

'No one likes using the dirties'

A study into the re-use of injecting equipment in Australia

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The Australian Injecting and Illicit Drug Users League (AIVL) is the national peak organisation for state and territory peer-based drug user organisations and represents issues of national significance for people who use or have used illicit drugs. Its mission is 'to promote and protect the health and human rights of people who use or have used illicit drugs'.

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Finally we would like to dedicate this report to people who inject drugs in the hope that our health and human rights are enhanced through the information shared in this report.

List Of Abbreviations And Glossary Of Terms

AIDS – Acquired immune deficiency syndrome

ATS – Amphetamine type stimulants

BBV – Blood borne virus

Bupe – Buprenorphine

Butterfly – Winged infusion set consisting of a plastic tube with a plastic 'butterfly' to give it stability and a needle tip attached to the end. Used mainly to inject larger amounts of liquid. In Australia they usually come with 25gauge or 23 gauge needle tips.

Dirties – Used injecting equipment, particularly needles and syringes.

'Done – Methadone

DUO – Drug user organisation

EAC – Expert Advisory Committee

Fit – Needle and syringe

Fitpack – Pack containing injecting equipment, usually a small number of 1ml syringes, alcohol swabs, cotton and sometimes sterile water.

HCV – Hepatitis C virus

HIV – Human immunodeficiency virus

ICE – Methamphetamine

IDU – Injecting drug user

Injecting equipment – Refers to any equipment used to inject drugs including but not limited to needles and syringes, alcohol swabs, cotton filters, water for mixing, different sized barrels, different sized needle tips, winged infusions sets, and wheel filters.

Larger barrels – Syringe barrels of 10ml size or larger.

NSP – Needle and Syringe Program

OST – Opioid substitution treatment

Peer – Somebody who is considered to share enough in common with members of a community to be identified as part of that community, in the context of this report, somebody with a history of drug use or a person who uses drugs.

PUD – Person/people who use drugs

PIED – Performance and image enhancing drugs

PWID – Person/People who inject drugs

STI – Sexually transmissible infection

Executive Summary

This report contains the findings of a peer-based qualitative research study into the re-use¹ of injecting equipment in Australia. It was undertaken by the Australian Injecting and Illicit Drug Users League (AIVL) who conducted the research between 2013 and 2015. AIVL was assisted in this study through the generous support and guidance of an expert advisory committee (EAC), all of whom have expertise in the area of hepatitis C and injecting drug use, and many of whom are key researchers within this field (refer to Acknowledgments for full details of membership of this committee).

The impetus for this research came from a growing frustration felt by drug user organisations (DUO) and others in relation to the consistently high rates of re-use of injecting equipment being reported in Australia over recent years (Iversen, Chow and Maher, 2014). This is despite relatively high levels of access to new injecting equipment (in comparison to many other countries). Re-using injecting equipment is a concern as it can increase the risk of transmitting and acquiring blood-borne viruses (BBV) such as hepatitis C and human immunodeficiency virus (HIV). It can also contribute to bacterial infections and poor vein health for people who inject drugs (PWID).

The best available data on the re-use of injecting equipment in Australia comes from the annual Needle and Syringe Program (NSP) survey.² This survey reports on the numbers of PWID amongst its sample who self-report re-use of injecting equipment in the month prior to the survey. It does not ask respondents about the reasons for re-use or identify specific risks that may have been associated with this re-use. The two key sources of data on injecting practices in Australia, the Australian Illicit Drug Reporting System (known as the IDRS survey) and the NSP survey elicit information from respondents on the nature of the relationship between those who are sharing equipment (such as close friend, partner). What this data does not do is delve into the questions that PWID may seek answers to in assessing their relative risk in relation to any sharing episode that takes place with close friends, partners etc. or any steps taken to clean the equipment.

AIVL considers this kind of information to be a crucial 'missing piece of the puzzle' if we are to effectively meet the challenge of reducing the rate of unsafe injecting practices in Australia. Therefore, this study seeks to explore further some of the specific decisions and practices involved when people report re-use or sharing of injecting equipment from their own perspectives. The findings presented here provide a useful expansion to the current data. They can assist us in the task of gaining a better understanding of the complex reasons behind the continuing practice of injecting equipment re-use in Australia. Importantly, this research adds the voices of drug users themselves to the examination of the issue.

1 A note on language. Throughout the paper we will use the term 're-use' of injecting equipment to refer to the re-use of one's own equipment and/or the re-use of equipment after another person has used the equipment – often referred to as 'sharing', 'borrowing' or 'receptive sharing' in the research literature. Where a distinction is necessary and needed we will highlight this and refer to sharing to distinguish between the use of one's own equipment and that of using another person's. More on the use of language will be covered later in the report in the Overview of Literature section.

2 The full title is the Australian NSP Survey National Data Report. The most recent is Iversen et al (2014).

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In 2014 the Australian Government released the most recent series of national strategy documents covering BBV in Australia. These five interconnected strategies include the National Hepatitis C Strategy 2014-2017 and the Seventh National HIV Strategy 2014-2017. They detail ambitious and necessary goals, objectives and targets for tackling BBV amongst PWID. Amongst these is the objective to 'reduce the risk behaviours associated with the transmission of hepatitis C' (Commonwealth of Australia, 2014, p. 8). One of the indicators is a reduction in the number of PWID who report re-use of another person's previously used needle and syringe. The findings of this report highlight that in order to achieve this we will need to go beyond merely increasing the volume of needles and syringes being distributed (which is necessary) and go further to provide access in ways that meet the needs of PWID .

AIVL recently held a National NSP Consultation Forum with PWID and stakeholders from each state and territory in Australia. The National NSP Consultation Forum found that there is 'a disconnect between the mode and timing of distribution and the needs of people who inject drugs' (AIVL, 2014). The findings in this report support this and outline a range of issues that impact upon the ability of PWID to access sterile equipment at the time they need it. These issues are often structural in nature and interact in complex ways with the individual circumstances of PWID. This report also highlights the varied and sometimes highly detailed strategies that PWID have developed in order to adapt to structural barriers and overcome obstacles to reliable access to sterile injecting equipment. Our research found a high degree of commitment to prioritising health and reducing harm within the community of PWID. Even within settings where one could argue that the structures enhanced the BBV risk (such as prison), PWID have developed approaches that are intended to reduce harm. Whilst this is heartening and admirable it is of concern that people who are often already marginalised by virtue of engaging in a highly stigmatised and illegal activity (in addition to any socio-economic or other disadvantages they may experience) are forced to develop and maintain what can be very precarious strategies in order to protect their health.

Despite having a significant number of focus group participants who identified as Aboriginal or Torres Strait Islander in our study we did not specifically aim to explore issues of re-use for this group of PWID. However, it is well acknowledged that Aboriginal people who inject drugs are vulnerable to a range of unique harms for reasons that continue to be poorly understood, documented and responded to (Kratzmann, Mitchell, Ware, Banach, Ward and Ryan, 2011). Although detailed analysis of issues relating to culture and ethnicity was not within the scope of this study, our findings indicate some particular issues for Aboriginal PWID. Analysis of our focus groups, for instance, suggest that further investigation of the impact of heightened surveillance and public harassment of Aboriginal PWID and the relationship between this and subsequent re-use of injecting equipment is warranted.

This study attempts to better understand some of the perceived challenges and strategies to overcome them from the perspective of PWID. With this information, we recommend ways we can move from analysis and discussion to real action that makes inroads into the objectives of the BBV strategies and contributes to enhanced health and well-being of PWID in Australia. This report highlights the need for policy makers and service providers to listen to the experiences of PWID in order to better understand the barriers standing in the way of PWID having access to sterile equipment for each and every injecting episode. This is a critical and necessary shift in emphasis and focus. After all, as is so clearly demonstrated throughout this report, and in the words of one of our participants, 'no one likes using the dirties'.

Introduction and Background

AIVL is the national organisation representing peer-based drug user organisations in Australia. This means we are run for and by current and former PWID. AIVL works to represent the interests of illicit drug users in order to improve access to health services and enhance their human rights. We do this by engaging in a range of activities. Amongst them is contributing toward the production of high quality research and knowledge on topics of importance to PWID.

A primary aim of AIVL is to contribute to national efforts to reduce the transmission, morbidity and negative social and personal impacts of hepatitis C, other BBVs and sexually transmissible infections (STIs) among people with a history of injecting drug use. Hepatitis C is a major public health issue in Australia. An estimated 230,000 people were living with the virus in 2012 (The Kirby Institute, 2014). Hepatitis C transmission in Australia occurs primarily through unsafe injecting practices. Indeed, current estimates are that approximately 90% of new infections of hepatitis C in Australia can be attributed to unsafe injecting practices such as the sharing of injecting equipment during illicit drug use. NSPs have been identified as central to the prevention of hepatitis C amongst PWID (Iversen et al 2013, Kwon et al 2009).

Despite the relatively high number of NSP in Australia providing free and low cost injecting equipment for drug use, PWID continue to report high levels of re-use of equipment in the annual Australian NSP survey (Australia's main bio-behavioural surveillance cohort study relating to injecting drug use). In 2013 for instance, 24 percent of respondents to this survey reported re-use of needles and syringes, 16 percent of respondents reported receptive sharing of needles and syringes and a further 33 per cent reported receptive sharing of ancillary equipment such as spoons and tourniquets (Iversen et al, 2014). These figures have remained relatively stable over the past five years and show no signs of shifting. Indeed AIVL is concerned that there is potential for under-reporting of re-use of injecting equipment in the current measures that are related to the stigma (real and perceived) and sense of shame that can be associated with admitting to the re-use of injecting equipment.

It is also worth noting that the language used to describe unsafe injecting practices varies. The literature uses a range of terms to refer to the re-use of injecting equipment with varying degrees of risk for the transmission of a blood born virus such as hepatitis C. Terms such as 'borrowing' and 'receptive sharing' can be used interchangeably and refer to the same practice, that is, the use of another's equipment after it has been used. 'Sharing of injecting equipment' can also refer to a practice of sharing a drug mix between two or more people using new needles and syringes and 'clean' equipment. This practice usually poses very low or no risk of BBV transmission or vein damage. 'Re-use' refers to the use of equipment on a second and subsequent occasion either by the original user of the equipment or by another person. The risks associated with re-use are not straight forward and are related to a number of variables including but not limited to the impact on the vein health of the person, the hepatitis status of the person prior to re-use, and the condition of storage of the equipment being used.

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AIVL believes that gaining a better understanding of the reasons for injecting equipment re-use is particularly important as the rate of reported 'receptive sharing', that is the use of a needle and syringe after it has been used by somebody else (the highest risk practice for BBV transmission) has not declined over recent years. This study seeks to get beyond the statistics and examine some of the reasons for the continued unacceptably high rates of injecting equipment re-use among PWID in Australia from the perspective of drug users themselves.

AIVL understands the 'risk' related to injecting drug use is contextual and relative. Injecting drug use does not occur in isolation but rather within a social, legal and historical context. We are keen to move away from de-contextualised individualised notions of 'risk behaviour' that belie the complexity of risk practices for PWID. AIVL was also interested to explore the possible role that drug of choice might play in such practices. There is some recent evidence that the type of drug injected may play a role in transmission rates for hepatitis C in Australia (Iversen, Wand, Topp, Kaldor and Maher, 2013). It is most certainly the case that the increasing popularity of pharmaceutical opioids and crystal methamphetamine (Stafford and Burns, 2014) is likely to have an impact upon the kind of injecting equipment used and therefore the ability to access suitable equipment for this purpose.

It is AIVL's hope that the information gathered together in this report will be used to inform future research, as well as NSP policy, service planning and the broader legislative and policy setting related to illicit drug use and BBVs in Australia.

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Approach to the study

AIVL is not a research centre or institute and has limited resources with which to undertake comprehensive and detailed research. We are, however, fortunate to have some staff who have a research background and most importantly, AIVL has unique access to PWID, the key 'informants' producing the main data of this study. Despite being the subject of many a research study PWID are often considered to be notoriously difficult to access due to issues related to marginalisation, stigma, discrimination and criminalisation (Benoit, Jansson, Millar and Phillips, 2005). There are barriers between the researcher and subject (real or perceived) that are difficult to overcome in the often short space of time during which research studies are conducted. This can impact the quality of research findings.

A unique aspect of this study is that it was conducted in its entirety, apart from some members of the EAC, by peers of those being researched. This includes the development of the research questions, the facilitation of focus groups, the data analysis and the final write-up of this report. Therefore, to a large degree the divide between 'researcher' and 'researched' was minimised. We believe this to be significant due to the fact that research is very rarely conducted by peers of the subjects of the study, even less frequently when those peers are current or former injecting drug users. We also believe the perspective peers bring to the research and analysis process is qualitatively different and enables access to different kinds of data that may not otherwise be afforded a similar research project conducted by non-peers.

Research Questions and Methodology

The results presented here are based upon data derived from eight focus groups held across Australia with a total of fifty injecting drug users. It was decided that a qualitative research approach best suited this study as we wanted to go 'beyond the statistics' on re-use of injecting equipment. Qualitative approaches are often able to explore topics in more detail and depth and allow for an increased level of flexibility and adaptation throughout the study. As we were keen to hear from drug users themselves in their own voice what they had to say about re-use of injecting equipment and to allow participants to focus on the topics that they felt were of importance, we decided not to collect data via a survey or questionnaire. These methods, whilst having the benefit of increased confidentiality and flexibility in relation to their completion, do not readily allow for exploring responses in great detail nor do they allow the researcher to follow-up on topics raised for further exploration. It was decided therefore that focus groups would best suit this study. In-depth interviews were also considered as they offer some advantages over focus groups. However, resource and time limitations lead AIVL to choose a focus group method for data collection.

Three focus groups were held with PWID in Canberra – one with heroin injectors, one with people who injected methadone or buprenorphine and one with a group of people who injected amphetamine type substances (ATS) (including ICE). Two focus groups were held in Perth – one with people who injected ATS and a small group of people who inject performance and image enhancing drugs (PIED). Two focus groups were held in Sydney – one with people who inject methadone or buprenorphine, and one with a group of people who had injected drugs in prison. The final focus group was held in Hobart with a group of people who injected ATS. The data was collected over a nine month period from March 2014 through to November 2014.

Participants were invited to complete a demographic sheet anonymously collecting information on gender, age, employment and cultural background. Whilst there was no specific effort made to recruit a particular cohort of PWID we were interested to gather this information with a view that it might yield some useful data to be considered alongside other aspects of the research. Not all participants filled in their details and not all participants completed all aspects of the demographic sheet.

AIVL completed an in-depth consultation and planning phase conducted with the EAC prior to commencing the research proper. Out of this process came the main research question:

- From the perspective of PWID, what are the reasons for the continued unacceptably high rates of injecting equipment re-use in Australia?

Two sub-questions were developed for use in the focus groups to elicit responses that were used to inform analysis of the research question. They were:

- What kinds of things would lead you to lend/share injecting equipment with somebody else and/or re-use your own?
- Is there anything about injecting (insert drug of focus) that you think makes sharing/lending/re-using more likely?

This second question was developed to enable the study to explore the impact that drug of choice and type of equipment used might be having upon re-use and sharing practices among PWID.

One of the focus groups focused on participants who had previous experience of injecting whilst incarcerated and in this group the second of the two sub-questions was modified to read:

- Is there anything about injecting in prison that makes sharing/lending/re-using more likely?

A review of the literature was undertaken and this was sent out for review by the EAC in late 2013.

Early in 2014 planning and preparation for the focus groups commenced, informed by the review of literature and subsequent feedback provided by the EAC. It was decided to keep the focus groups small (no more than 8 to 10 participants) to enable sufficient 'air space' for all to participate and for ease of later transcribing and analysis of the data. Small(er) groups also have the benefit of providing a level of intimacy which can be beneficial when discussing topics of a personal, intimate or 'taboo' nature. All focus groups were recorded and professionally transcribed. All of the groups were facilitated by two AIVL staff members involved with the project apart from one in Perth where for unavoidable reasons the group had one facilitator. The final focus group was conducted in November 2014 in Hobart.

Analysis of the completed transcripts began in late 2014 and continued through to February 2015. Despite this, an iterative process of data analysis commenced as soon as data was being collected as particular concepts, themes and ideas raised in focus groups were fed into subsequent groups. Two AIVL staff members read through the completed transcripts identifying and noting themes separately. A series of meetings were held to discuss and refine these themes and to develop loose categorisation of these. These meetings also helped to 'test' out the analysis and to triangulate the findings. The involvement of peers in the research and analysis process required careful reflection not only upon the benefits of 'insider' knowledge (of which most researching this topic lack) but also the need to regularly check for the influence of bias brought about by the researchers own perspective and personal experience.

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The table below sets out the demographic information obtained from the focus group and the participants. Where gaps are indicated the information was not available.

