# Drug user lifestyles and peer education

*This research shows how social networks of drug users – previously attacked as spreading drug use – can be central to the harm reduction effort. The findings contribute to a radical shift in how we view drug users – as part of the solution, not just part of the problem*

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SUMMARY

Research among heroin, cocaine and amphetamine users in three areas showed how peer education and outreach can build on informal risk-reduction strategies. Only by understanding these can services dovetail with drug scenes and with the lifestyles of those they target. Locally targeted interventions based on action research are essential, but regional consortia of agencies should develop strategies and guidelines to help ensure that these reflect best practice and research evidence.

The ACMD's latest AIDS report[1] stated that outreach aimed at drug users should now emphasise peer education and maximising new contacts. This involves targeting social networks of drug users, identifying the social factors that underpin high-risk behaviour, and encouraging behaviour changes that fit into drug users' lifestyles. For all this we need detailed 'ethnographic' research describing drug users' daily routines – we need to know what they are doing before we can decide what needs to be changed and how best to change it.[2,3]

This article summarises one such study (our own) and shows how qualitative research can be of practical help in devising peer education outreach initiatives.[4] It involved samples and networks of regular users of heroin, cocaine and amphetamine, in three areas: inner London, a Midlands town ('Midtown') and Hertfordshire.

### Using the networks

For practical and functional reasons – often connected to obtaining drugs – drug users tend to form social networks. Most respondents in our study were in contact with other drug users. These networks overlapped, highlighting the potential for using key individuals as indigenous advocates and peer educators. Almost unwittingly, the ACMD's suggestion that networks of drug users should be the targets for detached work is a radical rethink that reflects the reality of drug users' lifestyles. Like train spotters, hill walkers and wine connoisseurs, illicit drug users operate in networks with focal points, meeting places and methods of communication. These are our main findings about the networks we researched.

**The shapes of drug users' social networks affect the potential for health advocacy** The structure of these networks and the activities they mediate depend partly on the drug market they operate in. In our research the more diverse, hence more anonymous, London drug scene contrasted with the tighter networks in the other two sites; respondents from London had many more drug using contacts but fewer friends among these contacts.

Primary drug of choice and how it was taken also influenced the user's social network. Networks based on heroin use were more cohesive than those based on amphetamine and cocaine. Users of these drugs (who were more likely to be non-injectors) had more non-injecting friends than did heroin users; heroin users had more injecting friends.

Drug user relationships were commonly founded on the need to maintain drug supplies. This mutual aid may be threatened when supplies are short and users are forced to act more individualistically. Then the drug user 'grapevine' becomes even more important as a medium for communicating drug availability, quality and prices, if not for actual drug supply. Offshoots of the grapevine often linked different networks through common contacts.

For public health purposes, this grapevine – informal and nebulous as it is – offers a way of disseminating information. One of the key tasks is to identify and enlist well-connected individuals within drug user networks who can be used to convey updated and relevant health messages. This happens when agency clients tell peers about the activities and offerings of local services. Among those not in contact with services, we need to be proactive in identifying nodal points for disseminating information.

**Identifying roles and rules within social networks helps target interventions** We found that the cohesiveness of drug users' networks was influenced by factors such as the drug used, local drug economies, population density, and wider drug trends. London had fully functioning, open street drug scenes; there were no such venues in Midtown or Hertfordshire. Amphetamine tended to be distributed in semi-public venues such as public houses while cocaine and heroin might be traded on the street.

Information on drug use and dealing arenas is clearly essential to outreach interventions. It is also important to catalogue the social landscape – the rules that bind social networks and the individuals who enforce them. This helps us interpret the social interactions that encourage

## IMPLICATIONS FOR COMMUNITY-BASED SERVICES

To influence any interest group you need to understand its functions and contact key players and influential opinion leaders. High-status individuals, from specific populations of drug users have an important role as indigenous advocates in promoting health and peer education. By way of illustration, let us explore the increasingly recognised phenomenon of sharing of injecting paraphernalia.[9,10]

First, simple things can be done. The degree of risk involved in filter and spoon sharing is unknown,[11] but let's be safe rather than sorry. The message, preferably delivered by ex- or current drug users, should be, *Don't share or borrow or pass on or muddle injecting equipment. (P.S. This includes your lover, your friend, your running mate, Uncle Tom Cobbly and all).*

