

Drug Use and Risk Behaviours among Injecting Drug Users

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Points of view in this report are
those
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EXECUTIVE SUMMARY

This study focused primarily on patterns of drug use, injecting practices, risk behaviours for infectious disease, and experiences with treatment and health services among injecting drug users (IDUs) in Northern Ireland. The data for the study were collected through semi-structured interviews conducted between December 2003 and September 2004. Sample criteria included 1) 18 years or older and 2) injection of one or more drugs (excluding insulin or other medication that was prescribed for injection) within the 30 days prior to the interview. Various strategies were used to recruit respondents for an interview and the findings are based on interview data collected from 90 respondents who met the study criteria.

Females comprised 30% of the sample and respondents' ages ranged from 19 to 53 years (mean=31; median=30; mode=25.5). At the time of the interview, 45% resided in the Eastern Board, 41% resided in the Northern Board, 6% resided in the Southern Board, and 8% lived in the Western Board. We interviewed people who resided in one of five of the six counties in Northern Ireland although despite our efforts, we were unable to recruit from County Fermanagh. In addition to Belfast, respondents resided in one of 17 different towns, cities, villages or rural areas within Northern Ireland. Several methods were used to recruit respondents and this approach probably added to the diversity of the sample.

The average age at first injection was 23 years (range=13 to 40 years) and 75% of respondents had injected heroin at initiation. Two-thirds (66%) of the sample had initiated injection in Northern Ireland. On average, respondents had injected for 8.6 years and 61% of the sample had injected during the 24-hour period before the interview. The number of injections ranged from 1 to 180 during the 30-day period prior to the interview.

Nearly all respondents had used a new needle and syringe during most injection episodes in the 30-day period prior to the interview. However, within that 30-day period, various circumstances and settings contributed to the borrowing of used needles/syringes among some respondents. The majority of respondents had injected with at least one other person in the past 30 days. Although several had injected with new needles and syringes during this time period, most had used filters, spoons/stericups, and water that had been used by another injector. The social context of injection settings, the perceived trust of other injectors, as well as a lack of knowledge regarding infectious disease transmission, contributed to the borrowing of injecting equipment other than needles and syringes.

The vast majority of respondents had used a needle and syringe exchange scheme in Northern Ireland at some point since 2001. Favourable reports about the scheme were noted by several respondents. However, the data also showed a consistent pattern with regards to negative feedback about one exchange in particular. Additionally, the results showed that various factors associated with needle exchange scheme contributed to engaging in risk behaviours for infectious disease. These factors included restrictions on the number of needles

that were distributed at each visit, closure at weekends, evenings and holidays, the quality of injecting equipment, perceived stigma regarding “injector” status, and concerns about confidentiality in exchanges.

The data indicated that police practices contributed to risk taking among some respondents who had become greatly concerned about carrying used injection equipment. We observed this pattern primarily in the Northern Board.

We did not conduct tests for antibodies to hepatitis C, hepatitis B core antigen, or HIV. Nor did we ask respondents about test results. Nevertheless, 30% of respondents who were certain that they had been tested for hepatitis C reported to us that they had been diagnosed with hepatitis C. The data suggests that this figure is very likely to be an underestimate because some people had never been tested, most respondents had not been tested on a regular basis and many had not been tested for long periods of time. Respondents residing in the Eastern Board reported knowing several injectors with hepatitis C and some reported that most or all of the IDUs who they knew had hepatitis C. In comparison, the majority of respondents residing in the Northern Board knew very few injectors with hepatitis C. No-one reported that they had antibodies to hepatitis B core antigen and only 17 respondents reported that they had been fully immunised against hepatitis B. Approximately 15% of respondents had never been tested for HIV antibodies and 6% did not know whether they had been tested.

A total of 39% of respondents had consumed no alcohol during the 30-day period prior to the interview. Additionally, 37% had consumed small amounts of alcohol, i.e., a few drinks, during the same time period. However, several reported that they drank quite frequently prior to using heroin. Some respondents who were participating in a programme of Subutex maintenance reported that their alcohol consumption had increased since reducing their intake of opiates.

A number of respondents were consuming benzodiazepines on a daily basis. A total of 37% were in receipt of a prescription for diazepam whereas others purchased them from street or Internet sources, these drugs often differed in appearance from prescribed benzodiazepines. Still others obtained them at no cost from partners, relatives, or friends. Some IDUs had been prescribed the drugs for years, long before they ever injected. Most respondents had no knowledge regarding the dangers of benzodiazepine withdrawal, although, some had experienced lengthy withdrawal periods characterised by severe effects.

Sexual activity was rare among many long-term IDUs who had a partner who was also an IDU. However, a number of young male injectors had female partners who had little experience with drugs except for weekend use of alcohol or cannabis.

Some respondents reported being in good physical health, although others complained about venous damage which made injection into the sites either impossible or improbable. Several males and females reported injecting into the groin. With regards to emotional health, we observed that several respondents

reported a history of depression and a number had been prescribed antidepressants.

The interview data revealed three broad groups of IDUs: 1) respondents who were in contact with drug services (statutory or voluntary) at the time of the interview (40%), 2) respondents with a history of engaging or attempting to engage in drug treatment but who were not in contact with services at the time of the interview (43%), and 3) respondents who had never been in contact with drug treatment services (17%). We found considerable differences across board areas. A total of 62% of respondents from the Northern Board were in contact with treatment services at the time of the interview, compared to 23% of respondents from the Eastern Board. Four of seven respondents from the Western Board were in contact with drug services in Northern Ireland. None of the five respondents from the Southern Board were in contact with drug services at the time of the interview although all expressed an interest in treatment. The results suggested that drug services can provide various and effective assistance to IDUs, however, the data revealed a number of barriers to accessing treatment services.

The findings indicated that female injectors were significantly less likely than males to be in contact with drug services at the time of the interview (females=30%; males=44%). Females also were more likely than males to depend on someone else to inject them and females with IDU partners were more likely to inject with their partner only, compared to males with IDU partners. Females with children were concerned about the placement of children in the event that the female's injecting status became known. They were more likely than males to exercise caution when visiting pharmacy-based needle exchanges, were less likely to be tested for infectious diseases and were less likely to contact GPs about drug-related problems.

Several injectors requested advocacy, support or information from one or both interviewers. Generally, we contacted professionals who had expertise in these areas and then disseminated the information to the respondents through follow-up contact. Our expanded role was unexpected and reflected a major gap in services that could otherwise assist IDUs.

The results of the study have several implications for policy and additional research. Based on the findings generated from the interview data, the report concludes with 20 recommendations.

INTRODUCTION

Studies of injecting drug use (IDU) are rare in Northern Ireland, therefore, little is known about the extent of risk behaviours, infectious disease, treatment experiences and lifestyles of respondents who inject drugs. One (now dated) study of largely Belfast heroin users (the majority of whom were IDUs) found that respondents had engaged in various risk behaviours for infectious disease and had little knowledge about how infectious diseases could be transmitted. Moreover, very few heroin users in that sample had completed drug treatment, despite lengthy injection careers and substantial health problems (McElrath, 2001).

Recent information pertaining to IDU in Northern Ireland is available from various databases. The Northern Ireland Drug Misuse Database (DMD) records information on respondents presenting at a statutory or voluntary drug agency. An individual must consent before the data can be forwarded to the DMD. In 2002-2003, the DMD data showed that 21% of respondents presenting at a drug service had injected previously (Department of Health, Social Services and Public Safety, 2003). Data collected in 2003 for the Northern Ireland Drug Addicts Index identified 62 newly notified respondents whose injecting behaviour was known (Department of Health, Social Services and Public Safety, 2004). A total of 79% of this group were injecting compared to 45% of respondents who had been re-notified. Additionally, pharmacy-based needle exchanges distributed approximately 82,000 needles and syringes between 1 April 2003 and 31 March 2004. A total of 7,508 exchanges were made during the 12-month period, and females accounted for approximately 17% of visits to the exchanges (Drug and Alcohol Information and Research Unit, 2004). In 2002, the Unlinked Anonymous Prevalence Monitoring Programme was extended to Northern Ireland. The research was based on data collected from 77 respondents who were attending one of five drug services in the region (Health Protection Agency, 2003). A total of 88% had injected during the preceding 12-month period prior to data collection, and 60% (N=46) had injected in the previous four weeks. Among those who had injected in the past four weeks, 42% had “shared” needles and syringes. That figure was higher than that reported for all of England and Wales. Also, 62% reported “sharing” other injection equipment during that four-week period. The authors found that 16% of the respondents had antibodies to hepatitis C virus and 3% had antibodies to hepatitis B core antigen. None of the 77 study participants tested positive for HIV antibodies.

These indicators serve as useful baselines with regards to IDU, injecting behaviour and prevalence of hepatitis B and C and HIV among IDUs who were in contact with services in Northern Ireland. In recent years, studies conducted in various countries have focused on out-of-treatment drug users, and some of these studies have compared this group with respondents who have undergone drug treatment. From this literature we know that these two groups often differ in terms of their frequency of drug use or injection (Booth, Crowley and Zhang, 1996; Meandzija et al., 1994), risk behaviours for HIV and other infectious disease (Corsi, Kwiatkowski and Booth, 2002; Judd et al., 1999), and various

social and health problems (Kuebler, Hausser, and Gernasoni, 2000). In particular, out-of-treatment injectors appear to be at greater risk for infectious disease compared to IDUs who have undergone drug treatment. For example, Friedman et al. (1995) found that even in low HIV prevalence US cities, out-of-treatment injectors were significantly more likely than injectors in treatment to seroconvert to HIV infection during the study period. A study by Metzger et al. (1993) supported these findings in that drug treatment lowered the rate of HIV seroconversion among IDUs. One London-based study found that the prevalence of HIV infection was higher among female IDUs recruited from non-treatment settings compared to treatment settings (Judd et al., 1999).

The purpose of the present study was to compare IDUs in contact with drug services with IDUs who were not. The research focused primarily on patterns of drug use, injecting practices and risk behaviours for infectious disease, and overall health among IDUs in Northern Ireland. We also examined individuals' experiences with treatment and health services. In this report, we describe the methodology, present the main findings, and offer a number of recommendations based on those findings.

METHODOLOGY

The primary data for this study were collected through face-to-face, semi-structured interviews with injecting drug users (IDU) in Northern Ireland. Criteria used for interview eligibility were 1) 18 years or older and 2) injection of one or more drugs (excluding insulin or other medication that was prescribed for injection) within the 30 days prior to the interview. A total of 93 respondents were interviewed and 90 respondents met these criteria. The study criteria have important implications for the findings. Other researchers have defined “current injectors” as respondents who have injected a drug in the past two months (e.g., WHO Collaborative Study Group, 1993) or respondents who have injected during the past six months (e.g., Peters et al., 1998). Clearly, studies that use a longer time frame to capture “current injectors” have the potential for recruiting larger numbers of respondents. Indeed, Peters et al. (1998) used the sample criterion of injection during the six months prior to the interview because the authors were concerned that a more limited time period would create problems in recruiting respondents.

Several methods were used to recruit respondents for interviews. First, announcements of the study were distributed within pharmacies that offered needle exchange. Second, study announcements were placed on notice boards in venues where current injectors might frequent, e.g., health centres, in or near the offices of general practitioners. Third, we contacted the South Belfast Drug Outreach Team and community workers in various sites and asked them to distribute information about the study. Fourth, we distributed “business cards” to personal contacts and “street sources” who we believed might have access to respondents who injected. The cards contained information about the study and telephone numbers for the interviewers. Fifth, we relied upon snowball sampling or “chain referral” techniques (Biernacki & Waldorf 1981) whereby respondents who completed an interview were asked to refer friends and acquaintances. For ethical reasons we tended to avoid asking for referrals from respondents who were attempting to “get clean” because some of these people wished to distance themselves from the wider injecting community. We monitored referrals carefully and generally did not permit more than three or four referrals from any one respondent. Midway into the data collection stage we distributed copies of the study announcement to various drug services in Northern Ireland. These multiple sources of recruitment had two advantages, 1) increased the probability of recruiting more people into the study, and 2) increased the potential for sample diversity.

Interviews were conducted between December 2003 and September 2004. Two respondents – both of whom were female – served as interviewers. Before data collection, the second interviewer was trained in terms of the interview guide, ethical issues pertaining to confidentiality and anonymity and other issues relating to qualitative fieldwork. The interview guide was developed, piloted on the first five respondents and minor revisions were made throughout the study when we learned that questions were inappropriate or worded improperly. A copy of the interview guide is included in the Appendix.

Interviews in Belfast generally were conducted in university offices that offered a great deal of privacy, or in other venues convenient to the respondent (e.g., private residences). Interviews with respondents who lived outside of Belfast were conducted largely in private residences as well as community agencies, or semi-public areas.

Prior to the collection of data, the study received approval by the Queen's University Medical Ethics Committee. The first author also met with this Committee to discuss issues regarding the study. An Informed Consent Statement was developed and distributed to study participants before the interview commenced, and respondents were paid £20 for a completed interview. Interviews were conducted within a one- to two-hour time period and focused on issues related to first and most recent injection experiences, patterns of injection and drug use generally, perceptions about drug dependency, risk behaviours for infectious diseases, experiences with general practitioners, chemists and other health professionals, history of and experiences with drug treatment, experiences with drug outreach, issues pertaining to emotional and physical health, and related items. Respondents were encouraged to go beyond the subject area of the research instrument, when appropriate. About half of the Interviews were taped and subsequently transcribed by the first author. Very detailed notes were taken during the remainder of the interviews. Audio tapes were secured outside the jurisdiction until they were transcribed, and then they were destroyed.

For ethical reasons, it should be noted that the first author is a member of the advisory group for the South Belfast Drug Outreach Team. However, the second author conducted the vast majority of interviews in Belfast. Further, although 6% of the respondents were referred to the study by the Outreach Team, we also interviewed people who had made contact with the Outreach Team but who had not been referred by the Team. The first author is also a member of the advisory group for a voluntary drug service in Northern Ireland. We believe that these external roles did not affect the nature of questioning or the interpretation of results.

RESULTS

Sample Characteristics

These results are based on interviews with 90 respondents who had injected one or more drugs within the 30-day period prior to the interview. Females comprised 30% of the overall sample (males=70%). However, a significantly higher percentage of females were interviewed in the Eastern Board (40%) compared to the Northern Board (22%).¹ Respondents' ages ranged from 19 to 53 years (mean=31, median=30, mode=25.5). On average, females were slightly older than males (32 and 30 years respectively). Approximately 35% of respondents lived with a partner at the time of the interview, 23% lived with a relative, 6% lived with house or flatmates, 5% lived with their children only, and 31% lived alone. A total of 21% of respondents were employed at the time of the interview, although several had worked in full- or part-time employment previously. Approximately one-third of the sample (32%) had achieved a level of education of O Levels/GCSEs or beyond.

At the time of the interview, 45% resided in the Eastern Board, 41% resided in the Northern Board, 6% resided in the Southern Board, and 8% lived in the Western Board. We interviewed people who resided in one of five of the six counties in Northern Ireland although despite our efforts, we were unable to recruit from County Fermanagh. In addition to Belfast, respondents resided in one of 17 different towns, cities, villages or rural areas within Northern Ireland. Respondents had learned about the study through needle exchange schemes (27%), friends or acquaintances who might have been eligible for the study (25%), friends or acquaintances who participated in the study (19%), personal contacts of the research team (8%), the South Belfast Drug Outreach Team (6%), drug services (12%), and other statutory or voluntary agencies (3%).

Initiation into Injecting Drug Use

The average age at first injection was 23 years (range=13 to 40 years). On average, males initiated injection at significantly younger ages than females (males=22 years; females=24 years). The average age at first injection was the same in the Eastern and Northern Boards. At initiation, most respondents had injected heroin (75%). Others had initiated injection with other opiates (e.g., Morphine Sulphate Tablets, Palfium, Nubain), cocaine hydrochloride (powder) or crack cocaine, amphetamine, MDMA, LSD, barbiturates or steroids. Two-thirds (66%) of the sample had initiated injection in Northern Ireland. Additionally, among those respondents who had initiated in Northern Ireland, 90% had done so between 1995 and 2004.

¹ In most instances, we were unable to compare results from the Western and Southern Boards because of the few respondents who participated from those areas.