Focus Group location	Canberra	Canberra	Sydney	Sydney	Perth	Perth	Hobart	Canberra
Drug of choice or setting	ATS	OST	Prison experience	OST	ATS	PIED ATS	ATS	Heroin
Total number of participants	5	9	9	8	-	3	11	10
Age range	-	28 – 55	24–45	26–60	-	-	25–43	27–68
Average age	-	40	34	45–	-	-	-	44
Gender	3 men 2 women	6 men 3 women	4 men 3 women 1 transgender	2 men 3 women 1 transgender 2 androgynous	-	2 men 1 woman	7 men 4 women	5 men 5 women
Cultural background/identity	All identified as Aboriginal	-	2 Aboriginal 1 Maori 1 Tongan 2 Anglo-Aust 1 Philippines	-	-	-	-	1 person identified as Aboriginal 9 people identified as Anglo-Aust
Employment status	All unemployed	Most unemployed or studying. One in part-time employment	All unemployed	All unemployed	-	All employed	All unemployed apart from one who was employed as a nurse	All unemployed

Table 1: Demographic Information: ATS – Amphetamine type substances, OST – Opioid substitution treatment, PIED – Performance and image enhancing drug

Ethics

As a small peer-based not-for profit organisation, AIVL does not have a formal requirement to gain ethics approval through a particular body or process and does not have a direct relationship with a Human Research Ethics Committee (HREC) as would be the case within a university for instance. Despite this, AIVL prioritises the need to adhere to rigorous ethical standards in relation to all research conducted with PWID. To this end AIVL consulted with members of the EAC, a number of whom are currently working within national research centres and institutes that have their own formal ethics committees (often within Universities). The EAC provided input into developing suitable ethical processes for the study informed by their knowledge of the standards to which similar work would be held for formal ethics committee approval. It was agreed that submitting AIVL's proposal to an external research ethics committee would provide no additional benefit to the potential outcome of the research findings nor would the participants be disadvantaged by AIVL having not done so. Additionally, submitting to such a process may present significant delays and other difficulties that may unfairly disadvantage the viability of the research. AIVL therefore opted not to seek formal research ethics approval but rather to use AIVL's own internationally regarded 'National statement on ethical issues for research involving injecting/illicit drug users' (AIVL, 2002) to provide the overarching ethical framework and guidance for the project. This document covers a range of topics of particular relevance to research conducted with PWID such as consultation and consumer involvement, confidentiality in storing and managing data, uses of research data and consent.

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All participants were required to sign a consent form and were provided with an information sheet describing the nature of the study, outlining the processes in place to maintain confidentiality and the offering the opportunity to be provided with the results of the study if requested (see appendix for a copy of this). Participants were paid \$40 in cash for their time and expertise. Whilst there is some debate regarding the use of cash payments for marginalised research participants – especially PWID, we agree with Maher (2010) and Brogan (2010) who observe that often these hesitations are the result of stereotypes and misinformation regarding the perceived 'negative' impact of providing cash payments to PWID. Chief among the concerns is the perception that the money will be spent on illicit drugs. Apart from the fact that we believe it reasonable that participants should exercise agency and make their own choices regarding their spending priorities, there is good evidence that this concern is unfounded (Festinger, Marlowe. Dugosh, Croft and Arabia, 2008). We consider that a cash payment is ethically appropriate on the grounds of equity. PWID, like other research participants, incur opportunity costs when participating in research. We also view the provision of a cash payment as more analogous with receiving a salary or wage in return for the contribution of skills and knowledge.

Recruitment

Recruitment for the focus groups was undertaken by AIVL in collaboration with a number of AIVL's state and territory peer-based member organisations and Anglicare Tasmania. A recruitment flyer was displayed at drug user organisations, needle and syringe program (NSP) outlets and was distributed via peer networks. Word of mouth also proved to be an effective method of recruitment for some of the focus groups. The majority of the focus groups were held on the premises of a drug user organisation (DUO) or a NSP. Two were conducted at a nearby community space hired specifically for this purpose. These factors may have had an impact upon the demographic profile of the participants however we have no way of ascertaining this. The method of recruitment was chosen both mainly on the basis of convenience and in order to increase the likelihood of reaching participants. With more resources and time additional methods are likely to have been employed. The decision to hold the Focus Groups in the states that were chosen was made on the basis of convenience, best use of limited resources and also the desire to, as much as possible, enable exposure to differing settings.

Limitations and Obstacles

The AIVL study 'No one likes using the dirties': A study into the re-use of injecting equipment in Australia, was a relatively small study undertaken with limited resources. Recruitment for the PIED group proved challenging and resulted in less numbers in this focus group than the others. The addition of in-depth interviews perhaps would have allowed for deeper exploration of topics for which there may have been some reluctance to share in the larger group, however, is it difficult to ascertain to what degree this impacted the detail of the discussions. Despite the relatively large numbers of participants involved for a study of this nature, we cannot generalise from these findings to the broader population of PWID. In particular it is noted that despite considerable diversity in cultural background, sexuality and gender, most participants were unemployed. With additional recruitment strategies and with the use of in-depth interviewing we may have been more likely to access a broader range of PWID including those working full-time.

An Overview of the Literature

The hepatitis C virus (HCV) is a blood borne viral infection primarily transmitted through exposure to hepatitis C contaminated blood during injecting drug use (Edlin and Carden, 2006). As one of the most commonly notified communicable diseases in Australia, HCV is a major public health epidemic. Chronic hepatitis C (CHC) infection can cause serious liver disease such as cirrhosis of the liver and liver cancer (Lavanchy, 2011). It is estimated that some 310,000 people were exposed to HCV in Australia in 2013 with an estimated 230,000 people living with CHC including 80,000 with moderate to severe liver disease (The Kirby Institute, 2013).

Existing surveillance systems in Australia do not currently provide sufficient data to accurately monitor HCV incidence. Current estimates suggest that the incidence of new HCV infections declined between 2009 and 2013. However the rate of new infections remains high with an estimated 6,000 – 10,000 new infections per year (The Kirby Institute, 2013). People who inject drugs (PWID) are the population most at risk of contracting and transmitting HCV (Maher et al., 2006, Edlin and Carden, 2006). Available evidence shows that at least 80 percent of existing infections and over 90 percent of all new HCV infections are transmitted through the sharing of injecting equipment (Kwon et al., 2009, Wagner et al., 2011, Alavi et al., 2013, Robaey et al., 2013, Iversen et al., 2013, Doerrbecker et al., 2013).

The population of PWID in Australia is estimated at between 75,000 and 250,000 (Aceijas et al., 2004, Mathers et al., 2008). However, AIVL notes that this estimation is now considerably out of date and relies upon modelling based predominantly on opioid user's. At this point in time no accurate data exists on the number of PWID in Australia. Estimates of HCV prevalence among Australian PWID vary from 41% to 68% (Nelson et al., 2001, Aceijas and Rhodes, 2007). Recent longitudinal cohort studies in Sydney and Melbourne provide more evidence for the incidence and prevalence of HCV among PWID. HCV incidence among hepatitis C negative people who inject drugs enrolled in the Hepatitis C Incidence and Transmission Study – community (HITS-c) in Sydney was 10.2 per 100 person years in 2009 and 8.5 in the years 2011 – 2012 (The Kirby Institute, 2013). Prevalence of HCV among participants in the Melbourne injecting drug user cohort study (MIX) showed that 182 participants (52%) had current HCV infection and 78 (22%) a previous infection (O'Keefe et al., 2013).

PWID experience high rates of imprisonment due to the illegal nature of some drug use, and the crime sometimes associated with drug use. Almost half of Australian prisoners report a lifetime history of injecting drugs (Butler et al., 2011) and HCV infection is very common in Australian custodial populations, with a seroprevalence of up to 80% (Butler et al., 2011, Butler et al., 2007). New initiates to injecting drug use, culturally and linguistically diverse Australians, women and Aboriginal and Torres Strait Islanders are also disproportionately affected by HCV (Maher et al., 2007, Maher et al., 2004, Miller et al., 2009).

HCV cross-transmission between PWID is mainly associated with sharing needles and syringes (Hagan et al., 2001, Edlin and Carden, 2006, Koester et al., 2005, Gossop et al., 1997). HCV contamination of injection equipment may occur at various stages of the drug preparation process, which involves multiple steps and different pieces of equipment (Pouget et al., 2012). While it is commonly stated that risk of HCV infection through shared ancillary equipment (such as cookers, filters, water, and water containers) is similar to that of shared syringes, in-depth investigations of risks associated with sharing this ancillary equipment is inconclusive. Given that the sharing of injecting paraphernalia among PWID is common, recent reviews find that HCV transmission through this route could be contributing to the growing healthcare burden associated with this chronic disease (Corson et al., 2013). However, the evidence to demonstrate that the provision of sterile ancillary equipment reduces HCV transmission or modifies injecting risk behaviours is currently limited by an insufficient volume and quality of studies (Gillies et al., 2010, Corson et al., 2013, De et al., 2008). Further research is needed

to establish the contribution of shared ancillary equipment to the spread of HCV, and the effectiveness of services providing sterile paraphernalia in preventing infection.

Over the past two decades in Australia and internationally, the successful implementation of harm reduction programs such as blood-borne virus education and needle and syringe programs has led to a decline in the prevalence of needle and syringe sharing (Turner et al., 2011). Still, sharing of injecting equipment (needles, syringe and other injection paraphernalia) persists and contributes to continuing high transmission rates (Hagan et al., 2001, Pouget et al., 2012). For example, according to the most recent Australian NSP Survey the proportion of respondents reporting re-use of needles and syringes (including one's own) in the preceding month was 24% (Iversen and Maher, 2014). Sixteen per cent reported receptive sharing of needles and syringes and 33% reported receptive sharing of ancillary equipment. Of concern is that reported receptive sharing of needles and syringes increased from 12% in 2010 while receptive sharing of ancillary equipment has also risen again from 25% (Iversen and Maher, 2013).

The Sex in Australia study found that among people who had injected in the past year, 12% had shared needles and 43% had shared other paraphernalia (Grulich et al., 2003). Evidence from the Illicit Drug Reporting System (IDRS) survey indicate that at least 7% of participants had 'borrowed' a needle or syringe from another person (that is, used a needle and syringe after someone else, or receptive syringe sharing) and 11% of participants had 'lent' a needle and syringe (i.e. used a needle and syringe and then passed it onto another person) (Stafford and Burns, 2014). Twenty four percent of participants reported 'sharing injecting equipment' with another person ("equipment" is denoted in the study as being one or more of the following: spoons, water, filters, tourniquets, swabs, and wheel filters). IDRS participants were also asked about re-use, 40% reported reusing their own needle and 65% reported reusing their own injecting equipment. Like the IDRS, the National Prison Entrants' Blood-borne Virus and Risk Behaviour Survey (NPEBBV&RBS) found that 8% of participants who injected drugs reported use of unsterile injecting equipment in the last month.

The significantly different rates of sharing between the ANSPS (14%) and Sex in Australia (12%) in comparison to the IDRS survey (7%) and NPEBBV&RBS (8%) is noteworthy. This may be a product of the fact the IDRS and NPEBBV&RBS surveys are interviewer administered whereas the ANSPS is self-administered by respondents and the sex in Australia survey employed computer assisted telephone calls. Indeed, assessment of reported risk behaviours among PWID shows that those who receive assistance completing a survey (as opposed to survey self-completion) are less likely to report re-using a syringe after someone else (White et al., 2007). Self-completion of risk behaviour questionnaires should be considered as an alternative to interviewer administered questionnaires to maximise accuracy of self-reports.

Less data are available on the sharing of ancillary injecting equipment. One Australian study shows that of intimate partnerships where injecting occurred, 65% shared ancillary equipment in the last month (Bryant et al., 2010a). Similarly a survey of PWID who access injecting equipment at pharmacies reported high rates of sharing tourniquets (24%), spoons (43%), filters (22%), and drug mix (16%) (Thein et al., 2003). Despite the inconclusive evidence around the risk of sharing ancillary equipment, access to not only new needles and syringes, but ancillary injecting equipment is important for sterility.

While PWID continue to report sharing and reusing injecting equipment and HCV incidence remains high, strategies for reducing equipment sharing and re-use are needed. Evidence suggests that the per-event risk of HCV infection is small (Boelen et al., 2014) and thus strategies to reduce HCV transmission should include reducing the number of sharing events and reducing the per-event risk (e.g., provision of clean equipment and other decontamination strategies). In order to affect the sharing behaviours of PWID there needs to be an improved understanding of the reasons for injecting equipment sharing and re-use.

'No one likes using the dirties'

A study into the re-use of injecting equipment in Australia

This literature review aims to provide an overview of available research in relation to sharing and/or re-use of needles and syringes and other injecting equipment. The purpose of this review is to identify key issues in relation to the research topic and to refine the research questions and methodology for the "AIVL Re-Use of Injecting Equipment Study".

The research used as the basis of this literature review is derived from a variety of disciplines including epidemiological, clinical, medical and social research. Peer-reviewed journal articles, national surveillance reports and relevant grey literature have been included. Literature was reviewed for key insights into the reasons PWID share and re-use equipment, blood borne virus and safer injecting knowledge among PWID, social and contextual mediators of injecting behaviour and barriers to safer injecting behaviours. Sharing of injecting equipment has been a topic of interest in research for over 20 years with an early focus on HIV, rather than HCV. This review focuses on contemporary literature, emphasising that which is most relevant to HCV transmission in Australia, as well as including relevant international research and literature from the HIV field.

It should also be noted that the majority of the existing research has been conducted in higher income countries and contexts. It is therefore unlikely the same themes and issues would automatically apply or have relevance for other geographic, economic, social and cultural contexts, especially resource constrained and politically volatile environments with little or no access to sterile injecting equipment or NSP.

Risk Knowledge

Current research from Australia and elsewhere indicates that many PWID possess knowledge and an awareness of HCV, and therefore choose not to share injecting equipment with others (Ross et al., 1994a, Smyth and Roche, 2007). Education and safer injecting interventions, such as counselling, testing for HCV and information about needle and syringe programs, have also been shown to reduce sharing of equipment (Bailey et al., 2007), suggesting that increased knowledge about safer injecting practices help to reduce HCV among PWID.

Still, evidence suggests that confusion and uncertainty concerning HCV persists. PWID often do not fully understand HCV transmission risks or medical implications of infection (Rhodes et al., 2004). In particular, Australian literature suggests that it is common for PWID to be confused about the meaning of HCV antibody test results (Aitken et al., 2002b, Gidding et al., 2011, Grebely et al., 2011, Treloar et al., 2012). Young PWID and new initiates are also shown to have lower BBV knowledge. Data from New South Wales (NSW) shows that HCV knowledge is lower among younger PWID and that this poorer knowledge is related to increased sharing of injecting equipment (Bryant, 2013). Poorer knowledge is also associated with lower education attainment and unemployment (de Wit et al., 2014).

Perceptions of Risk

Much of the epidemiological data on PWID examines perceptions of BBV risk. Commonly, survey data shows that PWID rationalise the risks involved with sharing injecting equipment i.e. 'it won't happen to me', or underestimate the consequences of HCV infection. For example, a survey of PWID who collect equipment from pharmacies in Western Australia shows that respondents did not see themselves as highly susceptible to HCV and did not believe HCV was a severe condition (Wilson and Bryant, 2010).

While many studies focus on recording individual acts of equipment sharing, this approach is not able to elucidate the social context of risk behaviours for PWID. In some instances PWID will take actions to reduce the risks of contracting BBVs while still choosing to share injecting equipment such as cleaning used equipment (Burt et al., 2009, Hellard et al., 2004,

Rhodes et al., 2005, Ross et al., 1994a, Smith et al., 2013). That is, the injecting practices that a person might engage in one circumstance can change across environments and injecting partners (Unger et al., 2006). Research reveals that equipment sharing is not a random practice but rather, it is shaped by context, individual beliefs and social relationships. This literature is discussed further below.

Risk Management

Research suggests that the 'risky' practices of PWID vary within and between individuals and that individuals also regularly engage in protective practices (McGowan et al., 2013). In particular, sharing injecting equipment has been discussed in the literature as a selective and strategic act designed to minimise risk, reflecting an individual's perception of whom they will share with and who they identify as being too risky to share with (Valente and Vlahov, 2001, Loxley and Ovensen, 1995, Rhodes et al., 2004). For example, research from the USA shows a tendency to share injection equipment with a partner of like HCV status (Burt et al., 2009). Among participants sharing injection equipment, 39% reported that they had intentionally shared injection equipment with a partner based on knowledge of their concordant HCV status. Described by Smith et al (2013) as 'sero-sorting', PWID will often manage BBV risk in circumstances involving close friends and/or sexual partners where hepatitis C status is known or assumed, and where those with a positive status will use injecting equipment after people who believe they are negative, possibly reducing the risk of contracting the virus.

Cleaning needles/syringes is an important second-line harm reduction strategy associated with risk management. Little evidence on cleaning of injecting equipment is available in Australia. One qualitative study in south-west Sydney indicates that cleaning and re-use of needles/syringes is common (Nathani et al., 2010). While all participants reported cleaning and reusing only their own equipment, none of the techniques demonstrated would have been sufficient to deactivate human immunodeficiency virus (HIV) or hepatitis C virus. 'In Hot Water' (Australian Injecting and Illicit Drug Users League (AIVL), 2009), a national consultation and research report, it was found many PWID will attempt to clean their own used injecting equipment when new equipment is not available to them. While the reasons for cleaning are very important and need to be addressed (particularly barriers to accessing sufficient new injecting equipment), it is equally important to ensure that PWID have access to safe, effective, definitive messages, and a means of practicing the most effective way to clean used injecting equipment should the need arise.

Research also highlights a number of issues that mitigate BBV risk management for PWID. Risk management via 'sero-sorting' is potentially less relevant in intimate partnerships. One Australian study found that couples with discordant HCV status were no more or less likely than those with concordant status to share needles or ancillary injecting equipment (Bryant et al., 2010a). Indeed, sharing of equipment is most common in intimate relationships (Cao and Treloar, 2006, National Centre in HIV Epidemiology and Clinical Research, 2007). Risk management can also be compromised when the individual is "hanging out" in drug withdrawal thereby feeling the need to inject quickly (Habib, 2003, Ross et al., 1994b). International research suggests that risk management can be negatively impacted by social determinants, particularly depression and previous experience of sexual abuse, both of which have been found to be associated with receptive syringe sharing (Strathdee et al., 1997).

