaviour and the way ordinary people make sense of the things they do in everyday life. These tensions are most apparent in policy and intervention initiatives that focus solely on behaviours, such as unhealthy diet or unprotected sexual intercourse, without addressing the circumstances of people’s lives that make it difficult for them to avoid ‘risking risk’ (Lovell 2002: 804).

This is not to say that policy, education and intervention strategies are insubstantial means of curbing epidemics. The success of Australia’s needle and syringe program is acknowledged internationally (Des Jarlais et al. 1995). The prevention of an HIV epidemic among Australian IDUs is a public health success story. At the root of this success story is the innovative approach of health and welfare workers engaged on the front-line. An equally vital element is the willingness of IDUs themselves to enact protective behaviours at an individual and collective level. This includes employing methods of formal and informal peer education. The success of preventing an HIV epidemic among Australian IDUs has provided a breathing space in which the difficulties of the hepatitis C epidemic can be addressed.
While some of the hallmark strategies of HIV prevention apply to hepatitis C, for example the recommended ‘new fit every hit’, the hepatitis C epidemic differentiates itself in a number of ways. First, hepatitis C has been prevalent among IDUs for much longer than HIV. This has created a greater pool of infection, resulting in a very high risk of infection even when only a small number of needle-sharing episodes occur (Kaldor et al. 2000; Crofts et al. 1999). Apart from needle sharing, there is increasing evidence that HCV can be transmitted through ‘indirect sharing’ (Crofts & Aitken 1997; Thorpe et al. 2002). This involves shared use of injecting paraphernalia such as spoons, filters, water ampoules and tourniquets which may be contaminated with blood. There is also evidence that HCV is a much more robust virus than HIV, making it more easily transmissible (MacDonald et al. 2001).

Injecting can be a bloody business. Poor veins, rushed injecting and inexperience can all result in blood contamination of the immediate environment (Maher et al. 1998). Inappropriate disposal of injecting equipment can contaminate the immediate environment, as can normalised, habitual practices such as ‘squirting out’ syringes after use. The experience of the Medically Supervised Injecting Centre in Kings Cross, Sydney (MSIC Evaluation Committee 2003), has demonstrated that, even in the ‘best case’ scenario of a controlled clinical context, injecting can be a bloody affair. Indeed, it may be very difficult to avoid coming into contact with environmental blood, even when a person is very ‘blood aware’.

In light of the state of the HCV epidemic, the robustness of the HCV virus and the complexity of transmission factors, a realistic approach to stemming the HCV epidemic is warranted (Orr & Leeder 1997; Coutinho 1998; Crofts et al. 1999). A decrease in hepatitis C prevalence will occur in increments. Future prevention among injecting drug users therefore requires a strengthening of existing BBVI education and service provision initiatives such as needle and syringe programs and the intensification of education efforts designed to target specific groups of injectors or potential injectors. This includes the provision of peer-based education (Crofts et al. 1999). In addition, we would argue that a long-term, intersectional, whole-of-government approach is required if the causes and effects of severe marginalisation and problematic drug use are to be countered. Only a systematic approach is capable of alleviating the syndemic nature of health and welfare issues facing marginalised injectors (Singer 1994). This accords with Spooner, Hall and Lynskey’s (2001) recommendations on responding to the structural determinants of youth drug use. As these authors point out, it is imperative that we be realistic about the limitations of drug education, media campaigns and law enforcement. Single one-shot strategies are particularly ineffective. Drug use and abuse is a complex psychosocial issue that cannot be fixed by simple solutions. (Spooner et al. 2001: xi)
The body of research presented in this report underscores some of the social factors associated with risky injecting. The factors discussed here should not be viewed as the ‘holy grail’ answer to the question: ‘Why do injectors take risks with their health?’ Rather, the research indicates that an ecological or holistic approach is required if risky injecting is to be understood as a complex multi-factorial phenomenon. Risky injecting is as much a social practice as an individual behaviour. It is influenced by individual, group, cultural, subcultural, environmental, political, legal, historical and structural dynamics. ‘Risk’ is the sum of these dynamics, not a simple transparent concept.

