"A Shot in the Arm: A qualitative study of needle sharing in Ottawa"

by

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Abstract

The sharing of needles and injection equipment is an extremely serious and potentially deadly practice. Harm reduction strategies have been put into place to provide clean needles and injection equipment to people, as well as to educate them to the dangers of sharing injection equipment. These programs have had some success; however they have not been able to completely prevent needle sharing among the people they serve and do not reach the entire injection drug using population.

Research participants discuss a number of situations in which they have shared needles. These include the first time they injected, allowing others to use their needles, losing track of which needle they previously used, trusting the people that they use drugs with, not having a clean needle available at the time of injection or wanting to get high and not caring that the needle had been used by someone else.

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Chapter 1: Introduction

The sharing of needles and injection equipment is an extremely serious and potentially deadly practice. This practice increases the risk of transmission of blood borne pathogens such as Human Immunodeficiency Virus (HIV) and Hepatitis C (HCV); both cause prolonged illness, have high mortality rates and are costly to treat (Tapert et al, 1998). It is believed that HCV infects an estimated 50%-100% of the people who use injection drugs worldwide (PHAC). A new report from the Public Health Agency of Canada (PHAC) suggests that 19.5% of new adult HIV cases are attributable to injection drug use[1]. These deadly diseases disable people every day and are preventable. The 2001 projected cost of treating people who use injection drugs in Canada with HIV/AIDS was estimated at $14.7 billion over five years (Hickey, 2001). More recently the Canadian Aids Society (2006) has stated that "each case of HIV that progresses to AIDS means about $100,000 in direct medical care" with an additional $650,000 per person in the loss of earnings. Health Canada (2001) puts the estimate at $150,000 per each new person infected with HIV. As staggering as the cost of treating HIV, the costs involved with treating HCV is even higher (Hickey, 2001, Health Canada, 2001). HCV is the leading cause of liver transplants in Canada, each of which can cost up to $250,000 (Health Canada, 2001). It is believed that by preventing the sharing of injection equipment among people who use injection drugs the spread of these diseases could be reduced in this community.

Harm reduction strategies have been put into place to provide clean needles and injection equipment to people, as well as to educate them to the dangers of

[1] This is down from a high of 33% in 1996/1997

sharing injection equipment. These programs have had some success; however they have not been able to completely prevent needle sharing among the people they serve and do not reach the entire injection drug using population. Although the availability of clean needles is still a factor in sharing, researchers also have found social factors that contribute to a culture of sharing within the community of injection drug users.

Needle Exchange Programs

Needle Exchange Programs (NEPs) have been opened around the world to provide people who use injection drugs with clean needles, and equipment. NEPs are facilities that people who use injection drugs can go to with used needles and exchange them for clean ones (CCSA). NEPs often engage in street outreach where clean needles are delivered to people as well as having one or more stationary spots people can go to, in order to exchange needles. The philosophy behind these programs is that by providing greater access to clean needles, they will be able to decrease or cease the sharing of needles thus lowering the rates of disease transmission in this population. Although critics of these programs often charge that they encourage drug use, NEPs have consistently been found to "reduce the spread of HIV among injecting drug users (IDUs) without increasing drug injecting" (p.153, Dolan, Rutter and Wodak, 2003). Worldwide, cities with NEPs show an average rate of 6% decrease in HIV annually, while cities without these programs average an increase of 6% in HIV infections annually (CCSA). People do not start using injection drugs because of the availability of clean needles. Their ability to reduce risky behaviour without increasing drug use makes NEPs a successful harm reduction

strategy. Notwithstanding their success, they have been unable to completely prevent the sharing of needles among the people they serve.

There is considerable injection drug use in Ottawa. In a city with an estimated population of 839,620, approximately 3000-3500 injection drug users call this city home (Bigras, 2002)[2]. Moreover, the Public Health Agency of Canada recognizes Ottawa as having a significant injection drug use issue. Given that people in Ottawa who use injection drugs are found to share needles and other injection equipment, in spite of their contact with NEPs – my research question is; why and under what circumstances do people in Ottawa share needles? Through interviewing injection drug users I will explore the social context in which they use. Related to this is a secondary question: how does the situation in Ottawa compare to what is reported in the English language literature pertaining to other places in the Western world?