Among respondents who had reported that heroin was the first drug that they injected, 88% had smoked heroin prior to that experience. Some had smoked for considerable lengths of time prior to injecting (i.e., two years or more), and despite being in the presence of injectors on several occasions, they avoided injecting for long periods of time. For example, a 32-year old female injected for the first time a week before the interview. She had smoked heroin at the age of 29 and continued smoking for three years. A former male partner had been an IDU although she never injected with him.

For the majority of respondents, the injection was not planned. Many had little knowledge about the injection process and some knew very little about the drug that was injected:

“In July 1998 – I’ll never forget the month and that day. I was at a party and had just moved in with XXX [male partner]. I came in from work and there were all these people in my house. Couple hours into the evening there were all these drugs going around. I took cannabis before and speed and acid. Heard of Es but hadn’t tried them. And then somebody brought out [heroin]...just a wee tiny bit. I was terrified of needles and the girl just did it for me. I told her, ‘It’s not working,’ and about two seconds later, my head just fell and I fell asleep for about two days. That was the heroin – I was going to try the Es but I thought I’d try this other stuff.”

Interviewer: “Were they injecting Es as well?”

Respondent: “They were injecting them, eating them.”

Interviewer: “How did it [heroin] make you feel?”

Respondent: “It made me very sick. Kept getting sick every 10 minutes. Doesn’t seem to annoy you - being sick. Didn’t put me off.” (134, female)

A 27-year old male reported:

“When I was 16, Es and Speed. I noticed that I used to take more than anybody else...This drug came into town [Ballymena] that nobody knew anything about. Must have been about eight years ago. It was called skag. I didn’t know it was heroin. You smoked it in foil. Tried that. I was addicted to it probably, but I wasn’t getting any withdrawals. Then somebody told me it was heroin. Me being a diabetic, I had needles. And I knew that you could inject it. Somebody told me you mix it with citric acid. So I didn’t need anybody to show me how to inject it. I just mixed it up, cooked it and injected.” (117)

Other respondents reported that factors pertaining to the heroin market contributed to their initiation into heroin injection. For example, some respondents were smoking heroin in countries where the purity of heroin was notably higher, e.g., Holland. Upon their return to Northern Ireland, often with a

“habit,” they found that the purity of heroin was considerably weaker than that to which they were accustomed. Smoking was perceived to be no longer an option because it was not cost-effective and because low purity heroin typically must be injected in order to feel the effects. Changes in the heroin market in Northern Ireland also contributed to initiation into injection. Some respondents had sought brown heroin in Dublin but were only able to access diamorphine. Others recalled that brown heroin was not available in Ballymena for brief periods of time in 1996, 1998 and 1999. Diamorphine was available during these periods; however, that substance cannot be smoked. A 25-year old male reported:

“I came home from XXX [club in County Antrim] and the only guy I could find had the diamorphine. You can’t smoke it. It was late at night and couldn’t find anyone else. I had too much to drink – it was a late night. All the guy had was diamorphine so I had a dig.” (010)

A 30-year old male recalled a similar experience in Ballymena and like other heroin injectors perceived that injecting was more cost-effective:

“There was diamorphine about. No brown at all. You can’t smoke diamorphine and there was the brother there of someone we knew. He had injected before so he showed us. He did me first then the other fella. We hadn’t injected before...When we were smoking we were spending 100 pound a day on heroin. Then it went to 25 pound a day when we started injecting.” (026)

A few respondents reported injecting for the first time in order to “comedown” from another drug. A female had been using crack cocaine for nine years, after initiating crack use in England:

“See the comedowns from crack? Powerful. You get really depressed. That’s why I used the gear [heroin] that first time. I heard it eased the comedown. I was going mad, really really depressed. Made a plan and took the train to Dublin. You know Ballymun? Wee lads lined up on the street with their bags of gear. I couldn’t believe it. I used to get it there [Dublin] and then bring it back here.”

Interviewer: “So that was in 1995. There was gear about in Ballymena in 1995. Why didn’t you score here? Why did you go to Dublin?”

Respondent: “It was cheaper for me to take the train down to Dublin and score there. Here it was 35 pounds a bag and not that strong.” (034)

Use of other stimulant drugs led others to inject heroin:

“I was injecting amphetamine for 10-odd years then started injecting brown to bring me down after being up for 14 days without sleep. Heroin knocks you out for a bit. As it is insidious, before you know it you’ve got a raging heroin habit and the speed goes out the window.” (104)

Most respondents (82%) were injected by a male at initiation. A total of 11% were injected initially by a female and 7% of the sample had injected themselves at initiation. A male respondent reported that his first injection occurred in prison:

*“I was about 16 or 17, still a kid when I think about it. I was buying DFs [Dihydrocodeine] and eating them everyday. Then I woke up one day and didn’t have any. I was sick as F*** and didn’t have a clue what was wrong with me. Nobody warned me that I would end up rattling [withdrawal]. So I went and saw the guy I was buying DFs off. He told me that skag would make me feel better and he had no DFs left. Four hours later I was in a car in a car park in XXX [city in England]. It was arranged that me and my mate brought an ounce of heroin back to [N. Ireland]. We smoked it in the car. I felt it go through me and felt better. I had my first hit about a year later in jail. I nicked a syringe from a nurse and got somebody to get me a lemon from the kitchen. There were three of us. I knew what to do [how to inject] from watching others. It was my gear, so I went first.” (126)*

Some females recalled that males had expressed an interest in injecting them for the first time. For example, a female had a male partner who had injected for several years. They eventually separated during which time the female was offered “a dig” [injection] while visiting friends. She initiated at that time when a male acquaintance injected her. Later she reconciled with the male partner:

“He said, ‘You’re a bitch – you let them hit you up [inject you] and you never let me hit you up. Here let me show you how it’s really done. Let me give you a proper hit so you know what it’s really like’.” (148)

Patterns of Injecting Drug Use

Midway into the data collection, we began to collect information on the time between initiation and the “next hit.” From those data, 63% of respondents injected a second time within 24 hours of their first injection. However, a few individuals did not inject a second time until months or years later. A female reported that she injected cocaine at initiation. Her next injection occurred five years later when she injected Morphine Sulphate Tablets (MST). Daily injecting occurred rather frequently for most respondents. However, some reported “dabbling” [using infrequently] for several years during which they experienced few effects of withdrawal.

The length of time since initiation into injection ranged from less than one year (i.e., respondents who had initiated injection within 11 months of the interview) to 33 years. Respondents had injected an average of 8.6 years (median=7; mode=7). The number of injecting years did not differ significantly by gender (males=8.87 years; females=8.07 years). On average, respondents who resided in the Eastern Board had injected for approximately two years longer (9.1 years) than respondents in the Northern Board (7.3 years).

A total of 61% of the sample had injected during the 24-hour period before the interview and during that episode, most had injected heroin. In the 30 days prior to the interview, 40% had injected at least once a day. With regards to the *number of injections* in the past 30 days (as opposed to the number of injection days), we were able to collect these data from 81 of the 90 respondents. From that sub-group, the number of injections ranged from 1 to 180 during the 30-day period prior to the interview. In all, there were 2,397 injections among 81 respondents in a 30-day period. The number of injections during the past 30 days differed significantly across health boards. Specifically, respondents in the Eastern Board reported injecting more than twice as much in the 30-day period (54 injections) compared to respondents in the Northern Board (24 injections). This finding might be explained by the fact that a higher number of respondents in the Northern Board were in treatment at the time of the interview (discussed later).

Respondents who were not in contact with drug services at the time of the interview injected nearly twice as often in the 30-day period prior to the interview (mean=47 injections; median=30 injections; range=1 to 180 injections) than respondents in contact with services (mean=25 injections; median=23 injections; range=1 to 90 injections). Among respondents who were not in contact with services at the time of the interview, 22% injected once a week or less, compared to 40% of respondents who were in contact with drug services. Moreover, respondents who were participating in a programme of substitute prescribing (i.e., Methadone or Subutex) were injecting considerably less often than before they participated in the programme. Specifically, many of the methadone clients had reduced the frequency of injection from two or three times per day to a few times per month. Similar findings were observed for the majority of respondents on Subutex. A male had been prescribed Subutex for three months and had not injected until the day before the interview:

Interviewer: "Can you tell us why you think you had a dig yesterday?"

Respondent: "I honestly can't tell you. I was going to buy cannabis. Was up around [neighbourhood] and asked a couple of dealers if they had cannabis. Didn't have any. So walking down and seen this heroin dealer. As soon as I seen him - first words out of my mouth were, 'Any gear?' I wasn't even craving or thinking about it. Just bought it, and then I had it in my hand and saying to myself, 'I don't want this. What will I do with this here?' Walked about for awhile looking for someone to sell it to because I didn't want to take it and I knew it wouldn't do anything for me with the Subutex. Was going to take it back to the dealer but ended up coming back, cooking up and injecting it. Didn't really get much off it." (136)

- **Injecting patterns and type of drug**

A few respondents had injected one drug since initiation. The majority of respondents, however, reported that they had injected more than one drug over

the injecting career. A total of 97% had injected heroin (“brown” or Diamorphine) at some point. Additionally, 67% had injected powder cocaine and 31% had injected crack cocaine. Other drugs injected over the lifetime included amphetamine (45%), MDMA (18%), Morphine Sulphate Tablets (49%), Nubain (8%) and a host of other opiates. Some had injected LSD and others reported injecting vodka, paracetamol and water.

We observed significant differences between respondents from the Eastern and Northern Boards in terms of whether respondents had ever injected a particular drug. That is, respondents residing in the Eastern Board were significantly more likely than respondents in the Northern Board to report injecting cocaine (83% compared to 50%), and amphetamine (71% compared to 25%). No significant differences were noted for other categories of drugs.

A total of 46% of the sample reported that they had smoked crack cocaine. This figure is likely to be higher because in most interviews, we did not ask this question directly. Some respondents did not enjoy the effects of crack at all:

“It’s funny because like I did crack and it’s supposedly highly addictive. More addictive than smack. I smoked it, felt the buzz, and I didn’t like the buzz at all. I never touched it again at all. I just wish I could do that with smack.” (109)

We asked some respondents how they prepared crack cocaine for injection. A male had first smoked crack cocaine in Northern Ireland in 1989:

“We started off smoking it. We’d get cocaine and wash it up as crack. You see, you can buy crack or you can buy cocaine and wash it up.”

Interviewer: “How would you wash it up?”

Respondent: “Just a bit of ammonia, or you can use bicarbonate soda. Before it solidifies, I’d inject it. At first I was smoking 100 pounds a day. I was married then and I’d go into the bathroom, run the bath and have it stashed there. I used it all the time, always trying to hide it [from his partner].” (029)

The respondent continued to use crack for seven years, and eventually injected it. He smoked heroin for one year “*always after I used crack*” but never injected heroin.

No clear pattern emerged regarding the sequence of drugs that were injected, although 75% of respondents had initiated with heroin. Two male respondents who were part of the same social network reported smoking heroin in 1994, using crack cocaine and cocaine powder between 1994 and 1996, injecting their first drug (an opiate) in 1996 and injecting heroin for the first time three years later. Their drug of choice, however, was amphetamine which they preferred to inject.

A 31-year old respondent was 14 when he first snorted cocaine, and reported being “addicted” to cocaine by the age of 16. He smoked heroin for the first time when he was 18 and continued smoking for five years, before he injected heroin at the age of 23. He subsequently injected cocaine and a host of other substances. He reflected on this pattern:

“See I’ve thought about it. Used to be I didn’t like smackheads. Then I became one. Then I hated the injectors. Low lifes, I thought. Then I became one of them. I’ve become the drug user I used to despise.” (033)

Respondents who had injected cocaine, crack cocaine, amphetamine or Nubain on a regular basis reported injecting more frequently than respondents who injected heroin. For example, respondents who reported intravenous use of Nubain (for pain relief, the drug is usually injected into a muscle) reported that they had often injected the substance upwards of six times per day. Some amphetamine users recalled injecting the drug four to five times daily. Others reported that they had injected cocaine 10 to 15 times per day whereas others had injected every three hours. Several respondents reported that they injected ‘speedball’ or ‘snowball,’ a combination of heroin and cocaine. A 33-year old male described the experience:

Interviewer: “So do you use equal amounts when you inject them?”

Respondent: “Maybe a 30 pound bag [Belfast] – ¼ gram – and just a tiny bit of coke. The needle fixation really kicks in on the coke. You see, it’s a local anaesthetic so you don’t feel the needle.”

Interviewer: “So when you use heroin, do you inject less often than when you inject coke?”

Respondent: “Oh aye. I might have two hits of gear [heroin] a day, but with coke you might have 50 to 60 a day.”

Interviewer: “50 or 60 injections, yeah?”

Respondent: “Yeah. You can just keep the needle in your vein, inject, and then remove the syringe and fill another and replace it. Do that loads of times with different syringes and all the while, you leave the needle in the vein. Saves you from finding a vein each time. You’d do that more with speed or coke than heroin.” (030).

The respondent also noted that he generally did not inject cocaine. When the opportunity arose to inject the drug, he would often inject large amounts of the drug during a very brief period.

- **Controlled use**

Some respondents were able to “control” the frequency of injection in particular settings, or at particular stages of the drug career. A 39-year old male who had been using heroin for seven years and injecting for three years told us that he purposely had not used the day of the interview in order to participate in the interview more fully. We interviewed him around tea time that day and did not observe any visible effects of withdrawal. He also had moved back into his parents’ home so that “other people [IDUs] would not call to the house.” A few respondents reported that they had switched between injecting and smoking because smoking provided them with more control over their drug use (a few others told us that friends had resorted to smoking because of venous damage). Some managed to work in full-time employment, injecting after the work day had ended. A 30-year old male had worked steadily since he first injected in 1998 or 1999. He never sought treatment because he thought it would interfere with his work and feared that his employer would learn of his drug use. Another respondent who was employed full-time reported that although he injected heroin a few days each week, he smoked it during his lunch hours because he was better able to control his drug taking through this route of administration. A male in full-time employment described:

“I can tell you how many hits I’ve had [in the past 30 days]. I know that I’ve had five [injections] each week over the past four weeks. That’s how I do it. I maintain my habit with work. My wages are set out to where if I wanted to I could afford to buy one bag every day of the week.”

Interviewer: “Can you work when you’re...?”

Respondent: “Oh yeah, because my job is not strenuous at all. Any job that I’ve had in the past when I haven’t been using – I’m not fit to work.” (110)

A male reported that he worked for several years while using heroin:

“I can function on the job and be a normal person so the whole quandary is why they can’t prescribe me diamorphine and let me get on with my life. Without it, I’m a burden to society which just gets me further depressed which requires more medication, more doctors’ resources. I’ve always worked.” (104)

- **Injecting and social networks.**

A social network represents the nature and number of linkages among people within a particular subculture (Klovdahl, 1985; Williams and Johnson, 1993). Trotter (1995) concluded that an increasing number of studies have focused on the social networks of IDUs and the relationship between social networks and infectious disease. The nature and characteristics of IDUs’ social networks can

contribute to or reduce the likelihood of the transmission of infectious disease, e.g., HIV, hepatitis C, and can affect treatment entry and retention. Lovell (2002) described the linkages among IDUs: respondents who inject drugs together are said to represent a sociometric network. An IDU can be a member of more than one sociometric network, thus other IDUs in separate sociometric networks can be linked indirectly through the multiple membership of one IDU. Such networks can serve as conduits for the spread of infectious disease but can also be a source for transmitting information about injecting behaviours and risks associated with those behaviours. We observed several linkages between and among sociometric networks in our study. Females, in particular, appeared to be vulnerable for infectious disease through these linkages. For example, a female respondent noted that she was unattached to most other IDUs in her area. She knew very few IDUs and reported “sharing” injection equipment with her male partner only. A month before we interviewed her, we had conducted a separate interview with a close male associate of her male partner, who noted that he also routinely injected with the male partner. We observed this pattern in several social networks in which a female partner reported using injection equipment from her male partner only. That is, females tended to report injecting with one person only (often a male partner). Their male partners, however, often were injecting with other people. With regards to injection equipment, females tended to report that ‘I only share with him’. However, the male partner’s linkages with social networks of other IDUs created indirect risks for the females.

