TRANSITIONING TO INJECTING:

ANALYSIS OF PROGRAM AND POLICY IMPLICATIONS FOR PEOPLE WHO INJECT DRUGS AND HEPATITIS C PREVENTION IN AUSTRALIA

CONTENTS

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EXECUTIVE SUMMARY

The NSW Users & AIDS Association (NUAA) is the states only peer based drug user organisation. NUAA is funded through the AIDS and Infectious Diseases Branch (AIDB) of the NSW Health Department, and its mission is to provide the voice for people who use drugs on issues surrounding illicit drug use. The organisation was formed in 1989, in the peak of Australia's HIV epidemic, when a group of drug users, their friends, families and supporters established NUAA to be an independent, user-driven community based organisation. Although NUAA operates to be a advocate for the rights and health of all people who use drugs, the organisation has been significantly involved with health promotion initiatives that aim to prevent the transmission of HIV and hepatitis C amongst people who inject drugs. This has included being funded by the state government to operate a peer based needle and syringe program.

Peer based drug user organisations play an essential role in the development of health promotion policy and programs affecting people who use drugs. Through NUAAs direct experience the organisation is able to provide governments, services and the broader community with the ‘drug user perspective’ on a range of issues in relation to illicit drug use. Equally, as ‘peers’ NUAA also has the credibility and trust required to reach other people who use or have used illicit drugs who are isolated and extremely marginalised within the community.

This discussion paper aims to fulfil its commitment to providing peer perspective to policy debate through an in depth policy and program analysis of transitioning to injecting interventions, and how they affect the health and well being of people who inject drugs.

Addressing HIV and hepatitis C amongst people who inject drugs is a constant challenge for public health professionals and policy makers in Australia and internationally. Despite successes in controlling HIV amongst people who inject drugs since the introduction of needle and syringe programs in 1987 and the first National HIV Strategy in 1989, the management of the rates of hepatitis C continues to be a public health concern. It is apparent that the program successes in managing HIV have not been as effective for managing hepatitis C amongst people who inject drugs.

In looking for new ways to approach this problem, researchers and policy makers have begun to analyse the process of injecting itself as an independent factor to the high rates of hepatitis C transmission amongst people who inject drugs. Consequently discussions have progressed to developing and implementing strategies that may manage hepatitis C by controlling the numbers of people who are injecting. Research is attempting to show that by implementing programs to control the proportion of people injecting, and people transitioning to injecting, it could be an effective policy measure to control hepatitis C.

'Transitioning to injecting' has now become an important point of interest in harm reduction strategies in Australia. The concept is that by shifting people who inject drugs away from injecting to another route of administration, such as sniffing or smoking, the problems associated with blood borne virus transmission, particularly hepatitis C, could be significantly reduced.

Research and discussions of introducing transitioning interventions to Australia is becoming more topical amongst public health and policy workers. Much of the research and evaluation on

transitioning to injecting programs and interventions have been derived from trials in the UK and Europe. Although there are no long term evaluations of these interventions, these programs have been measured with varying degrees of success.

Transitioning interventions have been implemented in one of two ways:
Preventing initiation to injecting – preventing people who use drugs from starting to inject by deterring them from wanting to try it, and through promotion of alternate routes of administration, such as smoking or sniffing.

Reverse transition – A transition away from injecting to a non-injecting route of administration. These programs are often based on returning users to a non-injecting form of administration they previously used, or still use.

Transitioning to injecting is a relatively new area of work without specific research or evaluation. There has been, however, extensive literature analysing the characteristics and social networks of people who inject drugs; why and how they transition to injecting. Approaching the research this way aims to provide a broader understanding of how to develop transitioning to injecting interventions. The key areas being discussed in the research are focussed on how to identify and target 'at risk' groups – people they believe to be highly susceptible to initiate injecting - and looking at the availability and types of drugs people are using when they make the transition. Because of this context, the literature has resulted in approaching these interventions as from a disease prevention perspective operating independently of existing harm reduction philosophies.

If these transitioning to injecting programs are going to be introduced into Australia, there are significant current political, social and cultural implications regarding injecting drug use that need to be considered, particularly regarding how they will work alongside the current Australian harm reduction principles that underpin the National Drug, HIV/AIDS, and Hepatitis C Strategies.