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Younger Age Groups

Although they make up a small proportion of the current PWID population, younger PWID remain an important group for prevention and harm reduction. Research identifies the importance of targeting harm reduction interventions for younger initiates to injecting drug use. Young and/or new injectors are at high risk of HCV infection. Highlighting the susceptibility of new injectors to HCV, one Australian study found that up to 31% of PWID who injected for 1 year or less were HCV antibody positive, as were 53% of those who injected for 2 years or less (Miller et al., 2009).

Evidence suggests that young Australians who inject drugs possess low knowledge of HCV (de Wit et al., 2014, Bryant, 2013). Younger PWID have also been found to engage in high-risk injecting behaviours and that initiation to injecting drug use is often marked by a significant risk period characterised by unplanned events, formation of injecting partnerships, reliance on third-party assistance and the sharing of injecting equipment (Crofts et al., 1996, Roy et al., 2002, Hahn et al., 2002, Bailey et al., 2007). One study from NSW compared 18–25 year old PWID with those aged 26 years or older and found that young respondents engaged in riskier injecting practices than their older counterparts, with a higher proportion reporting that they shared needles and other injecting equipment (Bryant, 2013). Moreover, those young PWID who had shared equipment did so in a more risky manner than older respondents by sharing with a larger number of people and with people who were possibly less well-known to them, such as casual sex partners. Peer norms are thought to be especially salient in shaping the drug use practices of adolescents and young adults (Bailey et al., 2007, Hawkins et al., 1999, Thiede et al., 2007).

Research also suggests that sharing of equipment reduces with age. Using 11 years of a repeat cross-sectional study of sentinel samples of regular PWID Australian research examined the relationship between age and receptive needle sharing (past month) (Horyniak et al., 2013). As participants aged, there was a significant reduction in needle sharing suggesting that older PWID report significantly lower levels of high-risk injecting practices than younger PWID.

Aboriginal and Torres Strait Islander People

The small amount of literature available on Aboriginal and Torres Strait Islander PWID suggests high rates of sharing in some regions of Australia (Kratzmann et al., 2011). Reflecting rates similar to the national averages, an Adelaide-based study found that 12% of the sample reported using a syringe after use by someone else in the past three months (Holly and Shoobridge, 2004). Other surveys, in other regions of Australia, found higher rates. In rural South Australia, 28% of respondents reported sharing equipment in the past 12 months (Shoobridge et al., 2000). In Western Australia, 43% of Aboriginal and Torres Strait Islander PWID interviewed reported that they normally re-use injecting equipment (Gray et al., 2001). Similarly, of those who lived in the Brisbane metropolitan area and who had injected an illegal drug in the past 12 months, 39% reported that they had shared a needle in the past month (Larson et al., 1999). The rate of sharing among Brisbane Aboriginal and Torres Strait Islander PWID was even higher for participants aged under 20 years old with 63% reporting sharing in the past month.

In a recent paper describing patterns of injecting drug use and BBV-related risk practices among Australian Aboriginal and non-Aboriginal PWID, Aboriginal participants were more likely to share ancillary equipment (64.9 vs. 44.8 %) and less likely to know about BBV transmission (72.0 vs. 87.7 %) (Paquette et al., 2013). Aboriginal participants used services such as BBV testing and drug treatment at a comparable rate to non-Aboriginal participants however the findings suggest that Aboriginal PWID are at greater risk for acquiring BBV.

Despite a persistent notion of a 'culture of sharing' believed to occur among Aboriginal and Torres Strait Islander PWID, this has not been found in qualitative studies (Kratzmann et al., 2011). Authors note that they have not found evidence for a cultural value of sharing impacting on injecting practices (Gray et al., 2001, Holly and Shoobridge, 2004). Like the broader population of PWID, Aboriginal and Torres Strait Islander PWID largely re-use injecting equipment with a partner or within other close relationships (e.g. siblings) (Gray et al., 2001, Coupland et al., 2005).

Social proximity, intimacy, sex and networks

Research shows that sharing and re-use of injecting equipment is often patterned and influenced by social relationships. Research in Australia and elsewhere shows that higher levels of sharing and re-use is often associated with close social relations such as friendships, romantic ties and family connections between injecting partners (Rhodes et al., 2004, Sherman et al., 2001, Loxley and Ovenden, 1995). The extent to which people are connected to networks of other PWID (Miller and Neaigus, 2001, Koester et al., 2005, Lakon et al., 2006, De et al., 2007) and the nature of the relationships that they have with them can be determinant of needle sharing practices (Sherman et al., 2001, Valente and Vlahov, 2001, Loxley and Ovenden, 1995, Rhodes and Quirk, 1998). Within social networks, the more non-injecting friends someone had (or friends that did not share injecting equipment), the less likely they were to share injecting equipment (Sherman et al., 2001). For example, injecting couples in NSW were less likely to share needles with each other if they reported a low-to-moderate connection with drug using networks (Bryant et al., 2010a).

Risk perception is important in the context of social proximity as it has been associated with both past sharing and preparedness to share in the future, particularly within intimate relationships. Smyth and Roche (2007) found significant differences in risk perception when comparing PWID with and without a history of sharing with close friends and with acquaintances. Preparedness to share in the future was significantly associated with lower perceived risk in borrowing from sexual partners and close friends.

In order to elucidate the situations in which PWID would choose to share and/or re-use injection equipment McKeganey et al (1995) used vignettes about sharing equipment in order to assess risk perception and impact of social proximity. The closer participants felt to someone, the more likely they were to share with them (this included friends and sexual partners). Only 27.9% of people stated they would not be prepared to share injecting equipment under any circumstances, compared to 68.5% of injectors who stated they would borrow equipment in at least one of the vignette examples. Highlighting the "social obligations" that PWID feel towards their community, more people were prepared to 'lend' equipment to close friends and partners than those who would 'borrow' from others close to them.

Behavioural surveillance data suggest that the majority of equipment sharing occurs between intimate partners. In 2007, Australian surveillance data indicated that about 60% of needle sharing incidents occurred between intimate partners (National Centre in HIV Epidemiology and Clinical Research, 2007). Other Australian research shows similar findings with 64% (Cao and Treloar, 2006) and 51% (Bryant et al., 2010a) of PWID who share equipment doing so with their partner. Less data are available on the sharing of ancillary injecting equipment, however one Australian study shows that of intimate partnerships where injecting occurred, 65% shared ancillary equipment in the last month (Bryant et al., 2010a).

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Qualitative research finds that romantic love and intimacy figure prominently in the lives of PWID, and that romantic notions such as commitment, trust, care and support shape how individuals who inject drugs talk about BBV with their partners and how they account for injecting practices (Seear et al., 2012). That is, the very nature of sexual relationships – that they involve commitment and intimacy – can impact on perception of risk and behavioural patterns.

The act of injecting together can be part of the bonding experience for sexual partners (Rhodes and Quirk, 1998). Sharing drugs and equipment can be an important part of a relationship, including the perception of intimacy that comes from sharing injecting equipment. Sharing injecting equipment with a sexual partner can be conducive to emotional bonding, commitment, fidelity and mutual trust (Habib, 2003, Lakon et al., 2006, Loxley and Ovenden, 1995). Qualitative analyses show how sharing needles can create feelings of emotional closeness, commitment and trust between sexual partners (Rhodes and Quirk, 1998, Loxley and Ovenden, 1995) and how a refusal to share can be related to distrust and a rejection of intimacy in the relationship (Barnard, 1993). Based on these findings, researchers discuss how sexual relationships “give rise to, and influence, risk behaviour” (Rhodes and Quirk, 1998)p. 158), and how the commitment and intimacy within a relationship can accommodate, or indeed facilitate, sharing of needles in order to demonstrate trust and love for each other.

It should be noted that most of the research available refers to heterosexual relationships and very little is known about same sex couples and injecting drug use (Hopwood et al., 2015).

Gender

Another correlate of sharing and re-use includes being female (Dwyer et al., 2011, Sherman et al., 2001, Barnard, 1993, Bennett et al., 2000, Loxley and Ovenden, 1995). International research has found that women receive used equipment more often than men, particularly that injecting drug use risks are more often tied to sexual relationships among women who inject than men. Women are more likely than men to: have a sexual partner who is also an injecting drug user; be influenced by their sexual partner to start injecting; inject with a regular sexual partner (than with friends or other members of their networks); share injecting equipment with a regular sexual partner; use injecting equipment after their sexual partner; and be injected by that partner (Brener and Treloar, 2008, Sherman et al., 2001, Strathdee et al., 1997, Bryant and Treloar, 2007).

Some of the literature draws attention to what they describe as a ‘submissive’ role that some women inhabit within male-female injecting relationships. While this is not always the case in every heterosexual relationship in which injecting drug use occurs, higher risks of BBV transmission are associated with women having higher sharing or reusing rates – frequently a product of relying on men to inject them after the male has injected himself (Martin, 2010).

In Australia Bryant et al (2010a) found a significant difference between male and female activities that took place prior to and during injecting. Compared to female participants, they found male respondents were more likely to take responsibility for obtaining injecting equipment, getting the drugs and preparing them and also injecting their partners. Further, cross-sectional data from regular PWID in Sydney suggest that risky injecting practices were high among women (with over half the sample reporting they had used a needle after someone else in the preceding year). Although larger proportions of females reported lending and sharing injecting equipment (males largely reported sharing only) (Breen et al., 2005).

Social Context and Structural Barriers

While the larger proportion of the existing literature on sharing of equipment among PWID focuses on issues such as individual agency (including individual perceptions and knowledge of risk) and social proximity (including relationships and networks), a growing number of studies focus on social context and structural or environmental barriers including access to, and availability of, sterile injecting equipment. Sociological research suggests that complex "risk environments" (Rhodes, 2002) in which individual risk behaviours are shaped by social and structural factors, shape an individual's ability to avoid HCV (Harris et al., 2012). These include political and social environments that limit the availability of sterile injecting equipment and legal structures that constrain access, a legal and policy environment that focuses on social control and punishment of drug users and little social capital and social and economic power among PWID, which all contribute to stigma and discrimination (Maher and Dixon, 1999, Rhodes, 2009, Australian Injecting and Illicit Drug Users League (AIVL), 2010, Lomas, 1998, Latkin and Knowlton, 2005, Burris et al., 2004).

It is important to note that there is a significant amount of what is usually referred to as 'grey literature' in the form of peer consultations, policy discussion papers, articles in drug user magazines and other NGO publications that focus on the social context and some of the key structural and environmental barriers to accessing new injecting equipment and reducing sharing and re-use. Unfortunately much of this grey literature was unable to be included within the scope of this overview and relatively small scale study. This information does however remain as an important source of further learning and understanding, particularly in relation to the social and legal context in which injecting drug use occurs. How this 'context' interacts with the many structural and environmental barriers identified above that impact on the ability of PWID to use new injecting equipment and practice harm reduction strategies is also an important area for further learning.

Policy Barriers

Given that an individual's ability to avoid HCV infection is related to the maintenance of social and structural resources (Harris et al., 2012), structural changes such as NSPs can have a positive effect and have been associated with a decrease in risk practices (Gibson et al., 2002, Hagan et al., 2011, Holtzman et al., 2009, Kerr et al.) and a decline in HCV infections (Iversen et al., 2013). Given that injecting in public and semi-public settings, including cars, have long been associated with elevated risk for BBV infection (Bailey et al., 2007), harm reduction policies such as safer injecting rooms and the provision of opiate substitution therapy (Turner et al., 2011) have been shown to substantially reduce the risk of BBVs among PWID.

The majority of policy-focused research examines access to new injecting equipment (an essential resource in avoiding BBV). International research shows that higher needle and syringe coverage is strongly associated with reduced receptive syringe sharing (Bluthenthal et al., 2007). While Australian NSP attendees report high syringe coverage by international standards, prevention efforts could be scaled up. Approximately 20% of PWID are estimated to have insufficient new syringes for all injections (Iversen et al., 2012). International research also highlights inequitable access to the means of prevention among groups of PWID within poor minority neighbourhoods as one of the strongest factors associated with ongoing syringe sharing (Rhodes, 2009, Rhodes et al., 2005). Despite relatively good NSP coverage, neighbourhood access to NSP shape BBV outcomes for PWID (Cooper et al., 2009).

Looking beyond needles and syringes, Australian research evidences the need for new ancillary equipment, in addition to needles and syringes. In particular, high pharmacy syringe coverage did not diminish receptive needle sharing and PWID who exclusively access injecting equipment through pharmacies are more likely than those who use NSPs to report receptive needle sharing

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(Bryant et al., 2012, Bryant et al., 2010b). This not only points to a need to possibly improve awareness within pharmacy based settings regarding the needs of PWID but also access to ancillary equipment at no cost in existing pre-packaged pharmacy products.

In a study that interviewed experts as well as reviewing available literature AIVL identify a number of additional policy barriers to reducing the transmission of BBV among PWID (Australian Injecting and Illicit Drug Users League (AIVL), 2010):

- Arbitrary limits on the amount and type of equipment people can access;
- Lack of after hours and 24 hour access to NSP and new injecting equipment;
- Increasing cost of injecting equipment through 'user-pays' systems;
- "Hidden" costs associated with accessing new injecting equipment for PWID such as transport costs which can be considerable when distances and public transport are involved;
- Lack of access to new injecting equipment in prisons;
- Privacy and confidentiality issues relating to the location and/or design of services;
- Surveillance (real or perceived) – cameras and/or data collection in NSP services and vending or distribution machines;
- Lack of adequate staff training and support for NSP workers particularly in secondary outlets;
- Lack of awareness of NSP sites and the inability or unwillingness for NSPs to broadly advertise their location; and
- Limited accurate and accessible information on how to adequately clean used equipment should PWID find themselves with no other option.

International and National Evidence On Criminal Legislative Barriers

Laws and associated law enforcement practices are significant structural factors impacting on PWID exposure to BBVs (Burriss et al., 2004). The experiences of PWID with police and the law enforcement system have been associated with fear and uncertainty that in turn raises risk practices (Burriss et al., 2004). Studies in Sydney and Melbourne show how fear of police can lead to the unhygienic use of the mouth or nose to store drug packets, a reluctance to carry injection equipment, and pressure to consume drugs less safely (Maher and Dixon, 1999, Aitken et al., 2002a, Cooper et al., 2009) as well as PWID facing a higher risk of fatal overdose because they select injection sites away from police surveillance (Dovey et al., 2001).

In a study that interviewed experts as well as reviewing available literature AIVL identify a number of additional legislative barriers to reducing the transmission of BBV among PWID (Australian Injecting and Illicit Drug Users League (AIVL), 2010):

- Specific legislation in each state and territory preventing the distribution of injecting equipment by 'unauthorised' person(s);
- Mandatory/discretionary reporting in relation to harm to children, young people, neo-natal, pregnant women and families with children: and
- Local council by-laws and development applications pertaining to NSPs; and
- Drug laws in all states and territories and federally that criminalise both PWID and injecting & illicit drug use.

Summary

Current available literature on the circumstance and interpretation of why PWID share and/or re-use injecting equipment highlight a number of key areas for discussion. Given that the rate of HCV transmission remains high in Australia, despite education campaigns and relatively high access to NSPs, a more in-depth understanding of sharing practices among Australian PWID is required.

As commonly noted, knowledge of HCV among Australian PWID has increased over the past two decades however gaps in knowledge remain and a number of incorrect perceptions of risk persist (de Wit et al., 2014). This is particularly the case for younger PWID and Aboriginal and Torres Strait Islander PWID. New initiates to injecting drug use are a priority population for HCV prevention because of the high risk of acquiring HCV soon after commencing injecting drug use. Directed campaigns are needed to improve these disparities.

This review also highlights gaps in knowledge about modes of HCV infection. In particular, the inconclusive evidence relating to risk of infection via ancillary equipment. In the past in Australia we have seen inconsistency of messages around safer injecting practises related to cleaning of injecting equipment. Information provided by services and programs is frequently out of date, or incorrect and services avoid providing messages due to concerns about encouraging drug use or cleaning rather than obtaining new equipment (Australian Injecting and Illicit Drug Users League (AIVL), 2009). Given the high rate of re-use of one's own equipment, evidence about safe injecting and BBV transmission risks should be clarified and messages consistent.

Beyond individualistic modes of behaviour change, Australian and international evidence elucidates the inter-personal context of sharing injecting equipment. For example, several authors question the assumptions made in educational messages and materials whereby individual behavioural change is often the only factor considered (Fraser, 2004). In particular, because sharing practices commonly occur between sexual partners, the place of couples who inject together should be considered in prevention education in order to adequately address sharing practices (Dwyer et al., 2011, Fraser, 2013). Intimate relationships can be an important site for harm reduction, especially if harm reduction strategies are informed by the lived experiences and practices of PWID (Seear et al., 2012). Flowing on from this targeting of the inter-personal aspects of sharing injecting equipment, issues of gender inequality can also be addressed. Women are more likely than men to inject drugs within an intimate relationship, to be injected by and to share equipment with that partner and will therefore benefit from prevention efforts focused on the key dyad in their injecting relationships.

The most commonly considered social and structural barrier to BBV avoidance is NSP coverage. While improvements in the ready supply of new injecting equipment to Australian PWID is still necessary, future research, policy and practice must also include a broader approach to the health of PWID (Rhodes, 2002) and an increase in the use of structural interventions (Des Jarlais, 2000). An understanding of the social determinants of health and an empowerment approach to BBV prevention acknowledges the context of human rights and vulnerability more broadly. Beyond provision of education or equipment alone, there needs to be a shift in understanding of responsibility from the individual to a product of the social situations and structures in which individuals find themselves (Rhodes et al., 2005). The bulk of literature addressing BBV risks for PWID does not consider the political and legislative issues (such as NSP rules and policing laws) that intersect and contribute to a risky environment for PWID. Fear, uncertainty and social inequality shape risk practices and unsafe situations for PWID and should be reflected not only in contemporary research but policies and laws.