Conceptual Framework

There are specific terms associated with harm reduction and injection drug use. These terms at times can be ambiguous or used in various ways. To alleviate any confusion the important concepts used in my research are defined below.

Culture of Sharing:

> The norms within the injection drug community that creates atmospheres in which it is acceptable behavior to use needles previously used by another person to inject.

Equipment:

> All paraphernalia used in the injection process, including that which is provided by needle exchange programs and that which is not – needle/syringe, water, vitamin C, cookers, tourniquets, filters etc.

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[2] The national average of people who use injection drugs/have problem drug use ranges from 2.5-4.6 people per 1,000 population aged 15-54 (PHAC)

Harm Reduction:

Strategies aimed at minimizing the harmful effects of some high risk behaviors including injection drug use.

Injection Drugs:

Includes any illicit substance that people inject into themselves, with the goal of getting high. Popular examples include heroin, cocaine, crack, methamphetamines, morphine, and steroids.

Narcotics:

Illicit substances used to create a feeling of euphoria in those that use them.

Needle Exchange Programs (NEPs):

Programs that provide clean syringes to people who use injection drugs, sometimes requiring used syringes to exchange.

Needle/Syringe Sharing:

The act of one person using a needle to inject themselves, or to inject into someone else, that has already used by another person, or the willingness to use a needle already used by another injection drug user.

The Site program:

Ottawa's Needle Exchange Program

Syringe/Needle:

The specific equipment used to inject narcotics.

Theoretical Framework

The guiding theoretical framework for this research project is based in the harm reduction approach to addiction. Harm reduction models are based on theoretical perspectives that are focused on improving the quality of life of individuals with addictions through pragmatic and compassionate programming and minimizing the negative effects of the use of harmful substances on individuals and society (Marlatt, 1998). This progressive approach moves away from the disease and the moral models of addiction. The disease model was popularized by 12 step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)

(Denning, Little and Glickman, 2004). Denning, Little and Glickman (2004) problematize this model by stating that it sees "the only cure is total abstinence, which eludes up to 80 percent of alcohol and drug users who suffer harm from using these substances" (p.2). The moral model of addiction treatment also sees abstinence as the only option and is the basis for prohibition responses to drugs and alcohol (Denning, Little and Glickman, 2004). Prohibition is a particularly worrisome response to drug use, as it creates the environment for black markets (Beauchesne, 1997). Beauchense (1997) discusses drug use from a health perspective indicating that black markets aggravate many of the issues already associated with drug use, including health related concerns. Prohibition, while possibly decreasing access to certain drugs, has not been proven to decrease drug use, as other drugs may be used as a substitute for the prohibited drug. Moreover, fear of the law has not been able to stop drug use, demonstrating that criminalization of drugs may not be the most appropriate response to addiction issues. Harm reduction theory seeks to keep the power and control to change with the individuals who partake in harmful substance use and views moderation of use as a success rather than only viewing complete abstinence as success. Key to this research project is that harm reduction theory holds no judgment of those who consume drugs and alcohol.

A second framework for analysis guiding my research is a structural social work perspective. Mullaly (1997) explains that structural social work "views social problems as arising from a specific societal context – liberal/neo-conservative capitalism – rather than from the failings of individuals" (p.133). For the purpose of this research the use of injection drugs will be viewed as arising partly from within

the neo-liberal paradigm, which isolates individuals and marginalizes people. Rice and Prince (2000) identify the neo-liberal perspective of community as one where "individuals have no moral sentiments towards other members...people are fundamentally separate, unencumbered by obligations they did not choose; they are responsible for their own fates" (p.215). Mullaly (1997) goes on to explain that inequality problematized by structural social work "falls along lines of class, gender, race, sexual orientation, age, ability and geographical region" (p.133). These societal structures need to be addressed to deal with inequality. People who use injection drugs are a particularly marginalized and isolated fragment of the population. It will be important to be aware of this and remain sensitive to their particular social barriers while interviewing and analyzing from a structural perspective. Moreau (1979) states that "structural intervention works to reduce the inevitable unequal power relationship between social worker and client" (p.79)