This paper analyses transitioning to injecting as a policy measure for hepatitis C prevention amongst people who inject drugs by looking at injecting drug use culture and politics within the current Australian public sphere, by discussing the background to the development and implementation of transitioning to injecting research and programs internationally, and by highlighting the complexities of trying to diffuse transitioning to injecting programs in Australia.

Principally, this paper is concerned that transitioning to injecting interventions are eroding the harm reduction principles that have been fundamental to the successes of Australian drug policy, and NUAA is concerned that the promotion of health and well-being for people who inject drugs is being forsaken for the broader governmental focus on the disease prevention of hepatitis C amongst people who inject drugs.

NUAA believes harm reduction programs need to remain focussed on health promotion and healthy living, and supportive of individual freedom of choice. If transitioning to injecting interventions are to be considered within Australian harm reduction policy, the complexities around the social and cultural factors affecting injecting drug use need to be fully appreciated. By analysing the discourses and epidemiology surrounding transitioning to injecting in this paper, the limitations in policy development and implementation of delivering health promotion focused services and

interventions for people who inject drugs can be identified.

INTRODUCTION

The promotion of health and well-being for people who inject drugs has been, and continues to be, difficult to manage for public health professionals, health service providers, and government policy makers. The complexities in understanding injecting drug use and the people who choose to inject confront levels of negative public attitude that are still prevalent across many levels of society. The stigma and discrimination experienced by people who inject drugs has historically shaped the policy approaches to injecting drug use in Australia. For some time a zero-tolerance approach has been taken to the use and supply of illicit drugs in Australia, and is still being carried out by governments today. It was not until the panic of the HIV epidemic in the 1980s that Australia began to put policies and strategies in place that served to protect the health of people who inject drugs.

The public health concerns over blood borne virus transmission between people who inject drugs through the sharing of injecting equipment still remains a priority area for Australia's state and national HIV and hepatitis C strategies.

Transitioning to injecting interventions are a recent approach that the Australian government is discussing as a tool to prevent blood borne virus transmission between people who inject drugs, and is already being researched and trialled in some parts of Australia.

There are many complexities, however, in adapting such interventions in Australia, and it is NUAA's belief that these complexities have not yet been sufficiently discussed in literature surrounding transitioning to injecting to date. This discussion paper serves as a starting point to begin understanding the many factors and implications of introducing transitioning to injecting

interventions in Australia, and how these will affect existing harm reduction and health promotion initiatives amongst people who inject drugs.

This paper is divided into three parts. The first part will look at the political, social and cultural contexts regarding injecting drug use in Australia, the second part will look at the background of transitioning to injecting research and interventions, and the final section will discuss some of the main points of concern that must be taken into account in discussing implementation of transitioning interventions in Australia.

PART 1: SOCIAL, POLITICAL AND CULTURAL CONTEXT OF AUSTRALIAN DRUG POLICY

The single most effective way to analyse policy is to reduce the complexity of the process by emphasizing the primary causal and explanatory factors, and placing this in the broader holistic context of the government decision making processes. (Howlett and Ramesh : 2003) These factors, or 'policy determinants', are determined by macro-level socio-economic factors and by micro-level behavioural elements (Howlett and Ramesh : 2003).

In looking at transitioning to injecting policy, the social, political and cultural contexts affecting injecting drug use are particularly significant. Analysis of the policy determinants influencing transitioning to injecting interventions not only include the current political strategies and health promotion frameworks surrounding injecting drug use, but also take into account the broader social and cultural dynamics of drug availability, cost and using trends amongst people who inject drugs in Australia.

Harm Reduction and Australian Drug Policy

In order to conduct a comprehensive discussion about transitioning to injecting policy and interventions for Australia, the broader context of Australia's drug policy climate must be understood.

Internationally, there are three dominant policy discourses relating to illicit drug use – prohibition, legalisation and harm minimisation (Mendes: 2002).

Prohibition refers to policies that restrict access to and/or criminalise the use or distribution of illicit drugs (Hamoway: 2008). Prohibition is exemplified in the policy of "zero tolerance", aimed at the complete eradication of drug use (MacCoun and Reuter: 2001), and its implementation in the United States "War on Drugs" doctrine.

Contrasting prohibition is legalisation, which supports eliminating restrictive drug policy, while trying to limit the harms associated with the nonmedical use of drugs (Dupont and Voth: 1995). Legalisation has traditionally been associated with the radical politics of the drug user movement, but is slowly being adopted in more mainstream policy agenda. This can be seen in the implementation of heroin trials internationally, in countries such as Switzerland and the Netherlands, which have been evaluated with varying degrees of success.

