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BACKGROUND

Among people who inject drugs (PWID) in the UK, prevalence of Hepatitis C (HCV) is 33-56%, HIV 0-1%, and Hepatitis B (HBV) 6-18%. Harm reduction in the UK is facilitated by the provision of opioid substitution treatment (OST) and needle and syringe programmes (NSP). However, Public Health England's "Shooting Up" report (2015) indicates that while the sharing of needles, syringes and paraphernalia is lower than a decade ago, 38% of PWID continue to share mixing containers, filters, needles and/or syringes.

Project PROTECT is a NIHR HTA-funded study which developed and feasibility tested an evidence-based psychosocial intervention to reduce blood borne virus (BBV) risk behaviours among PWID in the UK.

To inform the development of the intervention, a qualitative interview study was conducted to determine the current influences on injecting-related BBV risk behaviours, such as sharing of needles, syringes and paraphernalia and injecting others/being injected. We report on these qualitative findings here.

METHODS

In-depth interviews were conducted with a convenience sample of 60 PWID ≥ 18 years of age who had injected illicit drugs in the past 4 weeks (15 from London, Yorkshire, Glasgow and North Wales).

Participants were recruited from drug treatment/harm reduction services, needle exchanges, sexual health clinics, and homeless hostels.

Purposive sampling was used based on gender, length of time injecting, drugs injected, involvement in sex work and homelessness.

Interviews were analysed using Qualitative Framework Analysis.

RESULTS

35 (58%) men and 25 (42%) women were interviewed, with a median age of 33 years (range 19-51). 82% were on OST. The main influences on injecting risk behaviours for BBVs included:

Drug-related states

Most participants cited withdrawal as the circumstance in which the sharing of needles, syringes and injecting paraphernalia was most likely to occur. Participants described similar scenarios of running out of injecting equipment and the 'desperation' induced by withdrawal symptoms meant their priority was to take the drug 'as quickly as possible' and therefore they used whoever else's equipment was available.

"when I have no needles and there's no...access to a needle exchange, it's after...six or seven o'clock in the evening...and you're starting to feel that, sort of, withdrawal and you know you want the heroin and the person has needles and so you take the risk."

Craving was similarly described as exerting a pressure to use drugs which led participants to share equipment when without their own.

Intoxication undermined participants' ability to manage risks. Alcohol and/or benzodiazepines were reported to cloud judgement and reduce inhibitions, leading to inadvertent risks and intentional sharing of equipment.

"if...I'd been drinking all day, and I was with, well, a few of my friends in the hostel, I could be a bit laxy (*relaxed/lazy*) in my way of thinking. I would never share a needle or that, but I could draw up from the same cook pot."

Similarly, the euphoria induced by injecting cocaine was reported to reduce vigilance, leading to equipment becoming accidentally mixed up.

Trajectory of Drug Use

In the early stages of their injecting drug use, participants lacked the skill to self-inject and were reliant on others to inject them. When being injected by others, participants' main concerns were the risk of injury if the person injecting them missed the vein or hit an artery or nerve and their dependency on others to obtain their 'hit', rather than BBV transmission.

"I was obviously a bit scared if they missed me and if they knew what they were doing... well they obviously knew what they were doing but sometimes it would miss me. You know you give them a lot of responsibility."

Most participants reported being asked by others to administer drug injections at some point. Participants' main concerns when injecting others were the stress created by difficulties finding a vein and the potential legal ramifications if the injection recipient died, rather than BBV transmission.

Relationships and social networks

Although not universal, sharing of paraphernalia and needles was more likely within couples, based largely on trust and familiarity. Many participants felt comfortable sharing equipment with their partners but not with anyone else. Participants were confident that they knew their intimate partner's BBV status. Thus trust often took precedence in intimate relationships over safer practice.

"I've been with my partner 20 years, and if she used a needle I'd use it after her, because I know that she hasn't got anything."

Negotiating drug preparation and injecting practices within group injecting situations could be challenging. Some participants reported feeling under pressure to go along with unsafe practices, including sharing paraphernalia, as they felt intimidated or feared causing offence.

"I've been in those situations where I've felt uncomfortable saying to the person about sharing spoons, because I don't know how they're going to take it... they might be, like, 'Well, what are you trying to say? Are you trying to say that I've got HIV or Hepatitis?' And some of them are dangerous people."

Access to resources

Homelessness meant injecting often had to take place outdoors or in public places where lack of resources, reduced control over the injecting environment, unhygienic settings and pressure to rush the injection led to intentional sharing of needles, syringes and paraphernalia as well as accidental BBV risks.

"[I]t's more when we've got nowhere to go. So we're doing it out of quickness...in car parks, in closes... You're trying not to get caught. That's when you will just go into at least do it quickly, you know, in and out... That's when you just go, 'Fuck it, I'll share that needle with you.'"

Many participants highlighted evening time and weekends as times when needle and syringe sharing were more likely as pharmacies and NSPs were closed. Some interviewees also felt there were not enough pharmacies offering needle exchange and not enough NSP in smaller cities or rural areas.

Values, mental health and life events

Participants frequently rationalised distributive sharing by viewing the risk taken by those who borrow used equipment as the recipient's responsibility.

"I try not to (*share needles/syringes*), but if they were pestering me and pestering me and...on and on and on at me and I just want to chill out, I tell them, I say, listen, I'm positive for Hep C, if you want to use it, it's your problem."

Poor mental health, e.g. psychosis, depression and low mood, was reported to cause indifference to one's health and reduced care around safe injecting.

"My sister died and I've been so depressed...that I've thought, you know, who cares?...I don't want to be here anyway...What does it matter if I use her set, her syringe, you know."

Health scares, including BBV scares and risk of amputation, prompted some participants to change risk behaviours.

CONCLUSIONS

- **An interplay of structural, situational and individual factors influenced injecting risk behaviours for BBVs.**
- **Priorities and risks other than BBV transmission are often paramount for PWID.**
- **BBV prevention initiatives should target other injecting-related priorities of PWID, including "symbiotic" goals, such as improving injecting techniques and venous care to promote the use of sterile injecting equipment.**
- **Protective practices and strategies to avoid injecting risk situations such as withdrawal and lack of preparedness should also be considered.**