Injecting Behaviours that Pose Risk for Infectious Disease

- **Frequency of loaning and borrowing injecting equipment (e.g., needles, syringes, filter, container, water, needle/syringe).**

Some long-term injectors without partners reported their preference to inject alone. Although there might be an increased risk for fatal overdose when one injects alone, the risk for infectious disease might be minimised if the injection equipment is new. Although some research has suggested that recent initiates engage in more risk taking than more experienced injectors (Peters et al., 1998), we interviewed one male in his 20s who had first injected in 2003, the year he was interviewed. He had never injected with another person and learned the mechanisms of injecting from safer injecting material that he located on an internet website. He described how he would inject:

“I score and get home as quick as I can. Go to my room, lock all the doors. I have a bottle of fresh water there. I take out a spoon and I clean the spoon with an alcohol pad. I empty the powder into the spoon and add citric acid to break down the heroin. I add about 120 mls of water, cook it, stir it up, put the filter in there. Suck the contents of the spoon into the needle. I rotate my veins and look for a vein that hasn’t been heavily used before in my arms. Put a tourniquet on, tighten it up. Find a vein.

Put the needle in, wait for the blood to make sure I've found a vein, and I inject it." (109).

Many other respondents reported that they had injected with one or more respondents in the 30-day period prior to the interview. At times, the cost of a drug contributed to the practice of injecting with another person. That is, two or more respondents could contribute financially to the cost of the drug so that a larger amount of the drug could be purchased (see also, Koester, 1994).

Although we were interested in the nature of and extent to which people borrowed or loaned used injection equipment, in most interviews we attempted to avoid the word "sharing." The phrase has different meanings among IDUs, and often lacks validity (Koester, 1994).² Use of a single question on "sharing" tends to show lower percentages of "sharers" compared to multi-item questions that specifically address various injecting equipment and sources of contamination through injecting drug use (Hunter et al., 2000). Initially, the interview guide included several questions that attempted to measure the number of times that respondents had engaged in certain behaviours in the past 30 days, e.g., injected with a needle that had been used by another injector, used a filter that had been used by another injector. We found that these questions generated confusion during the interviews, particularly for respondents who had injected with different people during the 30-day period. We concluded that these quantitative measures of risk lacked validity within our sample, thus we subsequently used a qualitative approach when asking about these behaviours. We found that in many interviews we had to "tease out" the extent of loaning and borrowing by discussing various injection settings, or by asking people to describe their recent injection episodes.

Nearly all respondents had used a new needle and syringe during most injection episodes in the 30-day period before the interview. When injecting with at least one other person, most respondents reported using a separate needle and syringe. We observed some exceptions to this finding. For example, many of the respondents who reported that they were positive for hepatitis C also stated that they had used another's needle or syringe in the 30-day period prior to the interview. Knowing that one had the virus appeared to increase the likelihood that s/he would inject with another's used needle/syringe:

Interviewer: "In the last 30 days, have you filled a syringe that somebody else had used, and then used it yourself?"

Respondent: "Yeah."

Interviewer: "Did you clean it?"

² We do note, however, that "sharing" is the term used in the collection of data from both the Northern Ireland needle exchanges and the Regional Drug Misuse Database.

Respondent: "It was already clean, I was told. The guy I borrowed it from I know him very well. As far as I know he's not positive for anything except for Hep C which I already have." (115)

A 26-year old male reported that he had used a new needle/syringe each time that he injected in the past 30 days:

Interviewer: "So in the past 30 days, did you ever pass on the needle or syringe to someone else?"

Respondent: "Yes, but I've always warned them – told them about the Hep. Usually it's someone else with Hep. Their attitude is like, 'Well I have Hep anyway.' I always say to them, 'Well, there's many different strains of Hep and you might have one and I might have another.'" (110)

The majority reported using one or more needle exchanges (discussed below) and appeared to be quite knowledgeable about the risk of contracting infectious diseases through injecting with someone else's used needle/syringe. Still though, particular circumstances and settings contributed to the likelihood that individuals would inject with needles/syringes that had been used previously by another injector:

Interviewer: "Has anyone used your syringe in the past 30 days?"

Respondent: "No, but people have asked and I've told them about the Hep C. It's up to them. Just dying sick. Even knowing I have it - people have used my syringes and needles." (128)

With regards to other injecting equipment, the data revealed that when two or more people injected together, they most often used the same filter, spoon/stericup, and water despite using separate needles/syringes. Again, withdrawal and limited availability of new equipment often led to this form of risk taking. Respondents reported that they had given their used filters to friends and acquaintances. A female reported that she had used filters and spoons from others when she had been sick:

"She said, 'You know I've got some filters like, but I've got Hep C.' And I went ahead and used it." (133)

A male respondent reported similar experiences:

Respondent: "Actually in the last month I have used a filter [someone else's filter] and I shouldn't have. But I was going to be sick the next morning."

Interviewer: "Did you ask him if he had Hep?"

Respondent: "Yeah, he said he didn't the last time he was tested, but he could well have it now."

Interviewer: "And you just went ahead?"

*Respondent: "Yeah, f*** it. I decontaminated the barrel."*

Interviewer: "Still used the filter?"

Respondent: "Oh aye." (125)

The data suggest that the number of spoons or stericups that were used during an injection episode appeared to depend on the number of bags that were bought and the number of people that would be injecting. One bag shared among two or more people usually meant that one spoon or stericup was used. Two bags for three injectors usually meant that two spoons/stericups and two filters would be used. A male respondent described:

"If we score together and get a bag each, we just cook up separately. But if we are going to split it, we throw it in the one spoon, cook it up, and use a clean spoon, clean water, new filter, and judge it by eye, you know 40-50 mls each. Split it like that. Hit it up." (105)

We discussed this pattern with an outreach worker of the South Belfast Drug Outreach Team. It was suggested that when two people have one bag of heroin, often they prefer to use one stericup or one spoon because it is easier to divide the drug when it is in liquid form and prepared for injection. That is, the calibrations on the syringe make it easier to divide the drug equally. Koester (1994) found a similar pattern in his 1988-1992 study of injectors in Denver. In many ways the risk for infectious disease might be minimised if the needles are new, the filter has not been used previously, the spoon is clean or the stericup is new, and the water is clean. Indeed, without specifically asking about this issue, some respondents clarified to us that the needles were new and were placed in the spoon at the same time. Risk can be increased, however, when respondents come into contact with the blood of another or when individuals inject a second time. A male respondent recalled that four months prior to the interview, he injected with five different people over a four-day period:

"We all got needles out of the needle exchange, so everybody had a needle but we shared the spoon and the filters. But we didn't share the needles. It's because it's a brand new needle and everybody's sticking their brand new needles into the filter, so there couldn't be anything on that needle."

The interviewer learned that the group injected a second time:

Interviewer: "So even though everybody's gouching [nodding off; sleepy state], would you use a fresh filter when you cooked up that second hit?"

Respondent: "No, we used the same one. New needles though." (136)

In this scenario, the filter was re-used among all injectors who were present. The respondent appeared to believe that risk was minimised because new needles and syringes were used during the second injection.

Respondents also reported the accidental use of another's needle/syringe. That is, two or more respondents injected and nodded off. Upon awakening, they observed their two sets of works but could not recall whose was whose. Some respondents reported that the situation had occurred "loads of times" (033).

The findings suggest that several if not most respondents lack knowledge about injection equipment (e.g., spoon/stericup, filters, water) that can serve as conduits for the transmission of disease (Hagan et al., 2001). Alternatively, the majority of respondents had knowledge regarding the importance of using new and separate needles/syringes. Two male amphetamine injectors reported using separate needles/syringes each time they injected together:

Interviewer: "So what about filters, water and spoons?"

Respondent: "We share all that." (012)

Interviewer: "So why do you use separate needles and share filters?"

Respondent: "Yeah, my doctor told me it was the same thing – sharing filters is the same as sharing needles." (013)

Respondent: "[Addresses interviewer] Is it the same thing?" (012)

In addition to feelings of withdrawal or the anticipation of withdrawal, respondents reported other reasons for using the needle/syringe of another. A male respondent had lived in England for a time, and had injected there:

Interviewer: "Did you ever use works from someone else?"

Respondent: "Oh yeah."

Interviewer: "Like on Sundays when the chemist was closed?"

Respondent: "No, the exchanges were open on Sundays. Seven days a week."

Interviewer: "And did you live close to an exchange?"

Respondent: "Yeah, close enough."

Interviewer: "How many pins [needles] did they give out?"

Respondent: “60 – we’ve a lot of users over there.”

Interviewer: “So help me with this one. Why would you use someone else’s?”

Respondent: “Laziness. You got your gear [and] want to get back to the house. You just can’t be bothered taking an hour out and getting to the exchange and back. You don’t want to leave the house.” (033)

A minority of respondents also reported that a weariness of frequent visits to an exchange led at times to a lackadaisical attitude with regards to obtaining new equipment. Despite knowing the possible health consequences, obtaining new injecting equipment prior to scoring, at times was just not feasible. For others, anxiety about carrying a “sin bin” to another location resulted in an alternative method of transporting injection equipment, which in turn created confusion:

“I keep my pins in the sin bin. But sometimes in a friend’s house we’ve just pulled them out of a plastic bag and sometimes they all mix. (122, female)

Some respondents reported that they borrowed and loaned equipment with one other person only. They perceived that the other person was “safe” or “clean” (i.e., did not have hepatitis C or HIV). Several noted, “I know [she] he is safe,” but the “evidence” for this belief generally was based solely on the relationship between the respondent and the other person, e.g., partners, siblings, close friends. This type of risk still can contribute to the spread of infectious disease, particularly in places where the prevalence of hepatitis C is high (Valente and Vlahov, 2001).

- **Dependency on others to inject.**

Several female respondents relied on males to inject them, despite having lengthy injection careers. Some women had never learned how to inject themselves, whereas others were uncomfortable injecting themselves. Women tend to have smaller veins than men (Kral et al., 1999) and consistent with this sex difference, we observed that females were more likely than males to report skin-popping, largely because “I’ve no veins. Never had them” (014). A 25-year old female had been injecting for four years but rarely injected herself:

*“I was shitting myself and even now I don’t feel confident shooting up...there’s usually somebody else there to dig me. My arms are F***ed. I’ve used my groin three times recently and a [male] marked it [site in the groin area] with a pen. I would skin pop when I’m on my own. It’s such a pain getting a vein. I lie under a sun bed to heat my body up.” (122).*

For thirty years, one female had relied on someone else to inject her:

“Somebody’s always done it [injected me]. I never had any veins. Got the artery once and that frightened the shite out of me...It was always like a guy would say, ‘I’ll do it, ‘I’ll do it.’ I could hit [inject] anybody up no matter how bad their veins are. I just don’t like hitting me up. Done my feet a few times, but that was extreme. And I’ve done my neck.” (147)

Some male injectors with poor veins from injecting also relied on other respondents to inject them. We noted however, that the males had a history of injecting themselves most of the time whereas many females had never done so.

- **Sources for obtaining needles/syringes – past and present.**

The first pharmacy-based needle exchange schemes were implemented in Northern Ireland in 2001. Several respondents recalled the difficulty of obtaining new needles and syringes prior to this provision. During that time, some IDUs travelled to Dublin or parts of England to collect dozens of needles and bring the supply back to Northern Ireland. In some regions of Northern Ireland, needles and syringes were sold for one pound sterling and could be purchased from a local dealer. Some respondents recalled periods of scarcity whereby needles were sold on the street for five pounds each. A few Ballymena respondents reported purchasing drugs from the money that they earned from selling needles. Other respondents reported that they eventually found a chemist – often located far from their residence – who would sell needles and syringes although in several instances the chemist eventually stopped selling. A number of IDUs relied on friends or acquaintances who were diabetic and a few respondents had diabetes which afforded them a constant supply, albeit sometimes not the preferred size. Despite these sources, needles and syringes were extremely difficult to obtain for the majority of respondents who were injecting prior to the implementation of the exchanges. Needles were valuable commodities and consequently would be used for several injections. A male who injected first in the mid-1990s reported:

“There was loads of sharing back then. We were all at it because needles were hard to come by...Just by luck I knew a diabetic and he was an injector as well. We used to get needles from him. I was going out with a girl from XXX [town located near Belfast]. Was there one day and by chance called to a chemist who sold me the needles. [Paid] £22 for 100. I used to get them there and bring them to XXX [place of residence] where I’d give them to some friends and sell them to others for a pound or two.” (028)

Several respondents from the Northern Board recalled the work of one community worker who in the late 1990s began to distribute new needles to local injectors. The majority of respondents from the area reported that several injectors had benefited from the distribution:

“If it wasn’t for him, this town would be a mess.” (037, male)

“He would have brought you needles anytime. 12:00 at night. He’d been out for you.” (137)

Elsewhere in Northern Ireland, respondents recalled the constant search for new needles:

“See the sharing that went on. I remember knocking on doors at 2.00 in the morning trying to get a needle, just because you knew that person used [injected]. You’d keep a needle for weeks – file it down to make it work better.” (male, Western Board)

Several other respondents reported methods that were used to sharpen needles, e.g., the use of matchbox edges. One recalled using superglue to repair broken needles. Still though, respondents experienced great difficulty in their attempts to inject with blunt needles:

“I was living up in Antrim and there was a chemist in Antrim who sold pins. You’d use them 10 times, and hold it against the wall just to get it in.” (144)

Koester (1994: 289) noted that “used needles clog and break, and plungers wear out.” He also observed that injecting is easier with new needles, particularly among IDUs whose veins have been damaged.

Some respondents experienced difficulty in accessing new needles/syringes despite the implementation of the exchanges. A 34-year old female respondent described a recent transaction of works:

“I had to give him a needle. He’s very lucky. It’s Easter [exchange closed] and I got these off a dealer. Someone was telling me earlier, when you go to the needle exchange and they ask you, ‘Do you share?’ Tell them you only share on bank holidays - whenever you can’t get needles. I mean, how can an exchange close for two or three days?” (133)

A young male respondent had first injected about seven months before the interview. He had just recently started to use the exchange:

Interviewer: “So where were you getting the needles before then?”

Respondent: “From the chemist [purchase].”

Interviewer: “And would you clean them?”

Respondent: “Aye, just with a tissue or a cloth, or my sleeve. Then rinse with water... We were all using the same needle.”

The interviewer learned also that he might have been injecting incorrectly:

Interviewer: "From the looks of it, you've been going against your blood flow."

Respondent: "Aye, I've been going down and all."

Interviewer: "You've been going down. Are you aware now that you should be going up?"

Respondent: "Aye, that's what they [drug service] were saying." (131)

- **Access to and utilisation of needle exchanges.**

The vast majority of respondents had utilised one or more needle exchanges in Northern Ireland (one respondent residing in Belfast did not know about the exchanges until we interviewed her). Some, however, preferred to purchase needles from pharmacies. Others accessed needles/syringes from both sources and some relied exclusively on other respondents as their source of injecting equipment:

"See that needle exchange on XXX [street name]? I get my prescription from there and I'm scared to go in there and ask for needles. I'm scared they will cancel my prescription so I've been using blunt needles and all... I've never used it once in the whole year. I've relied on other people to get me them. Been a nightmare. Means I've been using old blunt, wrecked ones." (120)

In most instances, respondents tended to report that pharmacy staff were friendly and non-judgemental. Clearly, some pharmacy staff had developed good relationships with needle exchange clients:

"See when you use this stuff [heroin], I really feel low all the time. When I go into the [pharmacy-based exchange in the Eastern Board] there are a couple ladies that work there and the gentleman with the grey hair. They really treat you like a person. Unbelievably like. I go in there feeling like crap – like these people looking down at me. I'm coming in there, not even spending any money. I'm getting needles to use hard drugs and these people are greeting me with smiling faces. I almost feel like getting these ladies Christmas presents." (110)

However, several respondents were very critical of one exchange in particular, citing the rudeness of the staff and the perception that staff "looked down" upon them:

"They look down at you and they keep you waiting half the day. They treat you like you are the scum of the earth." (006)

“You have to ask for a carry bag, I usually bring one with me – that cloth bag over there – and use that. I don’t think I’ll go back there. I don’t like it.” (036)

Interviewer: “So have you ever said anything to staff there who treat you like that?”