Harm minimisation is the cornerstone to the Australian Governments drug policies, and is consistent with the governments approach to reducing drug related harm in Australia. Harm minimisation is classified into three strategies: supply reduction, demand reduction and harm

reduction.

> **Supply Reduction:** Policy legislation and regulations that control the amount of the drugs available. Existing policy examples are the ban the cigarettes sales to under 18 year olds; prohibition of the importation and trafficking of heroin; liquor licensing laws controlling where, when and to whom alcohol can be sold.
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> **Demand reduction**: Interventions and regulations that aim to discourage illicit drug use, delay use, or reduce use through information and education strategies, treatment programs and regulatory controls. Examples are in raising the price of alcohol and/or types of alcohol through increased taxation; drug education programs; detoxification and rehabilitation programs for dependent users.
>
> **Harm reduction**: Health promotion programs and interventions that aim to help people who use drugs to do so in ways that are less harmful. Examples are the selling only low alcohol beer at sporting events; provision of clean needles and syringes to injecting drug users; and education of safe using practices to people who use drugs. (Australian Drug Foundation: 1999)

Harm minimisation is the official policy concept underpinning National and State public health strategies, such as the *National Drug Strategy* and the *National Hepatitis C Strategy.*

Harm reduction is the fundamental national, state, local government and public health response to hepatitis C transmission among people who inject drugs in Australia.

The *National Drug Strategy* has a partnership approach to harm reduction, with Federal, State and Territory governments in Australia endorsing the Commonwealth plan and approach. Through this endorsement of the Strategy, Australia's drug policy aims to be delivered through collaborative partnership between Commonwealth, State and Territory, and local governments, communities (including people who use drugs), service providers, industry, research and institutions. (Ministerial Council on Drug Strategy : 1998).

Policy differences in managing supply, demand and harm reduction has been problematic for the effectiveness of each arm, particularly harm reduction. The harm reduction approach acknowledges that it can be more effective for individuals and communities to reduce harms associated with drug use than to support attempts to eliminate drug use altogether. Government approaches to supply and demand reduction, however, have been focused on eliminating drug use altogether, as seen by the Howard governments 'War on Drugs' campaign. Even though harm reduction policy approach has been fundamental to National Drug, HIV and hepatitis C strategies, its success has been obfuscated by the policy agenda of supply and demand reduction programs. This has created a fundamental confusion to understanding what the drug policy agenda is all about, leaving room for interpretation regarding what the priority action areas need to be.

For example, one of Australia's most powerful harm reduction tools is the Needle and Syringe Programs (NSPs). NSPs are a public health measure implemented to reduce the spread of blood borne viruses, such as HIV and hepatitis C amongst people who inject drugs. (Commonwealth Department of Health and Ageing:2002) The establishment of NSPs in Australia in the 1980s is regarded as an essential reason for the low rates of HIV among people who inject drugs. The

programs are supported by the National Drug Strategy harm reduction framework, with the core business objective to prevent the transmission of blood borne viruses among people who inject drugs through the provision of equipment, and access to health promotion education to enable safer using practices.

In 2002 the Commonwealth launched a report on the “Return on Investment in Needle and Syringe Programs in Australia”. The report measured effectiveness of NSP in preventing the transmission of HIV and hepatitis C in Australia from 1991 to the end of 2000, and also calculated the return on investment in NSP during this period.

Over the ten-year period, NSP contributed to the prevention of:

- 25,000 HIV infections
- 4500 HIV deaths by 2010
- 21,000 hepatitis C infections
- 650 cases of liver cirrhosis among injecting drug users by 2010
- 90 hepatitis C related deaths by 2010

From 1991 to 2000, close to $150 million was spent on NSP for a return on investment of up to $7.7 billion. The figure represents the amount saved on treatment for HIV and hepatitis C. (Commonwealth Department of Health and Ageing:2002)

Despite NSPs successes as a harm reduction tool, there are contradictions in various state and territory policies regarding injecting drug use that have counteracted the programs harm reduction objectives.

Under the *NSW Drug Misuse and Trafficking Act 1985*, for example, an individual can be fined or imprisoned for self-administration of a prohibited drug. They also may be fined or imprisoned for possession of equipment for self administration of a prohibited drug. The implications of this mean an individual accessing a NSW government funded NSP, if caught with equipment they have accessed from it, or found implementing safe injecting messages they have been given through the program, may be fined or imprisoned. State policy contradictions such as this obfuscate the health promotion messages NSPs are funded to achieve and diminishes the effectiveness of harm reduction policy.