The research findings contained in this report highlight some of these dynamics, while others are less emphasised. Some of the findings triangulate or correlate between studies, while others are unique. In terms of the ‘big picture’, the needle and syringe program survey indicates that while over half the sample reported never having re-used someone else’s syringe, one in six participants reported such re-use in the last month. Factors associated with re-use in the last month were daily or more frequent injection in the previous month, being young (less than 25 years), being of Asian or Indigenous identity, and having injected outdoors in the previous month. Furthermore, re-use of someone else’s syringe was associated with re-use of injecting equipment other than syringes, self-reported hepatitis C infection and imprisonment in the previous year. Some of these factors were supported by findings from the Kings Cross case study which documented high-risk activity in public and semi-public environments and the common re-use of someone else’s injecting paraphernalia (swabs, filters, water ampoules). Similarly the Brisbane/New Farm case study discussed the risks of injecting in public and the vulnerability of youth. The national focus groups underscored these same factors, and more specifically the way the prison environment exacerbates risk practice.

Both qualitative case studies draw attention to the social dynamics of risk. In both studies, sociability and reciprocity increased risk. For example, the young non-injectors who accompanied their injecting friends to spaces outside of nightclubs were prone to put pressure on their friends to rush the injection. Networks of Kings Cross injectors who shared a similar precarious economic position were likely to pool their money and inject in groups, often in public situations. The social dynamics of the group were such that, even if members were friends, a person would be reluctant to leave the group to get a new needle for fear their share of the drug mix would be gone upon their return.

As the case studies and focus groups suggest, the impact of the gift economy on risk practice should not be underestimated. Social distance played a key role in the willingness of people to take risks. Danger was not often associated with close familial relationships, friendship or romantic partnership. Rather, notions of danger and risk were attached to the Other — those who were distant socially and different in some fundamental way from the self. This is illustrated in stories in which people believed that if a friend offered a pre-loaded syringe, it was not risky, or in the tale of a sister who refused to believe her brother could infect her with hepatitis C. Similarly, couples trust their partner not to infect them. Power relations are inherent in social interactions such as these. Power is undoubtedly implicated in risk. While the qualitative case studies and focus groups touched on power dynamics (in relation to
Dealing with risk

gender, age, group injecting and client/sex worker relations), more research on this topic is required. Moreover, there is a dearth of information on verbal and non-verbal communication strategies used by injectors in group situations.

It should be noted that the social dynamics implicated in risk practice are something of a double-edged sword. Dynamics of sociability and reciprocity serve to make life bearable, and sometimes even fun, for those who very often live in dire circumstances. The grinding poverty and severe marginalisation experienced by many participants in the various studies were relieved by acts of kindness including gifts of drugs and injecting equipment of dubious origins. Couples, close friends and siblings say they share needles because they trust each other. Bonds based on trust provide powerful protection for those facing the vagaries of a precarious existence. As Klee et al. (1990: 144) note, it is difficult for people to break strong normative patterns of sharing, as it can jeopardise relationships. Refusing to share a partner’s syringe, water, tourniquet or filter can be equated with a lack of trust. The same trust that provides protection also puts people at risk.

The qualitative case studies and focus groups provided information on a range of factors that impact on risk practice, including dependence and withdrawal (hanging out), comorbidity, access and availability of sterile needles and syringes, and the practice of ‘stashing’ injecting equipment. One of the most significant themes to emerge was the negative impact of certain policing practices on risk, a topic that has received much attention (Koester 1994; Maher et al. 1997, 1998; Maher & Dixon 2002; Southgate et al. 2000). Given the evidence that zero-tolerance policing exacerbates risky practice, it would seem sensible that the negative impacts of policing on the health outcomes of IDUs, and the ability of harm reduction services to function effectively, be given serious political attention.