We need also provide the means to achieve this. So injecting packs should include all that is needed; syringe, needle, swabs, sterilised water, filter. Some projects have provided needles that incorporate a filter.[12]

### *Build on existing behaviour*

Spoons may be a problem. These are used to heat the drug solution to prepare it for injecting, and form part of the routine of apportioning drugs. One way to sidestep this (tried in Holland) is for each kit to include a small plastic calibrated container for measuring out the 'hit'. A steady hand may be needed to pour the solution from the spoon into the container, but if the risks are made clear then we are in with a shout of changing this aspect of drug injectors' routines. Such innovative technologies need to be market tested among the target group and rigorously evaluated.

Peer education needs to build on drug injectors' existing informal strategies. Drug agencies need to know what goes on out there, not just yesterday, but today and tomorrow. Only by understanding the nuances of behaviour amongst networks of drug users, and plotting these on a continuous basis, can we provide services that dovetail with prevailing drug scenes and reflect, rather then conflict with, the lifestyles of those we target. Such research should be seen as integral to the development of services, not a threat. The type of work done by Hunt and his colleagues in Maidstone should be applauded.[13]

Again, simple things can be put in place under the rubric of what may broadly be termed action research. Outreach workers can routinely report shifts in drug scenes and behaviours. Focus or discussion groups can be held with agency clients to examine lifestyles and daily routines. Such simple but important information will keep service providers abreast of local drug scenes. Yesterday's heroin injector is not today's crackhead; just as the MDMA raver from the Summer of Love differs markedly from the clubgoer of today.

Locally relevant interventions are important, but one of the main criticisms of outreach work has been its lack of strategic direction. This not only relates to carving up the territory and agency strategies, but also to overall aims. A little autonomy is important (especially to encourage imaginative responses); too much can at best lead to wasteful duplication, at worst to an inefficient and inappropriate service. Sometimes 'autonomy' is used as an excuse for ignoring good practice and research evidence.

### *Coordinated autonomy*

Most drug workers will know that the flavour of the month is peer education with ex- (and dare we say it again, current) drug users acting as indigenous fieldworkers. Research suggests this can make a valuable contribution to harm minimisation.[14,15] But we must develop coherent and workable models of peer education that are relevant to the local population.

To this end, we should consider consortia of agencies (certainly at regional level) to develop these strategies, plus guidelines of good (as in 'effective') practice. This will help ensure that locally relevant interventions evolve and are effective, as well as underpinning resource allocation at regional level. Action research needs to be an ongoing facet of such initiatives and groups such as the national detached workers' forum and drug user advocacy groups should be involved at the outset.

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protective strategies or sustain high risk activities and identify ex- or current drug user who might act as peer educators.

In the networks we observed, some behaviours (like being too chaotic) were grounds for exclusion from the group and its support mechanisms, a process exemplified by one well-established London network. Founded on the sale and use of heroin and cocaine, its core established members passed advice and information to new or casual recruits to the network on issues such as the dangers of needle use and sharing, inappropriate drug combinations, and how to seek help. Advice was delivered spasmodically, arbitrarily, and informally, in the context of getting on with the main business of buying, selling and taking drugs.

For reasons of group security and cohesion, persistently chaotic members were eventually excluded from the network, but still gained in health terms from their temporary membership. A positive by-product was that excluded drug users could carry the informal health education gained while part of the network across to other groups of drug users, often more chaotic and younger both in years and in their drug careers. Such informal peer education should be built on and incorporated into innovative outreach interventions.

**Stigmatisation of injecting was common** Drug users who did not inject commonly stigmatised those who did. By using indigenous advocates as peer educators, this stigmatisation could help health educators discourage injecting.

But there is a risk of this tactic backfiring. Afro-Caribbean heroin injectors reported being doubly stigmatised: within their own communities, heroin was not seen as an acceptable drug, and injecting it was often labelled 'white junkie' behaviour. The result is that black drug injectors tend to be alienated from both drug using networks and from wider Afro-Caribbean society. In turn this is likely to lead to unsafe injecting practices.[5] Interventions using the indigenous advocate model need to be tailored for for these special situtations and groups.

### *Risk-reduction strategies*

Everyday strategies to control drug use and injecting risks were common.

