feature

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Getting the point across:

a cheap, effective, brief intervention to reduce injecting

Since the 1980s, targeted interventions with injecting drug users have largely involved secondary prevention strategies intended to reduce the risk of HIV transmission and make injecting a less harmful behaviour, rather than primary prevention work that aims to reduce the numbers of those who make the transition to injecting. The problem is, how do you reach those who have yet to inject? Paradoxically, one answer may be to target existing injectors

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While much progress has been made in reducing the risks of injecting, infections from HIV and other blood borne viruses, continue to result from injected drug use – albeit at a reduced rate.[1,2] And it remains uncertain how effective secondary prevention strategies, such as needle exchange and guidance on safe injecting practices, can be against viral agents as robust and infectious as hepatitis C.[3]

The challenge presented by hepatitis C and the other problems associated with injecting, such as greater dependence and an increased risk of overdose[4,5] (problems which are not addressed to the same extent by secondary strategies), demand that greater efforts are made to produce effective, targeted interventions that reduce the number of drug users who inject in the first place.[6] We describe a cheap, effective intervention to reduce the number of non-injecting drug users who make the transition to injecting drug use. It has been demonstrated in the community and found to be acceptable to drug users and drug workers.[7]

There are three potential problems associated with interventions to prevent injecting which seem likely to have contributed to their scarcity:

- non-injectors are less likely to be in contact with treatment services and are therefore more difficult and expensive to contact;
- the target group for prevention – the people 'at risk' of injecting – cannot be accurately defined because too little is

known of the processes which put people 'at risk';

• people likely to begin injecting may not engage with a preventive intervention because injecting is a behaviour they cannot conceive themselves undertaking and therefore the intervention is perceived as not relevant.[8]

The intervention described here gets around the problem of identifying and engaging drug users at risk of starting to inject by adopting a different point of intervention – that of the injecting drug user.

The rationale

The existing literature already supports the view that initiation is mediated through existing injectors, who often perform the first injection.[9,10] The following findings from ethnographic work suggests several other, possibly counter-intuitive, aspects of the initiation process that were relevant to the design of the intervention.[11]

• Initiation is usually sought rather than being pushed. Injecting drug users often report that they had to persuade their initiator to give them that first injection.

• Existing injectors preferred not to initiate others or, having done so, on reflection often wished that they had not.

• The decision to try injecting commonly arises through 'social learning' processes in which non-injectors observe how to inject, manage the associated risks and learn the economic and experiential benefits of the more intense and immediate effect of injecting.

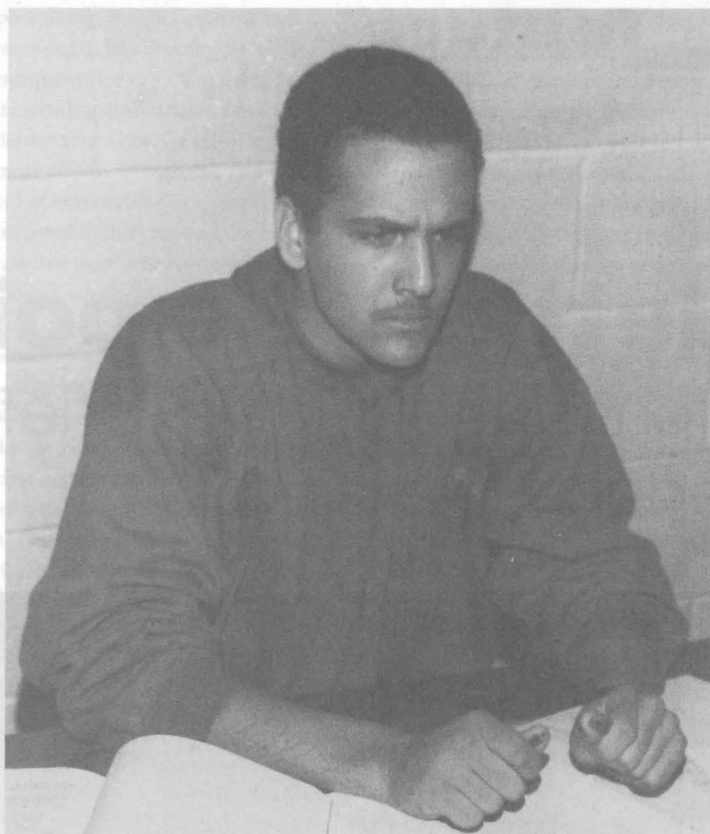
• People who inject had poor awareness of their, often unintended, influence on other people's decisions to try injecting.