‘Risky’ environments feature in the case studies and focus group data. The qualitative case studies paid attention to these environments in predominantly red-light districts in which open-air drug markets operate (further research is required on non-red light areas where drug dealing is a hidden phenomenon and in differing cultural/subcultural contexts). Health risks are increased by the unhygienic conditions in which public injecting occurs. Dirt, faeces and urine are present in many public and semi-public settings such as toilets, stairwells and alleys. Commercial drug injecting rooms are, at various times and to various degrees, similarly squalid. Within these environments blood is sometimes visible and sometimes not. Some injectors rinse or squirt out their syringes with water after injecting. They do this to ensure that the syringe is not blocked with blood and other debris in the event that the syringe needs to be re-used. The presence of blood-contaminated water on the walls, floor, tables, beds and basins of hotel rooms, for example, provides a possible environmental risk for HCV transmission. Diluted blood squirted around injecting settings is a relatively invisible source of contamination. Even if an injector is fastidious about blood awareness, the poor lighting in many settings makes it difficult to identify blood-contaminated surfaces.
Folk hierarchies of risk are evident in the qualitative case studies and focus group data. Severe marginalisation generates concerns which do not necessarily coincide with the public health agenda. For example, a spoon man or street sex worker might view the main risk to themselves as violence. For some, the risks involved in getting the money to buy the drugs outweigh health concerns. Situational hierarchies of risk are most apparent. A person who picks up a blood-tinged water ampoule out of the gutter, rather than risk getting clean water by leaving the group with the drug deal, is making an on-the-spot assessment of risk — health is but one factor that comes into play when decisions are made.

The notion of hierarchy of risk is also apparent in the way participants differentiate between the immediate threat of the ‘dreaded’ HIV and the less urgent, longer-term impacts of hepatitis C. The Kings Cross case study illustrated confusion regarding routes of transmission for HCV and understanding of hepatitis C serostatus. Further investigation into IDUs’ understanding of their serostatus in relation to prognosis and infectiousness is vital to inform prevention efforts. Likewise, more research is needed to uncover IDUs’ understanding of clinical terms, markers and symptoms of HCV infection. Interestingly, this case study illustrates a conflation of hygiene messages in which participants associate HCV transmission as much with pollution or ‘dirt’ as blood. The case study may indicate that the quantity, complexity and variability of education messages are confusing some IDUs. It may be necessary to rationalise and coordinate education efforts in the face of such an ‘uncertain’ virus.

It is heartening to note that findings from the IDU quality of life study indicate that IDUs are concerned about their health. Health, the number one rated domain, was listed above family, housing and money as the life areas most important to IDUs. ‘Health’ was variously described by participants as a fundamental part of a quality life, as a key factor in maintaining one’s responsibilities to others, and in relation to drug use and blood-borne viruses. These results suggest that IDUs view health in a holistic manner, a point substantiated by the focus group and case study data. The high rating achieved by the life areas ‘family’ and ‘housing’ underscores the need for prevention efforts to take a holistic approach. Finally, the high health rating indicates the central place that health issues hold for IDUs. This centrality has provided, and should continue to provide, a window of opportunity for interventions and health education aimed at preventing blood-borne virus infection.
9. Recommendations

Our research highlights the need for greater efforts to be made in addressing the social, environmental and structural, as well as individual, contexts of injecting risk behaviour. The research found that, even in areas relatively well serviced by currently available programs, risky injecting behaviours are still evident. Consequently, the possibility for blood-borne virus transmission remains high.

Given the ongoing epidemic of hepatitis C infection across Australia, it is reasonable to conclude that we are unlikely to see a reduction in transmission unless a range of new prevention strategies are tried, in conjunction with a strengthening of the current ones. The findings in this study that showed IDUs are willing to reduce their risks where possible are encouraging.

In this context, recommendations are offered under five headings: education messages; individual risk; social risk; structural and environmental risk; and future research.

9.1 Education messages

1. There is an urgent need to simplify, standardise and clarify the language and education messages around hepatitis C for injecting drug users, clinicians and other health workers, to reduce confusion.

   a) An information campaign to look specifically at hepatitis C language for injecting drug users is recommended. Such a campaign needs to be preceded by careful developmental work, with messages focusing on both the experience of diagnosis (individual level) and understanding of infectiousness (risks to others). Development of a campaign ought to focus on the meaning IDUs make of the messages and how they employ these meanings in everyday life, not just the information provided.

   b) The messages used by clinicians in providing a diagnosis and to describe the infectivity of the virus need to be simplified. This includes clinical terms such as ‘seropositive’ and ‘antibodies’; as well as the development of messages to improve understanding of hepatitis C status, re-infection and the ability to infect others. In addition, erroneous beliefs, such as the perception that jaundice is a reliable marker of hepatitis C infection, need to be specifically addressed. This includes understanding how expert and lay knowledge interplay to impact upon risk practice.
9.2 Individual risk

2. A more sophisticated understanding and dialogue of what constitutes ‘risk’ are necessary. Because risk is understood and interpreted differently by groups and individuals, public policy needs to be developed, and programs delivered, in close conjunction with the target groups and individuals.