Respondent: “Well, you’re the one who has to be kind. We have to be pleasant because we depend on the service.”

Many respondents eventually stopped using the exchange and attempted to obtain needles from another exchange even though it was located farther from their homes.

Elsewhere, a few respondents reported being barred from using an exchange because:

“He knew I was leaving back empty boxes. Sometimes I wouldn’t pick up more because I was doing something else. Then I’d call later and ask for a starter pack. He thought I was putting them in the bin or something. Wouldn’t serve me. Just started buying the insulin syringes up the street.” (105)

At times, returning the used needles was just not feasible:

“Say you’ve just scored. You’re not going to go all the way back home to get your dirty needles and then all the way back to get the new pins. You’re going to use the dirty needles, because they only give you two [without returning used equipment]. It depends on how long you’ve been on heroin. If you’ve no veins, well two’s no good. They call it a starter pack. It’s more like a disabled pack.” (104)

Although some respondents were not concerned over the lack of privacy in exchanges, several other respondents voiced criticism:

“You have to wait until everyone is out of the queue. They stare at you and there’s no private booth. Everyone knows what’s in that bag. I try and go in the side door – there’s cameras outside.”

Interviewer: “Why are there cameras?”

Respondent: “I don’t know. Maybe for the drug squad.” (005)

A few others reported that they refused to utilise certain exchanges because of perceived police surveillance.

A 26-year old male mentioned the “embarrassment” of being an injector. He reported that he once waited two hours outside the exchange in hopes of finding someone to utilise the exchange for him:

“You’d just wish the ground would swallow you up. [When inside the exchange] I’d wait five to ten minutes for the place to empty. Sometimes I send her [non-IDU female partner] in for me...Sometimes it’s OK, but it’s pot luck whether you’re going to get it easy or not.” (011)

The respondent rarely returned his needles/syringes to the exchange because “I hate going in that place. Embarrassing.” A male respondent from another board area reported similar concerns:

“I can’t get needles. I’ll go in with him but I stand back and he gets them for the both of us.”

Interviewer: “You go into the chemist, but you won’t ask for them?”

Respondent: “Yeah, it’s embarrassing. I’m just too embarrassed.” (012)

A female reported:

“They have that book there. You know, the one that you put your initials down. The book sits right out in the open. I heard that certain people go in and look in the book sitting there. Look at the initials trying to find out who is using the exchange. I find the whole thing very stressful. I use it, but it’s all very stressful.” (036)

“Secondary exchange” refers to injecting equipment accessed by IDUs from a needle exchange who in turn distribute the equipment to other IDUs who “cannot or choose not to attend” needle exchange schemes (Bastos and Strathdee, 2000: 1773). In the present study, some female respondents relied on male partners to access equipment from the exchanges. A 26-year old female had injected heroin, amphetamine and MSTs during the 30 days prior to the interview. In all she had injected approximately 51 times during the 30-day period, but had visited the exchange on two occasions only. She relied on her male partner to provide her with equipment during the other injecting episodes. Another female recalled:

“I was getting people to get them [needles] for me for a long time. My initials are probably found on that list maybe 10, 12 times...When welfare’s involved, I’m really careful. I mean careful – really terrified because of Social Services.” (132)

- **Residence and location of exchanges.**

The data indicate that the distance between the residence of the respondent and the nearest exchange created a number of problems for respondents who lived too far to walk to an exchange. Taxi and bus fares were costly for people who had no access to private transport. A 19-year old male was living about 20 miles from the nearest exchange. He visited the exchange when he scored in the area. He reported that he needed to organise these trips very carefully. His friend (also an IDU) is employed and after leaving work in the late afternoon, the friend would collect him for the journey to the exchange:

"[Several times] by the time he gets off work and we get to XXX [town], the place [exchange] is closed." (005).

A few respondents from Catholic areas in Ballymena noted that they avoided the exchange in Harryville because of the loyalist presence in the area:

"I would use both [exchanges] but I've been chased from Harryville a couple of times 'cause I'm a Catholic and this town is small. I know a load of people that have been chased by the blokes hanging around that area." (126)

Some respondents who were maintained on substitute prescribing but still were injecting (although considerably less so) obtained needles from the same pharmacy from where they collected their prescription. Most individuals who accessed these two services from the same chemist were unconcerned. However, a few reported problems in particular pharmacies:

Interviewer: "Does the chemist ever say anything? That you are getting needles and Subutex as well?"

Respondent: "Yeah, XXX [name of staff person in pharmacy] said once, 'I'll have to tell XXX [drug agency] about this.'" (012)

This experience caused him and others considerable anxiety, largely because they believed that Subutex was a positive experience for them and they feared that they would be removed from the substitute prescribing programme.

Within some social networks, rumours often circulated with regards to confidentiality in pharmacy-based exchanges:

"I heard last week that the doctors want to know if the Subutex ones are using the exchanges." (024)

- **Restrictions on the number of needles distributed through exchange schemes.**

In several exchanges, a starter pack included five needles whereas an exchange with a return supply included between 10 and 20 needles (the number appeared to differ across sites). Capping the number of needles during exchange transactions created problems for most respondents. A female from Belfast explained:

“But see the holidays? At Christmas they were shutting for two days and we had enough for two days, and they shut for another two days, and we were working through the box a third time. Picking the best [needles] the third time around. If they don’t allow you take extras, it’s difficult. I asked the guy [chemist] for an extra pack over Christmas – one each over Christmas. He won’t allow you any extra.” (129)

Additionally, many respondents reported venous damage, making injection more difficult. A 30-year old male who first injected five to six years before the interview reported that he often needed up to five needles for one injection. The exchange he used distributed 20 needles with a return of the same. Twenty needles allowed him to inject between four and five times, after which he would return to the exchange for more. At the time of the interview, he was residing approximately six miles from the nearest exchange and at the conclusion of the interview, the interviewer drove him to the exchange. Another male reported similar problems:

“And if you don’t take your old ones back they’ll only give you two from the needle exchange. Somebody like me who finds it hard to get veins, I need at least 20 needles to find a vein. Two are useless. And that’s from a needle exchange.” (104)

A 26-year old male had been injecting for five years:

“I have extreme problems getting veins. I’m not exaggerating – sometimes I’m poking for two or three hours before I finally get it into a vein. Other times I poke for two or three hours and there’s too much blood so I stick it into a muscle.” (110)

- **Quality of injection equipment obtained from exchanges.**

Several respondents reported that a needle sourced from an exchange had broken once it penetrated the skin. Some exchange needles were described as “barbed” or shaped like a small fish hook:

“It’s not a problem going in, but you feel it coming out.” (104)

Apparently there was a change in the type of needle distributed from the exchanges but some respondents reported that their experience with faulty needles occurred since the change had occurred. One respondent reported attending hospital after a part of a needle had broken in his arm. While in casualty, he was told to return the next day at which point it was discovered that the needle part had lodged near his lung where it remained on the day of the interview. If parts of a broken needle cannot be removed by the individual, immediate medical intervention, e.g., surgery, is needed (Norfolk and Gray, 2003), which was not provided to the respondent. Some respondents reported that they no longer used the exchanges because of the perceived poor quality of the needles. A 19-year old male reported:

“Whoever made the decision about the needles – they must have thought, ‘They’re only for skag heads – give them the cheapest ones.’” (005)

Although hardened veins also can contribute to needle breaking (Norfolk and Gray, 2003), the respondents in the present study mentioned that breaking occurred only with needles sourced through the exchanges.

Several respondents reported using the filters supplied by the exchanges, although through ritual, some continued to use cigarette filters. The majority of respondents reported problems with stericups, noting that they tip or melt easily resulting in the loss of drugs or burned fingers. Additionally, some respondents reported that the stericups cannot be heated for very long. New stericup holders have now been developed by exchange distribution companies in England although it is unknown whether they are available in Northern Ireland. It is likely that some respondents will continue to use spoons rather than stericups because of ritual; using a favourite spoon was reported by some injectors.

Saving filters for re-use.

Approximately half of the sample reported that they had saved used filters in the event that they were subsequently unable to obtain drugs. Used filters would then be heated with water and then injected. This practice has been observed elsewhere (Bennett et al., 2000). Risk for HIV, hepatitis B and C would be minimised for individuals who use their own filters and who inject solely on their own. A female reported that she often kept filters after she injected heroin:

“When it comes to desperation, and you’re running out, everything’s kept: powder from the spoon, filters, the lot.” (128)

Some respondents saved their filters but never used them. Others used them all the time. A female reported that she and her male partner would split a bag of heroin nearly every day. They used one filter between them, which was saved, after which she would inject from the used filter the next morning. The male partner rarely used the saved filter. She explained:

Respondent: "I would do them up. I would tend to be a greedy wee git. And if I went out and done all the running [i.e., scored], and done this and done that, I would normally take the filter."

Interviewer: "Does that cause arguments between you?"

Respondent: "Yeah it would." (112)

Some respondents reported that they had obtained used filters from another person:

"I just remembered. I did use this guy's filters a couple of weeks ago. He had no gear left but he gave me six [used] filters to cook up. He's a dealer but a good friend." (122)

Flushing

"Flushing" is a behaviour that involves multiple injections in the same site during the same injection episode. The substance is injected, the needle is withdrawn and then re-injected several times. The process differs from "registering" in which blood that fills the syringe is indicative that the individual has "found" a vein. Flushing can contribute to the spread of infectious disease (Abdala et al., 2004) and can damage veins.

We asked 59 of the respondents to describe the behaviour of flushing and whether they flushed regularly. Of the 59 respondents, 46% reported that they flushed. Some users reported that they flushed to ensure that all drug residue was injected. Other IDUs disputed this reasoning arguing that "it doesn't do anything for me" (116) or that flushing might be required for 2 ml needle/syringes only. Respondents reported that flushing occurred through habit or because they enjoyed the feeling and ritual of injection. Some described it in sexual terms ("It's like masturbating with a needle" 001; "There's definitely something sexual about it" 104). A female respondent described her preference for flushing:

Interviewer: "Flushing – have you...?"

Respondent: "I love flushing. I do it deliberately. I'd do it with water. I'd sit with the needle in my leg and watch blood coming in. Shooh." (128)

Interviewer: "How many times would you draw back?"

Respondent: "All depends on the vein. Loads of times. I love it."

Interviewer: "Like 10 times?"

Respondent: "Oh God, aye."

Interviewer: "What's the longest time you've seen yourself flushing?"

Interviewer: "Teasing yourself?"

Respondent: "Exactly, teasing myself... 'Cause I know the anticipation's there. It's not the hit, it's the anticipation, the thrill. It's like teasing a bloke. You know the whole thrill is the chase." (128)

A number of respondents described what they perceived to be a fascination with needles and injecting generally. A 38-year old female reported:

"I must flush six times [per injection episode]. I just have to make sure it [the drug] all goes in. I love to flush. He doesn't, but I do."

Interviewer: "So is it a needle fixation?"

Respondent: "Oh aye. The needles. I just love to see one coming." (034)

One male respondent noted that his love of injecting was his major problem:

"I've got loads of addictions. One's alcohol, another's Nubain. But the third is the needle. I am addicted to needles – love the feeling. I told them at [drug service] and they didn't understand. I'd say if I could stop the needle fixation, I'd stop the Nubain. When I'm waiting for something [some drug to inject] I think I could inject the water. I don't know what it is, but I love the needles. I get cravings for jaggging." (016)

Some respondents reported that for them, flushing depended on the type of drug they were injecting:

Interviewer: "What does the term flushing mean to you?"

Respondent: "Push it in a few times to make sure you got all the gear into your arm."

Interviewer: "Would you flush?"

Respondent: "Yeah."

Interviewer: "About how many times would you pull back?"

Respondent: "Gear – three to four."

Interviewer: "Would it change if you were injecting a different drug?"

Respondent: "Oh yes, Speed – I'd flush until the cows come home."

Interviewer: "And do you reckon it pumps the drug around your body more?"

Respondent: "Not particularly, I just like doing it. I've always been a needle junkie." (115)

Exposure to other injectors in "high risk" areas

The data indicate considerable exposure to other injectors from "high risk" areas. We defined "high risk" areas as those 1) in which large numbers of people inject *and* where research has found a high seroprevalence of infectious disease among IDUs, or 2) a prison or jail in which large numbers of injectors are housed and where research has documented high prevalence of hepatitis C or HIV among IDUs in the facility. Using this definition, 51% of the sample were exposed to one or more of these "high risk" areas. For example, several respondents had resided or visited, and injected with IDUs from Glasgow, Edinburgh, London or Dublin. Others had served time in jail or prison in Scotland, England or in Mount Joy prison in the south of Ireland. Respondents residing in the Eastern Board were significantly more likely than respondents residing in the Northern Board to report injecting in these high risk settings (Eastern Board=68%; Northern Board=19%).

A male respondent recalled an experience in Mount Joy prison:

"A syringe was being passed about and I nearly shit because the guy in my cell had the syringe. I thought he meant it had been used eight times but it had been in the wing for eight days." (126)

Some respondents had been in prison in Northern Ireland although very few reported injecting in those settings. A female had been on Subutex for three months when she was sentenced to Maghaberry for failing to pay fines:

"I told them to ring [my] opiate nurse. Told them I was on the Subutex. That was the first day. Second day I started to feel sick and begged them to contact [opiate nurse]. Gave them the number and all. I asked for a doctor. The last day they came to get me and told me I could go. They [prison officers] said, 'So do you want that doctor now?' Three days without my Subutex."

A male respondent reported being in a Northern Ireland prison before he was on Methadone maintenance:

Interviewer: "So what did they give you in prison? Anything to help with the sickness?"

Respondent: "Yeah. Gave me two paracetamol and Gaviscon and told me to sort myself out." (035)

Others were given diazepam and DFs and reduced over a two-week period. A 31-year old described the experience of his friend who was on Methadone maintenance before incarceration and spent three or four days in prison because of unpaid fines:

“They wouldn’t give him Methadone [in prison] and there he was, back [in detox] after he got out.” (028)

Police practices and risk

We found considerable evidence, particularly in the Northern Board area that police practices contributed to risk behaviours for infectious disease among IDUs. Within that board area, several respondents reported having needles confiscated, with threats of being charged for possessing needles that were tainted with drug residue. For example, a 19-year old male had a needle in his possession and the police confiscated it. They examined it “but there was no Class A drugs on it.” He recalled that he was not charged with drug possession but was fined £150 for possessing the needle. His friend noted that, “You need to have the sin bin with you all the time” (004) but the 19-year old noted that, “They still hassle you.” Another male reported:

Respondent: “If you’ve got the black box, they [police] can’t do anything about it.”

Interviewer: “What do the police do when they find a needle on someone who does not have the black box?”

Respondent: “They’d charge you with possession if they found even a trace of heroin in. They look down upon us. You’re walking up the street, and they stalk you. There’s an entry right there but they have to search you on the street [in view of passers-by]. It’s humiliating.” (006)

A 31-year old male from the Northern Board reported:

Respondent: “I was walking up the XXX [street name] and they [police] stopped me. I had one syringe on me – clean. And one spoon – not clean. They stopped me and confiscated them. Said in court that they seen me leaving the home of a known drug dealer. That wasn’t true at all but they had to find some way to justify stopping me. They found traces of heroin on the spoon. Only traces. Such a tiny amount. They did me for possession of heroin. 150 pound fine I got.”

Interviewer: “When was that? Was that before or after the needle exchanges were open?”

Respondent: "Oh the needle exchange was open alright. But the spoon and syringe were not in a sin bin." (028)

A respondent with diabetes reported that the police in Ballymena searched him on a Saturday afternoon in the middle of the town centre. The police confiscated his insulin syringes and placed them in full view of passers-by.

Females were not exempt from public searches:

"Got me once near the exchange. Made me take my socks and shoes off – pissing rain so it was. Right in the middle of the street, made me take off my socks and shoes. Tried to search me there and then." (034)

Recent data collected from the pharmacy-based needle exchanges showed that the percentage of needles returned to exchanges was significantly lower in the Northern Board (44%) than in the Eastern (72%) and Western Board (72%) (Drug and Alcohol Information and Research Unit, 2004: 2). Based on the findings presented herein, police practices in the Northern Board might have contributed to the lower rate of return in that board area.