Another major discrepancy in Australian harm reduction policy is access to NSPs for people in correctional facilities. Presently, there is no provision of NSPs in any prisons or correctional facilities within Australia. Studies undertaken within some Australian prisons show it is estimated that 30-40% of all prisoners are living with hepatitis C, and for women this is likely to be higher (in the range of 50%-70%) (AIVL: 2008). Given these statistics, it is impossible to suggest harm reduction programs are being implemented successfully when exclusions are made to the policy regarding the individuals and circumstances permitted to access to the health promotion interventions. This is a considerable oversight in Australian harm reduction policy, not to mention an infringement on prisoners' right of equal access to health services.

Given that harm reduction is the fundamental policy concept underpinning current policy strategies, these anomalies between the policy and practice around drug policy in Australia results in systematic limitations in policy development and delivery

The discussions and interventions surrounding transitioning to injecting continue to play out this conceptual divide in Australia's harm reduction policy. By analysing the discourses and epidemiology surrounding transitioning to injecting in this paper, the limitations in policy development and implementation of delivering health promotion focused services and interventions for people who inject drugs can be identified.

HIV and Hepatitis C in Australia

The Australian Federal Government is currently in the final year of the three year implementation for both the HIV/AIDS and Hepatitis C National Strategies, which have been in operation from 2005 – 2008.

The National HIV/AIDS Strategy is the fifth framework of its kind, and aims to continue the work that was begun in 1989 when Australia developed the first coordinated national approach to the HIV/AIDS epidemic. (National HIV/AIDS Strategy : 2005)

Since this first HIV/AIDS Strategy, Australia has had significant success in controlling HIV/AIDS, with the country's management of the virus receiving international accolade. According to the National HIV/AIDS Strategy, the level of diagnosed HIV infections fell from a peak of 1700 reported incidents in 1984 to current averages of around 700–800 per year. In the five years between 1994 and 1999 alone, there was a major decrease of over 30 per cent in the number of new HIV diagnoses.

The role of NSPs, as previously discussed, is recognised as one of the most dramatic factors contributing to Australia's success of HIV/AIDS prevention and keeping HIV/AIDS rates low among people who inject drugs. In NSW, HIV case reports for the state between 1984 – 1999 show direct correlation between the reduction in HIV incidents with the introduction of NSPs in 1987 and the first National HIV/AIDS Strategy in 1989 (Stewart : 2003) .

Despite successes in reducing incidents of HIV/AIDS amongst people who inject drugs, the

incidents of hepatitis C remain to be a significant public health concern. Hepatitis C is a slow acting virus that affects the liver, it is believed to affect one percent of Australians and is the most common reason for liver transplants in Australia (National Hepatitis C Strategy : 2005). At the end of 2006, an estimated 271,000 people living in Australia had been exposed to the hepatitis C virus, and 75% of these people were suffering a chronic infection (National Hepatitis C Resource Manual : 2008)

The National Hepatitis C Strategy recognises that the rates for hepatitis C are disproportionately high for people who inject drugs, this is particularly true for people in prisons, people who identify as Aboriginal or Torres Strait Islander, and people from culturally and linguistically diverse backgrounds. . At least 85% of prevalent and incident hepatitis C cases in Australia are injecting drug users (IDUs) with annual incidence estimated at 15%. (Wodak : 1997)

It has become apparent that the policy strategies that have been successful in reducing the incidents of HIV have not had the same success for managing hepatitis C transmissions.

It is in this context that transitioning to injecting has become a topical conversation for introduction in Australia's hepatitis C strategies. In the latest *National Hepatitis C Strategy 2005 – 2008,* "investigating strategies to prevent injecting drug use" was identified as a priority action area for Commonwealth harm reduction planning.

Drug Market and Culture in Australia

Analysis of the drug trends and culture in Australia is instrumental to understanding how existing policy measures have been developed, implemented and evaluated, and understanding the factors that can affect the development of new policies and strategies. In discussing Australia's drug trends and how they may affect transitioning to injecting policy, there needs to be analysis of the statistical data on drug use, including types of drugs injected, as well as the social and cultural factors affecting injecting drug use, including attitudes by people who use drugs as well as those from the broader public sphere.