3. People severely affected with a dual diagnosis (significant mental health and drug use problems) are especially vulnerable and their risk is further heightened by the relative marginalisation of this group. Targeted interventions for this subgroup are a priority.

4. Efforts are required to reduce the initiation of injecting. The study demonstrates that there may be an opportunity value in educating IDUs to resist requests to initiate new injectors. This issue warrants careful consideration of the risks and benefits of drawing upon this reluctance, particularly within the context of peer education programs.

5. IDUs new to injecting, and youth at risk of becoming injectors, should be specifically targeted for interventions, as young people were identified as having a high prevalence of sharing injecting equipment.

6. Non-injecting routes of administration ought to be encouraged, specifically for those who are at risk of commencing injecting.

7. Further strategies to facilitate drug users to enter drug treatment earlier in their drug using careers are very important. A range of treatment opportunities need to be maximised by ensuring that treatment is readily available, appropriate and attractive to drug users.

9.3 Social risk

8. High levels of support and better coordinated efforts are required to address the severe social and economic marginalisation experienced by some IDUs; including closer case management, mid- to long-term accommodation (and/or assisted living centres to supplement acute crisis accommodation), and assistance to navigate available services and facilitate social reintegration.

9. Different cultural needs ought to be considered for service delivery to ensure that services are appropriate for subgroups (e.g. different ethnic groups). Service delivery environments should be culturally sensitive and non-judgemental.

10. Alternative models for service delivery to highly marginalised groups are required. These may include targeted outreach services (which may or may not be attached to a ‘shopfront’ style of service), as they provide a high degree of flexibility to reach the most marginalised and at-risk groups.
9.4 Structural and environmental risk

11. Access and coverage of NSP services after hours should be improved through extension of hours and/or alternative outlets providing needles and syringes such as well-serviced vending machines.

12. In keeping with the data from the national NSP survey and focus group results of this research, and other research focused on prisons, it is recommended that

   a) services in prisons should be equivalent to those provided in the community and, as such, needle and syringe exchange programs should be piloted and drug treatment programs ought to be expanded; and

   b) differential sanctions for testing positive for cannabis and injectables be introduced. These sanctions may decrease the incentive to use drugs which clear the body more quickly but involve greater risk (e.g. injecting heroin) than others (e.g. smoking cannabis).

13. A revision of the legislation that prohibits self-administration is required. This legislation can lead to policing practices and injecting behaviour which may be unhelpful in relation to harm minimisation and reduction in the spread of BBVI.

14. Policing practices should continue to be monitored and reviewed to reduce negative consequences of particular approaches (e.g. practices that may result in disincentives to accessing sterile injecting equipment, IDUs rushing injecting episodes and inappropriately discarding equipment).

15. Development of closer working partnerships between health and other authorities with responsibilities for locations where injecting occurs, such as sex venues and entertainment venues, is necessary.

16. Consideration should be given to the recent evaluation of the Medically Supervised Injecting Centre in Sydney with a view to the value and appropriateness of establishing similar centres in some other locations.
9.5 Future research

17. Risky injecting often occurs in an environment of close relationships where a range of things other than drugs are shared. The issues of trust, friendships and the nature of relationships (as well as relationship structures, e.g. families) require further exploration to develop interventions that aim to reduce sharing of injecting equipment and other risky injecting practices.

18. Consideration of more sophisticated approaches to planning and management of public spaces, which can contribute to a reduction of risks associated with injecting and the disposal of injecting equipment, is required. Particular areas to consider include lighting, disposal bins and other waste disposal facilities, and public amenity.

19. A thorough assessment of the potential for positive and negative consequences of encouraging injecting drug users and peer educators to promote a 'don't initiate' ethos in relation to injecting is important (as a precursor to Recommendation 17).

20. The development of effective treatment approaches, in particular pharmacotherapies, for psychostimulant dependence should be a research priority.

21. Additional exploration of the client/sex worker drug use dynamic is warranted, particularly in the context of the initiation of clients to injecting.