For instance, standard education campaigns that do not address the social and structural barriers for PWID, as well as their everyday lived experience, will have relatively little impact on the prevention of HCV transmission and sharing of injecting equipment. A greater focus on

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PWID themselves and what they see as being the biggest obstacles to gaining access to new injecting equipment and/or using new equipment is needed. Researchers suggest that expanding education interventions to include relevant knowledge about common experiences for PWID, particularly the immediate, short-term concerns of PWID, may increase engagement in harm reduction messages, such as reduced sharing of equipment (Harris et al., 2012). PWID have good reasons besides the threat of HCV transmission for preferring new injecting equipment, such as venous care (Koester, 2012, Harris et al., 2012). Interventions that provide information through peer education training empower PWID and acknowledge that they have the potential to offer knowledge and experience that comes from the practice of injecting drug use and practicing harm reduction (Mateu-Gelabert et al., 2007, Garfein et al., 2007).

With the exception of the two main Australian sentinel quantitative survey studies, the Australian NSP Survey (ANSPS) and the Illicit Drug Reporting System (IDRS) in which respondents are asked questions about injecting related health issues, little is known about the 're-use' of one's own injecting equipment in Australia. While re-use may be perceived to be a 'harmless' activity (in relation to the risk of contracting a BBV) it is still problematic and a matter of concern for those injecting; especially given the rate of injecting related health issues (other than BBVs) routinely reported in these studies over many years. Such harms can include: vascular damage, serious bruising, abscesses and other injecting site bacterial infections that can and do lead to serious and life-threatening conditions such as endocarditis, septicaemia, spinal infections, gangrene and amputations in severe cases (World Health Organisation, 2009). It is also important to acknowledge that the more vein damage, the more likely people will encounter problems during injecting and therefore risk both a greater amount of blood present when injecting (particularly with others) and the likelihood of running out of equipment due to having to try multiple times and increasing the need to re-use. Prevention strategies that utilise peer knowledge and experience and approach HCV from the perspective of PWID has been shown to be effective (Harris and Rhodes 2012, Mateu-Gelabert et al 2007). In order to gain a better understanding of the motivations and priorities of PWID in relation to their injecting practices further investigation into the benefits of utilising peer based knowledge and understandings to address the re-use of equipment is required.

Finally, in the research literature different language defining 'sharing' is used throughout. This includes "recipient" (meaning person who receives the 'used' equipment) and "lender" (for the person 'lending' the equipment they have just used). As well as 'borrower', 'passing-on', 'ancillary equipment use', 'receptive use', 'receptive sharing', 'distributive sharing' and 're-use' (both of others and one's own) equipment. The language and meanings of sharing injecting equipment can be ambiguous; from the perspective of a research participant it could cause considerable confusion. In particular, these terms employed in surveys and research interviews are not always the ones used by PWID. In-depth research into the perspectives of PWID will help to elucidate the nuances and language of sharing practises in their everyday life, thereby bringing greater simplicity and consistency to the terminology used in research as well as validity of national data collection measures.

This literature review examines the key reasons for the continued high rates of sharing and re-use of injecting equipment among PWID. The available literature covers many of the key issues however gaps, including the issues highlighted above, remain. There is an urgent public health need to explore the sharing and re-use of injecting equipment in more depth, gaining a better understanding of the inter-play between PWID, their individual circumstances, inter-personal connections and the social and structural environments that surround them. In particular, a greater utilisation of PWID experience and their perceptions of facilitators and barriers to using new injecting equipment and/or using new equipment is needed.

Results and Discussion

The results presented here are based on analysis of eight focus groups in four Australian cities. A total of fifty people who inject drugs (PWID) participated in the focus groups, discussing their experience of re-use and sharing of injecting equipment amongst their networks. Although the type of study methods used means definitive conclusions cannot be made, several interesting themes emerged in the discussions. These themes and discussions have been explored in the context of research already conducted as well as exploring new ideas and alternative interpretations. Finally, recommendations for reducing incidences of sharing of injecting equipment were made based on the experience and suggestions of the participants themselves as well as analysis of the discussions.

Access To Injecting Equipment

Injecting equipment for drug use is provided throughout Australia in a range of locations and services. The provision of free and low cost injecting equipment through needle and syringe programs (NSP) as well as pharmacies has been an important part of Australia's national harm reduction response to injecting drug use for almost thirty years. For this reason, it is sometimes assumed that a person who injects drugs should be able to access the equipment they need for injecting whether they live in a small town or a large city.

Despite the comparatively high number of NSPs in Australia (Mathers et al, 2010) and the range of services through which injecting equipment is provided, PWID in Australia continue to re-use and share injecting equipment in unacceptably high numbers. A series of focus group discussions were held with Australian PWID to explore the reasons behind why they re-used and shared injecting equipment, and the ways in which these practices occurred, from their perspectives. As detailed above, the focus groups were held in four cities around Australia. They included Perth, Sydney, Canberra and Hobart. The participants had a range of experience. Some currently lived in a city, while others lived in a rural area, some had previously lived in different cities or country areas, and they used a range of drugs and a range of injecting equipment.

As detailed earlier, the focus groups were organised according to drug of choice. As is common to PWID in Australia, however, most of the participants had experience of injecting more than one type of drug. As a consequence, the focus groups often include discussions about drugs that weren't the intended focus. The fact that participants had experience of injecting more than one type of drug and were willing to speak about their different experiences most likely strengthened some of the information provided in the focus groups. Participants were able to think about the different drugs and compare their different experiences and injecting practices. We can also say that more participants than those explicitly in the amphetamine focused groups were able to contribute to information related to injecting amphetamines, etc.

A number of different factors were identified by focus group participants as affecting their ability, or their willingness, to access injecting equipment. In broad terms, the barriers to accessing new injecting equipment were either physical, environmental or psychosocial. Some appeared simple but on reflection could be less straightforward than they appear, while others involved a recognised and sometimes complex set of potential effects and outcomes, each leading to the next.

The barriers identified in relation to accessing, storing, and being able to obtain injecting equipment when it is needed can be grouped into several themes. These were shown in the ways participants understood their own needs in relation to what was considered a harm, and how they protected themselves and others from these harms. Harms included but were not limited to the transmission of blood borne viruses (BBVs). In some cases, harms might include a range of issues with some taking priority over others at different times. At all times, no matter

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what the reasons behind the choices made to share or not, came the question of access. No participant reported sharing equipment because they wanted to share equipment. If equipment had been readily available at the time they needed it, they would have preferred to use it.

Some themes did not just appear once in relation to a particular situation but might cross several other themes and relate to different aspects of the situation in different ways. It was clear from the focus groups that injecting drugs in Australia is not just a matter of appearing at the nearest NSP to get your injecting equipment whenever you want it. It is a nuanced activity requiring planning, adapting, and responding to a range of circumstances.

Access To Needle and Syringe Programs

NSP are a major part of Australia's response to BBVs, and in particular to HIV and hepatitis C. Most NSP in Australia is provided through a primary service in which NSP is the main service provided, or secondary services, usually a community health service or a hospital where injecting equipment is provided alongside other general health services. They are widely regarded as one of the most successful public health initiatives of recent times. NSP are part of the national health program, and there are primary and/or secondary NSP in almost all cities and towns in Australia.

The way services are delivered within these programs varies between states and services. The range and type of equipment provided through NSP also varies. These variations contribute to the ways in which participants reported being able to access the equipment they needed for their drug use and therefore, the situations in which they reported having to re-use their own or share injecting equipment. There were a number of other factors that also contributed to the ways participant's reported their relative ease of access to injecting equipment when they needed it that related to broader legislative and social factors.

The main barriers to accessing injecting equipment were reported as being:

- Opening hours and location;
- Limitations on amount or type of equipment;
- Type of service provided;
- Fear of punishment or repercussions; and
- Stigma and discrimination

Opening Hours and Location of NSP

Opening hours and locations of NSPs was reported as a major barrier for many participants. In particular, weekends and public holidays were considered by some participants to be a time when sharing of injecting equipment was more likely to occur. This was because NSPs are usually closed on weekends and other sources of injecting equipment were reported to be less reliable or less available on weekends and public holidays. Some of the participants, said they were rarely prepared for weekends, long weekends and public holidays. Even people who try to be prepared with spare "stockpiles" of injecting equipment get 'caught out' sometimes. Some spoke of this as being something that they felt is common to all PWID. There seemed to be a recognition that PWID often try to be responsible and prepared, but not everything can be controlled.

Many of the NSP services accessed by participants in these focus groups were reported to be open only during business hours. Some NSPs also close during lunch hours and have other regular times and days when their hours are reduced.

'Sunday's the worst, and long weekends and public holidays' (Sydney, prison experience)

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'Vending machines get emptied, places aren't opened. Christmas and shit when everything's shut and you use a lot more than what you think, so you're pulling out all your old ones and shit.' (Sydney, prison experience)

'Often when you need them, everything is closed.' (Hobart, ATS)

'You know nine times out of ten is when you want it is when nothing's around 'cause it's early in the bloody morning.' (Hobart, ATS)

For a few different reasons, several participants reported a need or a preference to access a small amount of injecting equipment, enough for one episode of using a drug, and only when it was needed. For this reason, the opening hours of the NSP was extremely influential on their ability to avoid re-use or sharing of injecting equipment. Additionally, a few participants including those who preferred to access only what they needed when they needed it, reported times when they were unexpectedly able to obtain drugs. They were therefore unable to always plan their access to NSP at the same time as they needed injecting equipment.

'So you know what I mean, so...'cause I'm not preparing, planning to do doing this thing, it might...something will just sort of (happen) spur of the moment.'

Responding: 'Yeah, and then it's like all I've got is my dirty one that I haven't returned yet so it's like, well, they're sharp or whatever. So I just rinse it out with some bleach, or whatever and off I go.' (Hobart, ATS)

Some participants reported that the opening hours of the service could change without notice. The participants were sometimes confused or unsure of the opening hours, locations, and equipment provided at particular NSPs in their local areas. Some participants reported re-using equipment because they didn't know where they could go to get what they needed, or times where they choose not to risk a trip to the NSP because they aren't sure it will be open.

'Yeah, but they're...like of a morning it's meant to be 10am...sometimes...ah, 9...sometimes it's 9.30.'

Responding: 'Well it used to be 9, now it's 10.'

Responding: 'Yeah, its 10 now but then it's sometimes not until 10.30am...' (Hobart, ATS)

'Access in Canberra is some of the best in the country.'

Responding: 'But we can't get them at hospitals like in NSW, you can't go to a hospital and get them.'

Responding: 'Well, we used to in Calvary, we used to.'

Responding: 'And Queanbeyan too but not now.'

Responding: 'Queanbeyan, I've been to Queanbeyan hospital and got them.'

Responding: 'Can you still get them? I haven't been there for a while.'

Responding: 'They've got them, they've got the black ones on the wall, you just go in and help yourself.'

Responding: 'Oh, I hate those.'

Responding: 'But they're better than nothing.' (Canberra, OST)

In Hobart, the primary NSP was staffed by one person. If the staff member was late or sick, the NSP would be closed when people were expecting it to be open. Therefore, people who access the NSP might be prepared to pick up injecting equipment but find the service closed. A few participants in this group said these experiences impacted on their access to new injecting equipment as they were unable to wait or be unwilling to wait an unspecified and unknown amount of time.

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'Say the place is shut, doesn't open 'til 12.30pm on Wednesday or whatever it is, we don't have a vending machine, or whatever. So I mean I'll reuse my own.' (Hobart, ATS)

'You're coming in, it's actually meant to be open and it's closed. Like you're waiting 20 minutes and then they're still not there to open the door.' (Hobart, ATS)

Primary and secondary NSPs attached to health centres are often located in the city or in major regional and suburban hubs. This is intended to increase access to NSP, as public transport is generally available in those areas. However, they tend to be limited in number and spread out with only a few across some capital cities, or in some of the smaller cities and major towns, one or two. They also are often located in areas where it is unsafe to use drugs. Their locations mean that many people who want to access them have to travel some distance from their home either by car or by public transport and return again to their homes or somewhere else where they can use the equipment. Outside of business hours, accessing these locations can be particularly difficult.

'That's why you'll find people reusing their own. Cause they've got no car. If it's after 7:00pm at night-time you're lucky to find a chemist anywhere.' (Hobart, ATS)

The time spent and the distance needed to travel to obtain equipment was recognised as a significant limiting factor for some people. Living in an area without easy access to reliable public transport added to the difficulties experienced by participants without cars.

'You can't get to the city a lot if you're not in the city.' (Canberra, heroin)

'You know Campbelltown... You know where they have to travel to get their fits? ... I think... is it? no, it's Liverpool.'

Facilitator responding: '... so how far's that?'

Participant 1 responding: 'Twenty minutes driving.'

Participant 2 responding: 'And imagine, you know, if you're hanging out.' (Sydney, prison experience)

In general there was a shared sense among participants that NSP locations and opening hours did not consistently meet their needs and contributed to incidences of re-use and sharing of injecting equipment.

Limitations on Amount or Type of Equipment

In most of the focus groups, participants were able to access as much of certain types of injecting equipment³ as they wanted, in particular the equipment that was needed for injecting heroin and ATS. For the Canberra participants, however, numerous barriers arose that were related to the small number of outlets, location and limitations placed upon how much injecting equipment people were allowed to obtain per day. Several participants reported the limited amount of equipment they could obtain each day had a direct effect on incidences of re-use.

'...with that Civic one (in the city), like, they tell you are only allowed six a day, but some days I have more, might have eight or nine shots a day....they're telling me how many shots I can have a day and that doesn't work out.' (Canberra, heroin)

'If you're living out of town and it's Friday you get three packets of 25 but if it's not Friday, you're allowed two packets of 25.' (Canberra, heroin)

For one or two of the participants in this focus group, the limited amount of equipment provided could be less than they needed on any one day. Therefore, going to the NSP because they intended to use drugs that day would not necessarily prevent them from having to re-use injecting equipment that day. They reported having tried to complain and ask for more than the

³ In general this refers to 1 ml syringes, swabs, cotton filters and syringe disposal containers

"allowed" amount, without success.

Participant (Canberra, heroin): 'I've argued with them so many times [about limitations on the amount of equipment allowed] and they sent me back a letter once saying that if I kept arguing I wouldn't be allowed back.'

In addition, some participants in the Canberra focus groups, spoke of an additional issue with the limitations placed on injecting equipment. They believed many PWID would have difficulty attending the NSP every day, therefore making it more likely they would sometimes run out of injecting equipment. For people with children, and people without their own transport, the ability to go to the city-based NSP daily could be at least difficult, if not impossible.

'Why do I have to go in every day to satisfy them? Why would I ask for more than six if I don't need them?' (Canberra, heroin)

'Because I can't get into town sometimes, you know. I'm too crook, can't go, can't get out of bed sometimes.' (Canberra, heroin)

In some locations where focus groups were held, NSPs that gave out unlimited numbers of some types of injecting equipment had either no or limited amounts of other types. For example, some NSPs limit the amount of large barrels (10mls or larger), wheel filters and butterflies they provide, and in some cases charge a fee for these types of injecting equipment. In NSW, larger barrels and butterflies were not allowed to be distributed by NSPs at all.

Some of the Canberra participants believed the limitations placed on injecting equipment by the NSP was directly contributing to increased HCV transmissions, and that is showed the policy to be based on lack of knowledge, discrimination, and a perceived lack of care. For these participants, the limitations were a symptom of the broader discrimination PWID experience on a societal scale (see section on Stigma).

'Their policy is adversely affecting your health.' (Canberra, heroin)

'The powers that be don't really care about our health or our situation or anything like that. They care about the cost.' (Canberra, heroin)

'What's cheaper, giving you a box of a couple hundred for yourself or getting new hep C (transmissions)?' (Canberra, heroin)

For some people, the stigma associated with injecting drugs seems to be a reason not to access injecting equipment through NSP. This is one of the reasons why having different types of services, and tailoring services to the needs of the many different types of people who use them, should be an integral part of Australia's harm reduction response.

Type of Service Provided

NSP services in Australia vary in the way they provide injecting equipment. For example, some NSP services provide outreach, after-hours services, or vending machines. Several participants spoke about the different types of services they knew about or had experience of accessing in their assessments about the suitability of NSP services.

In almost every focus group, participants reported that providing outreach of some kind, including foot-based and car or van-based outreach, and increasing access to injecting equipment to be available twenty-four hours a day would prevent people from re-using and sharing injecting equipment. Conversely, reductions in the way NSP services operated were reported to increase incidences of sharing and re-use of injecting equipment.

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For example, a drug and alcohol service in Hobart was reported to have provided NSP 24 hours a day in the past and other people in several of the focus groups had been able to access NSPs that stayed open until late in other locations or previous times. The closing of this particular service was reported to have had a significant impact on re-use of injecting equipment amongst local PWID.

'... There used to be a 24 hour bloody dispenser in town. A detox. And they stopped that.'

Participant responding: 'When they stopped that there was a lot of people re-using and ...' (Hobart, ATS)

The benefits and limitations of vending machines were discussed in almost all of the focus groups. Only the focus group with participants who injected performance and image enhancing drugs (PIED) did not mention them as an option for acquiring the equipment they needed. Although there are not vending machines in every state and territory in Australia, there was at least one vending machine in all the cities where the focus groups for this study were held and many of the participants spoke about vending machines as something they had used or considered using to access injecting equipment.