Similar interactions with police were reported by Belfast respondents, although to a lesser extent. One Belfast male reported that he was stopped by police while heading to a needle exchange. He was carrying the black sin bin which contained used equipment:

Respondent: "They asked me where I was going with it. I told them where I was going [i.e., to the exchange] and they took it off me."

Interviewer: "Why did they take it off you?"

Respondent: "Evidence."

Interviewer: "Evidence for what?"

Respondent: "I don't know – fingerprints, traces, whatever."

The respondent was searched on across from the needle exchange. No illicit drugs were found by police.

These police practices contributed to respondents' re-use of injecting equipment – either their own or someone else's. Other respondents were hesitant to return their used equipment to the exchanges because they feared police intervention. Returning to the exchange without used equipment, in turn meant that a smaller number of new needles could be accessed because of the cap on needle/syringe supply without a return. Although some respondents had never been stopped by the police, news of police practices involving injecting equipment travelled quickly through networks of injectors.

Respondents described how the label of “drug user” provoked further searches by police:

Respondent:” Searched me loads of times. Trousers down and all. There’s mates who they got on the ground, choking them saying, ‘Don’t swallow it.’ I was in the bus station once getting a timetable for me mum. Came out and there they were. Searched me right there in front of the bus station. Said I was acting suspicious.”

Interviewer: “Why did they think you were acting suspicious?”

Respondent: “Because I’m a junkie. Everybody suspects the junkie. They got nothing on me that day. Not a trace. Real humiliating though.” (035)

Some respondents who were told by police that they would be prosecuted for possession resulting from traces of a drug on injection equipment, never heard from police again. Others were fined £150; a few were given a year’s probation.

Alcohol and Benzodiazepines

A total of 39% of respondents had consumed no alcohol during the 30-day period prior to the interview. Additionally, 37% had consumed small amounts of alcohol, i.e., a few drinks, during the same time period. However, several recalled that they drank quite frequently prior to using heroin. Some respondents on substitute prescribing, Subutex in particular, reported that they were drinking more frequently because they were using heroin less often, or abstaining from heroin altogether. Overall, however, we interviewed very few frequent drinkers in the study. There were some notable exceptions, e.g., a young male who at the time of the interview was injecting morphine and benzodiazepine and drinking alcohol every day, beginning each morning.

A number of respondents were consuming benzodiazepines on a daily basis. A total of 37% were in receipt of a prescription for diazepam whereas others purchased them from street or Internet sources (which often differed in appearance from prescribed benzodiazepines). Still others obtained them at no cost from partners, relatives, or friends. Some IDUs had been prescribed the drugs for years, long before they ever injected. For example a 21-year old male had been taking benzodiazepines since the age of 12 and reported having a long-term “habit” (021). Some respondents had knowledge of the consequences of long-term use of benzodiazepines. At the time of the interview a male respondent was taking two 5 mg diazepam per day:

“They are dear now. £1.50 for each yellow, so that’s £3.00 a day for me. Price has gone up. Funny – the effect of the yellows. Valium’s supposed to calm you down. But after a while you get the same panic that it was supposed to take care of.” (025)

Others had begun using diazepam while participating in other drug scenes. For example, one reported that she had first used diazepam after leaving a club and “coming down” from Ecstasy (105). A female reported that she had been prescribed Librium and that “I didn’t even know they were benzos” (132).

Some people acknowledged dual dependence on their drug of choice and benzodiazepines:

Respondent:” Every time I mentioned [Consultant Psychiatrist’s] name, my doctor wanted to try and help us get off drugs. God knows how many DHCs and diazees [we were prescribed and took] over four years. Our habits got worse. We were addicted to three things instead of one. And I got down on my hands and knees, said, ‘Look, I’m begging you. I really need to see [Consultant Psychiatrist].”

Interviewer: “You literally got down on your hands and knees?”

Respondent: “Yes, hands and knees. I was crying and said, ‘Please get [Consultant Psychiatrist]. And outside four days I was in [in-patient detox unit].” (134)

Many respondents had no knowledge at all regarding the dangers of benzodiazepine withdrawal although some had experienced lengthy withdrawal periods characterised by severe effects:

“At least with gear, you know the end is in sight. You feel like shit but there’s an end in sight. With benzos, it’s months and months, and it’s much more subtle. Things like, you don’t sleep properly, nightmares, day trembling, suicidal thoughts. I never really felt depressed [except] when coming off the benzos. I had suicidal thoughts. It scared me. Even still using gear, it still didn’t help.” (105)

Sexual Behaviours

Sexual activity was rare among many long-term IDUs who had a partner who was also an IDU. Of this group, many reported that they had not had sexual intercourse for several years (e.g., 5 years, 8 years). This finding was also observed among long-term IDUs who did not have steady partners. However, many respondents also were taking antidepressants, some types of which can affect libido. We observed that Methadone and Subutex maintenance allowed for a return of sexual activity among some respondents, although some males reported experiencing a stronger sex drive with Subutex compared to Methadone.

Some respondents had partners who had never injected. In particular a number of young male respondents had female partners who had little experience with

any drugs, except for weekend use of alcohol, and less frequently, cannabis. A few of the female non-using partners had no knowledge of the male partner's injecting drug use:

Interviewer: "And what about your arms. Does she ever ask what happened to your arms?"

Respondent: "She's asked me. I just say I was beaten up."

Interviewer: "What about protection [condom use]?"

Respondent: "No that's why I am worried for her. The hospital told me I needed a test." (131)

Among respondents who had engaged in sexual intercourse in the 30 days prior to the interview, very few had used a condom. Moreover, when we asked the question about condom use, several respondents tended to assume that we were asking about birth control rather than about sexual risk for infectious disease. A male respondent maintained with Subutex noted a return to sexual activity with his non-IDU female partner. He and his partner confirmed that they had engaged in sexual intercourse approximately 12 to 15 times during the past 30 days:

Interviewer: "What about condoms? Would you use condoms?"

*Respondent: "No, she's got the f***y stopper [coil]." (011)*

A male reported having a "one night stand" with a female:

Interviewer: "So did you use a condom?"

Respondent: "No, she said she was on the pill." (111)

Physical and Mental Health

We asked people about their physical and emotional health. The responses to this question appeared to be influenced in part by the timing of the last injection. Respondents who had injected a few hours before the interview often reported good physical health and some acknowledged that the timeliness of their last injection affected their self-reported health.

Some respondents reported being in good physical health. Others complained of ailments relating to injecting, e.g., venous damage, making injection into these sites either impossible or improbable. Several males and some females reported injecting into the groin because of venous damage elsewhere. Friends would often mark the vein with a pen and respondents generally were aware of the proximity to the femoral artery. Sometimes the groin area was chosen to prevent non-IDUs from noticing the visible signs of injection. Respondents noted their

embarrassment over damage to veins, particularly those located on the arms, wrists or hands. Many sought to conceal the damaged areas by wearing long-sleeve shirts, even in warm weather. Getting clean or reducing the number of injections at times meant that respondents no longer needed to conceal the visible signs of injection:

“Look at me. A nice day and I’m wearing this shirt [short-sleeve shirt].” (028)

Other respondents reported problems with abscesses, septicaemia, irritable bowels, arthritis, osteoporosis, heart problems and lung infections/problems associated with smoking heroin and crack cocaine. Some women, including those in their 20s, reported that they had stopped menstruating. Many respondents reported having a poor appetite and some claimed that Subutex contributed to this condition. Some had been prescribed a health drink that provided valuable vitamins and nutrients and increased the appetite. A few reported that they had requested the health drink from their GPs but with little success. A 32-year old male reported that he had lost a large amount of weight but was denied a prescription for the health drink:

“He says it’s 24 quid a week and he won’t give it to me.” (032)

A male from another health board area reported a similar interaction with his GP:

“I told him everything. Just laid my cards on the table. Lost three stone over the years and asked him for [health drink]. He said it was too dear.” (033)

Some individuals suffered from panic attacks, and several had prescriptions for anti-depressants. Indeed, self-reported depression appeared to be quite high among respondents. A male reported being depressed before he ever used heroin and was depressed the day of the interview (while on Subutex):

“I overdosed myself in the last three months. One hundred diazepam and sleepers. The break up [with the former girlfriend]. They cut me off them [anti-depressants] because I tried to overdose myself. I’m alright now because it’s the daytime now. But see at night, the depression...” (137)

Others reported being depressed during periods of abstinence. Major withdrawal symptoms had long disappeared, however, to some extent cravings continued. Equally important, some respondents questioned their purpose for living and were bored with their current lifestyle.

HIV, Hepatitis C and Hepatitis B

We purposely chose to avoid asking respondents about any test results for HIV, hepatitis B and C because we did not have the expertise needed to address

post-test counselling issues. However, we did ask people whether they had been tested and the number of times that they had been tested. Additionally and without being asked, some respondents told us that they were positive for hepatitis antibodies. Of the 53 people who were certain that they had undergone a test for hepatitis C antibodies, 30% reported to us that were positive (none resided in the Western Board). In comparison, the Unlinked Anonymous Prevalence Monitoring Programme found that 16% of those participating in the 2002 study had antibodies for hepatitis C. The difference could be due to the different methodologies used in the two studies, the year of data collection, or the fact that the prior study was limited to respondents presenting at selected drug services in Northern Ireland. In the present study, a total of 38% of respondents who reported being positive for hepatitis C antibodies were not in contact with drug services at the time of the interview.

Respondents had thought a good deal about the source of transmission. One male reported that he contracted the virus while in prison (not in Northern Ireland) because he tested negative for hepatitis C antibodies shortly before he was incarcerated. Another male reported that:

"I can tell you exactly when I got it. I went over to a friend's house. He had a bit made up in spike. I took it out of the spike and put it into a new one. Took the needle off, drew the plunger out and poured it into a spoon...He'd sucked his bit out [before]. That's how I got it like. I was sick as a dog. Pushing 48 hours. Just not thinking...that one time, that's all it takes."

We believe that the self-reported hepatitis C figure of 30% is likely to be an underestimate. First, many individuals reported being tested one time only and did not appear to acknowledge or understand the need for regular testing. Second, some respondents had not been tested in several years. For example, a female who had been involved in sex work noted her desire to be tested because her last test was conducted approximately three years before the interview. Third, some were unaware whether testing had actually occurred, and at times there was confusion between hepatitis C and B. For example, some respondents reported being immunised against Hepatitis C. A female reported:

"I was tested for hepatitis B. No maybe it was C. I don't think I was tested for HIV. But they take the blood because I'm pregnant. Wouldn't HIV show up in those tests?" (023)

Fourth, 13% of the sample reported that they never had been tested for hepatitis C. A female reported:

"He's been tested. I don't go for tests. I just go by XXX's [male partner] test. He's been tested for Hep C and all, and he's clear for all that. We haven't shared with anybody [except between themselves], so I just think, if he's clean, I'm clean, but I don't know that [for certain]."

Interviewer: "And why would you not go [for testing]?"

Respondent: "Why would I walk in and say, 'I want a hepatitis C test'? Roll up my sleeve, they'd look at my arm. If I didn't have a daughter..."

A few reported that they had not been tested because health professionals had told them that testing via blood was not feasible because their veins were so damaged.

A few respondents actively pursued information about hepatitis C in particular:

"People don't want to know about Hep C. They forget about sex. They think it's through the needle only. It's not. They need to think about the spoon, sex, other things. And the cold sores through smoking crack, and burns on the lips and mouth, that's another way." (age 21)

A male respondent had learned that he had the virus a year before the interview was conducted. He was trying to stay clean and reported that his current social network included friends who had never used heroin. They did not know of his status. He tried to avoid alcohol because of the hepatitis:

"I tend to get sick after a few pints. I think they wonder if I don't drink. I'll just get me a bottle of vodka and make very weak drinks."

The anticipation of telling other people was raised by other respondents. A male reported:

"I haven't had a relationship in five years. I'm getting clean now and I'd like one. But how do you tell someone about the Hep C"?

A respondent recalled feeling anguished about telling their partner but did so soon after diagnosis. Members of the partner's family had told several other people in the community:

"Everybody found out. And [they said that] I didn't have Hep C, I had AIDS. I had cups smashed behind me in cafés..."

One male respondent had not yet disclosed to his female partner that he had hepatitis C. Two respondents were partners who had been diagnosed with hepatitis C. The interviewer asked whether they knew about interferon treatment to which the female respondent replied:

"It's terrible. You lose your hair, you get sick, withdrawal, stomach aches. You need to get six injections a day. We're not interested."

Respondents voiced frustration about the apparent ten-day wait to obtain results from their test for hepatitis C antibodies:

“In Europe it’s the same day. It’s frustrating.” (001)

At the time of the interview, a female had been waiting for three years to obtain a referral to see a liver specialist. The consultant psychiatrist had recommended it, but the GP was slow to make the referral. A male respondent reported that he was “expecting” to be told that he had hepatitis C Virus because “I shared with people – needles, filters.” He also voiced frustration in the wait for diagnostic tests:

“Now I’m waiting for the test results to find out what strain it is. You see it takes at least six weeks to get those results back. There are different strains of Hep C – six different strains I think. Some are treatable and some are not.”

We asked respondents to provide an estimate of the number of other current injectors whom they knew. These “other injectors” included partners, friends, relatives and acquaintances. Thirty-nine percent of respondents knew in excess of 100 other injectors, particularly those respondents residing in the Northern Board. We did observe substantial regional differences when we asked about the number of injectors whom they knew who had hepatitis C or HIV infection. Despite knowing several injectors (often in excess of 100 other IDUs), Northern Board respondents knew very few injectors with hepatitis C. This pattern differed greatly from what we observed among respondents residing in the Eastern Board who tended to report that half, most, or every IDU they knew had hepatitis C.

Overall we found that respondents had considerably less knowledge about hepatitis B than they did about hepatitis C or HIV:

“People wouldn’t mention that they have Hep B. That’s for people who are sleeping on the streets, people who are alcoholics, people who work in hospitals” (113).

No one reported to us that they had antibodies to hepatitis B core antigen and only 17 respondents reported that they had been fully immunised against hepatitis B.

None of the respondents told us that were HIV-antibody positive. Approximately 15% of respondents had never been tested for HIV antibodies and 6% did not know whether they had been tested. A number of respondents had been tested one time only. Additionally, 63% of respondents did not know any other injector with HIV.

Experience with Drug Services

The interview data revealed three broad groups of IDUs: 1) respondents who were in contact with drug services (statutory or voluntary) at the time of the interview (40%), 2) respondents with a history of engaging or attempting to

engage in drug treatment but who were not in contact with services at the time of the interview (43%), and 3) respondents who had never been in contact with drug treatment services (17%). We found considerable differences across board areas. A total of 62% of respondents from the Northern Board were in contact with treatment services at the time of the interview, compared to 23% of respondents from the Eastern Board. Four of seven respondents from the Western Board were in contact with drug services in Northern Ireland. None of the five respondents from the Southern Board were in contact with drug services at the time of the interview although all expressed an interest in treatment. A large number of respondents from the Eastern Board (65%) had previous contact with treatment services, compared to 19% of respondents from the Northern Board.

It is important to note that this study was not an evaluation of drug treatment services. Such an approach would need to be carefully designed and would require the use of one or more control groups. A thorough evaluation would benefit from multiple interviews with clients over a lengthy period of time and treatment providers would also need to be interviewed. With these caveats in mind, we report the findings here to indicate respondents' perceptions and experiences with drug services.

We observed that a number of respondents who had been in contact with drug services, particularly in recent years, reported positive experiences and good relations with staff. Drug services appeared to provide a range of services for some respondents. One young male respondent had injected for the first time seven months before the interview. He was a member of a small network of very young IDUs from Belfast, all of whom had initiated injection during the same time period. His drug use (injecting diazepam, DFs and morphine about four times per day during the past 30 days) and severe depression led him to contact a statutory drug agency one week before the interview. Staff there provided him with information about infectious disease and told him about the needle exchange. He reported being surprised after learning about the relationship between injecting behaviours and hepatitis C. He had injected about 120 times per month for the past seven months before learning how to access new and free needles and other injecting equipment. He began to utilise the needle exchange about a week before the interview. Prior to that time, he and his mates would use the same needle several times, "You should have seen the arms. All cut and all" (131). Clearly, the drug service had assisted him greatly in terms of reducing the harm associated with drug injection.