22. Although the quality of life study was a pilot, the high rankings apportioned to health and families indicate that more research into the important life areas (and thus opportunities for intervention) identified by IDUs is warranted.

23. More research is required on injecting risk within suburban and rural settings where groups of IDUs are more hidden than those linked to open-air drug markets.
10. References

Chapter 1


Chapter 2


Dealing with risk


Chapter 3


Chapter 4


Dealing with risk


Dealing with risk


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**Chapter 5**


**Chapter 6**


Chapter 7


Chapter 8


Appendix A: Profile of participants in the Kings Cross study

Female interviewees

Diane, 29, recently started using cocaine when a friend needed someone to go halves with her in a deal. Before this she had injected heroin for about three years. While Diane is unhappy doing street sex work, she will not give it up because of her cocaine habit. She might have contracted HCV through accepting a fit already mixed up with speed. She knows her boyfriend is HCV positive but has never shared any equipment with him, although they regularly inject each other.

Gina, 25, started injecting heroin at the age of 20 after the birth of her second child. She was introduced to it by her husband. Gina injects 3–4 times daily, mostly in public and semi-public locations. Gina always has an ‘ample supply’ of fits. She has ‘hepatitis C antibodies’ but cannot ‘work out’ how she got them. Sex work supplies Gina and her family with a regular income. Gina lives in a flat with her husband and two children.

Jill, 42, supports her heroin and cocaine use and her family by doing street sex work. She tries to educate everyone she comes into contact with about blood-borne viruses and drug dependence. She believes that the clients of sex workers, who inject with workers, are not knowledgeable about BBV transmission and other consequences of unsafe injecting.

Lisa, 31, is a full-time student and has been injecting heroin for five years. She got into injecting heroin after meeting her boyfriend at a party and injecting heroin to come down off ecstasy and alcohol. She is aware of the risks of contracting HIV but only recently learnt about HCV when she went on the methadone program. She believes that, even though a lot of women in the Cross have some power in injecting situations, many are physically and emotionally bullied and ‘stood over’, resulting in them sharing or using old fits when there are no new fits to go around in group injecting episodes.

Maree is a 31-year-old Indigenous woman who has been injecting since she was 19. Four years ago she was diagnosed with an illness for which she was prescribed strong painkillers, but found heroin to be more helpful for her pain. She has just completed detoxification for benzodiazepines. She is now on methadone, and living in Kings Cross, ‘sleeping rough’ with her boyfriend. She believes she got hep C from her husband who contracted it in prison. Maree would like to see more outreach workers or ‘street walkers’ who give out clean fits.
Margaret, 35, came from western New South Wales and started injecting at the age of 12 because ‘you wanted to be doing what everyone else was doing’. She used lots of ecstasy at dance parties, and found some of it had a ‘smackie’ feel to it. She took up injecting again in her mid-20s. She spent some time doing sex work, which she associates with injecting speed and heroin. She currently uses pot and heroin ‘to take the edge off’ her day. Margaret is on a disability pension.

Michelle, 35, says that she was attracted to injecting by seeing another woman injecting methadone and thought it was ‘gutsy’. She didn’t hear about hep C until she was in a halfway house and attended an education session on it. She feels her cocaine use led her to lose control and become incarcerated. Michelle feels that it is more risky to use cocaine because you tend to inject socially with people, whereas you can enjoy heroin alone. She is homeless, regularly injecting in public spaces in Kings Cross. She carries a supply of clean equipment and condoms to give away or to sell.

Maritsa, 34, is an Indigenous woman who arrived in Kings Cross when she was 12 years old. She is a homeless speed user. Maritsa sometimes uses heroin because it ‘keeps you warm when you have to sleep out’. Maritsa thinks she caught HCV after sharing a needle with her brother after he was released from prison.

Phoebe is 42 and has been on methadone for 15 years. She continues to inject heroin, speed and other drugs while being employed in full-time work. She had criticisms about the availability of needles at night. She visits a range of NSPs four times a week to ensure she has a plentiful supply of her favourite brand, which is difficult to get hold of at present. She thinks methadone has helped her to make choices about when and whether to inject heroin, but that her use of other drugs hasn’t changed over the years. Phoebe injects about three times a day.