In more than one focus group, participants attached importance to vending machines as a source of injecting equipment, particularly after hours. Some participants reported the number of vending machines needed to be increased as there were few available in limited locations.

'...but if there was a vending machine say in, like, City, O'Connor, Woden, Tuggeranong, that gave out free fits that would probably stop you having to go into the bin and find your own fit and re-use again.' (Canberra, heroin)

'There used to be one in Queanbeyan but then you've got to go all the way to Queanbeyan so that's ridiculous!' (Canberra, heroin)

In most of the conversations about vending machines, participants reported problems with them. Many of the participants reported having tried to access injecting equipment through the vending machines and having their money taken without getting the equipment, finding the vending machine had run out of injecting equipment, or finding it otherwise broken.

'I suppose you go all the way, you go into town, put your money in there and you get nothing. It's the only \$2 you had' (Hobart, ATS)

'You put in your money and it doesn't work) but then you think a second one and then, like, you still didn't get what you want so then you run around town, you got your change and come back, you know. It's not easy to do in Hobart at 2:00 in the morning. You know, you get two \$1 coins ...' (Hobart, ATS)

Where they hadn't had personal experience of problems, participants often reported having heard of problems from others. Many of the participants said these experiences, and hearing of negative experiences, resulted in a reluctance to access the vending machines.

'I've heard of people putting their money in and getting nothing.'

Responding: 'Yeah, they take it, yeah.'

Responding: 'That's why I don't use the vending machines, because of the reports I was getting that people were losing their money.' (Canberra, OST)

'You just don't know if it's going to be working.' (Hobart, ATS)

As stigma towards PWID featured regularly in the focus groups discussions, it was interesting to note, that while none of the participants reported they would ever vandalise or break a vending machine, and didn't know anyone who had done so, some were quick to attribute blame to "other" users of the machines rather than non-users or people who disagree with NSP.

'There are a lot of selfish people that would want to break into it because they're doing that for a hit.' (Canberra, ATS)

Despite the problems associated with them, vending machines were reported to be an important component in increasing access to injecting equipment. Several participants, and most groups, mentioned vending machines as an option when NSPs were closed. A couple of the participants reported using vending machines regularly, particularly people who felt they couldn't stockpile injecting equipment in their homes, accessing it only when they needed it.

'It is good if it is after hours though, and it does work for you.'

Responding: 'I'm happy with the machine.' (Hobart, ATS)

Vending machines tend to be used in emergency situations such as when other services are closed. As some people are more likely to use a vending machine when there is no other option, the problems associated with them can have a significant impact on the likelihood of people sharing injecting equipment. This is possibly a contributing factor to the participants listening to and repeating rumours about their problems without necessarily having experienced those problems themselves. These rumours appear to have a strong effect on some people's willingness to use a vending machine in a situation where they can access a different service, or even when their only other option is to share or re-use injecting equipment.

These discussions, and the strength of opinion expressed in the focus groups, support vending machines as being an important and necessary part of Australia's harm reduction response. However, while there are so many problems associated with vending machines, they are likely to be under-utilised.

Access to Injecting Equipment Through Pharmacies

Many participants in each of the focus groups, regardless of the type of drug used, reported using pharmacies at least some of the time to obtain their injecting equipment. As many of the focus groups were held with participants recruited through primary NSP, the common use of pharmacies is important to understand. For some participants, there was a perception that "everyone" who injects drugs will have a time when they need injecting equipment at short notice and the NSP they might prefer to use will not be open.

'There's always a weekend!' (Sydney, prison experience)

Although they used pharmacies, they were viewed by many participants to contribute to several barriers in relation to accessing injecting equipment. The barriers reported fit into four main categories:

- Cost of equipment;
- Range of equipment provided;
- Limited number of participating pharmacies; and
- Stigma towards people who use drugs.

For most participants in these focus groups, pharmacies were not the only or even primary place they accessed injecting equipment. Discussions in the focus groups, whether participants reported stockpiling injecting equipment or accessing it only as needed, recognised there will be unexpected situations where PWID will be in need of injecting equipment and having to find an alternate solution to NSP. For some, this was when alternative options such as pharmacies and NSPs, or in some cases more convenient options, were important.

'I can go to the chemist or vending machine. Or re-use. I re-use it. I always re-use my own at home.' (Hobart, ATS)

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The issue of cost was discussed several times in relation to accessing pharmacies. Some participants reported a willingness to pay pharmacies a price for injecting equipment. This was particularly the case in a focus group held in Canberra, where pharmacies are paid to artificially control the price of fitpacks at two dollars. Some participants in these focus groups reported a preference for accessing a pharmacy as compared to a vending machine as they would pay the same price but found the pharmacy more reliable.

'It (the vending machine) worked once or twice. More times I've been there it's been off... Take yourself down to the chemist because it's guaranteed.' (Canberra, ATS)

For some participants, however, the cost of fitpacks was a noticeable barrier even when the price was fixed. More than one participant the cost of buying injecting equipment at pharmacies as an issue that could lead to people having no new injecting equipment when they needed it.

'...some people can't pay two dollars for a clean needle...' (Canberra, ATS)

The issues associated with pharmacies varied by location. For example, in NSW, the policy preventing NSPs from providing larger barrels and butterflies means people who use them have to adapt or buy the injecting equipment from pharmacies. In Canberra, at the time of the discussion, the NSP only provided a limited amount of injecting equipment each day. This meant participants were often more reliant on pharmacies to obtain the less common types of injecting equipment. The cost of these types of equipment was seen to be prohibitive by many of the participants who had to buy it. Several participants reported having to re-use their own equipment, or in some cases engage in other risk practices.

'You can pay for them, but they're (large barrels), like, a dollar a piece.' (Sydney, OST)

'You can buy them (butterflies) from the chemist, but again, they're two fifty each.' (Sydney, OST)

'I'll always re-use my barrels all the time. But then, I'll end up selling it (methadone) to someone, and I've dipped my barrel in there, and I'll tell them and they don't care.' (Sydney, OST)

The lack of flexibility inherent in commercial markets such as pharmacies when trying to access these necessary products was seen as a barrier to accessing the minimum amount of equipment needed to inject safely. One participant described a situation which they believed showed pharmacies to be uncaring about their needs, demonstrating the business rather than health service focus of pharmacies.

'... We were 50 cents short and they wouldn't do it and I said to them, like "What if one of us have got hep C and we want to share this needle, or share a needle?", and they're like "Bad luck". I was like 65 cents (short) or something and I was so pissed off. They just didn't care, like, people don't know about drug users, you know. They don't ... unless you've lived like it you don't know anybody's situation.' (Hobart, ATS)

The number of participating pharmacies was perceived as a significant barrier in many of the focus groups. Participants had to know where they had to go to buy the equipment and reported difficulties some people faced in having to travel significant distances. This was an issue that cut across the type of drug being used. However, injecting equipment such as the larger barrels, wheel filters and butterflies posed a particular challenge because even fewer pharmacies sold them.

'There's only some chemists that distribute it.' (Sydney, OST)

'And sometimes they don't even have the larger barrels there.' (Sydney, OST)

This was also an issue for PIED, who reported they knew many people who were unwilling to access NSP and who are therefore probably more reliant on pharmacies and other commercial outlets.

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'That I know of, there are three chemists in Perth that'll sell you 3 'mil barrels and fucking 19 gauge draw ups for 23 and 25 gauge (butterflies)'. (Perth, PIED)

The limited number of pharmacies providing most types of injecting equipment at an affordable price has a significant impact on people who use a range of drugs, and people in a range of situations.

The issue of pharmacies that provide NSP was a particular issue in rural areas. The focus groups included a rural participant, and a few people with personal experience or friends who lived in rural areas. The problems reported by these participants related to the lack of choice they had. For example, the only pharmacies that sold injecting equipment might also be the only pharmacies that ran an opioid substitution treatment (OST) program. A participant in this situation worried their methadone program would be jeopardised if they bought injecting equipment from the same pharmacy. Confidentiality and social stigma was also an issue for these participants. The pharmacist or pharmacy staff were not trusted to maintain their confidentiality with their doctors, or sometimes with other people they knew in the community including family and friends.

'Not in Cooma you can't (get what you need). You can get barrels but no butterflies. And there's one chemist, or two chemists owned by the one crew, and that's where I dose.' (Canberra, OST)

'They've got half a dozen fits they'd use twenty times over, you know. It's like "Oh mate", and you know I take a backpack full down for them. ... It's the stigma.' (Hobart, ATS)

Cost, location, and limitations in the number of pharmacies providing equipment as well as the types of equipment provided were the main physical barriers reported by participants when discussing access to pharmacies. There were, in addition to these, barriers that related to fears of being punished or negatively judged. These will be explored in more detail in the following sections. As previously stated, pharmacies were not the preferred place to access injecting equipment for these participants but they were commonly used by them in situations where their preferred options were not available. Understanding the barriers to pharmacy access for PWID is potentially key to understanding why PWID may be more or less likely to re-use or share injecting equipment when injecting drugs.

Fear of Punishment or Repercussions

A few participants spoke of a fear of being discovered or exposed as a PWID. This fear revealed itself in different ways in the focus groups and was reported to effect participants' willingness to access, carry and store injecting equipment until needed. The possible outcomes of exposure varied and often related to who it was the participants wanted to hide their drug use from. The police or security were mentioned more than once, particularly by participants who were in the prison focus group or who had experience of being arrested. Thus, previous experience appeared to have a significant effect on participants' subsequent fear of surveillance and police searches.

'I'd rather use my fit at home than go to the city market chemist (where they call security) and buy a pack. I would rather use a dirty fit at home.' (Canberra, OST)

'I don't have them on me long enough for the fucking cops to get them.' (Hobart, ATS)

In a few conversations in different focus groups, people who had previous prison experience spoke of limiting the amount of injecting equipment they would obtain and of disposing of it immediately afterwards. They preferred not to have new injecting equipment on their person or in their homes. At the same time, however, they reported themselves or people they knew preparing for possible arrest by hiding a used and sometimes altered fit hidden somewhere on their person.

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'... They've always carried their own cut down, or their own old fit. Because you never know if you get caught, you get caught, you get locked up, at least you've got your own.' (Sydney, prison experience)

Within the prison group participants also reported being vulnerable to being found with injecting equipment.

'... if you get busted with it in your cell, you're gonna get charged for it, okay?' (Sydney, prison experience)

In more than one focus group, participants discussed police powers and surveillance in regards to their rights. Although some of them knew about policies that were supposed to protect them when accessing NSP or when carrying injecting equipment, there was common agreement that these protections did not necessarily exist in reality. In fact, being seen at NSPs or being found with injecting equipment was mentioned in more than one focus group as something that would lead police to harass and search the participants more thoroughly.

'And I went to parole and parole said, "Oh, the police said that you're still hanging around Newtown. They searched you and you had fits on you.' (Sydney, OST)

'I don't want to carry that card (that is supposed to protect you if the police find you with injecting equipment). Because then I think, then they're going to search you completely.' (Sydney, OST)

The police and prison guards were not the only people with authority to punish the participants. Security guards had also been responsible for punishing people when they were trying to access injecting equipment. In one location, two pairs of people, an Aboriginal brother and sister and an Aboriginal couple, both had experienced being harassed, followed and threatened by security after buying injecting equipment at a pharmacy. Although the participants discussed these experiences in a way that indicated their knowledge they hadn't acted unlawfully, they believed themselves to be vulnerable to these acts, without legal rights. Whether their status as Aborigines was a factor in experiencing this discrimination was unknown.

'I've been followed. We were here, and I was walking with my walking frame and I copped abuse. Never went there, never did anything. I only got a fit pack and went to the car and they followed me all the way to the car and we copped abuse.'

Responding: '... I walked out of there one time, went up towards the bathroom to go up towards Big W and they followed me straight up.'

Responding: '... Even when I went to the toilet, they tried to break the door in, and I'm going to the toilet.'

Responding: 'They did it to me and him' (indicating her partner). (Canberra, OST)

'Staff members ring security. I have been in the disabled toilet, using the disabled toilet with my brother. All I was doing was using the toilet. And I had a broken leg and I couldn't even put any pressure...' (Canberra, OST)

'But then you go to the police and the police will not come and arrest them. They'll say, "You're a fucking junky, you should be used to it". That's their attitude.' (Canberra, OST)

Surveillance and police harassment was also an issue in other discussions. Some of the discussions revealed a belief among more than one participant that police would be going to some lengths to watch NSP and pharmacy outlets with the intention of harassing people who were accessing injecting equipment. The knowledge that Australia has laws to protect people carrying injecting equipment did not diffuse this fear, as being searched appeared to be a fear in itself. This may relate to the likelihood people who are accessing an NSP would have illicit drugs on their person, may have fines or other charges that could be used against them, or it may be for other reasons such as confusion about their rights and laws relating to drug use.

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'And they've got a camera outside, like so the police also watch you or whoever's walking in ...'

....

Responding: 'Yeah, I've seen them sitting outside.'

Responding: 'The cop cars sit there and watch...'

....

Responding: 'So that could put people off by going getting some new equipment because the fear of that. ...'

Responding: 'But they're not allowed to touch you.'

....

Responding: 'But when you leave they are.'

Responding: 'They can pick you up and search you.' (Hobart, ATS)

A few of the focus groups included conversations about legislation and policies related to carrying new and used injecting equipment. Some participants in these conversations seemed well-informed about their protections, while others were unsure. Some participants appeared not to trust in laws that were supposed to protect them.

'But then sometimes you get the fucken' arsehole coppers who will just ...'

Participant (responding): 'Yeah.' (Sydney, prison experience)

A few participants offered each other advice for dealing with the police should they be searched.

Participant (Sydney, OST group): 'You know, you could put them in your bag and say you found them on the street. "I'm just doing my civic duty".'

A few participants in several of the focus group discussions reported feeling the need to limit the amount of equipment they accessed and kept as a way of hiding their use of NSP and similar services. This was mainly because of a fear of negative repercussions if their drug use was discovered, some of which related to police but other reasons were also revealed. For example, a few women with children reported being particularly frightened of "the authorities" taking their children from them as a direct result of discovering injecting equipment in their house. These women were less likely to stockpile equipment and more likely to access only enough injecting equipment for one or two episodes of drug use. Most of them also reported incidents of re-using equipment as a result of not having spare injecting equipment.

'I usually only have one or two – that's it.'

Responding: 'Is there a reason that you try not to have too many around?'

Responding: 'No need for them.'

Responding: '...when you got babies too...!' (Canberra, ATS)

'I just get a three pack, that's all I get, a three pack at a time and I bring the three pack back.' (Hobart, ATS)

Having their current injecting drug use discovered through accessing services or being found with injecting equipment was reported by more than one participant as leading to punishments related to their methadone or buprenorphine program. Some of the participants believed police, NSP workers, or pharmacists could intentionally break their confidentiality and tell their methadone or buprenorphine prescribing doctor that they were accessing injecting equipment. Punitive responses to their OST program was a serious concern, such as the removal of take away doses, and that these punishments could affect other aspects of their lives.

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'And I can't, I don't want to carry my barrels around, because I get searched by the cops and "Why do you have barrels? Are you shooting up your 'done?'" And then they, I don't want (them) to ring my clinic.... And the next time I went to my doctor's, they said, "No". So I rang, they didn't say who rang them, but someone rang them and I can't get them [take away doses] anymore.' (Sydney, OST)

The impact of being found to have injecting equipment, being discovered as a PWID, and being punished was described in a series of cause and effect by one particular woman. In this description, the woman believed being known as a PWID would lead to every aspect of her life coming undone.

'It's not the look that fears me, it's the fact that they then can talk to somebody and that's my methadone cut off and if I don't have my methadone, I can't be a mother. I can't go to school. My ex-husband will get my kids and just this cascade of other shit that I don't want to have to deal with.' (Canberra, OST)

The participants who only get the small amount of equipment they need for one or two episodes of drug use spoke of discovery, and punishment of some kind influencing their choice to limit the equipment they accessed. However, they also each spoke of being able to use a "dirty" when they had unexpected access to drugs. For some, carrying a pre-used needle and syringe was common, while others reported having one stashed somewhere for these, often unexpected, "emergency" situations. None of these participants explained why they would keep a pre-used needle and syringe rather than a new needle and syringe for emergency situations.

It is possible that for some people, a pre-used fit can be explained to those they don't want to know about their drug use as something that another person has used, or something that has been left behind by accident a long time ago, while a new fit indicates a possibility or even a desire to use drugs now and in the future. In the case of the police, this means an intention to take part in an illegal activity. Therefore, it may encourage more police attention. In the case of a loved one such as a partner discovering the fit, intending to use in the future may be seen as a less forgivable "offense" than having used in the past.. A new fit may indicate the other unforgivable "offense"; that the person isn't trying hard enough to not use drugs. In a society where illicit drug use is heavily stigmatised and criminalised, anything that discourages PWID from protecting themselves and others from sharing related harms is damaging.

Stigma and Discrimination

Participants reported both self-stigma, and stigma and discrimination from others. Stigma and discrimination from others was reported to have an effect on a number of levels related to the participants' access to injecting equipment and risk practices. Self-stigma also affected how participants reported their own experiences of sharing. Even when the participants didn't provide complex, detailed information about stigma and discrimination and its effects, the participants appeared to have a high level of awareness of stigma, discrimination and demonstrated an awareness that it had broader, societal causes and effects.

In the case of NSPs, some participants explained policies such as those limiting the amount or types of equipment people could access as being based on stigma.

'It's (the policy about not giving out larger barrels and butterflies) only fuelled by stigma.' (Sydney, OST)

Participants reporting of stigma and discrimination in accessing injecting equipment related most often to staff with low levels of understanding and knowledge of PWID, and pharmacies in particular. In some cases, participants directly reported a belief that peer educators, that is, people with a history of drug use themselves, would provide better services to them.