A structural analysis of addiction is crucial to understanding addiction at a macro level. It is important to understand why people turn to drugs and alcohol in the first place and what society's role is in reducing structural factors that lead to addiction. People experiencing addiction may feel increasingly isolated and marginalized. Class, gender, race, sexual orientation, age, ability and geographical region all interrelate with addiction. For example "drug users state of health varies considerably with social class and living conditions" (p.33, Beauchesne, 1997). Mothers may have concerns about losing their children if they do not keep their addiction private. To establish effective harm reduction that goes further than dealing with public nuisance and disease control "requires...devising ways to improve living

conditions, increase autonomy, improve access to services as well as provide information on managing dependency and thereby reducing harm" (p.33, Beauchesne, 1997).

Harm reduction theory and structural social work ideologies fit well together. Mullaly (1997) states the structural perspective "indicates that the focus for change is mainly on the structures of society and not solely on the individual" (p.104). Harm reduction strategies do not seek for individuals to abstain from the use of narcotics, but rather that steps are taken by the individual and by society to help minimize the risk involved with the use of narcotics. Society plays a critical role in enabling the recovery of injection drug users by creating new structures, such as NEPs, that facilitate the recovery process. Through programs like NEPs there is a shift in thinking away from individual responsibility for addiction, to seeing addiction as a community issue that impacts more than just individuals.

Harm reduction strategies are often sold to the public at large through an analysis of "health care dollar savings" which are attached to outcomes such as lower rates of blood borne disease in injection drug users that use NEPs. Through this rationale people's eyes are opened to the larger impact of injection drug use and society is encouraged to accept programs that support healthier lifestyles for injection drug users. This signifies a change in thinking from Rice and Prince's (2000) neo-liberal paradigm discussed above. People begin to see their fates as attached to others in society through the joint responsibility of a public health care system.

The introduction of NEPs can be viewed as a structural change that works from a harm reduction perspective. As Lundy (2004) states social workers are trained

to offer "help" to people and encourage change, however many of the problems people face "are rooted in broad social, political, and economic conditions, and only change in those conditions will "solve" them" (p.xv). For individuals to stop sharing needles, society needs to create the context in which this can happen. Further in her book *Social Work and Social Justice: A structural approach to practice* Lundy (2004) states that although structural social work critically views societal structures as at the root of social inequality it does not remove all responsibility from the individual. This is evident in NEPs as individuals are still ultimately responsible for using clean needles, once society has made them available.

The aim of NEPs goes further than preventing the sharing of needles and reduction in the spread of blood borne diseases; they aim also to gain access to people who may feel marginalized and isolated due to having issues of addiction in a neo-liberal society. Through harm reduction practices the Dutch are able to claim access to anywhere from 60-80% of the addicted population in Amsterdam (Marlatt, 1998, p.35). NEPs encourage injection drug users through continued contact with addiction professionals, who related to them in non-judgmental ways, to consider alternatives to their drug use. Other harm reduction strategies, including methadone maintenance programs can be introduced through NEPs. Rather than focusing on the individual to "fix" themselves, as might be expected in a neo-liberal society, obtainable options are presented that facilitate change over a period of time. Thus through viewing harm reduction through the structural social work lens, one can see how the structures of society change in such a way that marginalized and isolated members of the community are empowered to take back control over their lives, from what are often

very overpowering addictions. Viewing harm reduction through the structural social work lens fosters an understanding of specific issues people may face; for example that women may experience needle sharing in a different way then men.

Chapter 2: Literature Review

The following outlines the existing English language literature on the sharing of needles among people who use injection drugs. Articles are predominately from first world countries. The chapter starts with a discussion on NEPs, followed by an overview of the reported reasons for sharing needles. It then moves into what is currently happening in Canada and concludes with recommendations made by scholars in this field.