Sheila, 26, arrived in the Cross when she was about 15. She works on William Street as a street sex worker and is on the methadone program. She lived in squats in Kings Cross before moving into a flat with her partner. Sheila is committed to safe injecting, only sharing fits with her partner.
Male interviewees

Bruce came to the Cross when he was 13, and is now 33. His drug of choice is amphetamine and he is a sex worker. Now that he is older he practises safe sex, but says in the early days he consistently did not use condoms for sex work. He moves in and out of street-based Kings Cross injecting networks and the trendy ‘upmarket Surrey Hills injecting crowd’. He used to snort amphetamines but learned how to inject from older users, men just out of gaol and sex workers. He has always been wary of using needle exchanges, preferring to use friends or chemists because of his fear of being found injecting drugs. He sometimes injects in public places and believes that he caught hep C from picking up empty packets of amphetamine that he washed out and injected.

Carl is 40, and was a heroin smoker for a number of years prior to injecting. He says he started to inject because his girlfriend preferred injecting. He has been injecting for three and a half years, and believes the most important reason he is not hep C positive is because he hasn’t used anyone else’s fits. The only risks he identified were using a tourniquet that belonged to someone else and a spoon of unknown origin. Carl usually injects on his own to avoid negotiations about quantity or quality. Even though he is on methadone, he finds it difficult to sustain personal relationships, as he is constantly busy getting the money to fund his heroin habit.

Clive, 29, came to the Cross when he was 17 and lived in a squat with heroin users who introduced him to it. He is now on methadone but has at least one injection of heroin a day. Clive has committed and continues to commit petty crimes on a daily basis to get enough money to buy heroin. Clive says that his hepatitis C is ‘currently dormant’.

Cookie is a 33-year-old Indigenous man sleeping rough in Kings Cross. He regularly injects cocaine. He has lived ‘up the Cross’ for many years, using heroin for ten of these. He spends time with his family when he needs a break from the streets.

David, 19, lives alone in a flat. He has been a sex worker in the Cross, injecting heroin since he was 14. He believes that there are good drug-user services in the Cross. However, he suggests that there are not enough youth services which are drug-user friendly, and that ‘kids’ need someone to ‘back them up, to tell them they are OK and to give them a place to chill out, have a shower, and protect them from stand-overs and older kids’. He has clients that want to use drugs with him, but he believes that they don’t know how ‘unglamorous’ his lifestyle actually is. David refuses to inject with clients. He has a good knowledge of how HCV is transmitted and takes all precautions. He states that he is both hepatitis C and HIV negative.
George is 46 and started using drugs at the age of 12, when you could buy Mandrax for sixpence. He only started injecting at the age of 32 because of the lack of speed, saying it was ‘the only way to go’. He prefers to inject heroin and coke together. He was recently homeless, living rough in Kings Cross for about 18 months. He prefers this style of living to being in the suburbs where loneliness and boredom set in. He candidly admits that he wouldn’t walk any further than about two or three blocks for a clean needle. He believes that having information on how to reduce risks doesn’t stop him from taking risks, because he ‘psychologically blocks’ himself from thinking about it when he participates in risky activity.

Glen began using cocaine as a young sportsman. He started injecting cocaine at 27. He is 30 years old and homeless. He likes to use pills, heroin and alcohol. He learnt how to bleach syringes in gaol from a ‘lifer’. Glen has difficulty staying on social security benefits and finds it impossible to negotiate with government officials. He says he is ‘depressed’. He strongly believes methadone is more about social control than treatment, and thinks it is too difficult to negotiate the costs involved in being on a program.

Ken, 22, has been living at the Cross since he was about 18 and speaks of the risks people take like a war veteran. ‘They just don’t care.’ He talks about using heroin to stave off feelings of pain and depression, but feels he has always used in a safe way. He cannot identify how he got hep C as he was smoking heroin; however, he was sharing living arrangements with an injecting drug user who was hep C positive at the time. He began injecting at 20. He believes that people have become complacent about the risks they are taking, and that even safe sex is barely an issue for people.

James, 35, was introduced to injecting heroin by a colleague about ten years ago. They used every day for three months before he discovered he was dependent and he has tried several treatments since. He injects cocaine and heroin in public places and believes that needles should be at least as easy to get as heroin and other drugs. He has cleaned and re-used other people’s fits (through bleaching and boiling), believing that the old cleaning messages were never thorough enough. He usually carries his own fits to re-use when new fits are unavailable. Despite taking some risks, he has remained HCV negative. He is concerned about the high level of risk involved in public space injecting such as picking up opened waters and old spoons.