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****** (mentions name of service) had this policy you had to be five years clean to get a job at an NSP and that's led to a lot of people with no understanding of use at all, which has led to a lot of people discriminating, giving wrong advice.' (Canberra, OST)*

'... They have got to have staff people that are going to be easy with it, they're not going to be looking at him going "Oh...". You see, people like us, we can feel stuff like that.' (Canberra, ATS)

'It's a real power play, isn't it? That's the real difference between having a peer needle exchange and one that's run by that place (a drug and alcohol service).' (Canberra, heroin)

A different aspect of stigma was reported to be the reason some of the PIED participants reported they and their friends would not be willing to access NSP. Although there were only a few participants in the PIED group, they reported most PIED users being reluctant to access a service that was not only not aimed at people like them, but that it was aimed at people with whom they didn't want to identify. Stigma towards PWID was reported by the few people in the PIED focused group to be the main reason they wouldn't access an NSP to obtain their injecting equipment. The participants in this group thought other PIED probably didn't know NSPs were available, but wouldn't want to access them if they knew about them.

'I gathered there was a sort of stigma on this place (the NSP). I told a few people about it and they said, "Do you feel like a junkie?" (Perth, PIED)

"...it's a shame because people may not want to access the service, may look elsewhere just because of having to come here with a, you know, a different ... or not an addict or a drug user. And that's a common thing.' (Perth, PIED)

Several participants reported experiencing stigma and discrimination when they accessed injecting equipment through pharmacies. Buying injecting equipment at pharmacies had an additional element of risk for people who were on OST, that of being punished for illicit drug use, or punished for injecting their OST, through their OST program.

'I would rather use a dirty at home than go to the chemist and get ...'

Responding: 'And get judged.'

Responding: 'And risk my methadone.' (Canberra, OST)

Some won't touch your hand to take your money off you or anything like that.' (Hobart, ATS)

In some discussions, the attitudes of pharmacy staff had a strong impact on participants' willingness to access particular pharmacies for injecting equipment. For example, they would return to "the good" pharmacies, that is, pharmacies that were known to provide a non-judgmental service at an appropriate price.

Facilitator: 'So are you more comfortable at that chemist?'

Participant (responding): 'Yeah, the one down here in the plaza, yes.' (Canberra, OST)

Conversely, some participants reported the impact of negative experiences in pharmacies in which feelings of discrimination or lack of understanding by the staff resulted in an unwillingness to return.

'The problem is you get the packs at the front where it's just checkout people working at the front and they don't know about anything except the prices in the stores.' (Hobart, ATS)

Participant (Hobart group): 'I'll never go back there.'

One participant spoke about having to draw up the courage to access the pharmacy after having these kinds of experiences.

'It's for your own health – you've got to do it. It's pretty sad that a lot of people don't feel enough encouragement to go in there, you know?' (Canberra, ATS)

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'... even though I know some people are strong in there but when it comes to going to the chemists and or somewhere where, shit, do you know what I mean? What am I supposed to say, or how am I supposed to react or act? There's a lot of ways of people when they go into places like that because sometimes people don't want to go in there because of that sort of stuff.' (Canberra, ATS)

Some participants' statements revealed the complexity of being both criminalised and stigmatised. Although there are laws and policies that are supposed to encourage PWID to access injecting equipment, if they are being discriminated against or judged when trying to do this, it is not surprising people might feel vulnerable to the judgement that often comes with the illegality of their drug use.

'... They don't want to touch you.... And I've snapped sometimes and that sort of stuff because, hang on a minute, do you know what I mean? You think you're better than me? Like in the sense they're sort of looking down at you because you're I mean, you're trying to do it the healthiest way and that's a plain fact.' (Canberra, ATS)

'... I'm not going in there because she will be watching me, or what are they thinking or, do you know what I mean? There's a lot of things that what other people see me what they're going to think, what they're thinking, you know? That really makes people, especially people that use, paranoid!' (Canberra, ATS)

Stigma towards PWID was also exhibited by the participants themselves, either towards themselves, or towards an 'other', stereotype of a drug user. The stereotyped drug user was reported to be people who were selfish or thoughtless, and who ruined the services other PWID needed through their behaviours. For example, some of the participants reported 'other' drug users, not themselves or their friends, left used injecting equipment in public places or vandalised vending machines.

'They don't think of the consequences.' (Canberra, ATS)

'Sorry but what I'm saying is see a lot of people they will be heading up going, "Shit, I could get a bit of money out of this vending machine". Everyone would use it – they would be selfish enough to bust it and then the next person misses out, so if the machine was for free they wouldn't break it.' (Canberra, ATS)

The small PIED group also strongly distinguished between themselves and PWID, expressing opinions about PWID that conformed to the stereotype. This was a major reason they reported not wanting to access NSP.

'The stigma in the background It's a shame because people may not want to access the service, may look elsewhere just because of having to come here with a, you know, a different, ... not an addict or a drug user and that's a common thing.' (Perth, PIED)

In many ways, criminalisation, stigma and discrimination could be said to be behind almost every aspect of reducing protective practices and increasing risk practices among PWID. Despite the many barriers, however, PWID continue to adapt to their circumstances and develop ways to look after themselves and their communities.

Where, Why and With Whom? Drug Users Safety Strategies

When it comes to the sharing of injecting equipment for illicit drug use, it is often automatically assumed that sharing is inherently risky and that harm is invariably about BBV transmission . Research with PWID often focus on individual behaviours and incidences of sharing without examining more closely the circumstances in which needle and syringe re-use or sharing may have occurred.

As discussed by the participants in these eight focus groups, accessing injecting equipment

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comes with its own real and perceived harms. Some of these were specific to individuals or circumstance while others were commonly identified in the literature and the group discussions. Although both HIV and HCV were included, the participants in the focus groups had several different and complex ideas about what constituted 'harm'. These impacted upon the decisions which were made in relation to minimising harm, and the reasons for why these decisions were made. It was not a matter solely of individual behaviour but a complex set of changing circumstances and social relationships. In most cases, though, the participants had developed strategies for managing or even overcoming the harms in ways that satisfied them.

Several participants in the focus groups referred to experiences they had had of re-using and/or sharing injecting equipment. Sharing, it seemed, was not a rare occurrence, but neither was it inconsequential. More than once participants stated a belief that 'everyone who injects drugs' would have had experience of being without new injecting equipment when they needed it, implying that therefore every PWID has had to re-use or share injecting equipment at some time. Only a few participants said they would go without drugs if they were available but they would have to share injecting equipment to use them, and even these participants often had experience of having shared injecting equipment or occasions where they might consider it.

Outside of the many complex factors impacting on the participants' ability to access injecting equipment, probably the strongest influence on risk practices was that of drug withdrawal. Many participants discussed withdrawal as being the major reason they had ever chosen to share injecting equipment or re-use their own and attributed it a major reason that would influence others, regardless of the drug used. For these participants, longer term risks such as BBV transmission were outweighed by the immediate harms associated with withdrawal.

'It's just a drug habit, a heavy one. And it's worse if you have both. It doesn't matter, like, what drug it is, your addiction. If it's bad, you know, it is the same.' (Canberra, ATS)

'And you're not running right off (to the NSP) if you're really sick and you've just scored.' (Canberra, heroin)

'If I'm hanging out bad, I can't drive. So literally, I can't drive without drugs in my system. ... I'm a hazard on the road. ... And it's got to the point where I've gone, "Well, I can't get there." It's either have an accident and not get there, or, so sometimes I've, yeah, got to (re-use or share injecting equipment).' (Canberra, OST)

Very few of the participants spoke of not caring about transmitting BBVs or having them transmitted to them. However, some of the participants spoke of 'other' people who would engage in risk practices such as sharing injecting equipment, regardless of BBV status. The participants were usually not close to these people, they were people from outside the participants' social circle. They were, therefore, relating incidents they hadn't directly experienced. The stories about these 'other' people may have therefore been a way to distinguish themselves from the stereotype.

'Then you've got a lot of selfish people right, because they've got they've got and they've got no life. They want to make someone else have no life, do you understand? ... That's wrong. I don't give a shit who it is but that's wrong if people can't say what they've got...' (Canberra, ATS)

In some cases, however, participants were willing to relate occasions where they felt they had put themselves at risk of BBV transmission by sharing injecting equipment. These incidents were blamed for their positive HCV status, and generally referred to in a way that implied regret.

'That's what I did on the day that I contracted hep C. I was very young and I certainly had not had any contact with the user groups and the older users that I've had since that day. Like, my knowledge is far greater now and I don't think I would fuck up the clean now. But I obviously fucked up the clean on that day when I was that desperate to use that person's fit. But since that day I've learned a hell of a lot and now there's always at least one dirty and one clean in

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the house. If there's not one clean, there's one dirty. I never throw out the last dirty just in case.' (Canberra, OST)

Some other participants referred to close calls in which they had made a decision to share injecting equipment and had been lucky to avoid being 'infected'. These occasions were also referred to in a way that indicated the person felt shame and guilt. In these conversations, the person relating the incident seemed to blame themselves, to imply they had been 'stupid' or 'impulsive' in some way. They spoke of having regretted their decision to share injecting equipment, and had taken steps to manage the impacts as soon as possible. One of the participants related the fear and shame they felt in the months after the incident as they waited to find out the results of blood tests.

'... I had a scare earlier this year, where I straight away got a test, and I had to wait. I got a test, and then another test. And what lead me to using someone's fit, I mean, I, no, it was a solution. It wasn't a fit, it was a solution that had been in a fit. ... It was greed. Pure and utter greed. My greed that, that, you know, I didn't want the drugs to go to waste. ... I didn't want to take a risk, but I didn't want the drugs to go to waste. ...(I remember) just afterwards, and thinking, "Fuck, I've done this." ... "what have I done?" You know? "What an idiot!"' (Sydney, OST)

In most of these conversations relating their own experience of sharing equipment, the participants had learned to adapt their practices to reduce the chance of the same thing reoccurring.

One of the main ways the participants avoided having to share or re-use injecting equipment was to 'stockpile' equipment. In places where the NSP provided unlimited amounts of injecting equipment, some participants would take large amounts such as a box of one hundred 1 ml syringes. Another strategy participants used was to make sure they had new injecting equipment in convenient locations. They would then ensure they went to the NSP when their 'spare' equipment was running low, thereby avoiding situations where they might have drugs but no new injecting equipment.

'... in my car I always make sure there's at least a full pack of (fits). So no matter what, so if I get stuck in the middle of nowhere, and I've got something on me, I'm alright, because you need support to hold the morphine and we're talking about tablets and I used to shoot up morphine pills. Now, if I didn't have it on me I would start ... and literally I'd make sure, if I was going to x, y, z, I'd make sure I've got a full pack, I've got the spoon, I've got this, I've got that. And if I didn't have it, I didn't go anywhere.' (Canberra, OST)

Other participants reported always keeping a used needle and syringe for 'emergency' occasions.

'There's always a dirty up high in my closet somewhere.' (Canberra, OST)

It was much more common for participants to report re-using their own injecting equipment than equipment that had been previously used by another person.

Currently, NSP are not a part of any Australian prison. Therefore, one of the few options a prisoner could have for obtaining injecting equipment that is new or only used by themselves is to steal them from the health clinic in the prison. A couple of participants from the prison focus group reported having gone to some risk to obtain a needle and syringe that had been used by the nurse on them.

'... (I had a) blood test and as soon as she turned around, I put my hand in (and pulled the) needle back out. Fuck it, it's my needle.' (Sydney, prison experience)

'I had my first blood test, as soon as the nurse put it inside the little yellow bin and went back to her desk, when she turned her back, I just pulled my own needle out and took it back with me in my pants' (Sydney, prison experience)

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The harm associated with re-using your own equipment was often associated with the bluntness of the needle, and the pain and difficulty this might cause in the injecting process. However, a few participants also reported health problems associated with re-using their own equipment. A couple of participants reported re-using their own equipment made them feel sick, and a couple of participants spoke of increasing the effects of HCV on themselves by using their own already used needles.

'I still get really sick with the stuff, though, if I re-use my own.' (Canberra, heroin)

'Well, the blood's only got to be out in the air for a couple of minutes and it's off and then you're using off blood. It doesn't matter whose it is.' (Canberra, heroin)

'And then you get abscesses and so forth.' (Canberra, heroin)

'I've already got hep C and I'm not particularly well, so I'm not going to add any more to the load.' (Canberra, OST)

The social context of drug use is recognised in the literature as being an important influence on peoples' injecting behaviour. Strong social relationships and the influence of group norms can have structural and attitudinal effects such as how people access injecting equipment, and the injecting behaviours that are considered acceptable.

A few participants used a process of marking their own equipment in a particular way to ensure they knew which equipment they could re-use. In one focus group a participant reported asking friends who used drugs in their house to mark their equipment in a different way to the ways she and her partner marked their equipment. These participants were all able to use this process on a regular basis just 'in case' they found themselves without new injecting equipment on an occasion when they needed it.

'I'm a big fan of marking my equipment.' (Sydney, OST)

'I bite mine on the top. My boyfriend will scratch ...' (Sydney, OST)

Another strategy for minimising the risk of harm was that of cleaning used injecting equipment before using it again. The methods they used varied, and participants were not sure they would be effective. Methods that were mentioned included:

- Flushing with hot water;
- Flushing with cold water;
- Flushing with a mixture of water temperatures;
- Putting partly used solutions through wheel filters;
- Flushing with bleach;
- Flushing and wiping with an alcohol swab.

'I would use the hot cold, hot cold flush, like assuming there's no alcohol swabs or bleach available. I'd use that or go without most times.' (Canberra, OST)

Most of the participants were very strict and clear about who they would share injecting equipment with. The focus group discussions replicated most of the studies already conducted with PWID in that the participants were most likely to report sharing injecting equipment only with partners. For some of these participants, this was not something that necessarily meant they considered themselves safe from BBV transmission.

'With partners I think you would find it'd probably be safe to say yeah, we all of us have had that experience (of sharing) with partners.' (Hobart, ATS)

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'It's just what you put in your head really (that makes you decide to share with partners). We know that you can't catch hep C through sex unless you've got a bloody sore on your dick or something' (Hobart, ATS)

'... (you're) swapping spit anyway.' (Hobart, ATS)

Only a couple of participants said a refusal to share injecting equipment with a partner would be considered offensive or insulting.

'You wouldn't be too happy if you said to your partner "I won't be using the barrel after you.'

Responding: 'Yeah, "Man, I'm not touching that!"' (Canberra, heroin)

In a couple of discussions, participants reported using a process of 'sero-sorting' with partners or close relatives, similar to that of gay men in minimising sexual HIV transmission risk. The 'partners' would share injecting equipment not as a preference, but on occasions where it was necessary because they were already physically 'intimate' and 'sharing risk', and because they trusted their knowledge of each other's BBV status. The participants would use this knowledge of HCV status to reduce transmission risk between themselves and their partners and friends. For example, two couples in which one partner was hepatitis C positive and the other was negative had an agreement in which they knew the positive partner could use the equipment of the negative partner but not the other way around.

'I can use his but he can't use mine.' (Canberra, OST)

Several participants relied on others to tell them if they were HCV or HIV positive, and relied on their relationship with the person to protect themselves when sharing injecting equipment. Even in prison there was an implication that you could share with people you know. When it came down to a choice between not having drugs and having drugs, however, more than one participant reported bending their own rules.

'They'd (friends) be straight up with you. You'd know. Do you know what I mean? So it's up to you. It's your choice.' (Canberra, ATS)

Participants managed fear or guilt associated with sharing injecting equipment with others because HCV was something almost all PWID are living with, and was spoken of as an almost inevitable part of injecting drugs.

'Well they might have hep C as well so you think, oh fuck it, I've got hep C.' (Hobart, ATS)

Using found equipment that could have been used by others was mentioned by some participants. In these cases, the participants were usually speaking about times where they felt they had no other options and were in a state of desperation. Using other people's injecting equipment is, in some ways, a practice that is generally viewed negatively, something that is increased when the person who has used it is unknown. The discussions in which participants related having done this were told in ways that exaggerated rather than justified the experience, possibly to disguise a sense of shame or to offset fear of judgement from other people in the room.

'I'm going to admit it man. I, I've ripped a yellow bin off a toilet bin. I don't, I'm not proud about it.' (Sydney, prison experience)

'I'll pick it out of the gutter.' (Canberra, heroin)

Social factors were important influences for the participants in terms of their own potential risk behaviours and the ways in which they protected themselves and the people within their social groups. People who didn't have strong relationships and friendships with other people who injected drugs in their communities had to be self-reliant and prepared, even if that meant re-using their own injecting equipment sometimes.

'I can't stash because my partner doesn't know that I use, so I need to I don't need a ten pack,

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I just need a one pack for that minute and then I go and get the next time.' (Hobart, ATS)

'I don't know anybody and I do have a stockpile just for that reason.' (Hobart, ATS)

Friends were reported by many participants in almost all the focus group discussions as being an important source of injecting equipment. Peer-based models were also suggested as a way to increase access to injecting equipment. It was noted that some PWID already provide new injecting equipment to others in unofficial but effective ways. These tend to be people in convenient locations with more flexible available hours than the traditional and official service models of NSP.