**Controlling drug use** Nearly three-quarters of the sample of 100 drug users reported some measures to control their drug use. The most common were to buy small amounts and divide drugs into smaller portions. Most (especially heroin users) took periodic breaks from drug use by leaving the area. This often involved

## HOW THE RESEARCH WAS DONE

The research was funded by the Department of Health and took place from October 1991 to September 1993. A primary aim was to provide qualitative data to help existing and new interventions be more relevant and accessible to drug users.

The study involved samples and networks of regular users of heroin, cocaine and amphetamine sulphate in: an inner city area of London; a Midlands town ('Midtown'); and the semi-rural county of Hertfordshire. Respondents were recruited by 'snowballing' through existing contacts and 'cold' contacts at venues where drug users congregated.[16] Ethnographic fieldwork and participant observation facilitated by local drug users in each of the sites, employed for their knowledge of, and access to, local networks of drug users. Employing those with a drug using background as 'indigenous fieldworkers' has been discussed elsewhere.[17]

The principal methodologies were: a semi-structured survey of 100 drug users; focus groups; in-depth interviews that recorded details of their daily lives; and participant observation. Except for focus groups, each method was used in all the sites.

Of the 100 respondents to the survey, 58 were from London, 25 from Hertfordshire and 17 from 'Midtown'. There were two males to every female. Sixty-six per cent were 'white British'. Heroin was the drug of choice for 69 per cent, amphetamine sulphate 18 per cent, and cocaine 13 per cent. Polydrug use was common. Seventy per cent were current injectors.

staying with non-using friends or family, suggesting a role for these in encouraging harm minimisation and healthy lifestyles.

Other main control strategies included: testing the quality of drugs before purchase; substituting one drug for another (such as methadone for heroin or Dexedrine for amphetamine sulphate); and using drugs in a measured and controlled way.

The most common strategy for assessing quality was relying on a (trusted) dealer. Whether quality could be directly tested was related to how much was bought and where. Purchases under a certain amount rarely allowed for personal testing and the risk of being observed in open street dealing venues demanded a swift transaction which precluded testing. Prescribed drugs were commonly obtained to be shared, bartered or sold in times of shortage or as an alternative to the primary drug.

Any peer education activity needs to build on these informal coping strategies. Strategies used to control drug use should be encouraged and disseminated to other drug users by indigenous advocates.

**Coping strategies related to injecting** We know that drug injectors adopt personal protective strategies.[6,7] Our findings show how these form part of injectors' daily routines. This has implications for fitting interventions into the everyday lives of networks of drug injectors.

Ensuring a supply of new equipment and re-using their own syringes (often personalising them to prevent accidental sharing) were the most popular strategies to reduce the chances of sharing. None of our respondents were regular syringe exchange clients. Their main sources of new injecting equipment were a pharmacy, followed by a dealer, who may well be a friend. Four-fifths of the injectors had at least one other source of syringes. Other strategies to prevent syringe sharing were keeping spare needles and syringes around the house, leaving injecting equipment with non-using friends, going to dealers known to provide fresh equipment, and replenishing supplies when down to the last needle and syringe in a pack.

These strategies mean pharmacists and, in particular, user/dealer friends can play an important role in ensuring syringe availability. Outreach workers and peer educators should encourage drug users who obtain syringes from pharmacies and syringe exchanges to act as secondary distribution points, supplying especially those who are not regular syringe exchange clients. However, we must be cautious in how we engage active drug users in peer education. Any outreach initiative must be aware of the potential risks to their safety and well-being.

Protective strategies were in evidence even when syringes were re-used. Cleaning injecting equipment was common, though rarely efficient. Most popular was flushing/rinsing with water. Some were more rigorous when using another's syringe, as opposed to re-using their own. The few who used bleach or disinfectant were mainly those who used drugs in the privacy of their homes. Most injectors placed greater emphasis on the provision of sterile equipment, but indigenous advocates clearly have a role in educating on the best cleaning methods – especially given recent evidence that only at full strength is bleach effective against HIV.