A number of respondents reported that staff in community addictions and drug outreach were instrumental in helping them locate and access a GP or assisting them in other ways:

"I first went to the GP – had to, I was dying. I asked for DHCs. He bucked over. Pathetic. Gave me diarrhoea tablets. Went to Community Addiction and they got me a GP. Came up with me, helped me get on something [i.e., substitute prescribing]." (011, male)

Respondent: "I shared with XXX and XXX and they've got Hep C. I told my key worker and he took me to the GUM clinic. All clear."

Interviewer: "Your key worker drove you there?"

Respondent: "Yeah, drove me there, waited and drove me back. They do that for you. Brilliant so they are." (025)

We observed important differences across health board areas with considerably more favourable reports in one health board area in particular. In one other health board, we failed to observe any positive feedback at all. Some respondents who were dissatisfied with drug services in their area sought treatment in another health board. Some had made attempts to utilise a friend or relation's home address in order to obtain services in a health board other than their own.

Of those respondents who had never been in contact with drug services, some believed that contact would affect their employment or future employment. A male reported that his GP recently gave him a referral to a statutory drug service. He had not yet attended at the time of the interview:

"I don't want to be a registered addict. It's already affected my life – personally, physically, mentally. And I don't need it in writing. I don't need that label attached to me. Kind of like sex offenders, you're on some sort of a list and you don't know who is looking at it."

Others reported that they could not access drug services because their family members believed them to be "clean." We also observed gender differences with regards to participation in treatment services. That is, 44% of males were in contact with drug services at the time of the interview, compared with 30% of females. Female respondents voiced concerns over the placement of their children if they were to be identified as a drug user:

"I remember when she [social worker] first came in here. She said, 'How can you be a heroin addict when your house is so tidy?' We call them book readers – think they know everything about heroin use. All these myths they believe them. Like why can't a heroin user keep a tidy house? My child – I bathed him every night, he was always fed, and always had his nappy changed. Well looked after. Well cared for. But see when you get these? [Points to a small box of DFs], you're marked. That's what gets them [Social Services] involved at first. I know a girl, two kids and they are always begging for sweets in front of the shop. Wee things, have dirt between their fingers. But she's never lost those kids. Buys her DFs from the street, no script at all. So no one knows about her." (034)

We interviewed another female who had never been in contact with drug services. Nor did her GP know about her heroin use:

Interviewer: “So what’s stopping you from going [for treatment]?”

Respondent: “Social Services. My main worry is my daughter...I am just so paranoid about XXX [daughter].” (112)

Respondents residing in rural areas or small villages located a good distance from large towns had reported frustration at the lack of facilities in their areas. Some respondents had made several attempts to access drug services in various health board areas:

“I went into the clinic that night [this clinic was NOT part of addiction services nor was it another drug service]. That was the sixth time I had tried to get help. The sixth time. One time my Probation Officer tried to get me into that place in Belfast – XXX [voluntary agency that focuses on drug and alcohol]. We found out I had to come up with £400, [or alternatively] I had to move to Belfast. I [was required] to pay but just didn’t have the money. My [former] boyfriend and I heard about [Addiction Unit located outside their health board area]. We went to three or four doctors there trying to get into the place. None of them could help us. That night in the clinic, I was so sick. They didn’t give me anything. I got cheeky and they put me in lock-up. Why didn’t they send me to the XXX [local addiction services]? Why didn’t they tell me about it? I was there for a bit, and then this XXX [drug worker/counsellor] and XXX [consultant psychiatrist] came to see ME in the clinic. They told me about Subutex.”

In this instance, there were six occasions where she tried to get help for heroin dependence. She attempted to access services in two other board areas – neither of which was her own. She was not successful because of the “residency requirement.”

- **History of negative experiences**

A number of respondents had attempted to engage with drug services on at least one occasion, and several reported multiple attempts. Often this treatment history shaped their perceptions of current treatment practices. Extremely negative experiences with drug services contributed to total avoidance of all treatment services. Britlofex in particular was described as a “primitive” drug. A 34-year old male recalled his experience with a drug service in the year 2000:

“He [Consultant Psychiatrist] told me he could cure my heroin addiction in five days with Britlofex. I said, ‘With what? Britlofex?’ I had to laugh. I’d been on meth for over 10 years and knew it worked for me. And here’s this man so concerned about his job and he thinks he can cure me. I got cheeky with him. He told me if I came back he’d call the cops.” (015)

A male went through detox at a statutory drug service and was given Britlofex.

“I told them I couldn’t sleep, I was very stressed. I told them that I’d need Valium prescribed with the Britlofex. They said to go to my doctor to get those things because they couldn’t prescribe them. Then they phoned my doctor behind my back and told her not to give me any. So then I made the appointment with the doctor and she showed me on the computer screen. XXX [statutory agency] phoned her and told her not to prescribe diazepam under any circumstances. So they told me to go to the doctor, and then went behind my back. I was sick at the time and I didn’t need to be getting out of my bed to go to the doctor. If they had of told me the truth instead of lying to me – that’s what they did – they lied to me. So how are you supposed to trust a place like that? I’m still angry about it. I told the doctor about it. I said, ‘There’s no way I’m going near this place.’ ...Five days later – five days of Britlofex and I was crawling the walls, hadn’t slept in five days, I was sick, and I relapsed...We should be offered the same level of service as the rest of the UK.” (103)

A male respondent reported undergoing in-patient detoxification on two different occasions. He was detoxed with Britlofex and relapsed within five days after completing the detox. Another male respondent provided similar reports about the same drug service and relapsed shortly after he completed the detox programme:

“Dr XXX [Consultant Psychiatrist] is not a nice man. No help at all. Gave me Britlofex. He told me, ‘I’m not going to give you methadone. And you don’t need sleeping tablets. You’ll sleep OK here.’ I never slept at all the whole time I was there. There were mostly people in for alcohol and they slept fine. I’d hear them snoring at night and I was crazed. I wanted to sleep so badly.” (018)

In all four board areas, information about treatment practices passed quickly through social networks of injectors. One person’s negative experience with a particular drug service contributed to the avoidance of treatment among other IDUs.

Concerns about dispensing

Some respondents reported that they had developed very good relationships with chemists from whom they collected their prescriptions.

“My chemist has changed. The [former] pharmacist was discreet. Called you into the back and had a good chat with you while she was waiting for the Subutex to dissolve. I’m going to ask Dr XXX can I change chemists. In this new one there’s no private part. They just call you up to the front of the shop so it means everybody can see you.” (143)

Similar to the experiences in the pharmacy-based needle exchanges, many respondents noted that the lack of privacy in pharmacies created anxiety for them when accessing substitute treatment:

“Sometimes I have to wait half an hour to get my meth. She has to serve everyone first, even people who come in after me. I’m waiting there and people looking at me like I’ve got two heads. She’s getting paid for helping us, but you feel like you have to kiss her toes.” (025)

Many respondents attempted to collect Subutex or Methadone in the morning because there were fewer customers present. Additionally, some individuals needed a morning dose to prevent sickness. Other respondents noted that early morning visits often meant that they would not come into contact with other IDUs – visible reminders of their previous lifestyles or perceived sources of temptation.

Respondents who continued to inject or subsequently injected while being maintained with Methadone or Subutex, voiced concern about being removed from a programme of substitute prescription because of a positive urine test for illicit drugs.

“He [staff member in drug service] was going to throw me out. I begged him. I wouldn’t leave the building. I was in tears. He finally said, ‘Alright.’” (013)

In particular, respondents who resided in small towns were concerned about confidentiality in local pharmacies:

“I would be nervous going in there. There’s a few reasons. Your ordinary people come in and get their prescriptions. Could be your mom’s mate, someone down the lane, someone in the UDA.” (144)

A male reported a number of problems with the local chemist from whom he collected his substitute prescription.

“There’s one chemist in the village and everybody knows me. Everyday I go in there and they see the man put the tablet on the spoon. You have to sit there, waiting for it to dissolve. There’s no privacy. So much for the confidentiality of the chemist.”

Respondents questioned the reasoning of daily collections:

“The doctor knows that I need it. I’m not going to eat it all at once. That’s stupid, you’d just be sick. I need my daily drugs. That stabilises me.” (104)

He reported that a person who works in the chemist knew people that he did. Such is the nature of villages. However, the respondent believed that the staff

person in the pharmacy had told others about the respondent's involvement in substitute prescribing which identified him as a [former] heroin user:

"My work has stopped. A friend asked me, 'Why do you go to the chemist each day and take that tablet?' Who told him about the Subutex? [We've] no dirty urines...I've told Dr XXX [Consultant Psychiatrist], 'Test us, surprise us [with a urinalysis test]' we just can't be going in there every day.' The first couple of weeks were terrible. She [staff member in pharmacy] stood over me. I wiped my eye and she reported it to him [head chemist]. No trust at all." (020)

We learned that a chemist in one small village had only a few clients on maintenance. The chemist knew that the clients were acquaintances:

"She's asking me how XXX [other client] is doing and she asks him how I'm doing. She's not supposed to ask that, is she? Pure nosiness. She's not asking out of the goodness of her heart." (025)

- **Lack of involvement in treatment decisions**

Respondents who reported having little influence over treatment decisions often left treatment and relapsed. Some respondents recalled a "one size fits all" approach to drug treatment and found that approach to be unsatisfactory. For example, a male injector made three attempts to seek help (a statutory agency, a voluntary agency, and a psychiatric ward). In all three sites he was forced to engage in counselling:

*"They say more counselling. I don't need counselling. It's the same old questions about my background and relationships. I don't have any family trauma, no addiction, no nothing...I wasn't bullied, there was no child abuse. I keep telling them this but the same old questions they ask. Why do I need counselling? It does no good for me. I get my hopes up every time I have an appointment. I think, 'Maybe this time [they can help me].' But nothing. Then I come home more depressed than when I went in [to the drug service]. You get really down because you keep making these appointments with these so-called professionals and they know F*** all about my addiction. Don't get me wrong, the counsellors I've had are nice people. But I need more than nice...There's no help here for people. The rest will tell you the same thing." (016)*

- **Dissatisfaction with detox only**

A number of respondents indicated that they needed more intervention after completing detox. A male had been in the same in-patient detox centre on five different occasions. At one point he was in three times in one year:

Respondent: "The girls at XXX [statutory agency] are dead on. They really want to help. But they don't have enough information or experience to deal with heroin addicts. They start you on a low dosage of Subutex, raise you and then reduce you. Then they release you. And it's then that you start withdrawal."

Interviewer: "How long were you in for?"

Respondent: "14 days. That's another thing, I think that 14 days is far too quick. I think six weeks or so is more realistic."

Interviewer: "All those five times that you were in, did you ever stay clean after you left?"

Respondent: "For about an hour." (116)

Another reported:

Respondent: "Absolutely useless. No concept of drug users at all. I think they are used to dealing with alcoholics. The shock therapy might work for alcoholics but it certainly doesn't work for heroin addicts."

Interviewer : "What do you mean by shock therapy?"

Respondent: "Go clean that's it. Stay for two weeks, back on the streets, not going to use again. People have habits for 10, 15 years. How can they ever stop just by that detox? Because they can do that [detox] at home. They can get better drugs off the street to detox yourself. Kind of pointless really. Kind of a fundamentalist Christian attitude underlying it...They don't abide by clinical guidelines. I know they are just guidelines but...Do you know about the clinical guidelines that were published in 1999? About substitution therapy for opiate addicts? Basically loads of doctors drew up a plan for the NHS of how to deal with heroin addicts. One of the key things was that someone with a long-term problem should be offered maintenance therapy. No pressure to come off it, only when you're ready."

Interviewer: "Is this applicable to Northern Ireland?"

Respondent: "That's the strange thing. [Officially, it's known as the] United Kingdom of Great Britain and Northern Ireland!" (105, interviewed before April 2004)

A 25-year old male described the time that he went through detox at a drug treatment facility:

“You’re allowed one visitor so your friends can’t come visit. You need a separate room to come off the gear [but none is available there]. [When detox is completed] you walk out the door onto XXX [local area where drug transactions occur frequently]. No one ever managed to stop using.” (001)

A 27-year old female had engaged in detox with drug services on four different occasions. She offered a similar description and noted the monotony of the service:

“There’s nothing to do. They should keep you busy with meetings and activity. There is no rehab – just detox. You are on your own, few people to talk to. You get out and that’s it – XXX [same local area where drug transactions occur frequently] is just around the corner.” (002)

Substitute Prescribing

A total of 38 respondents (42%) were on Methadone or Subutex maintenance at the time of the interview. Subutex dosage ranged from 4 to 14, with most clients receiving a dosage of 8 or 12. Dose levels for Methadone ranged from 35 to 85, with 65 mg being the most common dosage. These individuals were pleased that substitute prescribing was now in place. A male on Methadone maintenance reported:

“I’ve got no problem with Dr XXX [Consultant Psychiatrist] now. At first I thought he was using the wrong methods. The wrong sort of methods for heroin addiction. I mean [years ago] I was prescribed Thorazine for addiction. That’s an anti-psychotic drug. They just didn’t know.” (028)

In general, we observed that respondents receiving Methadone or Subutex maintenance reported positive benefits of the interventions. For example, some respondents had fairly long periods of abstinence from heroin or other opiates since commencing a maintenance programme. All of the 38 respondents on maintenance had reduced the frequency of injection. Several, for example, recalled that they had previously been injecting daily or several times daily whereas at the time of the interview were injecting a few times per month.

In some health board areas, we observed an apparent preference among some drug service staff for either Methadone or Subutex. Indeed one staff member told a respondent that Subutex was the “preferred substitute drug of choice” in that health board area. A preference for one substitute drug over another (indeed a blanket policy appeared to operating in some areas) was justified in terms of “clinical judgment,” which often failed to consider individual needs. For example, one male respondent who did not meet the study criterion of injecting in

the past 30 days, had been on Methadone maintenance in another jurisdiction for a period of several years. With clinical support in that jurisdiction, he had reduced his dosage to 65 mg per day. He reported that the intervention had worked well for him for several years and that he was pleased with his progress. Upon presenting for treatment in Northern Ireland, he was offered Subutex only with a two-week stay in an addiction unit while he detoxed from Methadone. He faced the dilemma of continuing to travel twice weekly to collect his prescription in another jurisdiction, or switching to Subutex. He had stabilised well for several years without any problems with Methadone. Why then would “clinical judgment” seek to change that? To us, it represented a risk for relapse and also presented ethical issues in terms of clients’ input into treatment decisions.

We interviewed four respondents who had switched from Methadone to Subutex and six individuals who had switched from Subutex to Methadone. A 33-year old male had been switched on four separate occasions for a total of five separate treatment episodes in two different locations, involving either Methadone or Subutex. Very little research has examined which substitute drug works best for particular individuals so that clinicians often lack guidance regarding the appropriate choice of substitute drug.

We did observe that some respondents on Subutex maintenance began to experience cravings in the early hours of the evening. A male respondent was on 10 mg of Subutex for three to four months but reported:

“It didn’t work for me. It did the job until 4 or 5 in the afternoon, then I got cravings real bad.” (021)

For some people, cravings and withdrawal appeared to be related to setting. For example, a female reported feeling no effects of withdrawal after being stabilised in an addiction unit. When she returned home, however, the withdrawal effects began to surface. She purposely avoided collecting her Subutex until late afternoon in hopes of preventing the effects of withdrawal at night.

One respondent had been on 8 mg of Subutex for approximately one year but reported that the dosage did not “hold” him. At the time of the interview he had been on Methadone for one year and had reduced his injection frequency from a number of times per day to once a month or less:

“Sometimes I’d go a month without using. Then I’d have a dig and feel bad. I’d wonder why I did it because with the methadone, you don’t get much effect [from heroin]. Waste of money.” (028)

Other respondents on substitute prescribing preferred Subutex to Methadone and some were adamantly opposed to Methadone:

Respondent: “I wouldn’t touch it. Offered it, but it absorbs into the marrow in your bones and it takes months, years to get out of your system.”

Interviewer: “Who has told you this?”

Respondent: "A doctor."

Interviewer: "Your GP?"