'You go to a friend's house that's stockpile's that big. Someone and there's heaps of mates going in all the time 'cause they stockpile.' (Hobart, ATS)

'All the drug users knew that they could knock on his door and get a fit after hours. He gave out a lot of fits.' (Canberra, heroin)

'People actually get a little bit organised, you know? Where, you talk to whoever your using circle is and you say "Okay, we'll have it here Thursday afternoon or whatever. Do you want any?" and everyone dumps their dirties and it's more organised, you know?' (Canberra, OST)

Some of the participants themselves reported providing new injecting equipment to their friends. A few participants spoke about having 'stockpiles' of injecting equipment to give to friends if needed, or of obtaining 'extra' equipment they didn't need themselves when they accessed the NSP. For these participants, preparation and thinking about what was needed was an important part of their drug using experience or even a kind of social or community service. It appeared to be a role they viewed as important.

'We were just saying amongst one another we give out our clean fits to someone that asks for fits.' (Canberra, heroin)

'Yeah we share them out with, like, our community. Like she's at her community and I'm at my community.' (Canberra, heroin)

Social networks were also important for participants and their friends who had particular difficulties accessing new injecting equipment. For example, some discussions focused on the difficulties faced by PWID who live in rural areas including the stigma associated with injecting drug use, and the fact rural and isolated communities are often tight-knit, with everyone knowing each other and little chance of their confidentiality being protected.

'One of the things that's hard is when people that are in the country that use, right, with the stigma around it to start with the locals and getting to go and get it, 'cause they can't actually have it in the area where they are, they've got to go miles to go and get it.' (Hobart, ATS)

In these discussions, the PWID from rural areas had systems in which city-based friends, understanding their issue, would try to send or bring them injecting equipment.

'I'd go down and visit them and I...they've got half a dozen fits they'd use 20 times over, you know, it's like "Oh mate" you know I take a backpack full down for them.' (Hobart, ATS)

'He (my friend) sends me one week and then collects two and then when I come in I collect one. So between me and somebody who does a fair bit of running around [for me] I'm covered.' (Canberra, OST)

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One of the rural-based participants had a complex strategy for ensuring she would be able to access enough injecting equipment each month to have a new butterfly and barrel for each injecting episode. This person would access an NSP once a month in a trip that required several hours of driving and in between, a friend would both pick up some equipment from the local NSP and either keep it for them until they could visit or post it to the participant. The situation was made more complex because, at the time of the discussion, the closest NSP in Canberra placed limitations on how much injecting equipment could be taken each day.

'... (To come to the NSP) it's a 260 K round trip.'

Participant 2 (responding): 'So how often do you have to come here then?'

Participant 1 (responding): 'Well, I've got somebody here who will stick something in the mail for me too, so usually once a month I do a run.'

Facilitator (responding): 'And are you allowed to pick up more equipment on your trips to Canberra because you're an out of stater? ...'

Participant 1 (responding): 'My partner in crime does a pick up on my behalf once a week, so I get those as well as my own. So then I'm set for the month, you know?' (Canberra, OST)

For the other participants in this focus group, it was obvious the system that the rural participant and their friend had implemented was a highly precarious one. Many factors could interrupt the supply and result in the person being left without enough new injecting equipment, whereby the person would have to re-use equipment or go without.

'But see, the thing is, she's at risk because it's just this continuous, if for some reason one of those drops doesn't get to her, you know ...' (Canberra, OST)

The PIED participants also reported a reliance on friends to educate them about how to access equipment, such as through internet sites or pharmacies that sold them, as well as providing them directly to each other. The reason for accessing peers differed to that of the participants in other focus groups. It was because the participants didn't know about NSP and/or wouldn't want to go to an NSP.

'I got it (injecting equipment) through a few friends.' (Perth, PIED)

NSPs that limit the amount of equipment a person can take at any one time do not take into account the reasons PWID might larger amounts of equipment such as poor veins and different drugs that are used frequently. It also does not provide for people who are gathering equipment for more than one person. It was clear from the discussions that many people access NSPs not just for themselves or their partners, but also for friends and others in their communities. The ability to go to a friend's house and access injecting equipment when it was needed was a solution to the limited hours of NSPs, the sometimes more inaccessible or inconvenient locations, and the fear of being punished if drug use is discovered.

Along with the perception of several participants that they and their friends accessed extra new injecting equipment and provided it to others as a public service, a number of the participants had strong negative opinions about giving their used injecting equipment to others to use. As with borrowing used injecting equipment from others, lending it to others was something people considered carefully, in a small number of cases with the view to protecting themselves as much as others.

'No bloody way (I'd lend mine) 'cause if you find out you've got hep C, I know I've gotten rid of the hep C, but you're not pinning it on me, you know what I mean.' (Hobart, ATS)

Several participants reported experiences of having someone ask if they could 'borrow' or use their already used injecting equipment, something that was reported as being difficult either because the person felt it made them look like a 'junky' or because they understood lending

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equipment to be a behaviour that would put someone else at risk. In either case, lending used injecting equipment to others was a decision that was not taken lightly. The participants appeared to take responsibility not just for their own safety but also for the safety of others in their circles. Most participants in these circumstances would try to reduce risk to others by telling them of their own HCV status and encouraging them to clean the equipment. It was considered the person's own responsibility once they had been given the knowledge to make an informed choice.

'Like the other week, there was no clean fits and I, I was having a shot with someone, and I go, "Bro, I've got hep C." And he goes, "No, that's alright. Have a swig.' (Sydney, prison experience)

Although most of the participants initially said they would refuse to lend their used injecting equipment to another person, many of them also said there were factors that would convince them to change their minds. The most common of these was seeing the person in withdrawal. The participants' spoke of empathising with how the person was feeling, knowing if they were in the same situation they would also consider using another person's injecting equipment. This is something that has been shown in other research, reflecting the empathy and social obligations people dependent on opiates feel towards others in their community.

'Well, I did tell him that I had hep C, and he still didn't care. Well, like I said, he was literally spewing and shitting on himself. He was a sick man, yep.' (Canberra, OST)

'I told him about twenty times "It's dirty" but they're still begging you, crying ...' (Canberra, OST)

Most of the participants who discussed lending their equipment to others used strategies to mitigate the risk to the people who were borrowing it. In particular, they encouraged the person to clean the equipment to protect themselves from BBV transmission. Cleaning methods that were discussed varied, and several of these conversations revealed confusion about the most effective ways to clean needles and syringes.

'Squeeze the swab together 'cause it's alcohol and draw that back to clean it out.'

Responding: 'Boil it, boiling water.'

Responding: 'Aftershave, anything like that.'

Responding: 'And then, as I say, cold water's really good too.'

Responding: '... someone said to me to use warm water.'

Responding: '... 'cause it also makes the plastic, something to do with the plastic and germs can absorb in plastic in really hot water.'

Responding: '... so there's stuff we don't even know about like that. How long does it (HIV) stay alive, you know? All that.' (Hobart, ATS)

In a few focus groups including the focus group with participants who had spent time in prison, the lack of options for obtaining new injecting equipment did not stop participants from making decisions based on actual or perceived knowledge of a person's BBV status, reliance on people that were known to them to be honest about their BBV status or just people who were known.

'I'm a bad junkie. You know, if you says you haven't got it, you ain't got it.' (Sydney, prison experience)

'It is my mate, I suppose. I would take me mate's word for it.' (Canberra, ATS)

Within the prison environment the consequence for not fulfilling the obligation to tell others of a positive BBV status before lending them used equipment, could be severe. Participants both within and outside the prison focus group spoke disparagingly of the 'type of person' who wouldn't tell others of their BBV status and the punishments they received or even deserved.

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'HIV inmates should be charged with attempted murder if they infect someone.' (Sydney, prison experience)

However, some of the prison group participants were more circumspect. This group was one of the only focus groups who spoke about HIV as a concern, probably because they had been personally exposed to HIV as a risk factor in the prison environment through HIV positive inmates who were also injecting drugs in prison. Although some of these participants spoke of violent, potentially fatal consequences for people who were thought to have risked transmitting HIV to others in prison, they also recognised the complexity of the situation, as revealing positive HIV status in prison was also something that made prisoners vulnerable.

'But it is hard. A lot of them won't tell, like, they'll sit there and, too scared to say that they've got HIV. ... You don't ever want to appear weak.' (Sydney, prison experience)

'I'd rather tell them, than them finding out and getting killed.' (Sydney, prison experience)

HCV was seen as less of a threat in most of the comments made by participants. In the prison focus group, some participants spoke clearly about the similarities and differences between HIV and HCV. For example, they conversed about the improvements in HIV treatments, seen to be almost as good as treatment for HCV, spoke of people dying from HCV, and also identified HCV as being more easily transmitted than HIV. Despite this knowledge, HIV was still clearly seen to be worse than HCV in terms of personal health and stigma and discrimination from others.

'Inmates feel much more at ease admitting that they've got hep C (than HIV):' (Sydney, prison experience)

'When I found out I got hep C I just went "bugger it", because it's not an STD.' (Sydney, prison experience)

'Well, we've all got it (HCV):' (Sydney, prison experience)

The focus group participants in the prison group were the only participants who reported thinking about HIV transmission when making decisions about sharing injecting equipment. While concern about HCV transmission was discussed, it was HIV that the participants reported as being the factor that would prevent them from sharing injecting equipment in the prison.

'The dreaded (HIV) will stop ya (from sharing):' (Sydney, prison experience)

'As long as it's not AIDS.' (Sydney, prison experience)

However, there were some participants even within the prison focus group who reported the potential for HIV transmission would not be strong enough to stop them from sharing injecting equipment.

'There is no such thing as drawing the lines.' (Sydney, prison experience)

'Only for a certain amount of time (can you hold out) and then, like, you know, you give in eventually.' (Sydney, prison experience)

In another focus group the type of drug used had a direct impact on the likelihood of sharing injecting equipment. In this case, a culture sometimes associated with using the drug could also be associated with sexual and injecting related risk practices. A participant in the Sydney OST group related an experience about using ATS. This participant reported attending parties where groups of friends would use ATS over periods of days. The parties were aimed at gay men and would involve days of using drugs and having sex. Reducing the risk of harm in these parties required planning, systems, and cooperation from everyone in the party to be responsible for their part in the system. The focus group participant described the system as being potentially complicated as well as precarious. It was noted that 'accidents happen', particularly after the party had been going for a long time, or when new people who didn't understand the system were introduced.

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'I'm involved in a lot of gay sex partners, okay. And once everyone's shot up their ICE, things can get pretty crazy, so... what we do is, we're all given a different book ...with a sheet of paper So you're sitting here, I might be there. That'll be mine for the night. Two, three, four, and we'll all have our own things, and then put our equipment back on that. ... once that's injected and the clothes come off, anything can happen....and it usually does, seriously. so it gives us something to come back to as well. ... and we have everything, the porn that goes on, but an alarm will go off, we set an alarm so we all rehydrate And the other thing is that, to be prepared. If you've got six guys coming over that are there for a fuck and to shoot two point or however much ... It involves a little bit of, you know, preparation, obviously there's occasions where ... orgies,... they can be a bit tricky. ... with crystal, it's quite different to opioids.' (Sydney, OST)

It is outside the scope of this study to assess the impacts of wider factors such as social disadvantage or political, racial and cultural inequities on individual risk behaviours and vulnerability to BBVs such as those found in studies by Rhodes in 2002 and 2005. However, it is clear PWID are influenced by many different factors when thinking about and using drugs in the Australian context. There is no single, simple experience in which PWID find themselves passive victims of circumstance, reacting without thought. The fact most participants in this study had used other people's injecting equipment, lent their used injecting equipment to others, and were unsure about some basic facts such as the best ways to clean used injecting equipment to prevent BBV transmission are all serious areas of concern.

The people who spoke about their experience of using a range of drugs in this study made considered decisions to avoid harming themselves and others in the context of their drug use. These harm avoidance techniques are hierarchical, and are adaptable to changing circumstances. They also refer to a range of both short and long term harms, not just BBV risk, some of which take precedence over the risk of BBV transmission in some contexts. All of them, however, reveal willingness to engage in practices that are intended to protect people's own health and safety and that of their friends. It is essential for policy makers and services to understand the most important perceived harms to the individual PWID before occasions of unsafe sharing of injecting equipment can effectively be addressed and BBV transmissions reduced.

Conclusion And Recommendations

This study is unique in a number of respects. We believe it to be the only recent Australian peer-based qualitative study of this kind. We have examined the re-use of injecting equipment from the perspective of fifty PWID across four states in Australia. The study involved people who had close relationships with each other, some who were acquaintances, and strangers, all of whom injected a range of different substances. The focus group discussions focused on what contributes to the rates of re-use from their perspective.

The discussions covered extremely sensitive topics that are often difficult to speak about, even when all the participants and facilitators identify as PWID. It must be remembered that illicit drug use is just that, illicit. Speaking in detail about your own illicit activities to a group of people, including strangers when the information is being recorded is something that requires courage and careful consideration. Therefore, the particular activities participants were prepared to admit in this context could change significantly according to the people in the room and the conversations that were taking place.

In each of the focus groups we held, participants were willing to discuss not only others', but also their own experiences of re-using and sharing injecting equipment. For this reason, although sometimes a particular activity, perception or idea might be stated by only one or two people, we believe some of these statements may reflect more broadly the views of other participants in the groups, even if they didn't verbalise it, as well as potentially some views of the broader community of PWID in Australia.

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Injecting itself can also be a sensitive topic. Outside of conversations with other PWID friends, PWID probably rarely speak about their injecting except when accessing injecting equipment or drug-related health services, or participating in research. PWID may therefore tend to be careful about the type of behaviours they will speak about for fear of punishment, discrimination or judgment.

As stated earlier in this report, most conversations related to sharing and re-use of injecting equipment in the context of health care stops at the question 'have you ever shared injecting equipment?' This study endeavoured to go beyond this question to explore the reasons behind re-use of equipment. For PWID, the admission of sharing of injecting equipment carries an expectation of judgement. As we have stated above, PWID are rarely asked for more detail about their re-use or sharing of injecting equipment. This research reveals that when the possibility of sharing injecting equipment becomes a reality for PWID in the context of their social relationships and personal circumstances, the conversation about how to manage the harms associated with this is usually an honest, detailed and thoughtful one. When there is not enough injecting equipment available (for whatever reason) for everyone, PWID take seriously the responsibility of adapting to the limitations and protecting themselves and their friends from the harms that most concern them as best they can. The data shared in this report will help to better understand how PWID make decisions about the re-use of equipment in such circumstances.

The study had a relatively high number of participants. In all focus groups except one we achieved the minimum (and in one case, the maximum) number of participants aimed for. In total fifty (50) PWID participated in eight focus groups across Australia. There was a good cross-section of people in terms of age, gender and cultural background (refer to Table 1), however, as is the case with much of the research in this area, the study participants did not reflect diversity in relation to employment status is something that warrants further attention in future research of this kind. This study was not designed to assess the impact of these factors on re-use and sharing of injecting equipment. However, further research examining the relationship between these factors and re-use is recommended.

As noted in the overview of literature much of the research relating to BBV transmission risk, particularly among PWID in Australia, has focused on individual risk factors and behaviours. While the participants in the focus groups spoke of circumstances in which their own individual decisions had an effect on BBV transmission risk, their understanding of potential harm was broader than just that of BBV transmission. Their strategies for managing some of these harms were innovative and often effective. They also had a broad range of experience and ideas for change in several areas. For these reasons, we have included many of their strategies along with others suggested by the results of the study in the recommendations.

Based on the findings presented in this report, we offer a number of recommendations. They can be grouped under the following categories:

- innovative and better quality service models;
- understanding, criminalisation and reducing stigma and discrimination; and
- priorities for further research.

Innovative and Better Quality Service Models

It was clear from the focus group discussions that participants wanted to use new injecting equipment but experienced many different barriers to being able to access the services that provided injecting equipment when they needed it. They were also limited by the types of injecting equipment that were supplied at these services, and by the costs associated with accessing the equipment, either direct (such as transport) or indirect (the cost of a fitpack for

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instance). Services varied in their models of provision across the different states and territories, each with their own limitations. Prisons, of course, were notable for having no new injecting equipment available. Finally, stigma and discrimination, and lack of knowledge of staff around drug use created an additional barrier to accessing injecting equipment.

Many of the participants had their own suggestions about how incidences of sharing and re-using injecting equipment could be reduced. These suggestions focused almost exclusively on the ways NSP services are provided in the community and in the prison system. Many participants had experience with different types of service provision encompassing models that have been tried in the past and others that have continued in different locations around Australia.

The service models recommended by the participants that were considered to have the potential to have a significant impact on increasing access to injecting equipment and reducing rates of re-use and sharing of injecting equipment included:

- Outreach models – in vans or other vehicles, on foot or by post;
- Unlimited amounts of all types of injecting equipment at no cost;
- Extended opening hours of NSPs including 24 hour services;
- Peer-based NSP;
- NSP in prisons using appropriate models based on input from prisoners;
- Government subsidised injecting equipment in pharmacies;
- Free vending machines in more locations;
- Safer injecting facilities;
- Fitpacks including injecting equipment for different types of drugs available from all pharmacies and vending machines;
- Workforce development for NSP and pharmacy staff to increase understanding and reduce stigma and discrimination;
- Peer distribution models including volunteers and PWID in the local community; and
- Better models for service users to provide input into services.

Most of the participants in the prison focus group agreed prison-based NSP was needed but some believed it would “never happen” in “redneck wonderland” Australia (Participant, Sydney, prison group). However, when they spoke of the way it could be done, they agreed the complicating factors were mostly related to power dynamics within prisons. They spoke of the need for prisoners to protect themselves from the impact of these power-based relationships, as prisoners with drugs or injecting equipment could be vulnerable to harassment or violence. For example, showing weakness to prison guards is something the prisoners avoided at all costs, and that included allowing the guards to know they were on OST in certain situations while at the same time, other prisoners knowing they were on OST made them vulnerable to being stood over.