**Situations in which syringe sharing took place** Several factors were commonly linked to the non-availability of new equipment, leading to the sharing of injecting equipment. These echo observations since the mid-80s and included: being in a sexual relationship with another injector; the immediate need to use drugs (especially at night); withdrawal; intoxification; and being in situations or places where injecting equipment was scarce. Isolation or exclusion from social networks was liable to lead to high-risk activity as the user resorted to unfamiliar sources of drugs, such as street dealing scenes. High-status indigenous advocates could have a role here, providing sterile injecting equipment in street drug arenas and other high-risk 'hotspots'.

**Drug injecting paraphernalia as an HIV risk factor** Most injectors in our study reported sharing injecting paraphernalia, such as filters and spoons, commonly seen as a low-risk activity. Contributing to this was the fact that drug users were wary of carrying injecting paraphernalia, believing this might be used as evidence against them if arrested. Filters were used as an emergency drug supply in times of shortage and sometimes exchanged for other drugs, particularly pharmaceutical ones.

Social etiquette played an important part in the sharing of filters. Drug users would often find themselves injecting in another drug user's house; in some networks, used filters were commonly left behind for the host – both a courtesy and payment in kind, as after injection a residue of drug is left in the filter.[8]

Education about the risks of paraphernalia sharing and practical alternatives to sharing this equipment can be promoted by indigenous advocates, with the aim of changing the social attitudes and etiquettes that sustain this behaviour. We need to make clear to injectors that sharing any and all injecting paraphernalia can risk infection.

THESE FINDINGS have substantial implications for community-based services, explored further in the panel on page 15; in a nutshell, we have a fair idea of what works:

- peer education using respected 'indigenous fieldworkers';
- flexible (and imaginative) outreach interventions that incorporate an action research dimension;
- strategically planned and coordinated initiatives that involve agencies collaborating in inter-agency consortia. ❍


1. Advisory Council on the Misuse of Drugs *AIDS and Drug Misuse – Update.* London: HMSO. 1993.
2. Wiebel W. "Combining ethnographic and epidemiological methods in targeted AIDS interventions: the Chicago model." *In*: Battjes, R. and Pickens, R. *eds. Needle sharing among intravenous drug abusers: national and international perspectives.* NIDA: 1988, p.137-151.
3. Broadhead R. "Social constructions of bleach in combating AIDS among injection drug users." *Journal of Drug Issues*: 1991, *21*, p.713-737.
4. Power R. *et al. Coping with illicit drug use.* London: Tufnell Press, 1995.
5. Perera J. *et al. Assessing the needs of black drug users in North Westminster: final report to Turning Point.* 1993.
6. Kaplan C. *et al.* "Protective factors: Dutch intervention, health determinants and the reorganisation of addict life." *In*: Ghodse, H., *et al, eds. Drug Misuse and Dependence.* Carnforth: Parthenon. 1990.
7. Burt J *et al. Drug Injectors and HIV Risk Reduction: Strategies for Protection.* Health Education Authority, 1993.
8. Power R. *et al.* "The sharing of injecting paraphernalia amongst illicit drug users." *AIDS*: 1994, *8*, p.1509-1511.
9. Power R. *et al.* op cit. 1994.
10. Hunt N. *et al.* "You say 'sharing', I say...", *Druglink*, July/August 1994, p.10-12.
11. Work is currently being conducted in Miami USA; Chittwood, personal communication, 1994.
12. Donoghoe M. *et al. Syringe exchange in England: an overview.* Tufnell Press,1992.
13. Hunt N. *et al*, op cit.
14. Booth R *et al.* "Effectiveness of reducing needle-related risks for HIV through indigenous outreach to injecting drug users", *American Journal on Addictions*: 1992, *1*(4), p.277-287.
15. Kelly J. *et al.* "Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities." *American Journal of Public Health*: 1992, 80, p.1483-9.
16. Power R. "Participant observation and its place in the study of illicit drug abuse." *British Journal of Addiction*: 1989, *84*, p.43-52.
17. Power R. "Some methodological and practical implications of employing drug users as indigenous fieldworkers." *In*: Boulton M. *ed. Challenge and innovation: methodological advances in social research on HIV/AIDS.* Taylor & Francis, 1994.


A book with illustrative material from this study and which draws out its practical implications for service providers is now available from: The Tufnell Press, 47 Dalmeny Road, London, N7 ODY. *Coping with illicit drug use* by Robert Power *et al* (ISBN 1 872767 17 6) costs £4.99 inc. p&p.