The National Drug Strategy, as well as the National HIV/AIDS and Hepatitis C Strategies, provide a coordinated framework for drug issues in the Australian community. Feeding into these strategies is the National Drug and Alcohol Household Survey, which are conducted every three years by the Australian Institute of Health and Welfare.

In analysis of the National Drug and Alcohol Household Surveys since 2001, the dynamic nature and cultural complexities of injecting drug use can be observed. Methamphetamine has been consistently been reported as the drug used by people when initiating to injecting, however the statistic has fallen from 60.3% in 2001 to 50.4% in 2007. Heroin was consistently reported as the next most popular first drug injected. The reports for drug most recently injected was most commonly methamphetamine followed again by heroin. Interestingly though, methamphetamine statistics reflecting it as the drug most recently used fell by 10% from 77.1% in 2001 to 67.7% in 2007, and heroin has increased by nearly 20% from 22.9% in 2001 to 39.7% in 2007.

Although methamphetamines are commonly recognised as the drug many people use when they first start injecting, the fluctuation in statistics reflected in the recent surveys may be related to fluctuation in the availability of heroin reported over the past two decades.

During the mid to late 1990s in Australia the prevalence of heroin use increased as reflected in steeply rising overdose deaths. In January 2001, there were reports of an unpredicted and unprecedented reduction in heroin supply with an abrupt onset noticed in all Australian jurisdictions. The shortage was most marked in New South Wales, the state with the largest heroin market, which saw increases in price, dramatic decreases in purity at the street level, and reductions in the ease with which injecting drug users reported being able to obtain the drug (Degenhardt: 2004). Although research has indicated reports of reduction in heroin overdoses and deaths, there has been no research to suggest a shift away from injecting because of the shortage. In a study on the heroin shortage, large proportions of heroin users reported using more of different drugs, and there was an increase in reports of injecting more of different drugs (Degenhardt: 2004).

Australia has been reported to have a strong culture of injecting drug use. This has been attributed to the type and quality of the heroin found locally that is not suitable for other forms of administration (Dolan:2004), such as sniffing or smoking.

There are two main types of heroin in the world – diamorphine base (brown heroin) and diamorphine hydrochloride (white heroin). Typically, brown heroin is produced mainly in the Golden Crescent (Afghanistan, Pakistan and Iran) and is most common in the UK and Europe. White heroin, on the other hand is produced mainly in the Golden Triangle (Thailand, Burma and

Laos) and is traditionally the heroin consumed in Australia (Warhaft: 2008). This is of particular significance as white heroin is a salt, and burns at a higher temperature than brown heroin, making it not as suitable for smoking. It dissolves in water easily, however, which contributes to one of the reasons why Australia has a strong injecting culture of heroin.

The social factors concerning illicit drug use also play a key role in understanding the complexities of Australia's drug using trends. Although in the 2007 National Household Drug and Alcohol Survey, heroin represented one of the lowest statistics for illicit drug use in Australia, with less than one percent of the surveyed population reporting to have recently used the drug, it remains to have the highest percentage of public concern for perception of the drug as problematic. In the 2007 National Drug Strategy Household Survey, 35% of the surveyed population believed heroin to be the most problematic illicit drug used, followed by marijuana at 25% and methamphetamines at 16%. Although heroin use represents a small percentage of reported use, there is still significant public perception of it being the most problematic drug in society.

The social determinants amongst people who use drugs affecting their drug use are also interesting to note, especially in the peer perceptions of injecting drug use by people who use illicit drugs but do not inject. Amongst people who use drugs there is a reported 'hierarchy' of use, with people who use drugs correlating certain stigmas and attitudes with different modes and types of drug use. The stigma attached to smoking drugs, for instance, is much more socially acceptable than injecting even amongst people who use drugs. The attitudes towards injecting can even result in people who use drugs being unable to identify their own dependence. Results from an American study into new injectors showed that initiates were often ignorant of their dependence before they began injecting

(Harocopos: 2008). Dependence and injecting use are believed to come hand in hand, and injecting is perceived as overstepping the boundary of socially acceptable use.

The cultural attachment to injecting use for those who do choose to inject is also interesting to examine. Studies into “fixation” with needles, and the ritual associated with injecting drugs has shown to contribute to the preference people have to injecting, and their lack of desire to stop injecting (McBride : 2001). The process around putting together a shot and administering it has significant personal attachment for many people who inject, which is very important to note when attempting to implement strategies aimed at stopping them from injecting.