Oscar, 39, started injecting speed at 19 with flatmates. Even though he has had occasion to share fits, he believes he has put himself more at risk through unprotected sex than sharing needles. He rarely keeps more than a three-pack of needles on him. His method of harm reduction is to use only once a day, the same amount he has been using for 20 years. He only injects with other people because he likes the social interaction, but avoids doing it in public because he thinks he is ‘too old to be showing off and families just think it’s disgusting’.
Phil, 32, started to inject speed in an effort to achieve a better high than marijuana, after moving in with ‘full-time junkies’, as he called them. He has had several different diagnoses ranging from schizophrenia to manic depression and suffers from depression. He enjoys cocaine and injects as frequently as he can. He has HCV and believes that his depression led him to make decisions that put him at risk of contracting hepatitis C and HIV. Phil lives alone in a flat.

Ralph, 47, has used heroin for over 25 years and, more recently, cocaine. Up until five years ago he maintained his usage by running his own business but is now on methadone and a pension. He has had some serious health complications from injecting drugs but believes having his Housing Commission flat has saved his life. He injects in public regularly when the opportunity arises to ‘go in’ with others on the street in Kings Cross. He believes discrimination against drug users prevents them from accessing good-quality health care.

Stewart, 41, is in full-time employment, using heroin twice a day and is on a methadone program to try to deal with his drug dependence. Using since the early 1980s, he says that heroin users don’t discuss hepatitis in the context of injecting, but more in the context of maintaining health after infection. He and his friends purchase needles from chemists. Even though he lives close to at least three NSPs, he still keeps his old fits and bleach in the house where he lives, ‘just in case’.

Tony is a 30-year-old HIV positive, ‘part-Aboriginal heterosexual’ who moved to Kings Cross from the country when he was 18. He started using speed and then heroin. He likes to inject with a group of people for social reasons, usually at home. He keeps clean fits at home for this purpose. He would like to see a 24-hour NSP in the Cross.

Key informants/guides

Jimmy is 21 and has been injecting since he was 11, having left home at 9 years old. He taught himself how to inject and quickly learned about all the relevant services in Kings Cross. A typical day would be a dose of methadone followed by six or seven shots of cocaine, followed by marijuana at night. He lives alone in a flat.

Sam is a 38-year-old heroin and cocaine user. He is currently homeless but has his name down for a Housing Commission unit. He tried rehab but felt it to be an abusive system, rather like the family he had come from, and now believes he will use for the rest of his life. The most important things to Sam are being good to his family and his friends.
Appendix B: Interview schedule

Opening the interview:
1. Provide a brief introduction to the research.
2. Give out information sheet and consent forms and allow participant to read.
3. Briefly discuss information sheet, answer queries and ask participant to sign consent form.

1. Biographical snapshot
Can you tell me a little bit about yourself and how you became interested in drugs?
• Types of drugs used and age when you tried different types of drugs.
• Age of initiation into injecting. (What was it like, who with, where?)

2. Most recent drug use experience
Can you tell me in some detail about the last time you injected drugs (over the last six months)?
• What drug?
• When?
• Where? (i.e. public, private, commercial)
• How would you describe the space in which you injected?
• What equipment did you use?
• Where did you get your equipment?
• Did you re-use your equipment? Was it clean? How did you clean it?
• If no, did you re-use someone else’s equipment?
• If you injected with others, how did you decide on the injecting order – who goes first, second etc?
• Where did you inject on your body?
• Could you describe the exact procedure for injecting?
• What is safe injecting?
• Where do you get information about safe injecting?
• Do you have any problems getting equipment, information or referrals?

Is this the usual pattern for injecting?
• If not, could you describe your usual pattern? (Use list above.)
3. Injecting with others

When is the last time you injected with a group of people? Could you tell me about that experience?

• What drug?
• When?
• Where?
• How would you describe the space in which you injected?
• What equipment did you use?
• Where did you get your equipment?
• If you shared equipment, how did you decide on the injecting order — who goes first, second etc?
• Could you describe the exact procedure for injecting?