• Although people often preferred not to initiate others, they could be persuaded to do so by the potential injector in some circumstances.

This context provides a promising basis for an intervention as it offers several points to engage in work with current injectors in order to reduce their initiation of others.

The theory

The theoretical basis for structuring the interview is firstly Schutz's theory of 'relevance' as a basis for explaining risk behaviours within a social



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context[12,13] and also 'motivational interviewing'[14]

'Relevance' theory has four components:

a) Topical relevance

The worker has to get the client to consider the issue of initiating somebody into injecting.

b) Interpretational relevance

The next step is to get the injector thinking differently about actions they might take for granted, such as injecting in front of a non-injector. This helps people reinterpret these events as occasions when injecting might inadvertently be promoted – and can change the way injectors think about such situations in the future.

c) Motivational relevance

This is concerned with getting the person to actually act in accordance with their revised ideas about non-injectors, by introducing or emphasising the idea that helping somebody to begin injecting can have negative consequences for both parties and discussing what those risks might be.

d) Social recipes

Finally injectors need strategies to deal with those who may be trying to pressure them into helping them with that first injection. This is of particular importance since many of the strategies respondents reported for dissuading drug users from injecting or hiding injecting from them, were in fact likely to be ineffective or actually promote injecting. For example, an injector may try and give a balanced view of the pros and cons of injecting, even weighting the account towards the negative – but often all the non-injector hears are the more positive aspects (eg, the initial 'rush').

In delivering the intervention, the following features of motivational interviewing were used:

i) non-confrontational interviewing,

ii) restructuring and feeding back a

Social Learning Theory – an explanation

Social learning theory is a behavioural cognitive theory of learning. It has a number of components that explain the process by which some non-injecting drug users make the transition to injecting drug use.

- **A key part of social learning theory is that learning can occur when a behaviour is physically or verbally displayed in front of someone.**
- **Social learning theory separates learning and performance. Whether or not a behaviour is adopted depends in part on whether someone interprets the observed outcomes of a modelled behaviour as harmful or rewarding.**
- **Whether a behaviour is replicated is also dependent on how much a person believes they will be able successfully to perform the behaviour.**

Explaining Social Learning Theory within the Intervention – an example

Drug Worker: You say your friend was injecting before you and you got to see them. What did you think when you saw them or talked to them about injecting?

Client: Fucking great... I just wanted to try it....plus you used less.

DW: What about the way he did it, was he any good?

C: Yeah, he knew what he was doing...clean needle everytime.

DW: So you wouldn't want to encourage anyone to inject, or give someone their first injection.

C: No of course not...if they want it they can go somewhere else.

DW: But if they kept asking...like you with your friend?

C: I would just tell them to piss off.

DW: Even a friend, would that be hard to keep refusing.....

C: Especially a friend, I would just tell them to stop asking.

DW: OK.

DW: People don't generally start off in life planning to inject drugs, and many people who start using drugs initially hold the view that injecting is something that they definitely would not do. Lots of needle users are quite scared of needles to start with.

C: Yeah that was me. I hated needles.

DW: It is only after a while that you come round to thinking that you might try injecting. As you spend time talking with people who inject, or seeing them inject, some of these fears are reduced and you begin to think about the possibility of trying it. There are several main things that make this more likely:

- **seeing someone inject and learning how to get a hit together and avoid some of the risks**
- **feeling the odd one out in a group of people**
- **finding about how good the rush is and seeing how quickly the effects come on**
- **learning that it can be more economic to inject drugs**

Does that make sense from your experiences...how you come to inject?

C: Yeah I suppose so.

DW: You said before you asked him you thought it looked great..and you noticed that he used a clean needle and knew what he was doing ....did that effect whether you asked him?

C: Yeah...knowing it was safe was important.

DW: You said that you do not want to encourage anyone to inject, to get to where you are, but that you do sometimes inject in front of non-injectors. Do you think they'll be encouraged by seeing you? It sounds as though that's how it worked for you.

C: No. Well a lot of the time you don't really think about it.

DW: Perhaps if you don't want to be asked to inject someone or encourage them you might think how you started and what you do now around non-injectors...anyway thanks...let's move on to the next bit.

client's own accounts to make explicit perceptions and behaviours that are contradictory to their stated values or the expected effects of their behaviour, iii) emphasising personal responsibility and affirming their ability to bring about behavioural change, iv) assisting the client to explore alternative behavioural strategies.