PART 2: TRANSITIONING TO INJECTING

Overview

Addressing HIV and hepatitis C amongst people who inject drugs remains to be a challenge for public health professionals and policy makers internationally. The uptake of harm reduction philosophies across the world has seen ongoing investment into research, development and improvement of harm reduction interventions focused on the prevention of transmission of blood borne viruses for people who inject drugs. The development and research surrounding NSPs is a primary example of harm reduction policy progress in Australia. However, in spite of the gratifying health outcomes for investments in NSPs, the annual incidence of hepatitis C in Australia continues to rise. (Law and Batey: 2003)

In more recent years, policy makers and public health professionals have begun to focus on the routes of administration of people who use drugs, particularly the transition from non injecting to injecting methods, and the role it plays in blood borne virus transmission. Harm reduction interventions aimed at reducing the propensity of injecting drug use to transmit viral infections are now widely discussed as a plausible part of drug provision services in the developed world (Hunt: 1999).

The discussions on transitioning to injecting interventions are derived from the concept that by shifting people who inject drugs away from injecting to another route of administration it would minimize the problems associated with injecting drug use (Dolan: 2004), namely blood borne virus transmission.

Research has focused on transition interventions occurring in one of two ways:

1. Prevention of injection initiation - preventing drug users from transitioning from a less harmful form of drug administration, such as smoking or sniffing, to a more dangerous route such as injecting
2. Reverse transition – a transition away from injecting to a less harmful method of administration (PSI: 2005)

Background and History

The concept of shifting people who inject drugs away from injecting and to other routes of administration began in the 1990s through the work of Dr. Alex Wodak. Dr. Wodak is renowned for his efforts in implementing harm reduction in Australia, especially for championing the implementation of NSPs. Dr. Wodak recognised that other strategies were needed to be implemented to control hepatitis C in Australia. Strategies aimed at completely eradicating illicit drug use in Australia were unachievable. Dr. Wodak proposed, however, that there could be virtual eradication of injecting drug use by facilitating a switch to non-injecting routes of administration (NIROA) and this could control hepatitis C. (Wodak :1997)

In 2004, the outcomes of the first research project, conducted by teams from the National Drug and Alcohol Research Centre, University of New South Wales, and the Alcohol and Drug Services Team, St Vincent's Hospital (including Wodak), were published in the *Drug and Alcohol Review.* The aim of the project was to develop and trial an intervention in Australia that would assist willing people who inject drugs to shift to NIROA and to explore the acceptability and practicality of facilitating NIROA (Dolan:2004). Samples of people who inject drugs were entered into a cognitive behavioural trial with a psychologist. A proportion also were entered into treatment. On follow up, results suggested that it was possible to assist a minority of people who inject drugs to NIROA. However, results also showed further research was necessary before NIROA could be recommended as a viable harm reduction strategy in the Australian context.

Although the project proved the necessity for further research, it was acclaimed internationally for its innovation and led the way to further research being conducted (Hunt: 1999).

Literature Analysis

Most of the literature around transitioning to injecting focuses on characteristics of individuals and/ or their social networks. Although transitioning to injecting is a relatively new area of work without much research or evaluation to support its outcomes, extensive studies are being conducted into the characteristics and social networks of people who inject drugs, focusing on when and how they transition to injecting. Social determinants to injecting drug use are dynamic and difficult to measure. Research and policy around analysis of behaviour traits and decision making processes are complex and require extensive measurement and evidence base to support them.

The research seeks to identify the vulnerable groups 'at risk' of transitioning to injecting drugs, and the social determinants that effect the decisions for individuals to begin injecting in the first place. The literature is derived from an aim to broaden understanding of the initiation to injecting process, in the belief it may help treatment providers and public health professionals better identify the risk factors associated with a transition to injecting drug use and enable them to frame harm reduction messages using the language and concepts to those who are vulnerable (Harocopos: 2008).

Vulnerable groups

Routes of administration are identified to be influenced by a range of factors, which include cultural and economic factors, drug markets, drug efficacy and social or peer networks (Treloar et al: 2003). Young people are consistently targeted in the literature as the primary 'at risk' group. People who start using drugs at a young age are recognised to be more likely to transition to injecting than those who start using drugs when they are older (Brener:2008). Young users are also at particular risk for sharing of equipment when they start injecting (Treloar et al: 2003). In a recent study looking at

young new initiates to injecting in Sydney, Northern Rivers of NSW and Brisbane showed that nearly all participants had a history of illicit drug use prior to injecting (Treloar et al: 2003). Homelessness has also been found to be a particular risk factor for young people transitioning to injecting (Brener: 2008).