4. Injecting in public

Could you describe in some detail the last time you injected in a public place (over the last six months)?

• What drug?
• When?
• Where?
• How would you describe the space in which you injected?
• What equipment did you use?
• Where did you get your equipment?
• Could you describe the exact procedure for injecting?
• Were you visible to others (public/police)?
• Did this influence your injecting practice?
5. Current injecting practice
- How often do you inject?
- Which drug/s?
- Motivations for injecting?
- Effects of injecting?
- Attitudes (personal, friends, acquaintances, health professionals) to injecting?
- Feeling about injecting?

6. Safety
Under what conditions do you feel most safe when injecting?
- Could you describe in some detail the last time you injected under these conditions?
- When?
- Where?
- Could you describe the space in which you injected?
- Who with? What equipment did you use?
- Where did you get your equipment?
- Did you re-use your equipment (fits, butterflies, tourniquet etc.)?
- Did you re-use someone else’s equipment?
- Did you inject with others? How did you decide on the injecting order?
- Could you describe the exact procedure for injecting?
- What was it that made you feel most safe?

7. Initiation to injecting
Can you tell me in some detail how you got into injecting drugs?
- When?
- Where?
- Who with?
- Why?
- What equipment did you use? Where did you get it from?
- What did you like about it?
- What didn’t you like?
• Did you discuss safety?
• How would you describe your drug use before you tried injecting? (What did you use, who with?)
• How many of your friends also injected? What drugs were they into?
• How long have you been injecting?

8. Police
How do you find the police?
• When’s the last time you came into contact with police?
• Have the police ever found you injecting? If yes, could you describe the situation to me?

9. Tattooing
Have you ever had a tattoo?
• Could you describe this process?
• When? Where? Who?

10. Health
What health issues do you see as related to injecting?
• Have you had any personal health problems as a result of injecting (i.e. venous access)?
• Are there any barriers to injecting safely?

Have you had an HIV and/or hepatitis C test? Other hepatitis?
• What do you understand to be the result/s of those test/s?
• If positive, do you know when you contracted this virus?
• If yes, when and where?
• Could you describe in some detail the context of transmission? Where? When? Who with? What equipment was used? Injecting procedure?

What do you think government health departments and health services could do to help drug users that they’re not doing now? (i.e. pharmacy, GP, NSP, MSIC, methadone clinic)
• What are the best things they can do?
• What are the worst things they could do?
• What kind of information or services would you like to see?
11. Demographics

- Age
- Ethnicity
- Employment status
- Number of dependent children
- Education status
- Sexual identity (heterosexual, gay, lesbian, bisexual, other)
- Domestic arrangements
- Types of residence
- Postcode
- Sexual partners (regular, casual, single)

Closing the interview:

1. Interviewer explores any area not fully covered.
2. Interviewer provides relevant information and referrals where requested.
3. Interviewer thanks participant and reiterates points about anonymity, confidentiality and gaining access to published material in the future.
Appendix C: Focus group schedule

Age
Postcode (over last 5 years)
Ethnicity
Employment status
HIV/HCV status
No. of years injecting
Drug of choice
Other drugs injected
Why do you think [drug of choice] is your preferred drug to inject?
Do you prefer to inject [drug of choice] alone or with others?
If you inject with others, is it important that they also prefer to inject [drug of choice]?
Why?
What other characteristics are important about who you inject with? (Age, gender, ethnicity?)
Do you tend to take more risks, such as sharing any injecting equipment, when you’re injecting with these people?
Describe the sort of situations you’ve been in when you’ve taken some risks with your injecting? Do you do anything deliberately to avoid these situations now?
Where and when do you feel most safe injecting?
How did you learn to inject safely? Is there an individual or group that helps you to continue injecting safely?
Is it important where you choose to actually inject? (Own home, friends, SIP) Has this changed at all over the course of your injecting ‘career’?
Has experiencing an overdose and/or seeing someone else overdose changed your injecting practices in any way?
[For those who identify] How has being diagnosed HIV+/HCV+ influenced your injecting practices?
Have you been part of any treatment program or received medical assistance in relation to your injecting drug use? What sort of effect has this had on your injecting practices?
Are the people you inject with the same people you tend to socialise with?
Is there anything you haven’t mentioned yet that would assist you to inject safely every time?