Respondent: "No, a doctor who was standing in for Dr XXX [Consultant Psychiatrist]." (137)

- **Daily collections of Subutex or Methadone.**

Daily visits to a pharmacy created problems for some respondents, particularly if they were seeking to find employment:

"I need to get a job. But I go to the chemist everyday [for Subutex]. What if the job's in Antrim? How am I going to get my Subutex?" (011)

A 31-year old male reported his interest in finding employment:

"It's too much hassle. I got a phone call, says would I like to have the job. I was interested. It started though at 8.00 in the morning and finished around 5.30. How could I get the script? I needed to be in town at 9.00 or 9.30 or else be back by 4.30 or 5.00. I need to find work that allows me to get my script." (028)

Some respondents lived far from the dispensing chemist, even though other chemists were located closer to their residence. One male travelled by bus six days a week to the pharmacy where he collected his prescription. He left on the bus each morning at 7.30 and returned to the town of his residence at 1.30 pm, a journey of about five hours each day. The return bus fare cost him five pound sterling each day, reduced because of his DLA eligibility. He reported that the drug service was actively trying to find a chemist located closer to his residence, and who was willing to dispense.

- **Lifestyle changes**

Substitute prescribing contributed to major lifestyle changes for a number of respondents. They were able to form new friendships with people who had never injected, or re-establish links with former friends who had never injected. One planned to go to a concert with new friends:

"I never would have done that if I was on the gear. Just didn't want to go anywhere or be with anybody." (028)

These new or "rekindled" social networks at times focused on alcohol use, a substance that was generally avoided when people were using heroin. A 28-year old male had been on Subutex maintenance for several months.

He reported that he was drinking four to five pints per night, several times a week largely because we interviewed him during football season. His lifestyle had changed tremendously since he started a Subutex programme. At the time of the interview, he was spending time with his former mates who had never injected. He noted that alcohol was consumed often within this social network. Regardless, he described how Subutex has allowed him to be trusted again by his friends:

“Now I’m running about with my mates, my old friends. That’s helped. I remember sitting there in the pub and XXX [male friend] ran out of money and gave me his card and pin number [to obtain money from the cash machine]. That’s the best thing – gaining back their trust. I was skipping down the road with that card.” (024)

Waiting Lists

The overlap of social networks of injectors creates a setting whereby information about treatment and changes in treatment policy travels quickly, unless individuals are unconnected to one or more networks of injectors. Several IDUs knew of respondents or had heard of respondents who were able to “bypass” the waiting list and receive quick entry to a detox programme. Some believed that the perceived “system” was unfair. In some health board areas, getting a place in detox was perceived to be the “luck of the draw.” However, we observed that individuals who had experienced severe depression or who had attempted suicide, were able to circumvent a waiting list and be admitted quickly. For example, a young male reported knowing several people who were waiting for a place in a detox setting. He noted that his girlfriend had become extremely depressed from using heroin and was found to be “curled up in a ball on the Thursday. She was in XXX [drug service] by Tuesday” (005). A female respondent had smoked heroin for years and injected heroin for the first time a week before she was interviewed. Two weeks later her friend had phoned the interviewer and stated that the female was “in a bad way.” The respondent was extremely depressed and reported being desperate for a place in the local detox facility. She had been given an appointment for the following week but told the researcher, “I don’t know if I’ll be here [alive] then.” She was suicidal and her GP had told her to ring a crisis response team if she had difficulties over the weekend. The interviewer made contact with the female at several points over the weekend; the GP never visited the house nor did he follow-up with a telephone call. The drug service, however, found a place for her in the local addiction unit a few days later. Some males also reported an immediate entry into an addiction unit after they had attempted suicide. Clearly these events prompt immediate access to drug treatment. We were surprised, however, at the lengthy wait to obtain access to services for other respondents.

The waiting list created problems for people because the desire for treatment can vacillate over brief periods of time. A female who had never been in treatment

reported that she was on the waiting list for placement in an addiction unit. Her male friend had already been through the programme:

Interviewer: "I heard there's a wait to get in there."

Respondent: "Yeah, sometimes six months. When addicts want treatment they want it now. They're ready now. They may not be ready in six months."

Interviewer: "So do they contact you and tell you when to come in? Do they give you some notice?"

Respondent: "They say, 'Come tomorrow, or come the next day.' You have to be ready to go." (032)

Outreach Services

Shortly after the interviews commenced, we observed that several respondents most of whom resided in areas outside of Belfast, raised questions or issues with us that often called for expertise from other professionals. For example, we were asked about treatment options, ways to access treatment, pregnancy and treatment, conditions of treatment, benzodiazepine withdrawal, housing, access to children, locations of needle exchange, and a host of other things. On most occasions we made contact with relevant experts after the interview concluded and then followed-up with respondents. At times we found ourselves in an advocacy role and we know that this role might have created pressure for some staff in drug services. Nevertheless, the expansion of our research role is indeed a "finding" of the study. That is, injectors were searching for information or support that for one reason or another was not accessible to them. This finding indicates a gap in services in that most if not all of these issues could be addressed through drug outreach.

Respondents in Belfast who had been in contact with drug outreach services reported very positive feedback. Outreach served as a gateway into treatment and provided other services as well. For example, some GPs refused to treat respondents once they disclosed their drug use. Outreach assisted in obtaining a new GP, a crucial link to health care and treatment. Additionally, respondents noted:

"That outreach team. Really sound. They helped me get on the Meth and I haven't been clean this long in years. And they help with these forms as well." (030)

"Outreach – brilliant so they are. Real respect for XXX [outreach worker]. They phoned me at the hostel, said, 'I'll be there in half an hour.' Couldn't believe it. In XXX [city in England] it'd be six months. Phoned my mum,

told her. I said, 'Can you believe they were there in a half an hour?' “ (033)

Regardless of whether Belfast respondents had been referred to the study by the Drug Outreach Team or by some other source, we failed to observe any negative feedback regarding drug outreach services in Belfast.

Self-detox and Other Methods to Get Clean

Some respondents had utilised various methods for self-detoxification, without the intervention of drug services. These periods of detox were described as being very difficult and people sought different means of motivation. A 25-year old male recalled his most recent detox episode:

“A friend of mine was going on holiday and there was a month left on the flat. He told me I could stay there. I had hit rock bottom. I locked myself in for a week – no food, no Valium. I turkey’d it out. A friend brought me hash and I slept for a half hour...I was reading two books: Junkie by William Burroughs was one. I don’t know what your politics are but I read about Bobby Sands. I figured if he could have that much discipline, starving himself for what he believed, going without food for so long, I could go without gear. That was real motivation for me.” (001)

After arriving from England, a male respondent attended drug services in Northern Ireland where he declined Methadone and Subutex:

“I don’t want a prescription drug. Meth is worse to come off than gear. Takes twice as long. And people are injecting the Subutex. I did it [detoxed] myself before. [This time] I was getting on the plane – had 200 pounds in my pocket and nearly didn’t get on. Thought I would go for a bag. But I’m here. Getting easier each day. You know that, ‘one day at a time’? That’s what I say every morning. Just want my life back. Used to have everything – mortgage, beautiful woman, car. Then found myself sleeping in a bin shelter. Blood everywhere from trying to find a vein. Thought, ‘How’d I get here?’ “ (033)

Most of the individuals who had moved away from drug user networks and associated lifestyles eventually relapsed. A 29-year old male recalled how he moved from his hometown to another town in which few users resided in order to “get away from the gear”:

“But you always come across a group [of users]. I don’t know what it is. Either they find you or you find them.” (019)

Getting clean was perceived as easier than staying clean. A male reported the difficulties of abstaining from heroin for one year:

“All I could dream about was heroin. It’s crazy. I don’t want to be on heroin but I’ve been on it so long my mind is fixated on it.” (104)

Relationships with General Practitioners and other Health Professionals

Nearly all respondents reported having a GP at the time of the interview. Some respondents had never disclosed their drug use to their GPs:

“I was doing great. And then he stopped the script. He [male partner] was helping me because I wouldn’t go to a doctor. I wouldn’t go to a doctor and say, ‘I’ve got a heroin habit. I need help.’ So he was giving me half of his. Whenever we had no diffs [Dihydrocodeine], we started the gear again.” (112).

Others reported that they were the first “addict” ever to be seen by their GP. A number of respondents reported having excellent relationships with their current GPs. However, several attempts had been made to find a doctor who understood drug dependence. Respondents recalled their relationships with their former GPs:

“He was clueless. He said to me, ‘Why do you choose to take heroin?’ He didn’t want any junkies.” (001)

A male reported:

“A GP [long-term family doctor] actually told me that it’s my problem and I should deal with it myself. That’s my family GP so a friend recommended [another] GP. Went and seen him. I had to convince him that I was serious about staying off heroin. I asked for Subutex, Valium. He had to go to Dr XXX [Consultant Psychiatrist] and ask if he could prescribe Subutex.” (104)

A few homeless respondents reported the difficulty in getting a GP without a fixed address. Others had given up hope:

“I have been to seven or eight GPs but they’re all the same. They can’t do anything for me. I’m fed up chasing GPs.” (008)

His previous GP had prescribed ten Dihydrocodeine, and reduced it each day:

“Would you believe what my GP told me? She said that I might as well keep using [heroin] because she can’t help me anymore.” (008)

A 31-year old male reported that his former GP tried to remove him from her list of patients:

"It was right after Dr XXX [Consultant Psychiatrist] had told me that the GPs were going to give the scripts out. Right after that, I got a letter from my doctor that she was striking me off. I don't know if it was a coincidence or not. I rang for an appointment and couldn't get one. Said I wasn't a patient after 30 days. Went to my key worker and he contacted the GP. Then she said she would keep me but I had to sign a contract saying I would not use any more. The thing was, I was going there as a heroin addict. I never tried to hide that. How could I sign a contract saying I wouldn't use again? Now I've got Dr XXX [a new GP]." (028)

Other respondents also reported being forced to sign contracts:

"They make you sign a form and all. Call it a contract or something. Now there's XXX [acquaintance], now he can be violent. But why do I have to sign it? They just don't trust junkies, even junkies who are trying to come off it. (035)

"I get DHCs from my GP. Made me sign a contract."

Interviewer: "What kind of contract?"

Respondent: "I had to say, 'I'm a heroin addict' and abide by the rules." (037)

Respondents described their experiences with other health professionals. A 28-year old male respondent recalled that he overdosed immediately after he injected heroin for the first time:

"My mates took me to Antrim Hospital A and E. That was 1995. That doctor came over, looked at me and said, 'Someone else can deal with him – I've no time for these boys.' Times have changed, yeah?" (024)

Several respondents had not been to a dentist in years, despite having problems with their teeth. A few used the School of Dentistry in the Royal Victoria Hospital. Some respondents who reported to us that they had hepatitis C noted problems when they disclosed this status to their dentist:

"Family dentist – he's been my dentist all my life. As soon as I got the Hep C I told him and he told me that he wouldn't treat me anymore. Had to go to Dr XXX in the Royal." (110)

LIMITATIONS OF THE RESEARCH

A potential problem can arise when researchers recruit IDUs from treatment settings. That is, agencies can act as gatekeepers and selectively refer their “best” clients to participate in a study. We also were interested in recruiting respondents who were not in contact with drug services. For these reasons we did not “advertise” through drug treatment venues until six months after the interviews commenced. In all, two statutory drug services referred clients to the study and staff within those agencies were most helpful (e.g., some made telephone contact with the researchers directly, while the client was in the venue). In particular it was found that respondents residing in the Northern Board were more likely than other respondents to be in contact with drug services at the time of the interview. We observed this pattern occurring both before and after April 2004, when substitute prescribing for maintenance purposes was implemented fully. We began to ask respondents in the Northern Board if they knew other IDUs who were not in contact with drug services there. Although respondents reported knowing some individuals who were not in contact with drug services, most stated that the majority of the experienced injectors known to them had been in contact with drug services in the board area. We are unable to determine whether the finding was due to the perceived benefits of drug services in the Northern Board or whether it was due to a methodological artefact.

A second limitation of the study is that it is based on cross-sectional data, i.e., data collected at one point in time. In some of our follow-up conversations with selected respondents we observed that some had made contact with drug services since the interview, whereas others were using more frequently or had relapsed. We feel that drug use patterns and lifestyles can change rapidly among some IDUs and that cross-sectional data are limited in their ability to measure change.

A third limitation concerns our inability to generalise to the wider population of injectors in Northern Ireland. Drug use is a sensitive topic and drug users represent a hard-to-reach population. For these reasons, random samples of IDUs are not possible, thus, it is not known whether the results of the study are generalisable to the wider population of IDUs in Northern Ireland. However, qualitative data are best suited for sensitive topics with a hidden population.

Finally, we often were unable to “count” the number of times that respondents had engaged in particular behaviours. We observed that several quantitative measures of behaviours generated confusion and at times, frustration, during interviews. We acknowledge, however, that persons who are in positions to influence drug policy often prefer quantitative data.

RECOMMENDATIONS

Recommendation 1: It is recommended that the DHSSPS develop additional ways to distribute information on all aspects of safer injecting to IDUs.

The findings indicate that many IDUs lack knowledge with regards to the risks associated with loaning and borrowing injecting equipment, particularly equipment other than needles and syringes. Although some respondents reported that they loaned and borrowed used equipment from one injector only, the practice was not necessarily reciprocated by the other injector, who often borrowed or loaned with other members of a social network. Additionally, many respondents were unfamiliar with the risks associated with flushing and re-using filters. A few respondents had participated in a safer injecting course and this approach should be expanded. Peer interventions might also be considered; these methods have been found to be effective in reducing some risk behaviours among out-of-treatment IDUs and crack cocaine users (Cottler et al., 1998).

Recommendation 2: It is recommended that the DHSSPS develop gender specific information on the risks associated with injecting dependency.

Some respondents in the study reported that they needed someone else to inject them, although the reasons for this assistance varied somewhat. Males who relied on others to inject them often did so because their veins had been damaged through injection and they were currently injecting in hard-to-reach areas, e.g., the neck, back of a leg. Females' reliance on others to inject them tended to result from having smaller veins (as opposed to damaged veins) or because they had little knowledge of the injection process.

Recommendation 3: It is recommended that the importance of regular testing with effective pre- and post-test counselling should be emphasized and that the list of venues where testing is conducted should be expanded.

Several respondents appeared to lack knowledge with regards to the need for regular testing for infectious disease. Slightly more than half of the respondents were certain that they had undergone antibody testing for hepatitis C. Others had never been tested for hepatitis C, B or HIV, or were confused about the type of test that was conducted.

Recommendation 4: It is recommended that outreach services be expanded to other areas of Northern Ireland, and that different strands of outreach are needed.

Several respondents requested information from the researchers, and most of the requests pertained to accessibility of services, issues relating to current treatment, or aftercare. These requests could easily be addressed through effective outreach. The data suggest that two strands of outreach are needed. One strand of outreach should focus on respondents who are not in contact with

services. A second strand should address issues relating to current treatment and aftercare.

Recommendation 5: It is recommended that some pharmacy-based schemes should offer a greater degree of privacy.

The study found that some individuals were greatly concerned about privacy and confidentiality in pharmacy-based exchanges. As a result, some respondents avoided using the exchanges and others used them sparingly. The equipment is contained in a “box” and boxes should be placed discreetly in carry bags.

Recommendation 6: It is recommended that the number of needles/syringes should be increased to 30 per visit, and that further incentives should be developed to encourage return supplies of used injecting equipment.

Several respondents reported venous damage that made it difficult to administer injections. Some people reported using several needles before a substance was injected properly. The findings also indicate that a number of people rely on secondary exchanges (from other people who utilise the exchange) because they are concerned that they will be identified as an injector. The data show that a limited supply of needles/syringes contributed to risk behaviours for infectious disease.

Recommendation 7: It is recommended that all staff in pharmacy-based exchanges, including counter employees who deal with customers, should receive training in the delivery of this service. Training must include issues pertaining to customer relations.

Although most respondents reported that they had established good relationships with staff in pharmacy-based exchanges, the data suggested a pattern of negative feedback regarding one exchange in particular. Negative feedback from staff contributed to further risk-taking among some respondents. The data indicate that customer relations in pharmacy-based exchanges have the potential for affecting public health.