The intervention

The intervention is delivered in a single session and includes seven sections, each with particular aims.

1. Introduction

The aim of the intervention is described as being to allow the participant to consider his or her behaviour and attitudes towards initiating others and consider how he or she would wish to act in various situations. It is explained that there is no intention to be judgmental or prescriptive during the intervention. The difficulties of acting in the way that is felt to be correct, with reference to the initiation of others, are squarely acknowledged.

2. The participant's own initiation

The participant is asked for an account of his or her own initiation. Attention is paid to expectations that have proved false e.g. the ability to 'try it once', beliefs about invulnerability to problems. Restructured feedback is provided. An assessment of whether they would still choose to have their first injection is encouraged.

3. The participant's initiation of others

Participants discuss actual or potential situations in which they may be asked to initiate someone, and the difficulty of refusing requests to do so. If no-one has been initiated, a hypothetical consideration of the possibility of this occurring is encouraged. Attention is paid to any particular difficulties that are anticipated.

4. Risks to non-injector

The participant is asked about any potential risks that may arise for someone who begins injecting. Any of the main possibilities – such as infection, overdose and dependency, that are not mentioned spontaneously, are raised. Attention is drawn to the unpredictability of someone's first injection and the possibility that a person has an undiagnosed medical condition that increases the risks. They are asked to speculate on the non-

injector's ability to predict how much they will enjoy injecting and their ability not to do so more regularly. Where appropriate, this last point would be emphasised by referring the client to their own experiences after starting to inject, which have already been discussed in the session.

5. Risks to initiator

The participants are asked to describe any risks to themselves from initiating someone. They are then asked to consider any that are not spontaneously raised. The risks referred to include criminal prosecution – especially if something goes wrong, guilt – if the person proceeds to have problems associated with their injecting, criticism from friends of the participant who disapprove of initiating someone and the risk of assault by a relative or friend of the initiatee who learns that they gave the first injection.

6. Social learning theory and initiation

A simple outline of social learning theory, applied to initiation into injecting, is given in lay terms. The participants' account of their own initiation is drawn on to illustrate the model. Points of convergence between the theory and their experience are identified. These ideas are then discussed with reference to their current behaviour around non-injectors. Actions that may move people towards injecting are highlighted as are inconsistencies in the narrative.

For example, a number of the participants reported that their own initiation was influenced by seeing people inject but went on to report that, when non-injecting drug users saw them inject, it would put them off. Presenting the contradiction that this implies seemed effective as a way of getting them to reconsider the potential effects of their behaviour.

Participants received fewer requests for initiation. These were more than halved from 36 to 15

7. Vignettes

A series of vignettes are described which draw on common scenarios involving either requests to initiate someone or actions that may inadvertently make initiation of someone else more likely. The participant is asked to anticipate and describe their response to each vignette in detail. Vignettes include situations such as dealing with someone who asks to be initiated persistently, or people who say that they will inject anyway and that, by helping, the initiator will reduce the risks.

Summary results

86 people took part in the study and 73 of these were successfully followed up after three months. They were mostly male and had a mean age of 30. Their main injected drug was heroin (64 per cent), amphetamine (27 per cent) and methadone (13 per cent). They had been injecting for an average period of nine years. Forty per cent had previously initiated someone into injecting.

Comparing the three months before the intervention and the three months after:

- Willingness to initiate a Non Injecting Drug User (NIDU) fell very significantly, as measured by a 12 item attitude scale.
- Participants injected in front of half as many non-injectors in the three months after the intervention, falling from 97 to 49.
- Injecting Drug Users' (IDU) estimates of the influence of watching someone inject on promoting initiation increased significantly.
- The number of NIDUs with whom participants discussed injecting did not change. However, disapproval of talking about (a) the 'rush' from injecting (a pleasurable aspect) and (b) how to inject, increased significantly.
- Participants received fewer requests for initiation. These were more than halved from 36 to 15.
- The number of people initiated dropped from six to two.

Conclusion

A deliverable intervention has been developed that has good 'face validity' and is acceptable to staff and clients. Furthermore, while it requires only modest resources, it appeared to produce measurable attitudinal and behavioural change in a number of areas that would be expected to lead to fewer people being initiated into injecting. It is readily incorporated alongside syringe exchange work and is an easy and effective way of demonstrating added value at a time when specialist syringe exchange services are under growing pressure to justify their funding ■

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