Needle Exchange Programs

The first Canadian NEP opened its doors in Vancouver, British Columbia in 1989. The Site Needle Exchange Program (Site) began in Ottawa two years later in 1991. Site considers injection drug use to be a medical issue and keeps this philosophy in mind when working with individuals who inject drugs (City of Ottawa). The Site program offers anonymous HIV/HCV testing as well as Hepatitis A and B and influenza vaccination on site and through its outreach van (which delivers clean needles and picks up used ones). The Site program also offers general and substance use counseling, as well as first aid, treatment of abscesses and safer injection teaching and health education. The Site program has 12 partner agencies that serve a variety of client groups including poverty/homeless based organizations, youth based organizations and community health centers.[3]

[3] Site's Partners include: Carlington Community Health Centre, Centre 454, Centre 507, Oasis, Operation Go Home, Pinecrest-Queensway Health and Community Services, Sandy Hill Community Health Centre, Shepherds of Good Hope, Somerset West Community Health Centre, Wabano Centre for Aboriginal Health, Youth Services Bureau of Ottawa.

NEPs are considered to be a harm reduction strategy, although some are more progressive in the manifestation of this philosophy than others. Since NEPs began, it has consistently been demonstrated that programs offering greater access to clean needles have greater success rates. Rather than providing a one – to – one exchange, flourishing programs provide people with clean needles even when they have no used needles to drop off, and have high limits on the number of needles given to a person at one time (or no limit at all)(Canadian HIV/AIDS Legal Network, 1999). NEPs that resemble 'true' harm reduction models have implemented education around the risks related with injecting drugs, medical services including HIV and HCV testing, as well as counseling services. Some countries and/or cities have demonstrated a commitment to harm reduction by facilitating the opening of supervised injection facilities, where people who use injection drugs can bring pre-obtained narcotics and inject in a medically supervised atmosphere. Currently, Canada operates one Supervised Injection Facility in Vancouver, however, due to a lack of a concrete legal framework for these facilities to operate within, its existence may be somewhat precarious (CCSA).

There are high rates of HIV infection among users of NEPs, but it is generally believed this is due to selection bias. People who use NEPs tend to fall into categories that place them at a higher risk of sharing needles, moreover, they tend to lead lifestyles that put them at a high risk for HIV and HCV infection, notwithstanding the increased needle sharing behaviour (CCSA, Guydish et. al, 2000, Canadian HIV-AIDS Legal Network, 2005, Canadian HIV-AIDS Legal Network, 1999). NEP users are more likely "to be homeless, to inject drugs daily, to inject cocaine, to work in the

sex trade, to inject in shooting galleries, and to recently have been in prison" (Canadian HIV-AIDS Legal Network, 2005)[4]. All these factors place individuals at a higher risk for the transmission of HIV than the general population of injection drug users. Strathdee et al (1997) adds "psychiatric symptoms such as depression and anxiety" (p.1340) to the list of risk factors that lead to the sharing of syringes. Through attracting those injection drug users who are at the highest risk for HIV infection, it is expected that NEPs would demonstrate higher levels of HIV infection in the population that uses the services they offer. It is this group that is most crucial to reach.

Although NEPs have been highly successful at attracting those injection drug users at the highest risk of infection with the highest risk lifestyles they have not completely succeeded in preventing the sharing of needles with in the groups of people who use their services (Strathdee et al, 1997). People who use NEPs report sharing fewer needles thus demonstrating a positive trend towards reducing the risk of HIV and HCV transmission. Peterson et al (1998) report NEP users in Tacoma and New York demonstrated "a decrease in passing used syringes to others, from an average of 100 times to an average of 65 times" in a month (p.227). Although it is evident that NEPs are having a positive impact on the sharing of needles among the people who use these programs intravenous drug users are still sharing syringes. In many cities clean needles are readily available to people who use injection drugs at little or no cost, and people are using these programs to cut down on the risks associated with injection drug use. There seems to be a clear indication that people

[4] A shooting gallery is the street name for a place where a number of injection drug users inject. They are often abandoned buildings.

are aware of the risk of HIV that is associated with injection drug use, however, this needle sharing behavior continues despite this knowledge (Strathdee et al, 1997). The next section of this paper explores the reasons that people who use injection drugs share needles, regardless of whether they use NEPs.

Why People Share

Because people continue to share needles despite the existence of NEPs and increased access to clean needles, exploration has taken place to determine the reasons behind the continuation of this high risk behavior. In the late 1980s and early 1990s access to syringes was reported as the number one reason for sharing. However, we are now able to recognize that there is more to the decision to share needles than whether a clean needle is available. It has been found that sharing tends to take place with people who are familiar with one another i.e. friends, family and regular sexual partners (Strathdee et al, 1997, Barnard, 1993). Factors that contribute to sharing needles are availability at the time of injection, social norms within the injection drug culture, and belonging to a specific high risk group (i.e. youth or women). Barnard (1993) concludes that lack of accessibility sets up the situations in which people share, however, this sharing is then highly socially structured and is rarely a random act.

Availability becomes significant when people do not have a clean needle at the moment they wish to inject. This can be due to the person who uses injection drugs being too far away from an exchange or because the exchange is closed (The Canadian HIV-AIDS Legal Network, 1999, Tapert, 1998, Ross et al, 1994, Barnard,

1993). PHAC states that Canada now has over 200 NEPs in operation, however many rural communities and correctional facilities are still in need of this service. When asked about sharing "Respondents frequently indicated that this was not due to the lack of general availability but to availability at *the time and place of the* injection" (p.476, Ross et al, 1994). It is common among users to want to inject as quickly as possible after obtaining narcotics. Barnard (1993) relays a story of a person describing salivating with anticipation upon purchasing narcotics and feeling unable to wait to get clean equipment for injection purposes.

There are a number of reasons people do not have clean equipment on them the moment they wish to inject. One reason is due to confiscation from police. People report not keeping syringes on them to avoid hassles with the law enforcement (Tapert, 1998, Ross et al, 1994). PHAC (2001) discusses how the support of the police is vital to the success of the harm reduction goals in the Canadian Drug Strategy, however, despite support from leaders in the corrections community, generally these supportive attitudes do not always trickle down to the front line officers. Another group for which availability becomes a factor is those who are attempting to quit. This group of people frequently does not have any injection equipment on them when they make the decision to inject one more time, thus it is then common for them to ask to borrow equipment from someone else (Ross et al, 1994).

Availability also has an impact on the high risk injecting that takes place in prisons (CCSA, Dolan, Rutter and Wodak, 2003, Smyth et al, 2001). Due to the scarcity of needles in correctional facilities each injection is more risky (CCSA,

Dolan, Rutter, and Wodak, 2003). Inmates will often share a needle with several other people, rather than just one other person, and will often share with relative strangers. The risk is then exasperated by the high turn over of inmates increasing the number of sharing partners. The Canadian Centre on Substance Abuse (CCSA) has estimated that 48% of Canadian federal inmates have problematic drug use (other than alcohol). Prison syringe exchanges have been initiated around Europe. In 2003 there were 46 of these programs operational in six countries around the world (CCSA). Initial studies of these programs have demonstrated positive trends in the reduction of needle sharing. The number of people sharing needles in these correctional facilities has significantly decreased. There have been no reported cases of syringes being used as weapons and correctional staff have been generally accepting of programs (CCSA, Dolan, Rutter, Wodak, 2003, PHAC). The infection rate of HIV in the federal correctional system is 10 times higher than in the general Canadian population (CCSA). This suggests that prison based syringe exchange programs could be beneficial to Canada.

It is clear that in some situations sharing would not happen if people had even greater access to clean needles, especially if they were able to get clean needles at the same time they obtained narcotics. However, people share even when clean needles are available, demonstrating that there are other factors involved in the decision to share (Strathdee et al 1997, Barnard, 1993). There are "environmental, personal, financial and social factors [that] could all play an important part in motivating the decision as whether or not to share needles and syringes" (p.811, Barnard, 1993). Barnard (1993) suggests that syringe sharing is not haphazard, but rather highly

structured by social norms, in what she refers to as a 'culture of sharing'. She "demonstrates that needle sharing is seldom a random activity but one which is socially patterned and differentiated by gender" (p.805, Barnard, 1993). Injectors often report feeling bad saying "no" to people who want to borrow their equipment. They report feeling awkward suggesting to someone they may have a disease and come up with other excuses to get around lending out their equipment. Some people carry two sets of equipment in order to be able to give one away rather than take equipment back after someone else has used it (Barnard, 1993).