Australian surveillance data showed that rates of sharing injecting equipment is high among sexual partners. (NCHECR: 2006), and women with sexual partners who inject drugs are identified as a risk group for transitioning to injecting (Brener: 2008). Women who inject drugs have also been found to have a shorter transition to injecting from use of first illicit substances via non injecting route than men (Bryant and Treloar: 2007).

Social determinants of initiation

Adolescence and early childhood is consistently identified as periods of heightened exploration and change, with experimentation of substances around this time common often prompted by curiosity and peer group influences (Brener: 2008).In various research conducted around circumstances for determinants of initiation, samples have reported desire to experience the intense euphoria and superior efficiency of drug use. In a Canadian study amongst street youth the most commonly cited motive was curiosity, with nearly a third of this sample reported their initiation to injecting was also their first drug experience. (Harocopos: 2008)

Other factors that have been identified for people choosing to inject include the economy of injecting, the belief there is a lack of alternatives to injecting, involvement in the ritual of injecting, and the perception that injecting drug is part of their self image and identity, and even in some cases

self harm (Giddings: 2003)

What is apparent when analysing the literature surrounding transitioning to injecting, is that prevention takes priority over health promotion. Although much of the research and program evaluations are framed under an overarching health promotion agenda, because the issue discussed is fundamentally driven by how policy can prevent, reverse and control transitioning to injecting, the agenda becomes focused on prevention.

By focusing discussions on mechanisms to reduce instances injecting drug use rather than focusing on health promotion and human rights for people who inject drugs, positive health promotion harm reduction philosophies are being eroded.

Transitioning to Injecting Intervention: Case Studies

Interventions aimed at reducing the number of people progressing to injecting drug use is a relatively new area of work, of which there is not a lot of evaluation supporting their outcomes. The 'Break the Cycle' intervention in the UK was one of the first programs designed to target people who inject drugs and address the conditions that lead to the initiation of injecting drug use by non-injecting users. The 'One Shot' resource and the prevention of the transitioning to injecting (POTTI) project by the Kirketon Road Centre (KRC) in Sydney was derived from the work of 'Break the Cycle'.

Break the Cycle

The Break the Cycle (BtC) intervention was implemented in two different forms – health worker led and peer led.

The health worker led implementation was the original version of BtC, and has since been adopted by the UK Department of Health as a standard intervention for people who inject drugs. (PSI: 2005). The intervention was based upon trained counsellors supplying targeted education to people who inject around the dangers of initiating a non-injector, such as overdose, dependence problems and legal consequences. The purpose of this was to create and /or enforce a value position to the regarding initiation to a non-injector (PSI:2008). The role that social modelling plays in increasing the desire to be initiated is discussed so that people who inject drugs can make conscious decisions to avoid injecting or talking favourably about it in front of people who are not yet injecting (Hunt: 1999).

The Peer-Led version of BtC was an incentive based model of delivering messages by people who inject drugs through their social networks. People who inject drugs in contact with their local drug

services were regarded as potential disseminators, and offered financial reward for passing on messages (PSI: 2008). The objective of this intervention was to determine whether or not a peer-based model of delivery was a successful means to deliver the BtC messages (PSI: 2005).

KRC POTTI Project

This project also has two arms, and was derived from the BtC work outlined above. The first arm is aimed at preventing young people from transitioning to injecting, and involves targeted ongoing interventions, propagating information about the harms associated with injecting through a mobile outreach clinic at various refuges and rehabilitation facilities.

The second aims at targeting people already injecting drugs through a DVD resource package titled “one shot”. It aims to improve refusal skills to initiation requests of people who inject, as well as improving injecting practices so if they are initiating they can impart the safest messages. (KRC: 2008)

PART 3: DISCUSSION

Defining transitioning to injecting

Definitions of policy problems usually have narrative structure that evolves in some sort of transformation (Stone: 2002). In the case of transitioning to injecting policy and programs, the narrative structure has flowed from harm reduction; the prevention of blood borne virus transmission amongst people who inject drugs, recognition that route of administration is the facilitator of this transmission, and finding ways to change routes of administration. This story path, although seemingly a simple process of logical thought, has taken the journey from harm reduction, as the judgement free removal of harm for people who inject, to exploring methods to control individual's drug using behaviour.