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The participants with prison experience mostly agreed that;

- Prisoners need to protect themselves from legal consequences of prison staff knowing they have injecting equipment;
- Prisoners need to protect themselves from other prisoners knowing they have injecting equipment or drugs;
- Prisoners feel they need to protect themselves from prison guards or other prisoners knowing they are on methadone or buprenorphine; and
- If the model wasn't one that prisoners could access in private, confidentiality among health or NSP providers within the prison system would be paramount to an NSP model being successful.

Contrary to expectation, the study found few correlations between the type of drug used and reports of increased incidence of or different sharing practices. There were a few conversations in which risk practices were reported by participants that related to the type of drugs being used. In general, this related to the type of equipment being used. In particular, participants who injected opiate substitution treatment such as methadone and buprenorphine, or pills and other prescribed drugs, used types of injecting equipment that was often more difficult to obtain in the amounts needed. This equipment was more difficult to obtain because it was not provided in some NSPs, the amounts provided were limited in other NSPs, it was only sold in a limited number of pharmacies, it was not provided through vending machines, and the costs associated with buying it was considered to be unaffordable by many participants.

Pharmacies should be encouraged, through legislation and resourcing, to provide injecting equipment at an affordable price for PWID. We believe providing the types of equipment needed for injecting methadone, buprenorphine, other opiates and pills, in particular, larger barrels, winged infusion sets and wheel filters, should be provided for free at all NSPs in unlimited amounts, and that this could have a significant impact on reducing incidences of sharing and re-use of injecting equipment among people who inject these drugs. Fitpacks with all the equipment needed for injecting OST, pills and other types of opiates should be included in government-funded programs and provided free or for limited cost through pharmacies and vending machines. In addition, the number of participating pharmacies and vending machines catering to PWID should be scaled up in cities and regional and rural areas. This would significantly increase access to the injecting equipment needed by people who inject these substances.

This study clearly shows PWID have a range of different needs relating to their injecting drug use. The locations and opening hours of NSP and pharmacies reduces access to injecting equipment for people who need to access it at the time of injecting. A range of different service models is needed to cater to the different needs of PWID and their range of circumstances. Free access to an unlimited range of injecting equipment at all hours of the day and in various city, urban and rural locations would go a long way to meeting these needs. In addition, incorporating PWID themselves into services, from the design of services, through to peer-education could also increase access to NSP.

The participants themselves suggested many different ways injecting equipment could be better provided such as through different outreach modalities. One of the most important findings in this study is the potential impact support for peer education and peer-based NSP could have on reductions in sharing and re-use of injecting equipment. Some participants suggested they would volunteer their own services to improve after-hours access to NSP. While we would not suggest PWID should be asked to provide NSP on a voluntary basis, it is clear many PWID are already providing unofficial NSP amongst their friends and local communities.

Currently, most Australian districts do not have laws protecting or encouraging PWID to provide new injecting equipment within their social networks, i.e. peer distribution laws. It is essential laws allowing the peer distribution of injecting equipment be implemented as an urgent priority, and policies and resourcing to ensure their effective implementation also be introduced. At the same time, training programs for peer educators would likely increase the quality and number of these 'unofficial services'.

Understanding Criminalisation and Reducing Stigma and Discrimination

All of the people involved in this study injected substances that were illegally obtained. Injecting itself, and particularly injecting drug use, is also an activity that is extremely stigmatised in society. PWID usually try to keep their injecting drug use hidden. At the same time, PWID are encouraged to use new injecting equipment, the obtaining of which invariably involves publically admitting to injecting drug use to another person or at least undertaking activities that would be associated with injecting drug use – such as accessing a vending machine. There is therefore a disconnect between the reality of illicit drug use and the public health policy, provision and messaging related to BBV prevention which cannot be ignored yet is very difficult to overcome.

People related several experiences of stigma and discrimination as well as fear of stigma and discrimination. These experiences and perceptions had a significant impact on the ways participants accessed injecting equipment.

For example, several participants limited the amount of time they would be in possession of injecting equipment because they didn't want to be caught by police, by partners or by other significant people in their lives. This manifested itself in only accessing enough equipment for one incidence of drug use, and disposing of the used equipment as quickly as possible. As a consequence, these participants also reported regular occasions where they would re-use their own injecting equipment and in some cases would share equipment with others because they hadn't planned to use drugs and therefore were not prepared with sufficient new equipment.

As has been emphasised throughout this report PWID, including the participants in the focus groups, do not want to share injecting equipment. Re-use and sharing was associated with a number of harmful effects. However, the harmful effects were not always enough to completely stop people from doing it. Several of the participants reported keeping a used needle and syringe rather than a new needle and syringe for emergency situations such as unplanned or 'spontaneous' using opportunities. More research is needed to understand this practice and the internal rationale that PWID are drawing upon when doing this. At the same time, education of PWID and strategies to encourage keeping new injecting equipment instead might be effective. The most effective strategy would likely be increasing the range of convenient and quick after-hours options of outreach and other services providing injecting equipment. Advocacy and education with law enforcement also needs to be continued and improved to reduce incidents of targeting and searching PWID who have accessed NSP or pharmacies.

People who were prescribed OST and who injected drugs including their OST faced a particular barrier, that of being punished through their prescribed medication if their injecting was discovered. There was a high level of fear of "authorities" finding out about their injecting, police searching them and finding injecting equipment, or their doctor being told they were accessing injecting equipment by another service provider such as a pharmacist or the police. The ramifications of having their medications taken away or their takeaway doses removed went beyond just this, with participants fearful of spin off effects such as losing their children, their employment and subsequently, their ability to manage in their lives.

It is well recognised that people who are on OST do not always immediately stop their illicit drug use. Some people will continue to use other drugs while they are on OST. It would be

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useful to advocate for improved protections for people who use drugs and who are prescribed OST, to eliminate measures that lead to punitive responses in OST programs such as urine testing, and to ensure confidentiality is maintained. This may be particularly important for people some PWID such as those who have young children, and those with prison experience and/or conditions relating to law and justice such as bail conditions.

Stigma and discrimination is increasingly recognised as a driving factor contributing toward and directly producing harms towards marginalised populations such as PWID. Australia's National HIV Strategy and National Hepatitis C Strategy both include recommendations to reduce stigma and discrimination toward people who use drugs, and people living with these viruses. The recommendations, however, rarely come with specific ideas for how to address stigma and discrimination or key indicators to indicate success.

We recommend a comprehensive strategy to address stigma and discrimination toward PWID among health workers, NSP workers, pharmacists and pharmacy staff and staff of other services likely to work with PWID. AIVL has developed a training model for healthcare workers to reduce stigma towards people who use drugs, people on OST and people living with HCV. Training models such as these, incorporating the voices of PWID, can be used or adapted for a range of circumstances.

Additionally, it is essential drug use by itself not be an indicator for the removal of children from their parents. Advocacy and education for a range of services who are likely to come into contact with PWID including child protection services, law enforcement and justice services should be included in training and services. Legislative and policy that support maintaining children in the care of parents, particularly those on OST programs, when there is no evidence of abuse or neglect should also be considered. Further, services working with PWID should be resourced and supported to provide better quality, non-judgmental services to PWID and their families, that address any parenting needs that may exist within a supportive and understanding framework that does not stigmatise PWID.

Effective models of NSP should be implemented in all Australian prisons. The evidence for these programs is clear from prison-based NSP in approximately 60 prisons in over 9 countries (AIVL, 2008) as well as Australian harm reduction programs. Prisons are unquestionably vectors of BBV transmission in Australia. There is already support for prison-based NSPs from a range of professional bodies, policy makers and political leaders. It is time for the political will and commitment to take the next step and create policies and legislation requiring prisons to provide NSP to prisoners using models that are considered acceptable by prisoners, and that have been effective in other countries.

Further Research and Education

People who use and inject drugs have been and continue to be the subjects of research. Despite this, there is a need for further research that explores injecting drug use in ways that incorporate the knowledge of IDU themselves in working toward addressing some of the entrenched harms related to the re-use of injecting equipment. The available data gathered on re-use and sharing continues to tell the same story and the figures seem to be 'stuck' at an unacceptably high rate. This study provided an opportunity to get beyond the surface to better understand some of the lived experience of drug users and how this is impacting upon the current rates of reported re-use. Although AIVL was limited by resources and time, we have been able to demonstrate the value of research of this nature. More comprehensive and detailed research of this kind is needed into the future if we are to make inroads into the issue of injecting equipment re-use in Australia.

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Based on the focus groups, we recommend concentrating efforts on researching some of the following areas:

- The impact of legislation and policy criminalising PWID on access to harm reduction services in Australia;
- The impact of legislation restricting peer distribution of injecting equipment;
- The impact of prior experience/s of harassment when accessing NSP or pharmacy in reducing future access;
- The impact of previous experience of arrest and imprisonment on how PWID access and use injecting equipment;
- The impact of fear of punishment and punitive measures related to OST on reducing access to injecting equipment;
- The impact of child protection and other service involvement on reducing access to injecting equipment;
- Ways to use better understanding of the impacts of drug withdrawal in reducing incidents of sharing; and
- Better education of PWID on best practice cleaning of injecting equipment in real world situations.

The focus groups did not reveal significant differences between the types of drugs being used and injecting related risk practises. Most of the differences related to the equipment needed to inject the drug rather than the drugs themselves. However, one focus group did show a particular group of people whose ATS use involved a culture of potentially harmful injecting practices.

In this case, a participant reported attending parties in which several men would spend a number of continuous days using amphetamines and having sex. According to this participant, it was common for these groups to use complex and potentially precarious systems to ensure all the men involved could keep track of their own needles and syringes. The systems were intended to minimise the potential for the party-goers to use other people's needles and syringes. Rather than ensuring a large stockpile of new equipment be available, the re-use of their own injecting equipment tended to be encouraged through the system.

Further investigation about groups of people engaging in these types of parties and practices is warranted. In particular, gaining a better understanding of the practices people engage in, the systems they develop, and the ways these systems could be strengthened could decrease risk associated with these practices. There may also be ways services could better engage with the people involved and develop education and programs targeted at increasing safety and reducing risk.

The study had a high number of people from Aboriginal backgrounds. Two serious cases of surveillance and harassment were revealed by an Aboriginal brother and sister, and an Aboriginal couple when they were trying to access injecting equipment. In each case they were followed by security guards and ejected from a public building, in one case after being followed into a public toilet. Other participants and focus groups also reported surveillance systems and occasions where they believed law enforcement were watching them access injecting equipment and targeting them afterwards.

It was clear from the focus groups, that people who feel surveyed, targeted and harassed, and people who are fearful of police presence, are less likely to access services where they believe they are vulnerable to these practices. They are also more likely to access equipment in ways that are designed to minimise the chance they will be caught with injecting equipment but also

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increase their chance of not having new equipment available when they need it. We believe understanding the experience of Aboriginal PWID around Australia in relation to surveillance and harassment and accessing injecting equipment is needed. It is also important to better understand the impact surveillance and harassment may be having on re-use of injecting equipment and relatedly blood born virus transmission, particularly among some populations of PWID such as parents, Aboriginal people, and people with prison experience.

Many of the people in the focus groups who reported limiting the amount of time they were in possession of injecting equipment had experience of arrest and imprisonment. Several of these people reported always carrying a used syringe, often "cut down" and hidden on their person. Others knew someone else who had been arrested and imprisoned who also did this. Their reason for doing this was for the express purpose of having a needle and syringe that had only been used by themselves if they were arrested. While the participants did not or could not explain why having a used needle and syringe would be 'better' than being caught with a new needle and syringe, this could be another important area for further research.

It is not well understood how much impact legislation relating to peer-distribution limits PWIDs access to injecting equipment. While several participants discussed providing new injecting equipment to their friends and local communities, some were concerned about there being possible ramifications. This, combined with the illegality of using drugs such as heroin and amphetamines is likely to influence some people who might otherwise encourage more peer distribution within their social networks. More research on the impacts of legislation and policy preventing peer distribution is needed alongside pilot programs to look at models for encouraging appropriate peer distribution and peer education.

The participants had conversations revealing they were attempting to reduce harms to themselves without up-to-date and evidence-based information. For example, several different ways for cleaning injecting equipment were mentioned, and none of the participants were clear about which of these might be better than others. Research suggests cleaning of needles and syringes is discouraged by NSP workers for fear PWID will clean rather than use new injecting equipment. It seems people continue to clean and re-use their injecting equipment even when they are unsure about how to do it effectively. Therefore, better education about cleaning injecting equipment, best practice techniques, and other information of relevance to PWID should be a part of harm reduction messaging for all injecting drug users.

Final Remarks

There is no single, simple experience in which PWID find themselves passive victims of circumstance, reacting without thought. Instead, the people in this study who spoke about their experience of using a range of drugs make considered decisions to avoid harming themselves and others in the context of their drug use. These harm avoidance techniques are hierarchical, and adaptable to changing circumstance. They refer to a range of both short and long term harms, not just BBV risk, some of which take precedence over the risk of BBV transmission in some contexts. It is essential for policy makers and services to understand the most important potential harms to individual PWID as they see them before occasions of unsafe sharing of injecting equipment can effectively be addressed and BBV transmissions reduced.

As there is no one reason or explanation for the continued sharing of injecting equipment, neither is there one answer to address this. This report includes some of the recommendations made by the PWID who participated in the study, and some that were suggested by the findings. We recommend taking a comprehensive approach targeting a range of issues, all of which we believe contribute to the continued sharing and re-use of injecting equipment by PWID. Therefore, we recommend:

- Improved service delivery through NSP and pharmacy;
- Innovative service models that respond to the needs of local PWID including prison-based NSP;
- Free and low cost injecting equipment in unlimited amounts;
- Different types of injecting equipment for the use of different types of drugs available in a range of locations;
- Increased use of peer education and peer-based models;
- Training and advocacy for the health sector and law enforcement to reduce stigma and discrimination; and
- Better understanding of a range of factors that influence sharing related risk practices and protect PWID from harm; and
- Legislative change to address the impacts of criminalisation on PWID injecting related harms.

This study has looked at some of the harms associated with injecting drugs using the views of PWID themselves. The people who participated in this study had a strong understanding of the issues that faced them and their communities. They also made significant efforts to reduce harms and protect themselves and their friends from negative legal, health and social effects associated with injecting drug use. With matching commitment from policy makers, funders, service providers, and researchers to better understand the lives and concerns of PWID, and the resolve to work with PWID in decision making and services that affect them, BBV transmissions and other harms for PWID could be significantly reduced in Australia.

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Appendix

The Australian Injecting & Illicit Drug Users League (AIVL)

Participant Information Statement And Consent Form

Sharing And/Or Re-Use Of Injecting Equipment Study

The aim of the Australian Injecting and Illicit Drug Users League's (AIVL's) Sharing and/or Re-use of Injecting Equipment Study is to contribute to national efforts to reduce the transmission, morbidity, mortality and negative social and personal impacts of hepatitis C and other blood borne viruses (BBVs) and sexually transmissible infections (STIs) among people with a history of injecting drug use.

This study seeks to examine some of the key reasons for the sharing and re-use of injecting equipment among people who inject drugs (PWID) in Australia. It is hoped that the drug user community will benefit from this research as the results will be used to advocate for improved services for PWID.

If you decide to participate, we will ask you to attend a focus group session with 6-10 other participants, facilitated by members of AIVL's staff. The focus group will be in the form of a group discussion, will take 60 to 90 minutes and will be audio-recorded. The recordings will be destroyed once they have been transcribed. All data from the focus groups will be de-identified (so what you say will remain anonymous) prior to analysis and publication. All documentation will be securely kept at the AIVL premises, and we will make every effort to ensure your privacy and confidentiality. Reimbursement of \$40 will be made in recognition of your time and expertise.

If you give us your permission by signing this document, we plan to disseminate the findings through publication in scientific journals, conference and seminar presentations, on the AIVL website, and through AIVL and its state/territory member organisations. In any publication, information will be provided in such a way that you cannot be identified. Participants may contact the researchers to obtain copies of any published material arising from the project.

Your decision whether or not to participate is voluntary. Whether you decide to participate or not will in no way affect your future access to services, or your relationship with AIVL and its member organisations. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time.

If you have any questions, comments or complaints, please free to ask/tell us. If you have any additional questions after participating in the focus group session, Angella Duvnjak at AIVL (contact the AIVL office - 02 6279 1600 or mobile - 0407 391 078; email - angellad@aivl.org.au) will be happy to answer them.

This information page is yours to keep.

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By ticking the box below I confirm I have read and understood the information contained in both the 'Participant Information' and 'Participant Consent Acknowledgement' sections provided and in particular that:

1. I agree to participate in the study, and I am aware that I can withdraw from the study at any time. Further, I reserve the right not to provide any information that I do not wish to provide.
2. Whilst understanding that I may withdraw from this study at any time, I also understand that if I do decide to withdraw, I will not be able to remove the information that I may have provided earlier.
3. I understand the potential risks involved in participating in this study and I am also aware of the options should I experience any distress or discomfort related to participating in this study.
4. I understand that if I have additional questions related to this study I can contact a member of the research team.
5. I agree that de-identified research information collected from me can be included in future research related activities, including the publishing of findings in thesis papers, magazines and articles, presentation of results in relevant conferences and other public forums and may also be published in peer reviewed journals.

I acknowledge that I have read and understood the above information and that I freely give my consent to participate (Please tick box if you agree).

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM (continued)

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided above, you have decided to participate.

.....
Signature of Participant

.....
Signature of Researcher

.....
(Please PRINT name)

.....
(Please PRINT name)

.....
Date

.....
Date

Yes, I would like to receive a summary of the results. Please email: _____

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Notes:



