

**AT RISK AND UNPROTECTED:
FINDINGS FROM THE YOUTH, AIDS AND DRUGS (YAD) STUDY**

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ABSTRACT

The YAD Study was an investigation of injecting drug use, sexual behaviour and the psychosocial context of risk behaviour in a group of normal (non-delinquent, non-homeless) young people living in Perth, Western Australia. One hundred and five young people (under 21), three quarters of whom had injected illicit drugs at least once, were interviewed. The analysis was largely qualitative.

The major finding of the study was that most respondents felt that they were at little or no risk of HIV infection. The prevalence of HIV/AIDS in Perth, especially among young people, was believed to be low, and there was a general feeling that 'safe' partners (both sexual and injecting) could be chosen. Half of the injectors claimed never to have shared a needle, and those who had, or thought they might at some future time, maintained that needle sharing occurred only in those situations when the injector was 'desperate' - that is, wanted to inject but did not have a clean needle to hand. Those occasions were said to be rare. Unprotected sex was the norm, and there was a general dislike of condoms.

Respondents knew about HIV/AIDS and were clearly afraid of contracting it. However, a range of constraints prevented them from enacting their wish to remain HIV/AIDS free. These constraints operated through limited knowledge about HIV/AIDS and the prevention of infection, taken-for granted social beliefs and understandings, the demands of peer relationships, social disadvantage, gender roles, engagement in criminal behaviour, the nature of health and welfare services, the attitudes and practices of service providers, and the legal and structural provisions of the society in which respondents lived.

In general it was concluded that these young people were at risk of HIV/AIDS, other blood borne viral infections and sexual transmissible diseases because of inadequate education, lack of social support and a limited range of health and welfare services. A range of innovative health promotion programs and services needs to be initiated and/or expanded if they are to be protected

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EXECUTIVE SUMMARY

Young people often use illicit drugs casually and occasionally without coming into contact with health and welfare agencies. Some inject these drugs. Their risk of infection with HIV and other blood-borne viruses through needle sharing has often gone unnoticed because they have not been viewed as part of the 'injecting drug user' community. On the contrary, the risk of HIV/AIDS to young people has largely been seen as residing in their sexual behaviour.

The study reported here is an attempt to redress this lack by exploring the injecting drug use, sexual behaviour and psycho-social contexts within which HIV/AIDS risk behaviours are enacted, in a group of normal (i.e. non-delinquent, non-homeless) young people living in Perth, Western Australia.

One hundred and five young Perth people who used injectable drugs, 75% of whom were current or recent injectors, were recruited to the study through advertising and snowballing. Each was interviewed individually for at least 90 minutes and paid \$20 for participation. The study was largely qualitative, so permitting respondents to speak in their own words.

It was found that most of the respondents in this study felt that they were at little or no risk of HIV infection. Many believed that behaviours such as unprotected sex (and, for some, needle sharing) were not very risky because the prevalence of HIV/AIDS in Perth, especially among young people, was low.

For many of the respondents, injecting had been initiated very casually. Some respondents' first use of amphetamine was by injection, and even very occasional users injected. Only half of the injectors had ever shared a needle, but more than half could imagine a situation in which they might share, particularly with a lover. Needle sharing, however, was said to occur only in those situations when the injector was 'desperate' - that is, wanted to inject but did not have a clean needle to hand, and these occasions were said to be rare. Respondents shared injecting equipment other than needles more readily than they shared needles, and some did not understand the risk of contamination from these practices.

There was a general dislike of condom use, and most respondents claimed that their careful choice of potential sexual partners obviated the need to use condoms consistently. However, 'safety' between lovers and friends who wished to have unprotected sex and/or share needles, was more assumed than negotiated: that is,

there had seldom been adequate communication between the couple as to whether the assumption of safety was warranted.

In general it appeared that the use of sterile needles on most occasions had become the norm, except in the particular case of needle sharing between lovers. Many respondents, however, were prepared to accept the view that there were times when injectors just 'had to' share. Whereas sharing only occurred when there appeared to be no other choice, unprotected sex, on the other hand, was the norm, and condom use for many only occurred when there appeared to be no other choice.

The factors that impinged on the behaviour of these young people were complex and various. An environmental prevention model was applied, and it was found that individual behaviour was influenced at a multiplicity of levels, from the intrapersonal, through interpersonal interactions and cultural mores, to the social and legal environment. These factors were conceptualised as constraints that could prevent young people from enacting their wish to remain HIV/AIDS free.

The data suggested that these constraints operated through limited knowledge about HIV/AIDS and the prevention of infection, taken-for granted social beliefs and understandings, the demands of peer relationships, social disadvantage, gender roles, engagement in criminal behaviour, the nature of health and welfare services, the attitudes and practices of service providers, and the legal and structural provisions of the society in which respondents lived.

The implications of these findings for appropriate health promotion and education for young people like those studied were considered. Recommendations for this population in Perth are as follows:

- 1 Young people must be educated to have realistic perceptions of the risk of HIV/AIDS through needle sharing and unsafe sex; their knowledge about HIV and AIDS as a disease and as an epidemic must be improved; and young drug users must have better access to services and people with whom they can discuss their drug use, and be advised on ways to deal with problems arising from intoxication, withdrawal and dependency.**

- 2 Every attempt must be made to prevent or delay young drug users' transition to injecting as a route of administration. Examination of the legal status of marijuana should be undertaken with a view to enhancing the status of non-injectable drugs relative to injectable drugs.**

- 3 Peer educators and older current and ex-injecting drug users should be employed to make contact with young people who inject drugs. These educators should challenge commonly held beliefs about HIV/AIDS risk and transmission; promote the use of condoms and teach safe injecting. Special provision should be made for the identification and support of very young injectors, and female peer educators should be employed to make contact with, and take up issues of particular concern to, young women who inject.**

- 4 The availability of needles and syringes (N&S) should be increased and promoted through increasing the number of needle exchange schemes (NES), particularly in the outer metropolitan area; widely advertising the location of late night and 24 hour pharmacies that sell N&S; advertising the sites of the mobile NES van more widely; training pharmacy sales staff so that young people are encouraged rather than discouraged when purchasing equipment; increasing the number of vending machines for both condoms and N&S; reducing the cost of both condoms and N&S and widely advertising the availability of free N&S for those who cannot afford to buy them. In addition, the accessibility and user-friendliness of testing services must be considered, and primary health care providers encouraged to refer young people to testing where appropriate. There should be more dialogue between law enforcement and health promoters which promote positive relationships between the police and young people, particularly those who use drugs.**

- 5 Commonwealth and State education and health authorities should take responsibility for promoting AIDS preventive behaviour as clearly and widely as possible, and considering the effect of all relevant policy decisions on HIV/AIDS prevention. National, regional and local media outlets should be encouraged to present a balanced and non-sensationalised portrayal of the HIV/AIDS epidemic and the people who are involved in it.**

Overall, it must be acknowledged that there are large numbers of 'normal' young people in Australia who inject drugs, many of whom do not experience significant negative consequences from their drug use and are therefore not in contact with health and welfare services. They are at risk, through their injecting and sexual behaviour, of HIV/AIDS, other blood-borne viruses and STDs, and research and a range of innovative health advancement programs and services need to be initiated and/or expanded if they are to be protected.

INTRODUCTION

HIV/AIDS, the worst modern plague, was first identified at the beginning of the 1980s. In the developed world earliest concern was expressed for those communities that bore the brunt of the first infections: gay men and, a little later, injecting drug users (IDUs). Concern about heterosexuals, and, particularly, adolescent heterosexuals followed and there is already an extensive literature regarding patterns of risk behaviour in this population. Unfortunately there is a far smaller literature on young IDUs, perhaps because the modal injecting drug user found in research is a 28 year old heroin addict (Loxley, Ovenden, Hawks & Somerville, 1992) Other than in reports of street youth, the HIV/AIDS related risk of young people who inject drugs has largely escaped research attention.

HIV/AIDS AND YOUTH

Epidemiological evidence suggests that many HIV infections occur during adolescence and young adulthood. Thus, although only 2.1% of new known Australian HIV infections to 30 June 1996 occurred among people aged 13 to 19, 18.1% of AIDS cases and 13.1% of all AIDS deaths in the same period occurred in people aged 13 to 29 (National Centre for Epidemiology and Clinical Research, 1996). Given the long incubation period of HIV, it is apparent that many of these people would have become infected as teenagers.

The epidemiology of adolescent HIV infection in the developed world is different to that of adults, with more haemophiliac and heterosexual transmissions and fewer homosexual or injecting drug use transmissions (Goplerud & Resnick, 1991). It has been suggested, however, that experimentation with illicit substances and sexual activity, cognitive immaturity and inadequate knowledge about HIV/AIDS place young people at higher risk of HIV infection than adults (Goplerud & Resnick, 1991).

INJECTING DRUG USE

According to the 1995 National Drug Strategy household survey, up to 4% of people aged 14 - 19 and 20 - 24 may have injected themselves at least once, and 1% of 14-19 year olds admit to having injected in the previous 12 months (National Drug Strategy, 1996). Quantitative studies of young IDUs (e.g. Loxley, Marsh & Lo, 1991; Spooner, Flaherty & Homel, 1992) have found that while there may be few young people in Australia who inject drugs, a sizeable number of these may be at considerable risk of HIV/AIDS through needle sharing. There seem to be some

differences between young and older IDUs, and between those young people who do and those who do not inject, but little is known about the social, affective and cognitive processes that underlie risk behaviour or young people's norms and values about injecting.

SEXUAL BEHAVIOUR

The sexual behaviour of young IDUs has rarely been studied. There is, however, a large and burgeoning literature on the HIV/AIDS-risk sexual behaviour of adolescents and young adults.

Teenagers in the late 20th century initiate sexual activity at an earlier age than those in earlier times; they engage in frequent sexual activity; up to 20% may have had 4 or more sexual partners in their lifetime, and condom use probably takes place, at best, on no more than 50% of occasions (DiClemente, 1990; Fife-Schaw & Breakwell, 1992; Moore & Rosenthal, 1991a). There is a general acknowledgement that condom use has increased in more recent years as a direct outcome of HIV/AIDS (Hingson, Strunin, Heeren & Berlin, 1990), although this increase tends to be moderated by the extent to which alcohol and/or other drugs are used before intercourse (Strunin & Hingson, 1992). Most agree that the incidence rate of STDs among adolescents is alarming, with the prevalence of many STDs being higher among teenagers than in any other population group (DiClemente, 1990). Dunne, Donald, Lucke, Nilsson and Raphael (1993), however, found that Australian high school students were not well informed about STDs.

Australian research (e.g. Moore & Rosenthal, 1991a, Moore & Rosenthal, 1991b) has found that, despite having a good understanding of the ways in which HIV/AIDS is transmitted and how transmission can be prevented, adolescents generally do not fear the transmission of HIV/AIDS through sexual behaviour, many believing that they are personally invulnerable. However they do not apparently consider the risk inherent in serial monogamy which is the most common youthful pattern of sexual relationship, with the average length of these partnerships being around 6 months. Young people also tend to overestimate the extent to which their partners behaved monogamously. This discounting of changing partners every six months or so and overestimating sexual fidelity meant that many seriously underestimated their risk of infection. Similar findings have been obtained among 16-25 year olds in Britain (Woodcock, Stenner and Ingham, 1992).

SOCIAL BEHAVIOUR

Young people's drug use and sexual activity have to be considered in the context of their social lives. These behaviours are not only enacted with peers but are likely to be governed more by peer norms and values than by the norms and values of parents and other adults (Kandel, 1986; Jessor, 1987). Any discussion of HIV/AIDS-risk behaviours in young people has therefore to consider the particular nature of peer relationships.

The similarity of young people to one another is often noted, and the vast literature on youthful drug use makes much of the influence of peers (see Ovenden, Marsh & Loxley, 1993, for a review). The research evidence suggests that young people seek out friends who are like themselves in behaviours and beliefs, and that they either become more like each other as the friendship progresses or the friendship ends and each seeks others more like him/herself (Savin-Williams & Berndt, 1990).

Some studies have found that friends' perceived attitudes and behaviours influence HIV/AIDS-risk behaviours. Klitsch (1990), for example, found that young people's use of condoms was more influenced by social factors such as condom popularity with peers, than by knowledge of the health benefits.

Rolf, Nanda, Baldwin, Chandra and Thompson (1990-91) investigated beliefs about peers' attitudes to unsafe behaviour in incarcerated youth and found that young people believed that they were personally more worried about the risk of HIV/AIDS than were their friends. These beliefs had the effect of creating a peer culture in which it was not seen as 'cool' to admit concern and use precautions, and the authors suggested that young people should be given accurate feedback on their friends' level of concern. It is also apparent that communication among young people may not be as frank and forthright as one might wish. This is an issue taken up by Wight (1992) who believed that since adolescents can often not discuss sex with a potential partner, the notion of young people 'negotiating' safe sex can be an absurdity. Clearly there are barriers of embarrassment and diffidence that have to be broken down first.

KNOWLEDGE

The public health model of behaviour change maintains that accurate knowledge leads to attitudinal change and thence to behaviour change. Although it is now known that behaviour change is far more subtle and complex than this simple model would suggest, accurate knowledge is still presumed to be a necessary, even if insufficient, condition of behaviour change. It is therefore critical to assess the nature and extent of knowledge about HIV/AIDS that has been acquired by young people.

One of the difficulties in reviewing this area is that temporal and geo-cultural specificities make comparisons across studies very difficult. Despite these differences, however, there are some remarkable consistencies. Young people have generally been found to say that they know all that they need to know about HIV/AIDS, and then demonstrate that their knowledge is simplistic or inadequate (Memon, 1990; Barnard & McKeganey, 1990; DiClemente, Lanier, Horan and Lodico, 1991; Wright, Gabb & Ryan, 1991).

Injecting drug users have been found to have high levels of knowledge. In the Australian National AIDS and Injecting Drug Use Study (ANAIIDUS) knowledge among IDUs about HIV/AIDS and HIV/AIDS risks was found to be both high and accurate (Australian National AIDS and Injecting Drug Use Study, 1992). In the Perth ANAIIDUS, however, younger IDUs were less knowledgeable about HIV/AIDS than older IDUs (Loxley et al., 1991).

CONSTRAINTS ON SAFE BEHAVIOUR¹

Preliminary research for the project in this report was undertaken at this Centre in 1989. The aim of that study was to explore barriers to safer drug use and safer sex that might exist despite the implementation of harm minimisation programmes in Perth. Nine categories of barrier were identified: availability, cost, embarrassment, identification, personal characteristics, information, pleasure, situational and social (Loxley & Davidson, 1991).

External barriers - such as the cost of equipment and location and opening hours of pharmacies or the perceived actions of the police in monitoring needle exchange schemes (NES) in order to identify IDUs - were particularly important to respondents, but there was also considerable discussion of the extent to which drug effects, such as withdrawal or intoxication, changed the process by which decisions about safer behaviour were made.

DEMOGRAPHIC AND DRUG USE DIFFERENCES

¹ The word 'constraints' is used consistently in this report to refer to psycho-social factors which may deter, prevent or reduce the likelihood of HIV/AIDS-preventive behaviour. This follows the Macquarie Dictionary definition of constraints as 'confinement or restriction; repression of natural feelings and impulses; unnatural restraint in manner' (Macquarie Dictionary, 1986) in which it is clear that both internal characteristics and external forces can constrain individuals.

Age may be a significant factor in both perceptions of risk and behaviour. Younger adolescents have been found to be less knowledgeable about health factors than older adolescents (Millstein, 1993). Goodstadt and Mitchell (1990) maintained that age was the single demographic variable most reliably associated with 'problematic drug use' and that severity of drug problems was negatively correlated with age of onset of drug use.

Goodstadt and Mitchell (1990) also maintained that gender alone was not a good predictor of drug problems. Nevertheless Barnard (1993) found that women's patterns of needle sharing and access to equipment were different to men's which suggests that gender based differences in risk behaviour need to be carefully assessed, even if no overall differences in behavioural prevalences are found. The influence of gender on sexual risk has been more clearly described, and the interaction of risk with inequalities of power in sexual relationships documented (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1992; Wight, 1992).

While gender clearly interacts with sexual risk, poverty, living in an economically depressed area and minority status are all associated with the risk of drug problems. Early school leaving and unemployment which may be related to minimal education are associated with risk (Goplerud, 1990). Moore (1990) claimed that ethnicity and social class also influence drug using behaviours: in Australia this may be particularly seen among Aboriginal communities where the preconditions for high rates of HIV infection among urban and rural Aborigines exist (Adams, 1992).

This very brief review demonstrates that young people who use drugs or engage in 'problem behaviours' are not a homogenous group. Socio-demographic variables interact with cultural values and expectations to make some at more risk than others, and any detailed assessment of risk must take these variations into consideration.

INADEQUACIES IN THE LITERATURE

The literature on young IDU in Australia is limited in both general and specific ways. In general, there is a lack of good epidemiology. Stimson (1992) maintained that the estimation of the prevalence and incidence of drug injecting should be high on the research agenda. This has not occurred in Australia, where reliable information about the number of IDUs, breakdowns by age, gender and drug of choice, frequency of injecting, and distribution of IDUs through the different urban and country regions of Australia is still needed.

More specifically, little is known about young people who inject drugs. Much of the literature that has investigated youthful injecting has focused on street youth or those

in juvenile detention centres. Apart from the assumptions that this makes about young people's drug use, such a view distorts understanding of which young people inject, and fails to offer insights into the social, cultural, affective and cognitive processes that underlie adolescent illicit drug use. The literature not only fails to consider the young, but also fails to consider the drugs they commonly inject. In both the UK and Australia psychostimulants are the most commonly injected drugs by IDUs generally, but particularly by the young. IDU literature, however, has tended to focus on heroin users, perhaps because the traditional IDU research design samples drug users in treatment, and psychostimulant users are less likely than heroin users to be found in treatment centres (Loxley, Ovenden, Hawks & Somerville, 1992).

Concern about the risk of HIV/AIDS and other blood borne infections to young IDUs requires research that explores the social, cultural and individual aspects of young people's injecting, needle sharing and sexual behaviour. Such a study is described in this report.

METHODOLOGICAL CONSIDERATIONS

This project was designed to intensively examine as many factors as possible that might impinge on the safe or unsafe injecting and sexual behaviour of young people, and to do so by allowing respondents to use their own words to explain how HIV risk is understood and managed.

The literature briefly reviewed above suggested that the widest possible range of influences that might impinge on HIV-risk should be investigated. It is useful to conceptualise these in terms of a public health systems model similar to that proposed by Holder (1989). Maintaining that the prevention of alcohol-related problems required strategies that affected the environment as well as individual behaviour, Holder categorised important drinking-related factors in terms of five levels: a) individual factors b) the immediate drinking environment c) the family and workplace environment d) the community environment and e) the larger legal and cultural environment.

The adaptation of this model to young IDUs involved the renaming of these levels as: a) individual factors b) the immediate drug using environment c) the family and peer environment d) the community environment and e) the larger legal and cultural environment (Figure 1).

In Figure 1 examples of the factors that might be considered within each level have been culled from the literature cited above. It will be clear that not all of these factors could be investigated in a single project. Nevertheless, it has been possible to explore some factors at each level, and to categorise factors suggested by respondents within these levels.

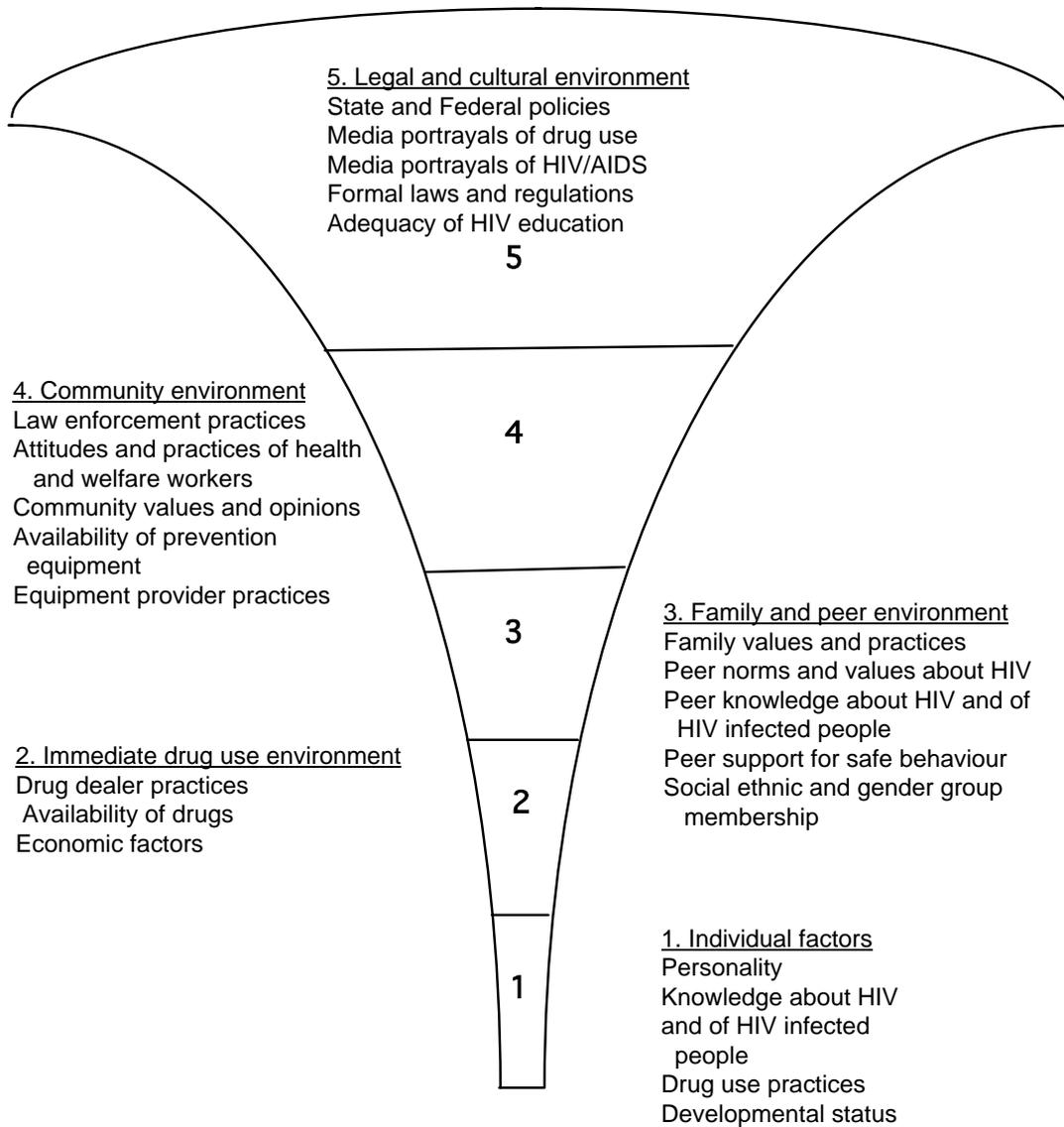


Figure 1: Holder's (1989) Prevention Conceptual Model Adapted For Young IDUs.

METHODS

All phases of the research received approval by Curtin University of Technology's Human Research Ethics Committee before implementation.

OVERVIEW OF RESEARCH

One hundred and five young (under 21) people who used injectable drugs, 75% of whom were injectors, were recruited to the study through a variety of advertising, snowballing, and direct referral strategies. They were interviewed individually and paid \$20 for their participation. No identifying information was recorded. Data were collected on a short questionnaire which assessed demographics, drug use histories and recent HIV-risk behaviour, and during an in-depth interview which lasted between 1.0 and 1.5 hours. Interviews concluded with a short information and education session. Interviews were tape recorded, transcribed verbatim and analysed using qualitative analysis techniques. Quantitative data were analysed using procedures in SPSS-X.

QUESTIONNAIRES AND INTERVIEW GUIDES

Quantitative data were collected with the Demographic and Drug Use of Teenagers Questionnaire (DDUT), a 15 minute, administered questionnaire developed for this study which has been separately described (Ovenden & Loxley, 1994) and the HIV Risk-Taking Behaviour Scale (HRBS). The HRBS is a brief, 11-item questionnaire developed to measure the behaviour of IDUs that puts them at risk of either contracting, or passing on, HIV (Darke, Hall, Heather, Ward & Wodak, 1991).

Qualitative data were collected using an Interview Guide which was structured by topic areas administered to all respondents, and examples of probe questions which could be used to elicit further information. Each topic was introduced with a standard statement or question.

The following topics were included in the Guide:

- Salience of HIV/AIDS to young people
- Initiation into illicit drug use - a) general b) injecting
- Scoring drugs - a) personal experiences b) friends' experiences.
- Description of a typical injecting/using episode
- Sharing needles and other injecting equipment - a) personal experiences b) friends' experiences.

- Sexual experiences a) personal b) friends'.
- Education about, knowledge of and attitudes to AIDS a) personal b) friends'.
- Knowledge and use of harm minimisation programs a) personal b) friends'.

RECRUITMENT OF RESPONDENTS

There were three main recruitment procedures: advertising, referral from agency staff and referral by respondents who had already been interviewed or snowballing.

Fliers were printed with the following information:

- Respondents would be paid \$20 to complete the interview
- The interview was anonymous
- People under the age of 21 who had injected drugs or who used pills and powders but did not inject them were needed
- People were required to talk about drugs, sex and AIDS
- The researchers' names and a contact number
- The study was approved by the Human Research Ethics Committee of Curtin University

Study cards were handed out to respondents and agencies for distribution. They contained the name of the study, the researchers' names and a contact phone number.

DATA COLLECTION

Respondents were interviewed between July 1991 and October 1992. Most of the interviewing was carried out by a research assistant employed for that purpose. Interviews were carried out in a field office rented for the purposes of this study which met the requirements of being in the city, close to public transport and in a nondescript building which was not associated with drug treatment or youth services. The address of the room was not given out other than over the phone to young people making an appointment for interview.

Legal advice was sought in relation to interviewing minors without parental consent. We were advised that it was acceptable to obtain consent from minors if the study was explained to them in a way that they would be able to understand and if it could be demonstrated that they understood that they were free to refuse to participate without negative consequence.

The head of the WA Police Service Drug Squad was informed about the aims and processes of the study, and it was agreed that members of the Drug Squad would not attempt to gain access to our respondents or our data.

A consent statement was used, but because respondents were being interviewed anonymously recording of these statements being read to respondents at the start of the interview and their verbal consent to proceed constituted informed consent. All interviews were tape recorded after the respondent's recorded verbal consent to do so had been received. All respondents were paid \$20 for their participation in the study.

Interviews were concluded with a short information and education session. This was often initiated by the respondents asking questions in response to issues raised in the interview, but was also an opportunity for the interviewer to correct fallacies and misunderstandings. Referrals to appropriate agencies for assistance with drug problems, advice about sexual issues or testing for blood borne viruses were also given. The correct use of bleach to decontaminate needles was demonstrated and respondents were offered leaflets, bleach sachets and condoms to take away.

DATA ANALYSIS AND PRESENTATION

Quantitative data have been presented as frequencies and percentages to describe sample characteristics and risk behaviour. Grouping variables (e.g. age, gender, education, age of first injection) for contingency table analysis were selected on the basis of the literature.

Drug use and sexual behaviour sub-scale and full scale HRBS scores were used to describe the sample, and validate behaviour reported in the interview.

All qualitative data were transcribed and analysed using NUDIST 2.3 (Richards, Richards, McGalliard & Sharrock, 1992) The following general framework for stages of qualitative data analysis was adopted: summarisation of the data; description of variables; preliminary presentation of the data; search for relationships; interpretation and verification.

Only those aspects of the data which are most relevant for prevention of risk behaviour are presented in this report. Other data have been, and will continue to be, reported separately. See Appendix II for a full list of all reports.

RESULTS

The selection of material for presentation and the sequencing of results proceeds from the proximal (individual) to the distal (community) as suggested by Holder's (1989) prevention model, and from the descriptive to the explanatory. The demographic and drug using characteristics of the young drug users are presented first, and these are followed by descriptions of the young drug users' two major behaviours of concern (needle sharing and unsafe sexual activity) and the major attitudes and intentions associated with them. A description of the social nature of young people's drug use follows, to set the scene for the analysis of the interactions between risky behaviours and the relationships which existed between the sharing or sexual partners. Details about associations between young drug users' knowledge about HIV/AIDS and people who have been infected, and their own unsafe behaviour follows, and then constraints on safer behaviour, both within the individual and within the community and/or legal and cultural environments are considered. The chapter ends with the presentation of material indicating the extent to which various demographic and/or drug using characteristics were associated with risky behaviour.

CHARACTERISTICS OF RESPONDENTS

Demographics

The major demographic characteristics of respondents can be seen in Table 1 on p. 69. There were 55 men and 50 women in the study group with a mean age of 18.3 years. The majority were unemployed, and around half had had less than 11 years of secondary education. Almost all lived with family or friends.

Twenty seven (26%) respondents were students. The majority (65%) of respondents derived their major income from government benefits, 15% derived their major income from employment, and a further 12% were supported by their families.

Seventy seven (73%) of the study group were born in Australia, one of whom described herself as an Aboriginal person. Most of those born overseas came from English speaking countries.

Ninety five respondents (91%) defined themselves as single; one as separated or divorced, and nine as *de facto*. No-one was married. Those who were in a steady relationship reported that these had lasted an average of 10 months (range 5 to 24, s.d. 5.7). The majority of the study group were heterosexual. There were no

exclusively homosexual men, and three lesbians. Five of the total group were bisexual, and two were celibate.

Drug Use

Table 2 on p. 70 shows the percentage of respondents who had used each of a range of licit and illicit drugs at least once during the 12 months, 3 months and month prior to the interview. Cannabis and alcohol were used by virtually all respondents, and the number of respondents using these varied little across the year. LSD, amphetamines and MDMA were the most popular injectable drugs, although only 30% of the study group had used MDMA in the previous month. There was relatively little opiate use, particularly in the previous month, although around one in four had tried heroin and one in five had tried homebake (heroin synthesised from codeine) during the previous year.

Table 3 on p. 71 shows the percentage of injectors who had injected each injectable drug at least once during the 12 months and month prior to the interview. Amphetamines were the most popular injected drug, having been injected by almost all injectors during the previous year, and by 91% during the previous month. LSD and MDMA were both popular injecting drugs, although the difference between the percent who had injected LSD in the previous year and in the previous month suggests that injecting LSD was more experimental than a regular experience. Around 30% had injected heroin in the previous year, and 15% in the previous month, and slightly fewer had injected homebake. Poly-drug use of around five different drug types in the previous month was the norm within the study group.

Characteristics of injectors are shown in Table 4 (p.71). Around half of the injectors had not injected at all, or had injected fewer than 6 times in the month prior to the interview. The rest were almost equally spread between six and more than 30 times. A few respondents could not recall how many times they had injected, which may have reflected heavy drug use. The average age of first injection was 16, and most had been injecting for longer than six months.

Respondents were asked whether they had ever had contact with a range of health, welfare and law enforcement agencies for their drug use (Table 5, p. 72). More than one in three respondents had not been in contact with any agency about their drug use, and a similar number had had contact with the police. Doctors were the most frequently accessed health service providers.

HIV Risk Taking Behaviour (HRBS) Scores

HRBS Full Scale scores could not be calculated for the full study group since the Drug Use sub-scale was inapplicable to the non-injectors. Scores on sub-scales and full scale scores can be seen in Table 6 (p. 72). It should be recalled that 30 is the maximum score that can be obtained on the Drug Use sub-scale, and 25 the maximum score of the Sexual Behaviour sub-scale with higher scores indicating greater risk-taking.

Table 6 shows low levels of both drug use risk behaviours and sexual risk behaviour, and only a trivial difference in the sexual risk behaviour of injectors and non-injectors.

THE SHARING OF NEEDLES AND OTHER INJECTING EQUIPMENT

Sharing Needles

This section presents injectors' experiences of sharing and the perceived risk of sharing, both generally and to themselves. Respondents' intentions in relation to sharing are described, and the apparent relationships between beliefs and attitudes, behaviour and intentions are considered.

Needle sharing was not a common behaviour. Half of the injectors claimed that they had never shared at all, and 80% that they had not shared in the month before the interview. Only one in three said they had ever shared unbleached needles, and then usually fewer than five times in total.

There was ample evidence that those in the study group understood that AIDS was a fatal disease (although not all were sure that all HIV+ people would develop AIDS), and that sharing needles with an infected person was a highly dangerous behaviour. Most, however, considered themselves to be at little or no risk of HIV from their drug use. Some of these said that they had never shared and believed that they never would; others maintained that the people with whom they had shared, or might share, were unlikely to be infected, and that therefore they were not at risk if they only shared with those people.

Most respondents had clear views about the situations and circumstances in which they would or would not share needles at some future time. These views have been termed Risk Management Strategies (RMS). RMS could be discerned for 77 of the 79 injectors as shown in Table 7 (p. 73). The most popular RMS was never to share:

this was followed by sharing only with lovers; sharing bleached² needles with lovers of friends. and sharing (unbleached needles) with lovers or friends.

There were apparent links between past experiences of sharing (categorised as never shared/ shared only bleached needles versus shared unclean needles); Risk Management Strategies; and assessment of personal risk through needle sharing as shown in Figures 2 to 4 (pp. 74-75).

Figure 2 shows clear links between past behaviour and future intention (RMS), such that most of those who had never shared unclean needles intended not to share without bleaching in the future, while most of those who had shared without bleaching in the past could imagine themselves doing so at some future time.

Figure 3 shows that the majority of injectors, whatever their past experience of sharing, considered themselves to be at little or no risk of HIV infection. Nevertheless, there was some link between past behaviour and risk perception such that more of those who had shared unbleached needles in the past than of those who had never shared considered themselves at risk.

Figure 4 shows, again, that most injectors considered themselves to be at little or no risk of HIV infection, but more of those who did believe themselves to be at risk espoused a more risky RMS.

In general, then, Figures 2 to 4 provide a simplified view of the links between reported past behaviour, assessment of personal risk of HIV infection through injecting and RMS. These figures are an attempt to make some objective assessment of whether respondents had put themselves at risk, whether they understood that, and whether they intended to continue to do so in the future. On that basis, strong links between behaviour and RMS are shown, with those who had been more safe in the past intending to be more safe in the future and vice versa. Moreover, although the majority of all respondents did not consider that they had put themselves at risk, those who had shared unclean needles were less likely to believe this than those who had not.

Respondents were asked about the sequencing of needle sharing, because using the needle first is an obvious risk reduction strategy for the individual. However, few

² Bleach was promoted as an HIV/AIDS prevention strategy in 1991 and 1992 when these data were collected.

respondents thought about it in that way. For some, injecting first had little or nothing to do with HIV. Some said it was more related to being in withdrawal: they wanted to inject first because they did not want to wait to inject. That wait was made more difficult if they also had to wait for the needle to be cleaned between uses. Other non-HIV reasons for injecting first included women saying that they injected before their boyfriends: sometimes as a chivalrous notion on the part of the man, or because they were believed to have more tender skin than men and therefore needed the sharpest needle. Additionally, women who could not inject themselves (which was common) said their lovers injected them first in order to have a steady hand. A few who injected with lovers also commented that they liked to take in turns to go first in order to watch each other becoming intoxicated.

For some it seemed that once the decision had been made to share with a particular person, there was no need to attempt to reduce the risk further by negotiating first use although others simply said 'I'm going first and that's that'. On the other hand there were some respondents who preferred to inject second so that they did not have the responsibility of risking infecting others. Finally, some indicated that the person who injected first had either financial or leadership power: they were the ones who scored, or mixed the drugs, or were dominant or more experienced than others. One young woman, for example, describing the only time she had shared, said:

R: I was just like the baby of the group. So I didn't really know, so I just let him do it [inject her with a used needle].

At least one other respondent, however, said he would encourage the inexperienced to go first because they were likely to be more anxious (and possibly less likely to be infected).

Passing on, or lending, needles, was seen in a rather different light from using them first. For many respondents lending needles was not an easy or a casual decision: as noted above some did not want to be responsible for passing on any diseases, to the extent that some even seemed to fear retribution from their friends if they did so. Others said they did not worry because it was not their problem. Most had attitudes between these two extremes, and demonstrated considerable responsibility about used needles.

Cleaning Needles

In discussions about cleaning needles, 32 injectors who had shared had cleaned their needle themselves, and 19 of these had used bleach on at least one occasion. Of those, half had used the bleach incorrectly (usually by using hot or warm water,

because they thought it cleaned better than cold water), and only half of the remainder gave sufficient detail to ascertain that they used bleach as recommended.

Other cleaning methods that had been used included hot water, which was the most popular, boiling or cold water and various other supposed decontaminants such as household disinfectant, after-shave, alcohol and antiseptic.

Fewer than half of those who cleaned with bleach had total confidence that it could kill HIV, and a common comment was that there was no need to use bleach if one picked one's sharing partner carefully. Similar concerns were expressed about cleaning by most other methods. Many respondents said that they did not trust the cleaning technique they used to kill HIV. Cleaning was mainly to remove blood clots which could clog up the needle. Again, a common response was that they would not have been sharing if they had considered their sharing partner could have been infected.

Sharing Other Injecting Equipment

While all the respondents understood that sharing a needle with an infected person carried a high risk of virus transmission, there was less certainty about the transmission risk of sharing other injecting equipment such as spoons, filters and water.³

There are two main concerns about sharing other injecting equipment. In the first place there is a potential for virus transmission if people re-use their own needles and syringes. Provided sterile needles are used at all times there is no risk of contamination from mixing up drugs in a clean common spoon and drawing them up with an unused common filter. The potential for contamination occurs when needles are being re-used, which may be when people are having a second injection, usually later the same night. Often there are insufficient sterile needles for the second hit, and it may be too late, or they may be too intoxicated, to go out for more. Attempts may or may not be made to clean the needles before they are re-used. Re-use of needles is thus a necessary, although not sufficient, condition of contamination.

The second level of risk may come from sharing drugs. Contamination of equipment can occur when people re-use their own unsterilised needles, and draw up their drug

³ It is acknowledged that sharing tourniquets or ties can carry a risk of transmission if blood from the injecting site is splashed around, but respondents did not discuss this practice.

from a common pool, typically from a spoon, and usually through a common filter. Since it is virtually impossible to draw up a precise amount in one movement, tiny amounts of the mix, contaminated with blood from the inside of the syringe, are usually introduced into the common pool and can be drawn up by another user. Simply placing a non-sterile needle into the spoon can also introduce contamination into the mix because there can be blood on the outside of the needle as well as on the inside of the syringe, and when the needle tip is placed on the filter this can further contaminate the filter. Contamination with water occurs if used needles are rinsed in the same container of water.

Mixing in the same spoon has to be seen in the context of the social economy of using powders such as amphetamines. Respondents described the way in which they usually pooled their money to purchase one packet of drugs which they then attempted to share equally. Since liquid can be measured more precisely than powder, mixing the powder with a measured quantity of water in a single spoon (e.g. 60 ml for two people, 90 ml for three etc.) and then drawing up measured amounts through a common filter into separate syringes was common.

Adding powder to the water increases its volume so that in order to share equally it should all be drawn into a syringe to measure the volume again. It is thus particularly important that at least one needle is sterile: this was sometimes the so-called 'grey nurse': a particular make of syringe included in an AIDS Pack⁴ with which IDUs disliked injecting. Thus it may be kept clean for measuring:

R: ... you get ... that one's called a grey nurse. You use that. No-one uses that needle. You always mix up with that one because no-one will use it because they're a pain

While mixing in a common spoon was the norm in the study group because it seemed to be the best way to ensure that everyone in the injecting group received equal shares of drug, there were exceptions to this: if respondents were in a hurry they might mix in a separate spoon, and if they scored for themselves they tended to mix up their own dose, although this was usually in a group with other friends who had also scored. In a minority of injecting groups the powder rather than the liquid was shared, and some injectors had their own special spoon which had become an important part of the ritual of injecting. Single dose drugs, such as ecstasy or other pills, or LSD, were mixed - if injected - alone.

⁴ The "AIDS Pack" was a precursor to the FitPack. It is no longer available.

Sixty four injectors discussed sharing other equipment. Those who had shared unclean needles were more likely than those who had not to have shared other injecting equipment. Almost three quarters of those who discussed sharing equipment other than needles indicated an awareness of the potential for contamination and not always successful attempts to avoid it, generally using one or more of five strategies to guard against it.

- Separate spoons were used if people were re-using needles. This was the most popular strategy.
- Those who were re-using their own needles drew their mix up from the common spoon after those who had sterile needles.
- Respondents claimed that they always used the mix first. There was some overlap between this and the previous group. Some of these respondents indicated that they were in a position of power in the group particularly in being central in the buying and mixing processes.
- Only brand new needles were ever used in a common mix. Clearly this was the safest strategy, but it was not the most popular.
- Bleach was used to decontaminate needles before they were re-used. Only one respondent mentioned this.

In addition to these strategies, awareness of the risks of sharing water, filters and spoons was indicated in other ways. Some respondents reported using a filter each in the common spoon, although this was uncommon; some washed the spoon out before it was used again (often after licking it first to get the dregs of drugs from it); others used separate containers of water to rinse the blood out of used needles.

A minority of respondents did not appear to understand and/or care about the risk of sharing equipment other than needles. These adopted three different positions: the majority who were unaware of the risk; those who tried to be safe but whose strategies were inadequate; and those who understood the risks but were prepared to take them under certain circumstances.

SEXUAL ACTIVITY

This section presents interview material on sexual behaviour; reasons given for behaviour including perceptions of personal vulnerability; and behavioural intentions or Risk Management Strategies. The apparent relationships between behaviour, attitudes and intentions are considered and the section ends with a discussion of contraception and decision-making about safer sex.

Safe and Unsafe Sex

Fewer respondents had had sex with casual partners than with regular partners. Condom use with regular partners was infrequent, with half saying they never used condoms, although around one in three reported using condoms often or always. Condom use with casual partners was bi modal with two thirds of those who had casual partners using condoms on every occasion and most of the rest never using condoms.

No respondent believed that unsafe sex was without risk, but levels of perceived risk varied: some groups of people (IDUs⁵ and gay or bisexual men and people who had multiple sexual partners) were perceived to be at most risk, some practices (particularly anal sex) were believed to be more risky than others and most respondents qualified their perception of the risk of unprotected sex according to different conditions.

Respondents were asked whether they believed that their sexual behaviour put them at risk of HIV infection. Seventy eight respondents (74%) thought that it did not, 21 (20%) thought that it did, and six (6%) were unsure or unclear.

Respondents were asked to describe which strategies to reduce sexual risk they would use in the future. One hundred and one gave responses which demonstrated clear decisions about sexual behaviour. These decisions have been termed Risk Management Strategies (Sex) (RMSS) which, as with those described for injecting, were expressed as behavioural intentions but could be conceptualised as personal strategies for dealing with the risk of HIV infection (Table 8, p. 73). The most popular strategy, endorsed by almost 60% of the group, was to use condoms unless the partner was believed to be uninfected, or until the individual believed it was safe to stop using them. Other strategies, such as using condoms always, not using condoms unless it appeared that the partner was high risk, or not having sex with people who appeared high risk, were endorsed by similar proportions of respondents.

It will be seen that only a minority of respondents had adopted a strategy which had a strong likelihood of being protective in most situations and, as the detail in Table 8 attests, the most popular strategy (2) allowed for a wide variety of judgements about a partner's infectivity. Strategies 3 and 4 relied on popular stereotyping or generalisations about those most likely to be infected: gay and bi-sexual men, IDUs, prostitutes, and the promiscuous, and demonstrate that for some respondents risk was believed to be located within groups rather than behaviour. The fifth group consisted

⁵. Often qualified as 'junkies', addicted, having problem with drugs etc.

of idiosyncratic strategies which were believed to increase safety but were generally ineffective or impractical.

The apparent links between past experiences of condom use (categorised as always/usually; sometimes or seldom/never⁶); RMSS; and assessment of personal risk from sexual activity are shown in Figures 5 to 7 (pp. 75-76).

Figure 5 shows that past behaviour was similar to future intention: those who had always used condoms were more likely than others to say that they would always use them, while those who had never used them were more likely than others to say that they never would. Those whose condom use was inconsistent were the most likely to espouse inconsistent condom use in the future.

Figure 6 shows that the majority of respondents, whatever their past experience of condom use, considered themselves to be at little or no risk of HIV infection through their sexual activity. Nevertheless, there was some link between past behaviour and risk assessment such that more of those who had used condoms inconsistently or not at all considered themselves at risk, or were uncertain of the risk, than those who had always used condoms in the past. This was particularly striking for those who had never used condoms, nearly half of whom considered themselves to be at risk, or were uncertain.

Figure 7 shows, again, that most respondents considered themselves to be at little or no risk of HIV infection, and that this assessment did not vary much among those who said that they would always or sometimes use condoms. However, nearly half of those who did not intend to use condoms in the future, or whose intentions were vague considered themselves to be at some risk, or were uncertain.

In general, Figures 5 to 7 show, as with needle sharing strong links between past behaviour, personal risk assessment and behavioural intentions. Those who had used condoms less consistently in the past were less likely to intend to use them consistently in the future, and, again, while a majority of all respondents thought they were at no personal risk of HIV infection through their sexual behaviour, those who used condoms less consistently were less likely to believe themselves safe.

⁶. Those who maintained that the question was non applicable to them have been omitted from this analysis.

Contraception

Condoms were not always, or only, used for protection against HIV and other STDs. Respondents were specifically asked whether their use of condoms was more motivated by concerns about contraception, HIV and other STDs or both equally.

The major concern for all respondents was pregnancy. Condom use was unpopular and only a minority of either women or men gave STD/HIV control as a motive for using condoms.

Only one in three of the men who discussed contraception used condoms to protect themselves, or their partners, against HIV and other STDs. Where condoms were used, this was primarily for birth control in situations where the men were not confident other means of contraception were employed.

Only one in three of the women said they used oral contraceptives, so that condom use for both birth and disease control were relevant concerns for the majority. While condoms were used for both birth and disease control, this could cause difficulty in regular relationships. There was a clear sense from some that both partners were considerably relieved when the relationship became steady, the woman went on the pill and condom use could cease because 'trust' had been established. As one man said '*you've then taken care of birth control and virus control*'. It seemed that for some young couples 'going on the pill' was a symbolic statement for both of them of the extent to which they trusted one another.

For some men the perfect risk management strategy was to start a long term relationship with a virgin and then 'put her on the pill'. There was little discussion as to whether or not the men were virgins too. Some women felt coerced by their lovers to stop using condoms and some felt that they had to lie about the pill in order to negotiate condom use. Several women commented that negotiating condom use to protect against STD was more difficult if they were known to be taking the pill.

Safer Sex Decision Making

The following section describes respondents' views about what happened when the subject of condom use arose with a partner. This has been called 'negotiation' of safe sex but, as will become apparent, the term was hardly applicable to many of these young people.

Each of the 50 women in the study group discussed safer sex decision making. Almost half considered that they had little or no difficulty with this; almost as many

had experienced some difficulty, and a minority stated that negotiation was not really an issue for them.

Those women who maintained they had little or no discussion with partners about condom use adopted the familiar 'If it's not on, it's not on' line, and felt little discomfort about doing so. Among the women who had experienced difficulty, much of the discourse related to the perceived unwillingness of men to use condoms. It was apparent that the stereotype that women want sex to be protected and men do not, accurately reflected their experiences.

Another group of comments in this discussion focused around relationships: for some of the women, the stage of the relationship or, as one put it, '*what's going down emotionally*' crucially affected the way decision-making took place, with the general feeling being that if you had only just met a man you might be less inclined to worry about whether you upset him. But one woman maintained that a woman's compliance to a man's wish for unprotected sex could be a way of encouraging him to initiate a longer term relationship.

There were a group of comments about embarrassment and the difficulty in raising the question of condom use. One woman was unclear about how to do this at the right time while others said that asking for a condom to be used implied that you did not trust him. A young Aboriginal woman, in a similar vein, said that asking a man to use a condom was '*shame*'.

For young people there is often the added difficulty that sexual activity - particularly with a new partner - takes place when one or both parties is intoxicated. Several of the women commented that their drug use made negotiation of safer sex more difficult:

R: ... when I was using speed a lot, most of the guys that I slept with didn't care about protection 'cause they were all off their faces as well ...

Fifty three of the 55 men discussed decision-making for safer sex which, as with the women, was mainly interpreted in terms of condom use. There were four general categories of male response, with different themes from those which emerged from the women. Some of the men said they would follow the woman's lead if she wanted to use a condom; fewer said they would initiate condom use; very few believed that the decision should be, or was, mutual and a similar number said that they would not use or never had used a condom and/or had no experience with negotiating.

Among those men who said that they would take the lead, the general picture that emerged was of a group of men who felt confident that they could use condoms when they wanted to, although several commented that this was mainly with casual encounters. In long-term relationships decisions were more likely to be consensual. Several of the men felt that the man should suggest that a condom be used because it was his responsibility, and one, who preferred his partners young and inexperienced, said that they might be too shy to suggest using condoms and so the man should.

Some men felt that the decision to use condoms should be mutual. Most in this group said that they talked about condom use with a partner, and that this had never been difficult. One commented that condom use could be fun and that he had never had any difficulty persuading a partner of this.

Those who would not or had never negotiated safer sex were either strongly opposed to using condoms, or had little experience of condom use. One appeared to go along with the woman's wishes but sabotaged them by removing the condom during sex, while another who believed that he 'ought' to use condoms had never actually done so because he was always drunk when he had sex.

In summary, while 40% of the women had experienced difficulty in negotiating condom use, mainly because they wanted to when their partner did not, a similar proportion of men said they would comply with their partner's wishes for condoms, and a further one in three said they would take the lead in initiating the discussion (although that did not always mean initiating condom use).

SOCIAL WORLDS

Drug Use

Drug use was a social event for our respondents. Very few used drugs when they were alone: most had small groups of three to five close friends with whom they took drugs, but often in the context of larger social groups of up to 20 young people.

Drug use for non-injectors often took place outside of the home, and was frequently associated with events such as raves, concerts, outings and going to night clubs. Injectors were more likely than non-injectors to use their drugs at home, and less likely to go out afterwards. Those who lived with other injectors might inject in the company of friends in their own home, while others (perhaps those who lived with parents) might go to friend's houses, or use at the dealers' house.

While the social groups were relatively fluid, some respondents were wary about strangers or acquaintances knowing what they were doing:

R: I am pretty, you know, careful, ... I know a lot of people would, you know, could be shocked by shooting up or something ...

Some injecting group structures were tight, with some respondents referring to one or more being a leader or the 'Doctor' (who injects the others - these are not necessarily the same person):

R: Like there is always people who call themselves the 'Doctor' and that, just because they like mixing up and they like doing it and all of that, that's what I, I like, I like it sort of thing. I prefer to do [inject] other people than do myself because I rush myself and I do it but yeah, it's good.

Because drug use occurred within groups of close friends, often in a relatively structured way, it seems highly likely that unsafe injecting and sexual behaviour, if it occurred, would take place in the context of the relationships within those groups. The nature of those relationships is examined next.

Needle Sharing With Friends and Lovers

Respondents were more likely to share needles with close friends and intimates than with casual acquaintances. Thus, in an analysis of the last occasion on which they shared a needle, out of 27 who described sharing unbleached needles, nine had shared with a lover, and 14 with a friend - of the remainder, three were unclear about the nature of the sharing partner, and one had shared with a stranger. All of those who shared with a lover, and half of those who shared with a friend, felt safe in doing so because the friend or lover was believed to be known well enough for the respondent to feel confident that they were not infected. In total, only two respondents described ever sharing with strangers.

Decisions about the risk of sharing needles on a particular occasion were therefore less likely to be made globally than on a case-by-case basis. Almost half of the injectors believed that the risk of sharing could be eliminated or reduced with careful selection of sharing partners. A typical comment was that their friends and/or lovers were unlikely to be infected, and that therefore there was little or no risk:

R: Oh, not very risky, oh the people that I shared with I've know since in primary school and I think they're pretty safe.

In some cases this was because an assessment had been made about the apparent prevalence of the disease:

I: Before you shared needles you were not sharing needles. Your reason for not sharing needles then, what was that?

R: That was 'cos I was a bit worried about AIDS and that. Then it sort of just went bang. No-one here has AIDS.

And in others because it was difficult to imagine that friends could be infected:

R: ... I had shared needles before as well, you know, but the people that I had shared with I, I, you know, they were all close mates of mine and I trusted them so, you know, I trusted they had been sleeping around with no, you know, I don't think they'd got AIDS or anything. They didn't look like it ... well you'd have to know 'em pretty well. You know, if, if he's a mate, he's not an outsider or an outsider's mate, then I wouldn't do it, but if it's just a mate yea, yea, if you're mates then, then I, I'd do it [share] you know.

In other cases the judgement was made on assumed knowledge about the other's serostatus:

R: ... 'cos like, it's like I know the people pretty well and know that they haven't like had a sexual partner like for ages and ages or something like that, and like a few of them have had like tests for AIDS sort of thing.

Some respondents considered their friends to be safe because of their shared social worlds:

R: No, I sort of had known this guy for heaps long, guy that I shared the needle with. He would have slept with who I would have slept with as well. I wasn't really worried.

In other cases, feelings of safety related to prior sharing (presumably without apparent consequences):

R: ... the guy was my best mate and we'd shared a few times before anyway .

or assumed knowledge about drug use histories:

R: ... there was only one needle left and my mate had used it, and I thought "no worries he's right, he's clean", you know, I don't, I mean he, this is his like sort of first time as well you know, well not his first time but sort of you know he, he's had it about three times in the arm.

These few examples can be augmented with justifications used by the few injectors who canvassed the possibility that they might share with a friend. Almost all qualified this by specifying the particular circumstances and the nature of the friendship within which they might share.

Thus the decision to share with a friend was not made casually. Respondents clearly believed that it was only safe to share needles, if at all, with those with whom they were most intimate because such intimacy conveyed knowledge about the individual and their history.

As detailed below, sharing with lovers was often justified on the grounds that the couple had already had unsafe sex. It was clear that many couples had never used condoms, and where they did, this was usually for contraception, and often ceased within a relatively short period when they felt they could trust one another. This, however, was rarely done after having HIV/AIDS or other STD tests. Usually, little was known about the partner's sexual or injection history before the decision to no longer use condoms was made.

There was comparatively little discussion about monogamy in sexual relationships. Whether this was because it was assumed that people were always monogamous once an exclusive relationship had been declared or whether people knew that lovers were not always faithful to one another is not clear. Some respondents were aware that non-use of condoms in an exclusive relationship was only safe if there were no other partners or if condom use with non-regular partners was consistent. Several said that they trusted their partner not have other partners, and several others that they would only be ready to stop using condoms with a current partner when they trusted them enough not to have other partners.

As noted above, the second most popular Risk Management Strategy was to share needles only with a lover. Twenty eight (35%) injectors - 20 women and eight men - said that they might share an unbleached needle with a lover. This gender difference may have related to the fact that the women were more likely to be in steady relationships than the men: it is not known whether more men than women had lovers who were themselves IDUs.

A number of interlocking themes underpinned the discourse about sharing with lovers, but it should be noted that in almost every case the sharing of needles with anyone was described as being a 'desperation' measure. While the themes were not independent of one another (although presented separately for clarity), they were also not independent of decision making about unsafe sex. In some cases it was clear

that the decision to share needles was made subsequent to the decision to have unsafe sex; in other cases, both the sequencing and the decision making processes were less clear.

A common theme was that sharing with a lover was safe because the lover was well known. It was unclear in many cases whether this knowledge related to longevity of acquaintance, or actual details about history. Nor was it always clear, when respondents said they knew 'about' their lovers, whether this was knowledge of sexual or drug use histories. Discussion of knowledge was often vague:

R: Yeah because you sort of know them a lot, and after, you know, you sleep with them, it's easier ...

'Knowing' could involve some knowledge about recent past, but this did not preclude the respondent wanting to convince themselves that the partner was 'safe'. The following young woman, who had a bi-sexual lover, was a good example of this:

R: ... I'd probably share with him just yeah ... I'd feel pretty safe because I live, I've lived with him for a year and he doesn't go out, he just doesn't go out and sleep with people, so and he doesn't ... I mean when he shoots up it's basically his own needle. I mean he shoots himself up all the time with trips and like he re-uses his own needles and shit and I, I don't know, he just, he's never getting sick or anything, he's never done anything wrong, he seems to do everything well and clean and that and there just doesn't seem to be any problems with him so. Yeah I trust him.

For this woman, the desire to trust the lover seemed less to do with preserving the relationship than with the need to feel safe. The same respondent described her relationship in terms of exclusive sex with a friend, rather than romance and commitment, and suggested that it had come about because of anxiety generated by earlier, risky sexual activity:

R: I used to go out and just have sex with people just for the hell of it ... and I got really sick last year and had an AIDS test and it turned out clear and so I thought right well I know I'm clear now so from now on I think I'll just you know, stay, stay safe basically and I met up with this guy and he was gay but you know he had only had sex a few times and he said that every time he had sex with guys he always used a condom ...

While some respondents seemed to suggest that one could come to know a partner well enough to have confidence in them, others seemed a little unsure, to the extent that one thought that he might take additional precautions (albeit, probably too late):

R: Well you know them pretty well ... you know what they use and that ... You know whether they're a junkie or not, whether they just use occasionally or something ... You know more about the person you know. Yeah, you can build trust up between two people, you know, and you just trust each other. Like, I still go out and have a blood test now and then ...

Two others said that they would share with their lover because they were engaged to be married:

R: Yeah. Well we plan to stay together, I mean, for ever, to be together, you know. Thinking about getting married, so ... I wouldn't use anyone else's needle again.

A second theme was to do with readiness to share with a lover being enhanced by the fact that the couple were having unsafe sex. In some cases this was related to a belief that once unsafe sex occurred, it was 'too late':

I: What about sharing with like the guy you sleep with?

R: Guess I would but he, he doesn't ever inject anything. But I, I guess I would because I don't really see it as any different. We have never bothered to have safe sex or anything so sort ... I don't know if anything's happened it's sort of too late anyway.

Some believed that no additional risk was incurred by sharing:

R: I guess I would [share] I mean it's not going to make any difference if you are not going to wear a condom then it is the same risk isn't it? Is it?

Others appeared to believe that once a decision to have unsafe sex was made there was no further need to consider needle sharing as risky:

R: ... You'd have to be pretty stupid to share unless like it's a partner that you sleep with all the time. I've shared with M. a couple of times because we live together and we don't sleep alone. We don't sleep around on each other.

But in only four cases did the decision to have unsafe sex follow HIV testing.

Other comments about sharing with lovers related to the feeling that once the couple had shared on one occasion, they might just as well do it again.

Peer Group Comparisons

In order to assess the nature and strength of the influence of the norms and values of peer groups on individuals' attitudes and behaviour, respondents were asked what their friends thought and did about HIV/AIDS in terms of injecting and sexual behaviour. The central focus in describing peer attitudes and behaviour has been the extent to which respondents perceived their friends' attitudes and behaviour to be similar to or different from their own.

Most of the injectors maintained that their friends' attitudes and behaviour towards needle sharing were similar to their own. For example one woman said of her friends:

R: They all feel the same. They don't share needles - it's been drummed into you long enough.

And another, who was willing to share with friends, said her friends would share:

R: As long as they know that they're decent people, 'spose they'd think, no they haven't got AIDS 'cos they're decent people.

Injectors who believed their friends were less safe than themselves gave a variety of reasons for that belief. Half talked about their friends having low risk perception and not caring about themselves while others said their friends used too much/were addicted and hence did not care. Not all of those, however, who thought that their friends were less safe than themselves had strict personal RMS.

Half of the respondents said their friends' sexual attitudes and behaviour about HIV were similar to their own. These were spread across the range of personal sexual responses to HIV. For example, one woman who seldom used condoms said:

R: ... everyone sort of worries about AIDS but they don't do much about it basically and I'm guilty of that myself as far as sex is concerned.

A man who was meticulous about condoms use also said that he and his friends shared the same views:

R: ... they [friends] basically share the same views as me. They are like group views that we've all got; its just a safety option that we've all decided to equip ourselves with.

Others commented that attitudes and behaviour within their social group had changed in response to the HIV epidemic:

R: ... there is such a high risk factor now of catching AIDS and that, and like no one wants AIDS ... everyone finds it now trendy to use condoms, like different coloured condoms and that sort of thing, so everyone sort of enjoys it. So it is good in a way.

Only a minority said that their friends' sexual behaviour was less safe than their own.

Communication with Friends

A few respondents did not know what their friends thought or did about safer drug using and/or sex. This raises the issue of the level of communication between friends about issues related to HIV prevention. There was often little communication between peers about HIV: only 25 respondents (14 women and 11 men) indicated that they discussed these issues with their friends. Many maintained that this was not an easy thing to do, or that it was done in a less than satisfactory way. One woman said, for example, that discussions took the form of joking while another said that her friends found it difficult to talk about HIV/AIDS so she initiated the discussion. Some women felt that it was easier to discuss safe sex with women friends than with a lover.

Several respondents distinguished between talking about sex and talking about injecting. The balance between talking about sex and talking about injecting was, for some, related to the salience of each activity:

R: We don't really talk much about sex. If we are together we always talk about drugs. 'Cos I don't know, sex has sort of been replaced a bit by drugs in a way because it, you get a better feeling than sex.

For others, sexual activity was much more private - and therefore less likely to be discussed - than injecting.

R: It [sex] is just something you don't talk about really, whereas talking about sharing picks or something you'd be completely at ease.

Around half of the respondents said they rarely or never talked about HIV with their friends: some said that there was no need to, either because neither they nor their friends worried about HIV or because they believed that everyone did *'the right*

thing'. There were also respondents who indicated that discussions about AIDS were too difficult and so were avoided.

Support for Safer Behaviour

Apart from the small amount of direct communication between friends about safer behaviour there were other ways in which friends could and did support one another in their practise of safer behaviour, but almost half of the injectors believed themselves and their friends to be unsupported in their needle use. This was often related to a belief that it was not appropriate for friends to comment on each other's behaviour. Others, as has been noted, felt that there was no need for discussion or support because they and their friends were safe anyway.

Those who did feel supported and/or were able to support their friends, however, suggested that support and the sense that there was someone who could look out for them was an important aspect of drug use particularly when it could have tragic consequences.

Most respondents believed there was level of peer support for safer sexual behaviour, but this was often only the simplest act of being ready to offer a condom if it was requested.

KNOWLEDGE AND BELIEFS RELEVANT TO HIV/AIDS RISK-REDUCTION

Knowledge About HIV and AIDS

This section describes aspects of respondents' knowledge about HIV/AIDS as a disease and an epidemic, and their understanding of and confidence in two major prevention strategies: bleach and condoms. Assuming that knowing HIV positive (HIV+) people would raise the salience of HIV for individuals, the section concludes with a description of respondents' acquaintance with HIV+ people and their own experiences with HIV antibody testing.

Respondents' knowledge about HIV/AIDS as a disease was elicited by asking 'Can you tell me everything you know about AIDS?'. While all respondents were asked this question, there were no other standardised questions designed to establish the extent and sophistication of their information. The material presented below is thus based on spontaneous comments and may not represent the totality of respondents' knowledge about HIV/AIDS.

The major transmission routes, other than vertical transmission, were well understood, reflecting those which were most salient to this population. Some of the men were concerned about blood and wounds which may have been related to lifestyles in which violence and bleeding were common occurrences.

Descriptions of the causal agent of HIV/AIDS varied. There were 21 mentions of 'virus' but no mentions of bacteria. About half of the respondents mentioned the immune system, usually in the context of it being attacked or broken down by HIV. A few gave descriptions meaning essentially the same thing without using the words as in: *'you lose whatever it is that helps you fight off diseases'*.

Disease progression was mentioned less frequently. Half described AIDS as fatal, and about a third, more accurately, said *'you die of other diseases'*. One in four mentioned dormancy or incubation periods ranging from 1-10 years (although one said 30 years) and a few mentioned 'categories' or stages of AIDS. Only three indicated that they understood that HIV and AIDS were different. Very few mentioned a window period between infection and observable antibodies, and similar numbers said that they were not sure what happened after infection.

More specific knowledge about disease progression was limited. Forty one respondents said they did not know what proportion of those who were HIV positive

went on to develop full-blown AIDS; 12 said not all did, and eight said all or many. One said it depended on *'How much they've got. How much of a dose'*.

Knowledge about the outcomes of AIDS were equally unsure. Thirty three did not know what proportion of those with AIDS would die, but 21 said all or most. One said only 20% would die. A few referred to the incurable nature of AIDS but only two mentioned vaccines (in terms of them being difficult to make). Three mentioned AZT or other drug therapy.

There were very few total inaccuracies⁷: a few thought that the virus attacked cells, or the *'nervous system'* (rather than the immune system), and several overestimated the risk of transmission, with one believing that you were *'guaranteed'* to become infected if you slept with an infected person. Two respondents (one woman and one man) referred to gender differentials in transmission risk. One (the woman) said that women could infect men but men could not infect women, and the other, discussing who went on to get AIDS, said:

R: Some, a lot of girls don't. A lot of girls can store them inside them and give them to people. But can't catch it ...

One young man demonstrated a not atypical limited view of HIV/AIDS when he said:

R: You can die of it. It's not good to have. They're about the two main things.

This information, plus the fact that AIDS is transmitted through needles and sex, has been the main message of media campaigns. It is, perhaps thus not surprising that this was what most respondents recalled.

Knowing HIV Positive People

Around one in three respondents knew, or knew of, someone who was infected, but this was apparently not related to risk perception, injecting behaviour or sharing intentions. Knowing an HIV+ person was, however, related to sexual behaviour and intentions. There was a trend for those who did not know someone infected to be less likely to use condoms.

⁷ These, and other deficiencies in information, were corrected by the interviewer at the end of the interview.

Testing for HIV/AIDS

Just under half of the respondents had been tested for HIV at least once and those who knew someone who was HIV+ were more likely to have been tested. Half of the tested injectors had only had one test; 1/4 had had two and the rest had had more than two tests. Only seven non-injectors had been tested, and most had had only one test.

Respondents' motivations for being tested varied, and were often as much to prove to other people that they were not infected, as to establish their own serostatus because they had engaged in risky behaviour. Only a few had been tested as a consequence of a specific instance of unsafe behaviour.

The decision to be tested, and the process of being testing, were difficult and intimidating for some respondents. Some assumed their own HIV status on the basis of their partners' because they were unwilling go through this process for themselves. While some did not collect test results, others could not bring themselves to be tested, and relied on their partner's negative serostatus to alleviate their own anxieties. The following young man was one such. He described a situation when he and his lover may have shared because their needles became muddled. This made him very anxious, not least because he believed his lover had been at risk both sexually and through needle sharing. His response was to have her seek testing, but he was unable to follow through with his own test:

R: No, I am planning on it ... I actually did go to the doctor to get one but I didn't, I just couldn't face telling him that, you know, I used drugs intravenously, 'cos it does make me feel low about myself, so I -

I: You didn't think of saying 'oh you know I ... were at risk through sex'?

R: I didn't feel comfortable with it.

This case demonstrates that presenting to a clinic or doctor and describing behaviours that have put one at risk of HIV can be a daunting prospect for a young person.

In a similar case a woman described how her lover used her test results to make assumptions about his own serostatus:

R: He just sort of went on what they said about me. So he should really get a test done though.

I: He hasn't been tested?

R: Nah, we sort of went on what they said about me because I mean if I have got it he has got it and if he has got it I have got it, so. He is really nervous about things like that ...

Other problems with the process were described. One woman found test counselling to be so intimidating that it seemed unlikely she would ever be tested again. Describing pre-test counselling, she said:

I: They asked me what my opinions were of condoms and I said, 'I hate them' and they said - they take such a harsh attitude towards why you're there. You know like, I said I hated condoms and they said, 'Well, you know, look what situation you're in now, then. You're in an STD clinic, you're having an AIDS test - you know you're putting yourself in a predicament where you're gonna catch it'. So they really like throw it at you, they really like drop you in it full-on and you kind of think, 'Oh my God!' It's really daunting when you're in there. It's not a nice place either. It's not that it's not nice but you're in this clinic and all these people have kind of got diseases and stuff. So they really kind of, you know, throw it at you.

And another indicated that the process of deciding to be tested was far from simple because the outcome could be so terrible:

R: I think everyone should be tested. I'm very much for that but I'm too bloody scared to do it ... I tried to work myself into it - made the decision and wanted to and just sort of worked myself out of it, not worked myself up to it but worked out of it. 'It's all right, it's okay' ... I probably should get tested - should get tested, definitely should get tested. I don't know - just for the peace of mind, but you only get peace of mind if you don't have it. If you do, you'll never have much peace of mind at all. That's when the hell starts.

CONSTRAINTS ON SAFER BEHAVIOUR

The prevention model (Holder, 1989) described earlier hypothesised a series of constraints on safer behaviour which related to different levels of influences on individual drug-taking behaviour. Many of these hypothesised constraints were touched on or described fully by respondents in the course of their descriptions of their lives as sexually active drug users.

Injecting as a Route of Administration

Much of the emphasis in this report has been on the exploration of needle sharing as the major drug-related HIV-risk behaviour. Injecting, however, is also a phenomenon that needs exploration, since the prevention of injecting as well as the prevention of sharing is clearly an important risk-reduction strategy. Factors that enhance, maintain or constrain injecting were explored through a consideration of the relative position of injectable and non-injectable drugs in the illicit drug market,⁸ and respondents' views of injecting as a route of administration.

Ninety six of the young drug users described their experiences of buying and selling illicit drugs. In general their accounts suggested that at the time of interview marijuana was plentiful, but not much cheaper than amphetamines. Only a minority had experienced difficulty in obtaining the drugs they wanted: where substitutions were made they were commonly between the three most-used chemical drugs: amphetamines, LSD and ecstasy. Only five respondents said that their first use of a particular drug was because another drug was not available and in only one case was this the first use of an injectable when a non-injectable drug was sought.

Respondents' views on injecting as a route of administration (ROA), relative to other ROAs such as snorting, smoking or swallowing were also explored. Almost half (44%) of the injectors had their first injection with a drug they had never tried before (almost always amphetamines). The remainder of the group had first tried the first injected drug by another ROA. The most common progression among these was to snort amphetamines at least once or twice before proceeding to inject. Oral use of amphetamines was less common, although several both drank and snorted them, and three had smoked them (on a 'snow cone' - powder amphetamine on a cone of marijuana). No-one had snorted or ingested heroin or other opiates before injecting them.

Respondents were asked whether they thought there was a 'fashion' (that is, whether it was a popular way to use drugs) for injecting. Most injectors and non-injectors agreed that injecting was fashionable, and explained this by the ready availability of needles and syringes; the high cost of drugs which made injecting the most cost effective ROA; the 'rush' that was obtained by injecting and the 'addictiveness' of needles.

⁸ A study of dealers' perceptions of the illicit drug market was undertaken as an adjunct to this study. It has been separately reported. See Appendix II for reference.

The major explanation given for the popularity of injecting was that users sought the 'rush' (the quick onset of the drug). Some respondents compared this to snorting or drinking amphetamines:

R: ... if you drink it, you know, it takes a while to come on. Or if you snort it you've got it dripping, a yucky taste down the back of your throat, and stuff like that, you know.

Another common reason given for injecting was that it was the most cost effective way of using, given the high price of amphetamines (around \$60 - 80 a gram) and Ecstasy (\$50 a tablet or capsule). However, price was not the only determinant: it was clear that many respondents valued the rush effect, and were not prepared to use lesser (and therefore cheaper) amounts of drug which would have given them a less intense experience.

A few respondents mentioned the ready availability of needles and syringes as a reason for injecting being both common and fashionable. One said:

R: Everybody sort of knows about the needle ...

An important theme in discussions about injecting related to the so-called 'addiction to the needle', with respondents suggesting that once one had injected a few times one would be as addicted to the needle as to the drug, and therefore would find it very difficult to change to an alternative ROA. That this was described by 37 respondents (33% of injectors and 42% of non-injectors) suggests that there were widespread cultural beliefs in this population about the association of injecting and addiction. Themes within these discussions are described below.

Twenty one injectors spoke of an addiction to the needle in terms of 'it's the needle not the drug'. Some described what has been referred to as 'needle-freak' behaviour:⁹

R: ... When I am hanging out I just grab a pick, fill it with blood and push it back in and it makes me feel better. Heaps better ...

R: ... Just watching your blood come back when you jack it up, it is just lovely.

⁹ Bradley and Moorey (1988)

A more common explanation of 'addiction to the needle', however, was that it did not matter which drug was injected because it was the rush rather than a specific drug effect that was sought. What is unclear, however, is whether these injectors had ever experienced injecting substances other than amphetamines, and were therefore able to discriminate craving for the rush of injected amphetamines from a more generalised craving for injections:

R: When I started to rush it was just like the best feeling I'd ever felt in my life ... I didn't think it was terrible any more, and I kept doing it, because I think that if I hadn't have shot up the first time I probably wouldn't have, because it was the needle that I got addicted to, it wasn't the speed. When you try speed for first time and you don't shoot up it's just completely different, it's really weird.

Several said 'I just love needles' (meaning 'I just love injections') or spoke of liking the feel of the needle ('the feel for the steel' as one man said) but, again, it was not clear whether this was related to the rush or to anticipation of the rush as the needle slid into the vein.

Some believed that addiction to the needle was almost instantaneous. For instance, the following man talked about his first experience with a needle somewhat ruefully:

R: It wasn't that good ... It felt alright, I mean I had sort of a rush going up my body but it was sort of like pathetic, that was it and all I had was like a needle fixation after that, that was it.

Another theme in these excerpts related to ritual and expectation. It was quite clear that for a few the forbidden quality of drug injection, the relationship to blood, and the expectation that something almost mysterious would occur, contributed to a heightened sense that IDUs participated in an esoteric experience which differentiated them from other drug users. Several, for example, mentioned the fascination of needles, rebellion, or the belief that injecting was somehow 'grown up'

R: ... the three of us had gone thirds in a gram and I sort of thought, I suppose again a sort of curiosity. Maybe try to, more of an adult way, you know that, like growing up, growing up using the needle and that sort of thing and curiosity, watch them pull out all the paraphernalia, interesting ...

Others said that injecting was 'macho' and thus appealed to men, while for others the sight of blood was exciting:

R: ... when you see the blood come back into it and that, some sadistic little streak in me sort of liked it.

Another respondent vividly demonstrated the important role that expectation can play in drug effects:

R: I have seen people ripped off on water and stuff for their first time and all and they don't know. They think that they are spinning out and you laugh at them.

There was another series of comments about the belief that the rush was so powerful (and so good) that once one had injected one would become addicted - not to the needle, but to the drug. This was a common belief, particularly among non-injectors who used it as a reason for not starting to inject:

R: ... I think really injecting drugs would be that intensely pleasurable that it would be hard to stay out of it once you tried it once.

There were no injectors, however, who claimed that they had become addicted because they had started to inject, although some commented that the fear of addiction had been a barrier to their initial injection.

Once the transition to injecting had been made there were, however, other constraints which could make it difficult for the injector to use a new needle and syringe (N&S) on every occasion. These included the perceived availability of N&S and perceived attitudes of police officers towards young drug users.

Availability of Needles and Syringes

All injectors gave details of their source of injecting equipment. Nearly three out of four obtained at least some of their injecting equipment at pharmacies. They reported a number of general problems and difficulties in obtaining equipment, the most common of which was that buying needles in a pharmacy was perceived to be difficult, embarrassing or intimidating, or in some way raised the anxiety level of the respondent.

Opening hours of pharmacies was also noted as a difficulty with several respondents commenting that they did not know where the nearest 24 hour pharmacy was. Others found the cost of needles in a pharmacy was prohibitive and one respondent commented that buying injecting equipment in a pharmacy in a small country town was difficult because he would be known to the pharmacy workers.

Transport was also a problem for some respondents, with some commenting that if they did not have personal transport and if it was late at night and they lived in the suburbs, the nearest sources of equipment were liable to be in the city and buses to the city were unlikely to be running.

Around half of the injectors had used a needle exchange, either exclusively or on occasions when pharmacies were closed. Of the various needle exchange schemes (NES) that were available to them a gay bath house which operated a NES during the late evening and early morning, known as the Sauna, was the most popular and had been used by more than a 1/3 of respondents. The mobile exchange van and 24 hour NES in the city were known to and used by only a small number.

Concerns about NES included being identified by the police or the public as a drug user if one obtained needles at the mobile van, and the belief that the Sauna as a gay bath house was an inappropriate place for heterosexual young men or women to be seen.

In general obtaining equipment was opportunistic: that is, there were no consistent patterns. Respondents tended to buy or obtain equipment as and where they could, depending on the situation at the moment.

Experiences with Law Enforcement

Respondents were asked whether they had ever been 'busted' (apprehended and/or arrested) for drug use, and whether they had ever had contact with the police for their drug use (this did not always mean arrest). Thirty seven respondents (35%) had had such contact. Discussions about being 'busted' revealed that in more than half of the cases this was for marijuana use.

Injectors (38%) were marginally more likely to have been in contact with the police than non-injectors (27%), but some groups of respondents were considerably more likely to have had this contact than others. Males, younger people and those with less education were more likely to have had contact with the police (usually in the form of a 'bust') than those who were female, older and had more education. It is possible that younger less educated men who use drugs are targeted by the police, and are at particular risk of being arrested or apprehended.

This apparent targeting of some respondents by the police was also evident in the demographic characteristics of those who commented about police attitudes and activity. Twenty seven respondents made a comment about the police: these represented 39% of those under 18, compared to 12% of those over 18; 33% of men

but only 18% of women; and 41% of those with less than year 10 education compared to 22% of those who had more education.

Eleven comments referred to harassment or name calling by the police, and some felt that this was particularly the case since the AIDS epidemic:

R: I think the police are really frightened of the AIDS risk, actually - really frightened. And that's why they don't like junkies, I think.

More specific comments about the police and injecting equipment included concerns about needle disposal (and therefore using public bins to avoid police locating sources of disposed N&S); being stopped by the police when carrying (clean) N&S; keeping (clean and dirty) N&S in the house and buying N&S in pharmacies (in case the police were watching NES).

There were also specific concerns about using NES. The following was a typical comment in which a young man was talking about using the Sauna:

R: I don't like the idea of, you know, the police watching me go in there which is bit of a worry. I mean I've gone in there with drugs in my pocket and walked up the stairs and thought 'Oh, shit', they could be, you know, watched.

Injectors who had had personal experience with arrest or apprehension or had friends who had had such experiences, were asked whether this had changed anything about the way they subsequently used drugs. Although most said that it had not, a few commented that it had made them more careful, particularly in not keeping injecting equipment in the house; not using in public places; not buying drugs and needles at the same time or in disposing of all equipment immediately after injecting.

Drug Effects and Risk Behaviour

One of the concerns of this study was to identify the ways in which respondents' alcohol and drug use interacted with both injecting and sexual risk behaviour. As has been demonstrated, these respondents were not only users of injectable drugs but also poly drug users, with alcohol playing a large role in their daily substance consumption. It was thus conceivable that intoxication, with alcohol and/or other substances, at least, but possibly withdrawal and experiences of dependency as well would interact with other aspects of their daily lives and specifically with those behaviours that could put them at risk of the transmission of HIV.

While ways in which respondents viewed injecting, and particularly beliefs about the 'addictiveness' of this behaviour, either to the needle itself, or to the drug effect that

could only be obtained by injecting, have been described, there were also, scattered through the transcripts, comments and discussions about what might be referred to as 'the power of the drug'. These are related to the previous discussion, but are more general in that they illustrate respondents' perceptions of the relationship between drug use and unsafe behaviour. The heart of this issue is the extent to which respondents felt that they controlled their drug use, or that it controlled them, and the perceived behavioural consequences of this in terms of unsafe injecting and/or sex. This is developed through an exploration of respondent's beliefs and expectations of addiction¹⁰, 'hanging out'¹¹ and intoxication.

Forty nine respondents had views about addiction. These ranged from drug use being a dangerously attractive obsession (one respondent) to admissions that the respondent was or had been addicted (eight respondents). All but one of the latter said that addiction had been - or was - a negative experience:

R: In the beginning it was good, but after that it was fucked.

I: What changed?

R: Using too much, like I used to go out score and like speed out for about ten or eleven hours and go to sleep and it was alright. Then after awhile though it was like go out, score, whack you up, just like to function you know. Just to get through the day.

It was more common, however, for respondents to claim that they had their own drug use under control, but that they knew friends or others who did not. As has been noted, it was common for non-injectors to associate needles with addiction, and claim that not injecting would keep their drug use in check, but several of the injectors felt that they were (mostly) in control too.

Some respondents' comments about the perceived addiction of friends or acquaintances (and in a few cases their own addiction) indicated that they believed

¹⁰. 'Dependency' is the preferred term in drug use literature. However, 'addiction' was the term which respondents commonly used and understood.

¹¹. Anecdotally, 'hanging out' had rather a different meaning for these primarily recreational stimulant users than it does, for example, for the stereotypical heroin user in treatment. In the latter case, 'hanging out' usually means severe withdrawal involving sickness and, often, pain. In the current study it was more likely to mean a strong desire (or possibly craving) to use.

that once a person was addicted they would do anything, even share dirty needles, to have an injection. Typical comments were:

R: Sometimes the drugs have just gone too far into their heads and they don't know what they're doing, so they'll share with anyone, they don't care anymore and they will just share and don't care if they catch AIDS and die.

Only two respondents - one commenting on his own addiction and one on others' - suggested that even those who were addicted might be able to make choices about sharing.

Considerable fear of addiction was demonstrated, although some respondents described personal rules which they used for ensuring that they did not become dependent, such as not beginning to inject, or ceasing injecting if they felt it was getting out of hand. Many commented that they would never share needles with 'junkies', users 'with a habit' and so on, implying that such people would more than likely have put themselves at risk by sharing.

Comments about hanging out were not unlike the comments about addiction, but related more to the immediacy of the situation rather than to a general state. Some injectors said they would not share a needle, no matter how badly they were hanging out, and claimed that they would wait, use by another ROA or go to some lengths to get a clean needle. Others, however, described times when they had not felt able to wait:

R: Well, I have shared once ... I was hanging out ... I didn't care. I just didn't care. Like, like getting a whack was more important than, than - that's like as soon as you stick a pick in you get it, you whack it up and you get it straight away, AIDS, I mean you might not get it for six years.

One said that she would not share a needle if she was hanging out, but might share other injecting equipment:

R: I wouldn't share needles and but, if, if it was things like reuse needles or spoons or whatever just casual things like that, I probably be sitting there going 'I want the drug and I want it now and I don't care what I have to do to get it'.

Once again, the largest single group of comments referred to others who would share needles if they were hanging out (usually drawn as a comparison with the respondent who would not). For example:

I: Why do you think some people do share needles?

R: Mainly because they are hanging for, for, like the actual needle use sort of thing and 'cos, 'cos there's like, like not a Chemist open, they can't get needles or they weren't served mainly yea, because they have got the amphetamines and they are either coming down and they are hanging for another taste or they haven't had a taste for a while and they are really hanging, like, and that's mainly the reason, yeah.

Comments such as this one, despite apparently being about others, describe situations so vividly that it is hard to believe that the respondent is not speaking from his own experience.

Hanging out, like addiction, was an experience familiar to many respondents, and the belief that this effect was so powerful that it might drive one (others, if not self) to share injecting equipment in order to alleviate the craving by injecting, was common. Some of those who spoke about hanging out said that they would not share no matter how serious the craving, indicating that the notion of the omnipotent drug was not universal, but there were some who said that they could not wait to inject and would share if they were hanging out. These tended to be among those whose drug use was heaviest.

Intoxication (usually with alcohol) was a common reason given for unsafe (usually sexual) behaviour. Some respondents, as with hanging out, talked about their friends rather than themselves, but in ways that suggested the experience was familiar:

R: ... when people aren't thinking straight, like when you are pissed at parties and things like that, it is a lot easier just to end up in bed with someone and not worry about it, as much as if you were straight ...

Unsafe sexual behaviour while intoxicated was believed to be more likely than unsafe injecting practices. This suggests that unsafe sex was believed to be less risky than unsafe needle use, and indeed this was borne out in some comments. There were only a few respondents who were prepared to concede that they might share - against their better judgement - if they were intoxicated.

In general, intoxication was given as a reason, excuse or justification for unsafe sex by at least a third of respondents, most of whom seemed relatively unconcerned. The general impression given was that, as far as casual sex was concerned, respondents would use a condom if they could, if they were not too drunk and if one was available at the time. However, as noted above, many casual sexual encounters appeared to occur when one or both of the participants were intoxicated, which

suggests that many would have been unprotected. Needle sharing, on the other hand, was less likely to happen because the participants were intoxicated. Most respondents could imagine retaining enough control of the situation and of themselves not to allow it to occur.

As well as intoxication, there were other constraints on safer sex, which are described in the following section.

Buying Carrying and Using Condoms

Seventy six respondents discussed their source of condoms, and approximately half of those described problems and difficulties. The commonest problem, again, was embarrassment in the one-to-one situation of buying condoms in a pharmacy. Others maintained that this embarrassment was primarily a problem for the younger adolescent, and that it wore off as one became more accustomed to purchasing condoms. A few respondents commented on the cost of condoms, with others saying that there were too few places where condoms were given away, and a few commented on the inconvenience of pharmacy opening hours and locations, particularly for those who did not have transport. When asked how the situation could be improved most suggested more vending machines in a variety of locations.

Data relating to carrying condoms were analysed separately (Loxley, 1996). In general it was found that both men and women believed that the opposite gender would be more censorious of them for carrying condoms than they actually appeared to be. This was particularly so for women, with only 10% of the women, but 45% of men believing that men would react positively towards a woman who carried a condom.

Respondents were asked to describe positive and negative experiences which they had had with using condoms. Seventy one percent of responses, were judged to be negative, 32% neutral and 5% positive. The most common complaint was that the condom broke or burst while being put on, or fell off during sex. When this occurred on the first occasion that a condom was used, it could have the result of making future condom use unlikely. Another common complaint, particularly from the women, was the condom was left behind after the man had ejaculated and withdrawn. Both men and women said that condom use could cause the man to lose his erection. Many comments were made about discomfort when using condoms. Forty three respondents mentioned lubrication, but 74% of these had never used it. A few mentioned the use of lubricated condoms as an alternative. Several of the men mentioned that they had 'never needed' to use lube: this may have been a veiled reference to their sexual prowess.

A general dislike of condom use has been referred to on several occasions above. Five broad categories of attitudes to condom use could be discerned: positive (10%), neutral (17%), resigned (14%), negative (44%) or unclear/not applicable (13%). Comments were categorised as positive if some reason was given for wanting to use condoms. Most positive comments referred to the protection afforded by condoms

and the value that was placed on this. Neutral attitudes were characterised by non-specific comments which did not refer to either positive or negative aspects of condom use. Typical comments were: 'They (condoms) are OK' 'Doesn't bother me' and so on. Others said that condoms were now a normal part of sex. Resigned comments were different from those categorised as neutral in that respondents were somewhat negative towards condom use, but nevertheless felt that they should use them for the protection that they afforded.

There was a range of negative comments about condoms which included the following: sex is better without condoms; condoms create a barrier between partners; condoms interrupt the action; sex with a condom is not the same; condoms are plastic/unnatural; condoms are impersonal; condoms break; condoms are horrible; condoms reduce sensation; it is difficult to obtain condoms; condoms cost too much; condoms are revolting or disgusting; condoms can hurt (a comment made by a young woman); '*girls dry up quicker*' when using condoms (a comment made by a young man). The following comment is from a young man who not only did not like using condoms but had some difficulty with the notion of safer sex and partner choice. When he was asked why he did not like condoms, he said:

R: Well decreases the sensations for one and secondly if you're in bed with somebody who you need to be using a condom with, you probably shouldn't be in bed with them in the first place.

Attitudes to condoms were found to be linked to condom use. Those who always used condoms were more likely to have neutral or resigned attitudes and those who never used them more likely to have negative attitudes. Inconsistent users of condoms were between these extremes.

Situational Effects

This section describes the situations in which respondents thought unsafe injecting or sexual behaviour was most likely to occur. These situations were almost always those in which more than one of the factors described above occurred at the same moment.

Respondents' descriptions of the last occasion on which they shared a needle suggested that at least one, and more usually two or three of the following conditions, preceded sharing.

- The injector found it difficult to obtain a sterile needle at that moment ('equipment difficulty').

- The injector was reluctant to wait to use drugs, or to use by some other route of administration, or was intoxicated with alcohol and/or illicit drugs ('drug effects').
- The injector believed that the risk of HIV from sharing with a particular person or persons was relatively low ('feelings of safety').

More than one of these conditions was present in most descriptions of respondents' last sharing occasion. About half of the descriptions mentioned all three conditions, as is typified in the following:

R: ... my other mate shot up and I just used the needle after him. I didn't really know about cleaning it up and stuff and I just used it again and there would have been blood in it as well, I am sure ... couldn't have got another needle anyway because it was about three in the morning or something, and I just said 'oh stuff it' 'cos I had been tripping as well and had just started to come down from the trip and we had an E [ecstasy] and I thought yeah that will bring me back up. So, I didn't really care ... I sort of had known this guy for heaps long, guy that I shared the needle with. He would have slept with who I would have slept with as well. I wasn't really worried.

Where only two conditions were mentioned, these were typically equipment difficulty and feeling safe, or equipment difficulty and drug effects. In only four cases was there a single condition.

Only one other condition for sharing was mentioned by more than two respondents. Four mentioned negative mood states, including being angry, depressed or tense. In most cases this was given as a justification for wanting to inject immediately as a way of coping with the mood and being unwilling to wait to get a clean needle or use by another route of administration where the rush would not be as immediate or as intense.

Respondents were also asked to discuss the circumstances and situations in which they felt the likelihood of unprotected sex would be enhanced. Almost half of the responses related to intoxication in some form. All of these respondents said that if they were intoxicated ('wrecked' 'out of it' 'off my face') they would be less likely to use condoms than if they were sober. Some said that they would be more likely to have casual sex if they were intoxicated and one woman described a near-rape that took place when she was drunk. The majority of respondents specified alcohol, rather than other intoxicants.

The second most common potentially unsafe situation was when condoms were not easily available. There was also a group of responses related to mood effects: '*horniness*' (strong sexual desire); sexual spontaneity; being '*young and stupid*'; partying; and the cost of condoms.

Many of the responses, however, suggested that unsafe sex was most likely to occur when more than one of these situations was present: usually when people were intoxicated, and did not have a condom. Not all respondents felt at the mercy of the moment or the drugs, however. One said he never mixed drugs and sex, and another that on her first sexual encounter she had been drunk but had been able to insist on condom use. Several others said the situation was not influential, but they tended to be those who seldom used condoms anyway. Finally one young man said that if he were very '*horny*' he would be more likely to use a condom, because it would inhibit premature ejaculation.

Generally, then, intoxication put many of the young people in the study group at particular risk of unsafe sex which was further exacerbated when condoms were not readily available. It is also of interest that despite all of the young people in the study group being users of illicit drugs, alcohol was still reported to be the most common intoxicant when sexual activity took place.

DEMOGRAPHIC AND DRUG USE DIFFERENCES

Descriptions of behaviour, attitudes and intentions to this point have generally been presented for the study group as a whole: in this section associations between demographic and drug using characteristics, as measured in the demographic and drug use (DDUT) Questionnaire, behaviour as measured in the HIV Risk-Taking Behaviour Scale (HRBS), and behaviour, attitudes and intentions as described by respondents in the main interview are considered.

There were six grouping variables: gender, age and level of secondary education; injector status, age of first injection, and number of injections in the previous month.

Gender

Gender was not related to whether respondents were injectors or past sharing but was related to condom use and sexual relationship status, such that women who sometimes used condoms were more likely to be in, and men who sometimes used condoms less likely to be in exclusive relationships. Women were also more likely than men to be in steady relationships and to admit to a willingness to share with a

sexual partner should the need arise. This appears to have been based on beliefs about trusting partners.

Age

Age was not independently linked to risk variables, but, as described below, was associated with education and age of first injection

Education

Years of secondary education completed was related to both HRBS drug use risk behaviour and HRBS sexual risk behaviour scores in injectors, with more education being associated with lower risk. A similar association was found in the qualitative data where half of those who had no more than 3 years of secondary education said they had shared unclean needles at least once, only 20% of those with more education had done so. Condom use was also associated with education. Those who had had more education were more likely to always use condoms, and less likely to have negative attitudes towards condoms than those with less education.

There was also a relationship between education and HIV testing: 2/3 of those with Year 10 or less, but only 1/3 of those with Year 11 or 12, had had at least one HIV test. This may have been related to greater contact with services: those with less education were more likely than those with more education to have had contact for their drug use with GPs, hospitals, treatment centres, detoxification facilities and the police. Indeed while only 26% of those with less education had not had contact with any of these services, nearly half (47%) of those with more education had not had any of these contacts.

Injector Status

There were no differences between injectors and non-injectors in sexual behaviour and attitudes: condom use, attitudes to condoms or Risk Management Strategies for Sex.

Age of First Injection and Frequency of Injecting

Both the age of first injection and the number of injections in the previous month appeared to predict injecting risk such that those who started to inject earliest, and those who injected most frequently, had higher levels of risk behaviour than those who started to inject at a later age and those who had not injected so frequently in the previous month.

Inter-Relationships Between Demographic and Drug Use Characteristics

Each of the six grouping variables was compared to the other five to ascertain the extent to which they were related to each other.

Gender was not related to any of the other grouping variables.

As noted, age was not independently related to any of the major sexual and injecting attitude and behaviour variables. It was, however, associated with education. Specifically, respondents up to the age of 18 had completed fewer years of secondary education than those aged 19 or 20. The obvious inference is that some of those who were younger were still engaged in secondary education, and had not yet reached years 11 and 12. This, however, was not the case. There were only 3 respondents in the study group who were still engaged in secondary education: one aged 15, one aged 16 and one aged 19.

The second possibility is that the recruitment of University students biased the older age group in the direction of more secondary education. The relationship between age and education, however, held even when all 27 students (3 school, one TAFE and 23 University) were removed from the group. Younger respondents and those with less education were also more likely to be unemployed.

Whether or not a respondent was an injector was not associated with age or gender but was associated with education. Eighty percent of non-injectors, but only 47% of injectors had stayed in school to year 11 or 12.

Age of first injection was associated with education, such that those with fewer years of education started injecting at an earlier age than those with more education.

DISCUSSION

VALIDITY AND RELIABILITY OF THE DATA

The conditions which Turner, Miller and Moses (1989) specified as necessary to obtain valid self-reported data from IDUs, were met in the present study. That is, respondents' privacy was protected, they were guaranteed confidentiality; and the research was independent of drug treatment services or law enforcement.

Interviewer ratings of co-operation and truthfulness as recommended by Spooner and Flaherty (1992) were collected and most respondents were judged to be both truthful and co-operative. Further evidence for the goodness of the data can be obtained from the results presented above, where accounts of behaviour, attitudes and intentions tended to coalesce, suggesting that these represented thoughtful attempts by respondents to give a true account of relevant issues.

Respondents in the present study were similar to drug users recruited in the few other relevant Australian studies (e.g. Spooner et al, 1992). It therefore appears likely that the study group approximated, even if they could not be said to be representative of, other young people who used injectable drugs. The findings of the study should be applied to the population with caution, however, pending further investigation of their generalizability.

MAJOR AREAS OF CONCERN RELATING TO HIV TRANSMISSION

A summary of the most important relevant aspects of the data is presented below.

- *Low risk perception*
Most of the respondents in this study felt that they were at little or no risk of HIV infection. Many believed that behaviours such as unsafe sex (and, for some, needle sharing) were not very risky because the prevalence of HIV in Perth, especially among young people, was low.
- *Readiness to inject*
Respondents referred to a 'fashion' for injecting among young drug users. Some respondents' first use of amphetamines was by injection, and some even very occasional use was by injection.

Readiness to share

More than half of the injectors could imagine a situation in which they might share a needle, and 41% said they might share a needle which had not been bleached. One in three injectors were prepared to canvass the idea that they might share an unbleached needle with a lover, which is a concern if the serial nature of such relationships is taken into consideration. Respondents shared injecting equipment other than needles more readily than they shared needles, and some did not understand the risk of contamination from these practices.

- *Unwillingness to use condoms*

Most respondents' sexual Risk Management Strategies involved 'careful' choice of lovers rather than consistent use of condoms.

- *The assumption of safety*

The term 'negotiated safety' was coined by Kippax, Crawford, Davis, Rodden & Dowsett (1993) to refer to unprotected sexual activity that is safe in a particular context even though the same activity is deemed unsafe in the abstract. Elements of such safety are known concordant serostatus and negotiated safe sexual activity within and outside of the relationship. While it was true that there was evidence of 'negotiated safety' for some of the respondents this was not the case with the majority. Most respondents in steady relationships seemed, rather, to *assume* safety on the basis of little objective evidence, and very little discussion. Moreover, the assumption of safety in terms of one unsafe behaviour (unprotected sex) then apparently gave permission for the partners to engage in the other, and riskier, unsafe behaviour: needle sharing. Unprotected sex, however, was often initiated in the presence of intoxication, and this only increased the likelihood that there would be little decision making and negotiation around condom use and general feelings of it being 'too late' to initiate condom use after a first unprotected encounter.

- *Cultural norms.*

The use of sterile needles on most if not all occasions was the norm, except in the particular case of needle sharing between lovers. Many respondents, however, were prepared to accept the view that there were times at which people just 'had to' share. Whereas sharing only occurred when there appeared to be no other choice, unprotected sex was the sexual norm, and condom use only occurred when there appeared to be no other choice. These norms may be as much related to attitudes towards preventive techniques as to risk perception: new needles

were perceived to be more comfortable than used needles, but condoms were perceived to be less comfortable than unprotected sex.

CONSTRAINTS ON SAFER INJECTING AND SEXUAL BEHAVIOUR

All but two of the 105 respondents in this study had developed strategies to deal with the risk of HIV/AIDS. Objectively, some strategies were more effective than others, but, regardless of which strategies they had adopted, most respondents thought they were at little or no risk. It could be argued, therefore that Risk Management Strategies assisted them to manage the anxiety of being drug injectors and sexually active in the HIV/AIDS era.

While respondents generally felt that they were managing well, a number of psycho-social constraints to safer behaviour were identified. In some cases, these were barriers that respondents could recognise, such as the difficulty of obtaining clean N&S at the moment when they were needed. In other cases, constraints were inferred from the things respondents said. Attitudes and perceptions which diminished the likelihood of safer behaviour made up many of these. Others were legal or structural conventions, such as the criminal nature of drug use, about which most respondents had barely thought.

These constraints have been grouped together in the levels of the prevention model adapted from Holder (1989) presented in Figure 1 (p. 8). Constraints identified in the data are related to elements within the levels of Holder's model. These elements have been italicised in the discussion for clarity.

Individual Factors

There are, undoubtedly, a range of personality, cognitive and developmental factors which constrain safer behaviour and which have not been investigated in this study. The identification of constraints is thus limited by the scope of the research, but it could be argued that it is most limited at the individual level. Some individual factors have, however, been identified in the study.

While *personality* characteristics were not measured as such, respondents referred to individual motivations such as negative mood states and strong sexual desire which precipitated drug use or sexual activity even when safety could not be assured. There was also clear evidence of defensive avoidance, denial and wishful thinking, particularly in discussions about the likelihood of lovers and close friends being infected.

In terms of *knowledge about HIV* many respondents had a limited understanding of the extent of the HIV epidemic and of the progression of HIV disease. It may be that

the knowledge that respondents could recall was based on what they had been taught in school, and this presumably reflected the degree of knowledge about HIV/AIDS at that time. Many respondents, for example, believed that not everyone who was infected with HIV would progress to AIDS. This is a belief which might have been based on information now superseded but which was presumably used in school-based health education at the time. Of those respondents who knew, *or knew of, somebody who was HIV+*, very few were acquainted with a HIV+ person who was either an IDU, a heterosexual, or a young person. Known HIV+ people were usually gay or bisexual men. This allowed respondents to believe that HIV/AIDS was a disease which happened to people who were not like them.

Respondents' descriptions of various episodes of unsafe behaviour further suggested that some believed that because they had not become infected through these behaviours in the past, they would not become infected through the same behaviours in the future. An example of this was some respondents' belief that because they had had unsafe sex with a particular partner and had not apparently become infected, they could continue to have unsafe sex or share injecting equipment with the same partner because there was now no likelihood that they would become infected. These beliefs may have been related to misunderstandings about the ways in which HIV is transmitted.

Patterns of *drug use* influenced unsafe behaviour. Intoxication, unwillingness to wait to use drugs ('hanging out'), and craving were linked to episodes of unsafe sex and/or needle sharing. Alcohol intoxication was commonly used as a justification for unsafe sex. The unwillingness to wait to inject once the drugs were present, whether or not sterile needles were available, was used by some respondents to explain needle sharing. This was particularly the case with those whose drug use was heaviest.

The Immediate Drug Use Environment

Factors identified at this level were largely related to the illicit drug market. In general the economy of illicit drug use was such that the use of injectable drugs was only a little more expensive than the use of non-injectables. The low purity and perceived high cost of psychostimulants, as well as the desire for the strongest possible effect, made injection the preferred route of administration for young respondents. Many found that they were able to obtain almost any drug that they wanted, injectable or not injectable, with very little difficulty. The sale of amphetamines in powder form, and the social nature of young people's drug use, increased the likelihood of mixing and sharing drugs in common equipment.

The Peer Environment

Peer environment in this context refers only to friends and lovers. While Holder's original model specified 'family and workplace environment', very few respondents discussed their families in any detail, and few were employed.

It was apparent from respondents' discussion of attitudes to injecting and unsafe sex and Risk Management Strategies, that these tended to be held in common by respondents within their friendship groups. The fact that there were only four major RMS for each of injecting and sexual behaviour, meant that respondents had not developed idiosyncratic ways of dealing with HIV/AIDS. Most believed their attitudes and beliefs to be similar to those of their friends.

These beliefs included perceived susceptibility to HIV/AIDS in Perth. It was commonly believed that infected people could be picked, and that if one 'knew' the potential partner, one could assess the probability of their being infected. This was accompanied by a common belief that very few young people in Perth in 1991 and 1992 were likely to be infected. Unsafe sex was believed to be less risky than sharing, and therefore less importance was placed upon safer sex than upon safer injecting. Sharing unsterilised needles with an intimate was believed by some respondents as safer than sharing bleached needles with a stranger or acquaintance, and condom use was commonly seen as optional: perhaps in part because condoms were generally disliked.

Respondents held general stereotypes of groups who were held to be at greatest risk of HIV infection. These groups were gay and bisexual men, prostitutes, the promiscuous and 'junkies' (IDUs, usually heroin users, who were out of control and/or dependent upon drugs). By locating risk within groups rather than within behaviours, respondents were able to distance themselves from the probability of infection.

There was a double standard about drug use. On the one hand drugs were believed to be powerful influences which could make people lose control and engage in risky behaviour, such as needle sharing. On the other hand, some respondents were pejorative about such loss of control, maintaining that they could control their own drug use and that those who could not were weak willed or deficient.

While many of these beliefs could be described as peer norms, some beliefs about drug use were particularly normative. It was clear that injecting was fashionable and that this fashion was related to the belief that the 'rush' that could only be obtained by injecting was the most potent reason for using some drugs.

A further belief was that the level of risk behaviour practised by the respondent and her/his friends was the norm. Given that some respondents' behaviour was less risky than others', it seemed that individuals compared their own behaviour with those to whom they were closest and most alike, and may have been unaware that more stringent risk reduction strategies were endorsed within other peer groups.

The data were studied with gender issues which affected risk behaviour. As an example, the greater likelihood of the women than the men to be in exclusive relationships may be one explanation of why the women were more likely than the men to indicate that they might share needles with a lover. The women were also more likely to discuss trust and the maintenance of their relationships, and to demonstrate the importance that they placed in having faith in their lovers. Gender/power issues were evident in discussions of decision-making about safer sex where many women indicated that they felt they had less power to negotiate than men.

In one respect, however, respondents anticipated stronger gender stereotyping than may have actually existed. Both women and men thought that the opposite sex would disapprove of their own sex carrying condoms. However when questioned directly, neither men nor women were as negative as they were predicted to be. These beliefs, no matter how unfounded, undoubtedly played a role in the reluctance of some respondents to carry condoms.

Other forms of social group membership and their relationship to unsafe behaviour were evident. Within the study group there were some who were at greater risk than others, and these appeared to be characterised by a constellation of factors reflecting disadvantage, such that leaving school early, starting to use drugs at a younger age and unemployment were all linked to being an injector, sharing needles, unsafe sex and heavier drug use. That these respondents were among the youngest in the study group was linked to the fact that they started to inject at a younger age than others. Heavier drug use, as I have noted, was apparently an independent predictor of increased risk behaviour.

The Community Environment

Respondents identified a number of barriers to safer practice in the structures of service provision. Some respondents were unaware of the availability of HIV testing services or the process by which one could be tested. Inadequate pre and post test counselling, particularly that provided by doctors, was described and some respondents described the test process as distressing or anxiety-provoking: that this

anxiety was not always allayed was demonstrated by the fact that some were unable to return to collect results. Others were too anxious to be tested at all, and it was clear that there were situations in which respondents were not encouraged to be tested, for example by their GP, when this might have been useful.

The non-availability of N&S at the moment when they were needed was commonly given as a reason for sharing. Some respondents found the purchase of N&S from pharmacists anxiety-provoking and embarrassing, and the actual and perceived negative attitudes and behaviours of providers were significant aspects of this. Respondents also cited the cost of N&S, the location and opening hours of pharmacies and the lack of public transport to get to pharmacies, particularly at night, as difficulties. Many respondents had never used a NES and did not know where NES were, and there was a clear need for information about NES, particularly the mobile van, to be made more available to this group.

Respondents also described difficulties relating to the acquisition and purchase of condoms. These related to embarrassment; the location and opening hours of pharmacies; the cost of condoms; and/or the attitude and behaviour of providers. Respondents were frequently unaware that condoms could be purchased in a wide variety of places including supermarkets where less personal contact with sales assistants would be required. Many indicated that they preferred to obtain condoms from vending machines, but that there were insufficient machines. The importance of increasing the availability of condoms by attention to all these considerations will be recognised when it is recalled that the difference between having safe sex and having unsafe sex often turned on whether a condom happened to be at hand at the moment.

Respondents' descriptions of the activities of some police officers suggested that these were inimical to harm minimisation. The perceived negative and stereotypical attitudes of police officers to drug users; the descriptions of general harassment of young people by police; and the fact that some groups, particularly young males, appeared to be targeted by police, meant that planning ahead for drug use by buying and storing N&S was less likely. This was accompanied by a general fear of activities such as buying, carrying and disposing of N&S, because of concerns of being identified as IDUs by police who stopped and searched young people simply because they were young people.

It is possible that the considerable trust and reliance which was placed in friends and lovers was related to respondents' feelings that because they were illicit drug users, and therefore by definition both criminal and deviant, and because they considered themselves to be harassed and targeted, not only by the police but by other agents of

adult authority, they were alienated from the adult world. They placed their faith and trust in their friends so strongly, perhaps, because their experience was that they could not trust anyone else.

The Legal and Cultural Environment

This level refers to such factors as State and Commonwealth policy, and formal laws and regulations.

It was noted above that respondents' knowledge about HIV disease and the HIV/AIDS epidemic was limited. Respondents also had insufficient knowledge of the need to protect the IDU community by not passing on used needles. They were unfamiliar with the notion of accretion of risk such that continued episodes of unsafe behaviour increased the possibility of infection, and some failed to understand the risk inherent in sharing equipment other than needles. In addition, many respondents demonstrated that they had little understanding and/or experience of the correct use of condoms, and almost all were unaware of the necessity of using lubrication with condoms.

These comments suggest that these young people were inadequately prepared to prevent HIV infection by the practical means of using new N&S, being meticulous about needle hygiene or using condoms correctly. The picture suggests that their HIV/AIDS education had been simplistic and may have been largely obtained from media campaigns. Because they tended not to come into contact with treatment or welfare services, these young drug users had not been educated in how to use drugs safely. They had also not been educated in how to practise safe sex.

The fact that respondents believed some groups in the community to be most at risk of HIV infection, and did not include themselves within those stereotypes, may be one outcome of media portrayals of the HIV/AIDS epidemic as one that is peopled by the 'guilty' (drug/heroin addicts, gay men, prostitutes) and the 'innocent' (haemophiliacs, children etc.). These stereotypes enable young people to distance themselves from the perceived likelihood of becoming infected. Even the young IDUs rationalised that it was 'junkies', who were addicted to opiates, rather than young people who occasionally injected psychostimulants, who were most at risk.

Finally, it appears that the prohibition of the recreational use of drugs other than alcohol and tobacco has resulted in discontinuities between the demands of supply reduction and the demands of harm reduction. This is evidenced by accounts of the economies of illicit drug use, such that the non-injectable marijuana was not much cheaper than injectable drugs, and the activities of some police officers which made

some respondents reluctant to take advantage of harm minimisation programs such as NES.

RECOMMENDATIONS FOR SPECIFIC HEALTH PROMOTION

The following recommendations relate to young injectors in Perth, but could probably be generalised to other cities and other groups of young drug users.

Individual Factors

Denial of the risk of HIV infection from, particularly, heterosexual sex but also needle sharing, was a major concern in the study. Denial of risk occurs through a variety of cognitive and affective distortions and these beliefs must be challenged at every opportunity so that perceptions about the negligible risk of HIV infection for young heterosexuals and IDUs in Perth are altered. This could perhaps be achieved by the circulation of stories about infected young Western Australian heterosexuals or IDUs, so that it is difficult for young people to deny that HIV/AIDS is a disease that could infect them or their peers.

Knowledge about HIV/AIDS as a disease and as an epidemic must be improved. Young people need to know how many people are infected (locally, nationally and globally) and how the epidemic can be prevented in not only individuals but also communities. Specifically they must be advised of the necessity for needle hygiene at all times, particularly in terms of not lending used injecting equipment and sharing equipment other than needles. Current information about the progress of HIV/AIDS as a disease must be circulated, so that young people understand that it is now believed that almost everybody who becomes infected with HIV will progress to AIDS and ultimately death.

In terms of unsafe behaviour in specific situations, young people must be counselled about the effect of mood state, sexual desire and the desire for drugs on unsafe behaviour, and encouraged to plan ahead by carrying condoms and/or safe equipment at all times. Those who experience drug problems such as craving or withdrawal which may lead to needle sharing should be encouraged to seek professional help.

Intoxication put many of the young people in the study group at risk of unsafe sex and peer-based interventions that are linked to licensed drinking environments would seem to offer some promise in this regard.

Recommendation 1: Young people must be educated to have realistic perceptions of the risk of HIV/AIDS through needle sharing and unsafe sex; their knowledge about HIV and AIDS as a disease and as an epidemic must be improved; and young drug users must have better access to services and people with whom they can discuss their drug use, and be advised on ways to deal with problems arising from intoxication, withdrawal and dependency.

The Immediate Drug Use Environment

It should be a matter of priority to prevent young people from making the transition from smoking to injecting drugs (Strang, Des Jarlais, Griffiths & Gossop, 1992). For those who have not already started injecting, the use of marijuana rather than injectable drugs could be promoted by the decriminalisation of marijuana use. The illegal status of drugs means that it is difficult if not impossible to change influences in the illicit drug market, where there is currently little real difference in the price of marijuana and the price of amphetamines for novice users.

Recommendation 2: Every attempt must be made to prevent or delay young drug users' transition to injecting as a route of administration. Examination of the legal status of marijuana should be undertaken with a view to enhancing the status of non-injectable drugs relative to injectable drugs.

The Peer Environment

Most of the attitudes and beliefs that underlay behaviour and behavioural intentions reflected cultural norms, and these can best be challenged by peer educators. The perception among respondents that it was possible to tell, on the grounds of acquaintance, whether or not someone was infected is one which has been found in young people in other countries and in relation to behaviours other than injecting (Ingham, Woodcock & Stenner, 1991). It must be challenged, and young people encouraged to think and talk to their friends about ways in which they can make more objective decisions about HIV risk. A further concern is the ideology of self determination which governed much of the thinking of the people in this group. This is a cultural norm that may be particularly difficult to address given that it may relate to developmental processes. Emerging from the constraints of childhood and adolescence may make young adults particularly sensitive to their rights, and the rights of their friends, to make their own decisions. Nevertheless, there is a great deal of peer support and concern which can be mobilised so that young people find ways

to express concerns about friends' risky behaviour, without necessarily impinging on their self determination. The protection of the population by never passing on used equipment to friends could be encouraged by similar mechanisms.

There was a general lack of concern about unprotected sexual activity, and a dislike of condoms, even by some who had never used them. Given the strength of the feeling against condoms by some respondents, the best that may be achieved is resignation about their use, unless heterosexual peer educators can find ways to eroticise condom use in the same way as has been done within the gay community. Peer educators should not only encourage young people to handle, play with and talk about condoms, but also teach their correct use, including the use of lubrication. Few respondents understood that lubrication may have helped to reduce breakage and discomfort. Raising the awareness of the very high incidence of other sexually transmitted diseases such as chlamydia, genital warts, and herpes, and increasing knowledge of prevention of these diseases, is also vital.

Common beliefs about the safety of injecting, as long as sterile needles were used, contributed to risk behaviour. The low purity of street drugs, and desired 'rush', as well as the expectation that needles were addictive, make it unlikely that those who have already injected amphetamines would change to another route of administration unless they had experienced negative outcomes of injecting, but the understanding that injecting may not be safe in non-HIV ways (such as collapsed veins, abscesses etc.) or that most injectors, sooner or later, find themselves in situations when they share, was not widespread. Young people need to be taught to inject safely, and the widespread beliefs in the 'power of the drug' should be discussed and challenged. Cultural myths about drug use abound, and young drug users often talk about their drug use with no-one but their peers. Opportunities for them to talk to more experienced drug users could be created by peer educators who were, or are, themselves IDUs.

Social group membership was a particular concern. The 'constellation of disadvantage' identified as being particularly related to greater injecting and sexual risk behaviour, includes starting to use and inject drugs at an earlier age, using drugs more heavily, early school leaving and being unemployed. These respondents were younger than the average in the study group. This suggests that very young IDUs are at special risk through their inexperience, cognitive developmental status which includes difficulty in recognising the risk of various behaviours, and present time focus. A special effort should be made to locate these very young injectors and work with them, and, again, this might best be done by other young people.

A number of gender issues which put women at a disadvantage were identified in the present study. These were often related to concerns about relationships, and focused around trust, romance, perceived lack of power in negotiation and sexual protection against conception as well as infection. These are difficult and sensitive issues which have to be addressed by female peers, in one to one or small group discussions. One cultural norm which can be addressed fairly readily, however, is the stereotype, not supported by these data, that neither men nor women approve of the other sex carrying condoms. The provision of inter-gender information would undoubtedly help to reduce this stereotype and promote a more positive approach towards people carrying condoms as a matter of routine. That this issue should be addressed is evident from White, Phillips, Mulleady and Cupitt's (1993) finding that carrying condoms was one of the best predictors of using condoms.

Recommendation 3: Peer educators and older current and ex-injecting drug users should be employed to make contact with young people who inject drugs. These educators should challenge commonly held beliefs about HIV/AIDS risk and transmission; promote the use of condoms and teach safe injecting. Special provision should be made for the identification and support of very young injectors, and female peer educators should be employed to make contact with, and take up issues of particular concern to, young women who inject.

The Community Environment

A range of constraints to buying or obtaining injecting and sexual equipment were identified. A general concern was in the limited use of NES, with pharmacies being the preferred source of N&S. The provision of user-friendly advice and referral is, however, more limited (if it happens at all) in the pharmacy than in NES.

Clearly young drug users (and probably older ones too) will have some difficulty at some times when buying or obtaining equipment. However the proportion of respondents' complaints about pharmacy staff compared to complaints about other aspects of buying such as cost, location, opening hours and lack of transport, suggests that the young are particularly sensitive to real or implied criticism, and it behoves pharmacy staff to be very careful and friendly with young IDUs if they are not to be put off, and go away without buying clean equipment. Unfortunately, not all pharmacists believe that it is in the community's best interests for young people to be supplied with sterile injecting equipment. A sign in the window indicating whether or not the pharmacy is prepared to sell needles without question would diminish embarrassment and hard feelings.

Condom buying was difficult for some, but not for the majority, and again there was some reliance on others to obtain condoms where the individual found it difficult. Perhaps buying condoms has always been embarrassing. In this regard, it is perhaps strange that not more respondents bought their condoms in supermarkets where they are probably cheaper and less personal contact with sales assistants has to be made. Perhaps these young people did not know that condoms were sold in supermarkets or could not find them in the supermarket and were too embarrassed to ask.

The question of the cost of both needles and condoms is more difficult. Many of the young people in this study were on limited welfare or unemployment benefits, and while the cost of a needle and syringe from a pharmacy may seem to be relatively small to a health professional, it may assume altogether different proportions to an impoverished IDU who has just spent all his/her money on drugs. Free needles and condoms were available in Perth at the time of interview, but many respondents did not know how to obtain them. They are less available now under 'user pays' arrangements. This study suggests that many young people prefer to buy equipment at pharmacies, but that free supplies should also be easily available to those who can not afford to do so.

Respondents' descriptions of HIV testing suggested that there was room for improvement, particularly in pre-and post-test counselling. Since these data were gathered there have been major changes in the provision of testing services in Perth and it may be that practice in this regard has improved. It is of critical importance that testing situations be monitored and the experiences of, particularly young, clients fed back to practitioners and policy makers, so that services can be improved as necessary.

The relationship of police officers to young people generally, and young drug users particularly, is a matter of concern. Reports by some young people of continual harassment by police officers meant that their drug use was more hurried and secretive and less likely to be safe than it needed to be. Young unemployed men wandering around the city who may appear to be drug users are easy targets for the police, but these contacts do not make for good relationships between police and young people. If law enforcement policies could be encouraged to move in the direction of harm minimisation, rather than the identification and punishment of drug users, police officers could be an effective resource for putting young people in touch with services such as NES. These are issues which need to be debated within law enforcement agencies and between health and law enforcement policy makers.

Recommendation 4: The availability of N&S should be increased and promoted through increasing the number of NES, particularly in the outer metropolitan area; widely advertising the location of late night and 24 hour pharmacies that sell N&S; advertising the sites of the mobile NES van more widely; training pharmacy sales staff so that young people are encouraged rather than discouraged when purchasing equipment; increasing the number of vending machines for both condoms and N&S; reducing the cost of both condoms and N&S and widely advertising the availability of free N&S for those who cannot afford to buy them. In addition, the accessibility and user-friendliness of testing services must be investigated, and primary health care providers encouraged to refer young people to testing where appropriate. There should be more dialogue between law enforcement and health promoters which promote positive relationships between the police and young people, particularly those who use drugs.

The Legal and Cultural Environment

A number of constraints at this level were identified, and recommendations to overcome some of these have already been made. These constraints include inadequate HIV/AIDS education, the failure of authorities to promote safe sex as widely as possible, the move towards user-pays services which has meant, among other things, that N&S are no longer free, and the maintenance of the criminal status of all currently illicit drugs. It is vital that pressure is exerted on policy makers in relation to these issues.

The media have played a role in 'demonising' certain groups in relation to HIV infection (Juhasz, 1993) and the stereotypical thinking about HIV/AIDS of the respondents in this study demonstrated that they were not immune to these influences. The media should be encouraged to present as responsible and reasonable position as possible in relation to HIV/AIDS and its effect on the community. This includes the representation of people like the young people in this study as liable to become infected with HIV.

Recommendation 5: Commonwealth and State education and health authorities should take responsibility for promoting AIDS preventive behaviour as clearly and widely as possible, and considering the effect of all relevant policy decisions on HIV/AIDS prevention. National, regional and local media outlets should be encouraged to present a balanced and non-sensationalised portrayal of the HIV/AIDS epidemic and the people who are involved in it.

CONCLUSION

It is difficult to summarise the findings of such a detailed study in a few words. It can be said, however, that this study has offered an insight into the lives of young people who inject drugs. mImportantly, it has demonstrated that injecting drugs is a common if infrequent behaviour for some young people, and that their understanding of the risks associated with it is inadequate at best, and tainted by their desire to inject at worst. Unsafe sex has been found to be the norm among young people generally, and the young drug users in Perth are similar in this respect, but their risk may be higher because the people with whom they have sex are often IDUs. It becomes particularly important to convey to this group, and groups like them, the double risk that may be involved and various ways to do this have been outlined. The constraints that young people experience operate at all levels, and must be taken very seriously if permanent behaviour change is to occur, and the risk of transmission of HIV/AIDS is minimised.

APPENDIX I
TABLES AND FIGURES

Table 1: Demographic Characteristics of Respondents (n=105)

Gender (%)		
	Male	52
	Female	48
Age (years)		
	Mean	18.3
	Range	14-20
Employment (%)		
	Unemployed	73
	Full time	6
	Part time	21
Education (%)		
	Less than 11 years	48
	11 or 12 years	36
	More than 12 years	16
Accommodation (%)		
	Family/relatives	40
	Friends/lovers	44
	Alone	6
	Street/supported	10

Table 2: Percent Using Each Drug*: Respondents (n=105)

Drug	Previous 12 months	Previous 3 months	Previous month
	%	%	%
Cannabis	99	96	93
Alcohol	99	92	85
LSD	93	78	57
Amphetamines	91	75	54
Tobacco	84	78	76
MDMA	60	42	30
Mushrooms	51	27	15
Tranquillisers	48	24	15
Avils	36	11	6
Other ¹	31	14	11
Other Opiates	29	11	10
Inhalants	33	15	10
Heroin	24	14	8
Cocaine/crack	20	5	1
Homebake	18	10	7
Methadone	3	1	1
Barbiturates	3	1	1

* Multiple Responses

¹ Amyl nitrite, ketamine...

Table 3: Percent Injecting Each Drug*: Injectors (n=79)

Drug	Previous 12 months	Previous month
	%	%
Amphetamines	96	91
LSD	42	19
MDMA	39	37
Heroin	30	15
Homebake	23	13
Other Opiates	14	9
Tranquillisers	13	6
Other	13	4
Cocaine/crack	12	2
Alcohol	5	2
Methadone	3	0
Barbiturates	3	2
Avils	1	0

* Multiple Responses

Table 4: Injecting Characteristics of Respondents

Injector status (%) (n=105)		
	Injector	75
	Non-injector	25
Injections per month prior to interview (n=79)		
	Mean	6.0
	Median	0.0
	Range	0-61
Duration as injector (%)		
	Less than 6 months	13
	More than 6 months	87
Age of first injection (years)		
	Mean	16.4
	S.D.	1.7

Table 5: Health And Welfare Contacts for Drug Use*: Respondents (n=105)

Agency	f	% responses	% respondents
None	39	22.0	37.1
Police	37	20.9	35.2
Doctor	29	16.4	27.6
Drug Treatment	28	15.8	26.7
Hospital	24	13.6	22.9
Detoxification	8	4.5	7.6
Other	12	6.8	11.4

* Multiple Responses

Table 6: HRBS Drug Use, Sexual Behaviour and Full Scale Scores: Respondents (n=105)

Scale	Mean	Range	S.D.	Median
Drug Use (Injectors)	4.1	0-29	5.6	2
Sex Behv. (Injectors)	4.2	0-21	3.7	4
Total (Injectors)	8.2	0-50	7.7	6
Sex Behv. (Non-Inj.)	4.4	0-12	4.0	4.5

Table 7: Risk Management Strategies For Injecting: Injectors (n=79)

RMS	f	%
Accept used needles from no-one	35	44
Accept used needles from lover or friend only if bleached	12	15
Accept used needles only from a lover	22	28
Accept used needles only from a lover or close friend	8	10
Unclear	2	3

Table 8: Risk Management Strategies For Sexual Behaviour: Respondents (n=101)

RMSS	f	%
1. Use condoms always	14	14
2. Use condoms unless or until... ¹	58	57
3. Don't use condoms unless... ²	10	10
4. Don't have sex with.... ³	13	13
5. Other ⁴	6	6

1. Use condoms unless or until: partner is a virgin; one or both partners have been tested; one or both partners have been tested and the pill is used, partner is 'known'; partner is on the pill.

2. Don't use condoms unless: partner appears 'high risk'; partner cheats, partner is a gay male.

3. Don't have sex with: anyone, people you don't know/trust, people who appear 'high risk', men (if you are a lesbian or a man).

4. Other. Stay in current (safe) relationship; use condoms next time/when you're older; use withdrawal.

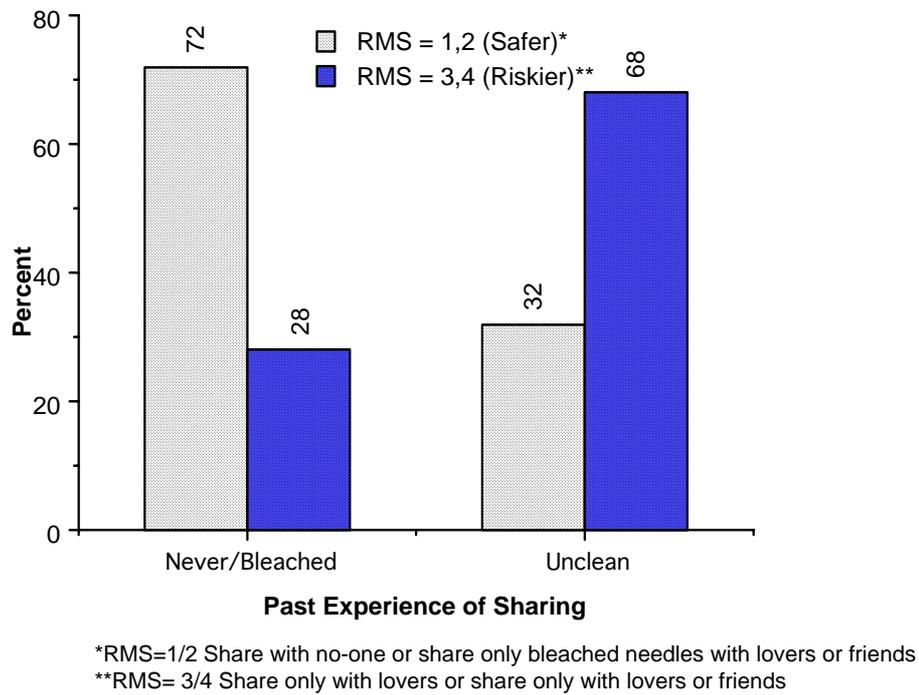


Figure 2: Risk Management Strategies By Past Experience of Sharing: Injectors (n=75).

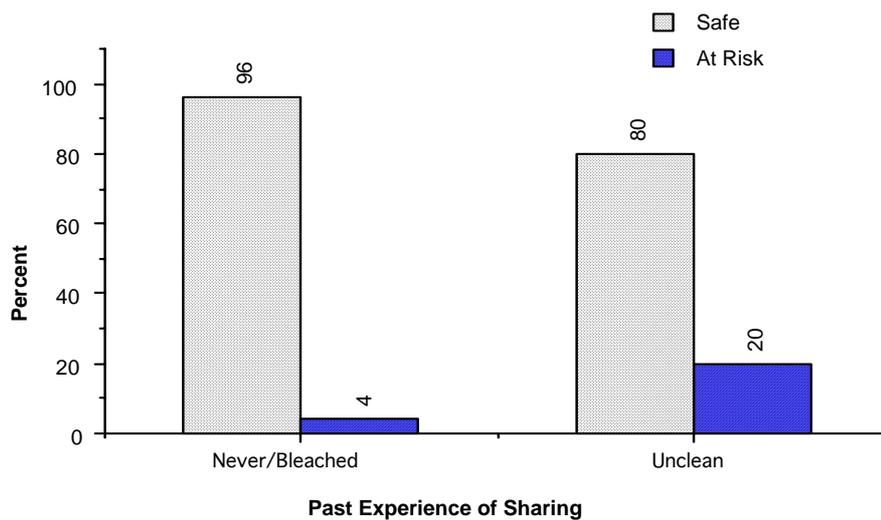
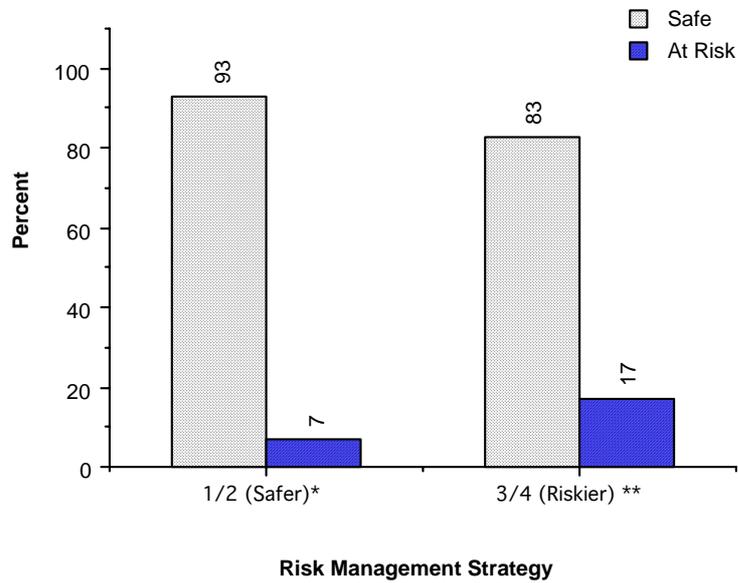
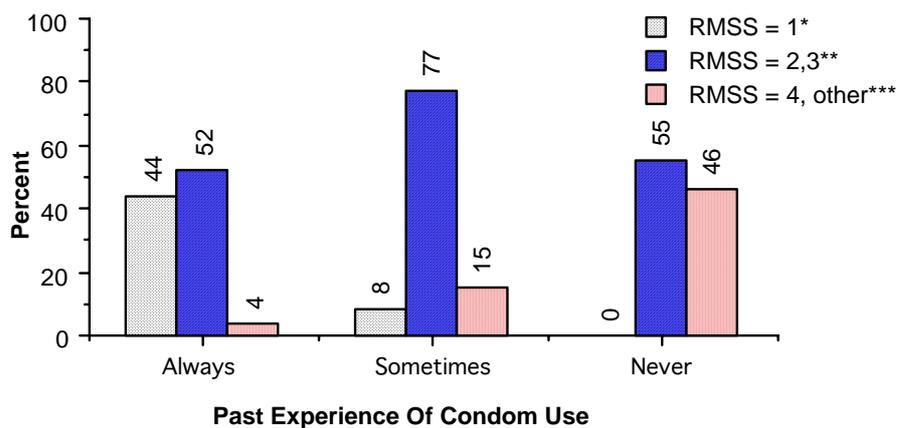


Figure 3: Personal Risk Assessment By Past Experience of Sharing: Injectors (n=75).



*RMS = 1/2 Share with no-one or share only bleached needles with lovers or friends
 **RMS = 3/4 Share only with lovers or share only with lovers or friends

Figure 4: Personal Risk Assessment By Risk Management Strategy: Injectors (n=75).



*Always use condoms
 **Use condoms unless.../Don't use condoms unless
 *** Don't have sex with.../Other

Figure 5: Risk Management Strategies For Sex By Past Experience of Condom Use: Respondents (n=98).

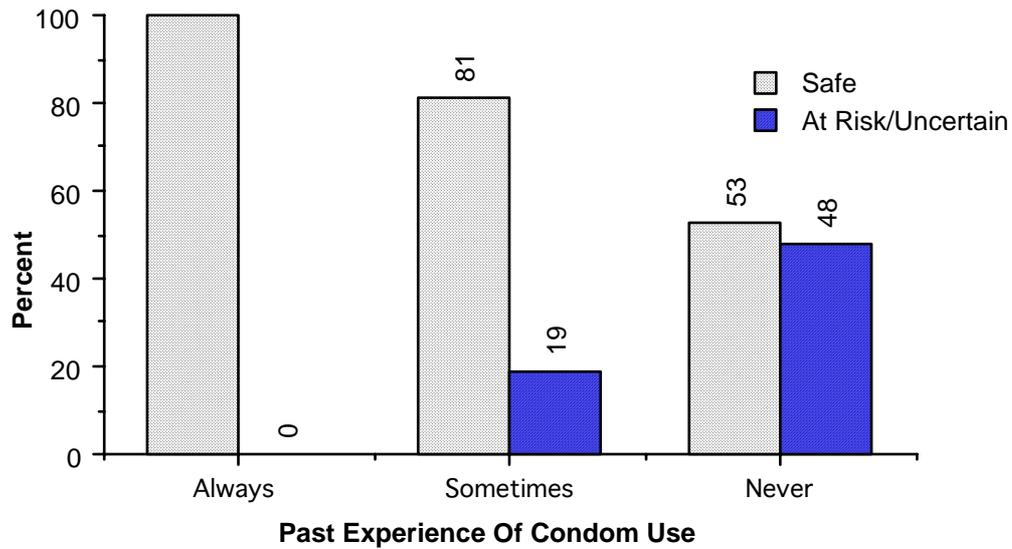
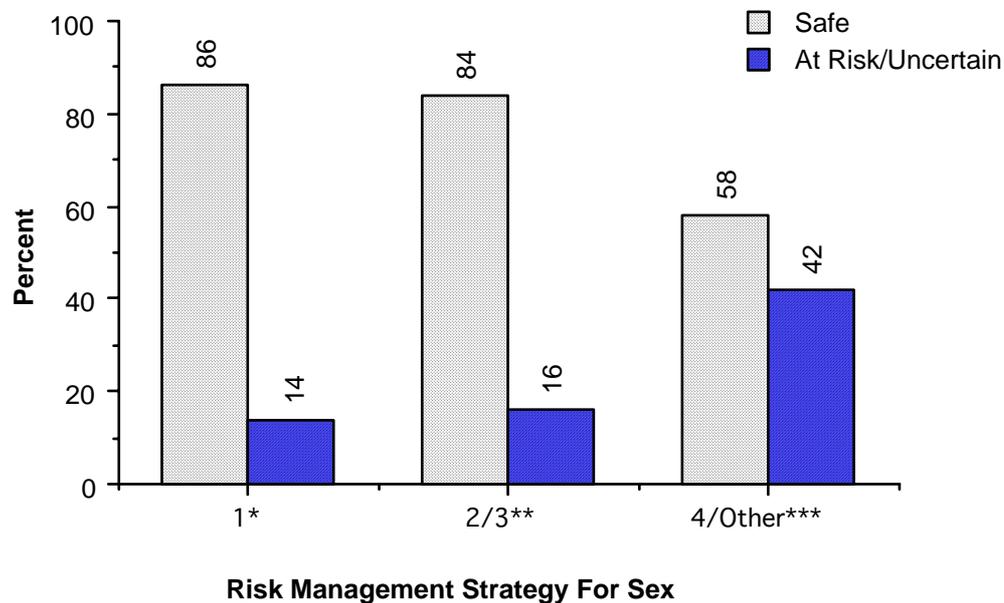


Figure 6: Personal Risk Assessment From Sexual Behaviour By Past Experience of Condom Use: Respondents (n=96)



*Always use condoms

**Use condoms unless.../Don't use condoms unless...

***Don't have sex with.../Other

Figure 7: Personal Risk Assessment By Risk Management Strategy For Sex: Respondents (n=96)

APPENDIX II

PAPERS AND PUBLICATIONS RELATED TO THE YAD STUDY

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