Peer Education

Harm reduction strategies have always included Peer Education as an essential tool in successful program implementation.

Prevention of transition to injecting interventions are fundamentally based on stopping peers from educating each other. People who inject drugs are targeted with programs to enforce negative attitudes of sharing information to people who inject drugs, such as in the BtC campaign, or by using resources such as the “One Shot” video.

Peer education, particularly through the dissemination of safe using practices, has been an integral tool to success of NSPs. By having a harm reduction program that tells peers not to educate is counteracting previous successful harm reduction programs and will only serve to create further confusion and alienation felt by people who inject drugs.

This approach is also ineffective as research shows that there already is an existing negative sentiment amongst people who inject drugs about requests for initiation. People who are injecting already perceive requests for assistance with injecting from non-injectors as unwelcome. (Hunt : 1999). It is also apparent that people who have never injected that are responsible for instigating the transition to injecting in their networks. By targeting existing injectors, who already have an aversion to educating non injectors, and not targeting the non injectors who are they key drivers in this process, the prevention interventions are overlooking the primary catalysts in the transitioning process.

Attempts to deter initiation by people who inject drugs by preventing peer education is not only problematic in achieving its intended outcome, but is ignoring the obvious need for safe using messages amongst new injectors.

Problems with policy diffusion

Diffusion of policy is becoming an important policy tool in an increasingly globalized world. Policy diffusion is the transfer of policy innovations from state to state, has important consequences both for theories of public policy and real policy outcomes (Buckley: 2002). Policy diffusions must be supported by sufficient and proper evaluation, appropriate and prepared cultural settings, and proper policy support.

Successful policy diffusion requires discrete event history analysis, including analysis of internal and external determinants of policy (Buckley: 2002). The analysis must sufficiently discuss the overarching agenda and strategies driving policies.

The research and evaluation surrounding transitioning to injecting policy and interventions have been insufficient. Transitioning to injecting has been recognized as a new area of work without a lot of evaluation supporting any positive outcomes of prevention. Instead, the research is focused around methodology and program development. There is significant data collected on the processes of transitioning, however the long term impact these interventions have on injecting drug use, and more specifically on hepatitis C prevention, have not been adequate to warrant successful policy diffusion into Australian harm reduction strategies.

Harm reduction strategies must be underpinned by health promotion. The research and evaluation on transitioning to injecting has been focussed on disease prevention. This has resulted in the projects overlooking the principles of enabling and participatory health promotion, and eroding the philosophies of harm reduction in the process.

Interventions regarding health and human development must be supported by a societal capacity to adapt to the changes, use of existing materials, and cultural and social resources. Communities must be able to incorporate such a capacity within their everyday social practices. (Keating : 2004) Presently, there is insufficient research and evaluation regarding the effects of transitioning campaigns, and in the analysis of the cultural and political issues regarding injecting drug use in Australia, the societal capacity for people who inject drugs to want to change from injecting to non injecting methods has not been proven.

Conclusion

Injecting drug use and harm reduction policy in Australia is very complex. The issues affecting it are multi-faceted, with broad encompassing factors such as public attitudes to illicit drug use and specific particular issues such as blood borne virus transmission amongst people who inject drugs affecting it.

Fundamentally, harm reduction must approach all relevant policy determinants with a focus on the reduction of drug related harm through health promotion for people who use drugs.

Health promotion needs to focus on the positive reinforcement of healthy messages and enabling people to take control over their own health. What has been learnt in discussing the range of issues and factors influencing transitioning to injecting policy is the application of an intervention targeted at the behavioural choices of people who inject drugs is about top down control and treatment of a policy problem, rather than enabling and educating people who inject drugs to be responsible for their own health.

Meaningful policy change can only occur in an enabling environment. Policy directives must not only be borne from evidence based research, but aim to encourage a shift in societal discourse where the capacity to make that change is shared by all stakeholders. The disease prevention framework in which transitioning to injection discussions are conducted, alongside the lack of societal and policy alignment regarding injecting drug use culture in Australia, is resulting in the erosion of harm reduction policy, and is impinging on the human rights of people who inject drugs. Without respect for social acceptance and civil liberties, including respect for personal freedoms to

have access to education messages that allow people to make their own decisions about their health, harm reduction discourse will not progress in a way that advances the health and human rights of people who inject drugs.

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