Recommendation 8: It is recommended that the DHSSPS develop additional methods to distribute new injecting equipment to IDUs.

The majority of respondents generally injected with one or more IDUs. Among this group, most individuals tended to resist loaning or borrowing needles and syringes. However, the social setting in which injection occurs (e.g., semi-public spaces) as well as individual circumstances (e.g., withdrawal or the anticipation of withdrawal) contributed to greater risk. In many instances where respondents loaned or borrowed a needle/syringe, the practice occurred because new needles and syringes were not available. The data show that the accessibility of new needles/syringes is hindered by various structural factors, including limited hours of pharmacy-based exchanges, geographic locations of exchanges, caps

on the number of needles/syringes per exchange, difficulties in purchasing needles/syringes, perceptions about stigma and concerns about confidentiality (largely from other customers) in exchanges. Needle exchange represents one way to distribute new injecting equipment. However, the source is limited in its ability to reach injectors who were interviewed for this study.

Recommendation 9: It is recommended that the DHSSPS develop different forms of information, support and advocacy for IDUs.

The study found that several IDUs required information and advocacy and that without these services, relapse or continued risk taking are likely. On several occasions, the researchers provided very basic services that could easily be addressed through outreach. The information and advocacy provided by the researchers indicated a major gap in services. Although individuals who had been in contact with the South Belfast Drug Outreach Team reported very favourable outcomes, the Team is for the most part restricted to a particular area of Belfast and resources are limited.

Recommendation 10: It is recommended that the DHSSPS or other government body review the training material currently provided by the PSNI regarding injecting equipment and injecting risk behaviours for infectious disease. Based on this review of training material, additional training may be required with regards to the relationship between police practices and risk behaviours for infectious disease. Training should incorporate a multi-agency approach that seeks to develop better relationships between the police and drug services and between police and staff working in needle exchange schemes.

The study found that police practices, particularly in the Northern Board area, are at odds with public health initiatives in that the threat of arrest for possessing injection equipment contributed to risk behaviours among injectors. Staff in drug services from the Western Board also reported to us that similar police practices have been observed in that area.

Recommendation 11: It is recommended that interventions be developed so that IDUS can increase their knowledge of benzodiazepine dependence and withdrawal, and that further research is needed with regards to the use of benzodiazepines among IDUs.

The study found a high rate of benzodiazepine use among the respondents. Indeed, several respondents acknowledged their dependence on benzodiazepines. One potential danger of benzodiazepine use concerns their link with hepatitis C infection, particularly among women (Cottler, Meeks and Ben Abdallah, 2002). However, use of benzodiazepines is unlikely to change much within this group in the event that GPs are discouraged from prescribing. In the event of such a policy, respondents would most likely access the substances from drug markets which would pose other risks and fail to address the problem of dependence. The results from this study found that when GPs refused or

discontinued prescriptions for benzodiazepines, some respondents accessed the drug through illegal markets.

Recommendation 12: It is recommended that treatment modalities for cocaine and crack use are identified and implemented.

The study found high rates of lifetime and recent injection of cocaine or crack cocaine. Cocaine and crack cocaine injectors did so with greater frequency than heroin injectors. Currently, there are fewer treatment options for cocaine and crack users compared to opiate users.

Recommendation 13: It is recommended that the DHSSPS identify the prevalence of hepatitis B and C and HIV among IDUs in-contact and not-in-contact with drug services.

The protocol used by the Northern Ireland Unlinked Anonymous Prevalence Monitoring Programme should be expanded to include IDUs who are not in contact with services.³ Given an expansion of the Programme, it would be important to utilise various strategies to recruit hard-to-reach IDUs. The results from the present study indicate a very strong likelihood for an epidemic of hepatitis C virus among IDUs in Northern Ireland. Several findings support this conclusion: A) We did not ask people to share test results with us, however, of the 53 people who were certain that they had undergone antibody testing for hepatitis C, 30% reported that they were positive. B) Most of the IDUs engaged recently in the loaning and borrowing of injection equipment. C) Despite some or regular use of needle exchanges, respondents reported that accessibility to new needles/syringes was restricted at certain times or in particular settings. D) A number of male and female IDUs engaged in the behaviour of flushing. Elsewhere, the practice has been linked with hepatitis C infection (Abdala et al, 2004). E) Approximately half the sample had resided in or visited “high risk” locales where they had frequented with other injectors, and we believe that the history and nature of social networks is important in the transmission of disease. Additionally, some respondents had been in prisons with a number of other injectors. F) Several respondents appeared to lack knowledge with regards to the need for regular testing for infectious disease. Others had never been tested, were confused about the type of test that was conducted and a few were uncertain whether they had been tested. The data suggest that an epidemic is likely to occur first in the Eastern Board (primarily in the Belfast area), and then in the Northern Board. On average, respondents in the Eastern Board had been injecting for longer periods of time, were less likely to be in treatment, were injecting more often, and knew considerably more IDUs with hepatitis C compared to respondents residing in the Northern Board. Prevalence estimates of antibody hepatitis C with diverse groups of IDUs would assist with epidemiological monitoring.

³ The measures contained in the Monitoring instrument may need to be revised in order to increase the validity of self-reported “sharing.”

Recommendation 14: In communities where injecting drug users reside, it is recommended that drug outreach teams in conjunction with community workers should have on-going discussions about the nature of heroin addiction and the importance of treatment and needle exchange with identified informal “leaders” within those communities. This approach is particularly important in small towns and villages.

Injectors perceived that their behaviours are greatly stigmatised. In particular, respondents who reside in small towns, villages and rural areas voiced considerable concern that others knew of or would learn about their “injector” status.

Recommendation 15: Considerable work is needed to address the needs of women injectors. It is recommended that the DHSSPS adopt the recommendations in the Home Office report, *Women Drug Users and Drugs Service Provision: Service-Level Responses to Engagement and Retention* (Becker and Duffy, 2002).

Women with children were more likely than men to voice concern about being identified as drug injectors. They were more likely than men to avoid treatment, to avoid testing, and to avoid disclosing drug use to their GPs because of their concerns. We observed that the perceived community stigma was a factor contributing to further risk taking, and at times, relapse.

Recommendation 16: It is recommended that the time to avail of detox and treatment should be significantly reduced. Treatment on demand is the preferred goal although realistically, resources are unlikely to be available to meet this objective. Still though, all efforts should be utilised in order to reduce the waiting time to a 30-day period.

Several respondents residing in the Eastern and Northern Health and Social Service Board areas reported lengthy waits for placement in a detox setting. In most instances, the placement was required before maintenance could begin. In the Northern Board, respondents reported that the Addiction Unit had space for ten respondents only, and there was some confusion over whether the ten spaces were “reserved” for heroin users only. The number of detox “beds” is seriously limited in Northern Ireland.

Recommendation 17: It is recommended that an independent evaluation be conducted with regards to the effectiveness of drug services that have the potential to assist injecting drug users. The evaluation should incorporate the views of clients, staff, GPs and possibly other individuals.

Although some respondents reported that they benefited greatly from treatment services and that staff-client relationships were very good, several others identified negative experiences in treatment settings and these experiences shaped their current views about drug services. Moreover, views about drug services tended to vary across board areas. In particular, “blanket” policies in

which consultant psychiatrists refuse to prescribe a particular substitute drug (i.e., Subutex or methadone) to any client should be evaluated closely by the DHSSPS.

Recommendation 18: It is recommended that research explore the links among depression, initiation into drug use and injecting, and relapse.

During the initial interviews, respondents were not questioned about depression. The issue surfaced shortly thereafter and we then began to enquire about depression. A large number of respondents reported that they were in receipt of prescriptions for anti-depressants. Depression has been linked with risk behaviours for infectious disease (Lovell, 2002).

Recommendation 19: It is recommended that further interventions are needed to encourage condom use among IDUs. Encouraging change among long-term partners represents a significant challenge in terms of public health.

This study found that sexual risk taking was rare among long-term injectors; sexual interest or arousal had diminished over time, even when respondents were involved with partners over the course of several years. The length of the injection career, however, was associated with sexual risk taking. That is, several younger IDUs were involved with female partners who had never injected. In these relationships, most respondents reported having engaged in unprotected sex with one partner in the past 30 days.

Recommendation 20: It is recommended that the DHSSPS further develop ways to increase the accessibility of training among GPs. Training issues should include the nature of drug dependence, relapse and injecting behaviours.

Although some respondents reported having excellent relationships with their GPs, several others noted that GPs lacked knowledge about drug addiction or were unsympathetic. A number of respondents changed GPs on multiple occasions, eventually relying on drug services or outreach to locate an appropriate GP.

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APPENDIX

Questions asked and topics covered in the Interview Guide

1. Tell me about the first time that you injected (e.g., drug injected, age at first injection, place of first injection, number of people who were present and whether they all were injecting, relationships with people in the setting).
2. If someone injected you this first time, did you know the person? Were they a stranger, acquaintance, or friend?
3. What was the experience like for you? Prior to that experience did you think that you would ever inject a drug?
4. How soon after the first injection, did you or someone else inject you again? (IN DAYS, WEEKS OR MONTHS)
5. Tell me about the last time that you injected or that someone injected you. When did this occur? What drug(s) were injected?
6. The last time that you injected or that someone else injected you, were you by yourself? How many people were with you? Had you meant them all before that time? Did they all inject? If someone present did not inject, do you know whether they have ever injected?
7. If more than one person injected, how many needles were present? Were you the first to inject or did someone else inject first? What was the reason for that order of injection, that is, why did so-and-so inject first, and another person inject second?
8. Take me through the injection process. Describe it for me.
9. What drug(s) do you inject most often? Would this drug be your favourite or preferred drug? Tell me about that.
10. Think about the drug that you inject most often. I'm going to ask you 5 questions about this drug, and for each question I'd like you to choose one answer from the list of answers that I give you.
11. Do you think your use of _____ is out of control? (Never/Almost never, Sometimes, Often, Always/Nearly always)
12. Does the prospect of missing a fix or a dose of _____ make you anxious or worried? (Never/Almost never, Sometimes, Often, Always/Nearly always)
13. Do you worry about your use of _____ ? (Never/Almost never, Sometimes, Often, Always/Nearly always)

14. Do you wish you could stop using _____ ?
(Never/Almost never, Sometimes, Often, Always/Nearly always)
15. How difficult do you find it to stop or go without _____ ?
(Never/Almost never, Sometimes, Often, Always/Nearly always)
16. What other drugs have you injected? Have you injected more than one drug at the same time? If so, what drugs have you injected at the same time? Do you inject differently depending on what drug you are injecting? Tell me about that.
17. How many *times* have you injected in the past 30 days (that is, since _____ (SHOW CALENDAR) (NOTE THAT THIS QUESTION FOCUSES ON THE NUMBER OF TIMES RATHER THAN THE NUMBER OF DAYS)
18. In the past 30 days, how many different people have you injected with? (SHOW CALENDAR) Were these people friends of yours? A partner? Did you inject with any strangers or with people that you didn't know very well?
19. Do you often inject with this same group of people (or same person)?
20. Tell me about the different drugs that you have injected in the last 30 days?
21. In the past 30 days, how many *times* have you filled a syringe, and used it when it had already been used by someone else?
22. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)
23. In the past 30 days, how many *times* did you let someone else fill their syringe from one that you had already used?
24. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)
25. In the past 30 days, how many *times* did you draw up from a container, such as a glass or a cup, into which someone else had put a used syringe?
26. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)
27. In the past 30 days, how many *times* did you put a *used needle* into a container such as a glass or cup, that was then used by someone else?

28. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

29. In the past 30 days, how many *times* did you use a filter that someone else had already used?

30. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

31. In the past 30 days, how many *times* did *you* use someone else's rinse water?

32. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

33. In the past 30 days, how many *times* did someone else use *your* rinse water?

34. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

35. In the past 30 days, how many *times* did you let someone else use a filter that you had used?

36. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

37. In the past 30 days, how many times did you use the same water as someone else?

38. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

39. In the past 30 days, how many times did you use works that had been put in the same container as someone else's used works? What kind of container was this?

40. What was your relationship to these other people? (CIRCLE ALL THAT APPLY) (Sex partner, Friend not sex partner, Other relation, Acquaintance, Stranger)

41. Have you used the same needle more than once during the past 30 days? Did you ever attempt to mark it some way so that you would know that it was yours? Tell me about that.
42. In the past 30 days, have you cleaned any needle or syringe? (If so) About how often do you clean needles/syringes? Some of the time, all the time? Does cleaning depend upon who you are injecting with? How did you clean them or what did you use to clean them?
43. Tell me about “flushing.” What does the word mean to you? About how many times in the past 30 days have you flushed in the presence of other people who were injecting? Were others flushing as well? Think about the last time that you flushed in a group setting.
44. Have you ever used a needle exchange in N. Ireland? If so, tell me about that experience.
45. How many *times* have you used a needle exchange in the past 30 days (SHOW CALENDAR)
46. (Persons who have never used a needle exchange in N. Ireland) If you have never used a needle exchange in N. Ireland, why have you not done so?
47. Is a needle exchange a good way for you to get new needles? Is there any other way that you can think of that would help people get new needles?
48. In the past 30 days, from what other sources have you obtained new needles/syringes?
49. In the past 30 days, from what other sources have you obtained used needles/syringes?
50. Have the police ever found needles or other paraphernalia on you or in your home? Tell me about that. When did this occur?
51. Have you ever used benzodiazepines? Tell me about that. (Have you used benzodiazepines in the past 30 days? How often have you used benzodiazepines in the past 30 days? When do you prefer to use them? Are they prescribed? Why do you use them? How do you use them?)
52. Do you drink alcohol? How many days in the past 30 days have you drunk alcohol? (SHOW CALENDAR) In the past 7 days, how many days have you drunk alcohol? What was your daily intake?
53. In the past 30 days, how many times have you had sexual intercourse?
54. In the past 30 days, with how many *different* partners have you had sexual intercourse?

55. In the past 30 days, have you used a condom? (Try and get at the whether condoms were 1) always used, 2) sometimes used, or 3) never used. Try and note whether condoms are used with regular sex partners or other sex partners)
56. Do you have a GP?
57. Have you ever visited a GP to seek help for your drug use? If not, why not? If so, tell me how the GP responded.
58. Has a GP ever prescribed something to help you with your own drug use? If so, what drugs have you been prescribed? Did these drugs help you?
59. Tell me about how you and your GP (or previous GP) get on?
60. Have you ever read about or has anyone ever told you how to 1) inject correctly or safely? 2) reduce the risk of overdose? Was this person a friend, drug worker, GP?
61. Do you have a dentist? [If so] Do you visit on a regular basis and for what reasons?' Have you ever discussed your drug use with the dentist? [If so] How has s/he responded?
62. Tell me about your health. Have you had any health problems that might be related to drug use? If so, what do you do about these problems?
63. How do you feel about your own drug use? Do you feel OK about it? Would you like to reduce the amount that you use?
64. Have you ever attended a drug service or drug treatment agency in N. Ireland? When did this occur? Tell me about those experiences.
65. Have you approached some other service, agency, or organisation for help with your drug use? When did this occur? Tell me about that.
66. Are you in treatment now or are you attending a drug service now?
67. Would you like treatment now? Why or why not?
68. Have you ever been given methadone, Subutex, or Britlofex here? Tell me about those experiences. (Get at dosage, whether the substances were used for detox only or for maintenance)
69. I don't want to ask you about test results, but have you ever been tested for HIV? [If so] How many times? [If not] Why have you not been tested?
70. Have you ever been tested for Hepatitis C? If so: How many times? If not: Why have you not been tested?

71. Have you ever been tested for Hepatitis B? If so: How many times? If not: Why have you not been tested?
72. Have you ever been vaccinated for Hep B? (Did you complete the series of vaccinations?) Tell me about this experience.
73. How many injectors would you know in N. Ireland?
74. About how many injectors or friends of injectors in N. Ireland do you know who have HIV? Hepatitis C? Hepatitis B?
75. Gender of respondent:
76. What year were you born?
77. Employed?
78. Tell me about any education or training programmes that you have completed.
79. County of residence
80. County where from
81. Currently lives in: a large city, a small city, a town, rural location, other
82. Health Board
83. Do you live alone, or with other people?
84. How did you learn about this study?

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