There are several groups that are identified as being at a higher risk for sharing than others. Prisoners and those attempting to quit are at an increased risk due to lack of availability as already discussed. Other groups at an increased risk are youth, new users, women, and people who inject frequently. It is believed that there are cultural reasons in these groups that impact the decision to share.

Adolescents and young adults are at a particularly high risk for sharing needles (Smyth et al, 2001, Guydish et al, 2000, Strathdee et al, 1997). "One estimate is that 25% of new HIV infections occur in youth under the age of 22 years" (Guydish et. al., 2000). Young injection drug users tend to engage in high risk activities without recognizing the possible outcomes. Guydish et al (2000) discuss several studies where age is linked to sharing needles. One reason may be that young users are less likely to use NEPs or use them less frequently than older users (Guydish et. al. 2000). Notable is that the rate of injection drug use is significantly higher among street involved youth than it is among the general youth population (Peterson et al, 1998).

People tend to be at a higher risk of sharing close to the time that they start injecting; many people report sharing the first time that they injected (Smyth et al, 2001, Guydish et al, 2000, Peterson et al, 1998, Ross et al. 1994). People who are learning to inject frequently need help with the process. Through relying on seasoned users, new users give up a lot of control over the injection process (Guydish, et. al., 2000). Rather than actively deciding to inject with a used needle they are passively accepting whatever needle their injecting partner has decided to use.

Women are at a higher risk for sharing injecting equipment as well[5]. Women use injection drugs at a ratio of 1:3 with males (Peterson et al, 1998). Similar to new users, women often report needing assistance injecting, and generally receive this assistance from their partner (Guydish et al, 2000, Ross et al, 1994). The majority of women who use injection drugs have sexual partners who also use injection drugs, and inject with their partners, who assist them in the process. Peterson et al (1998) suggest that women are often introduced to injection drug use through male partners, who remain their connection to drug use. She states "the illicit drug distribution system is dominated by men and may restrict women's ability to obtain their own drugs" (p.248). Most women who use injection drugs reported sharing needles occasionally or habitually with sexual partners (Peterson et al, 1998). Female injection drug users are more likely to report having sexual partners who use injection drugs, and are more likely to share only with their sexual partner. Male injection drug users, however are more likely to share with more than one other person and more likely to share with relative strangers (Smyth et al, 2001, Peterson et al, 1998,

[5] Often women who inject drugs engage in other high risk behaviors as well, including prostitution, where they may be having high risk sex to increase wages (Peterson et al 1998).

Barnard, 1993). Strathdee et al (1997) have found that people who share injection equipment with their sexual partners are less compelled to change this behavior. Interestingly many women did not "view the behavior as worthy of comment if it involved their partner" (p. 810, Barnard, 1993). Due to the volume of needles they share with their partners they are at an increased risk of disease transmission (Barnard 1993). This risk becomes even greater if their partners are sharing with people outside of their relationship. Due to structural barriers that women face there can be increased pressure for them to accept high risk behavior initiated by their male sexual partners (Peterson et al, 1998).

Men are often tasked with the "work" involved in getting high, including purchasing the narcotics and obtaining clean needles (Peterson et al, 1998, Barnard, 1993). As there are more male users than female users, women can feel awkward in the world of injection drugs. Women have reported feeling uncomfortable going into NEPs as there is a stigma within the injecting drug community around women using injection drugs (Barnard, 1993).

There is also a correlation between the risk of sharing equipment and the type of drug injected and frequency of injection (Guydish et al, 2000, Strathdee et al 1997). Some drugs need to be injected more frequently than others. For example cocaine can be injected up to 20 times a day (CCSA). When people are injecting this frequently they are at a higher risk of sharing needles.

On a positive note there is a large number of people who use injection drugs that do not share needles with other users. Reasons people report for not sharing include the risk of transmission of HIV and other diseases (Ross et al, 1994). They

also report that new needles are preferable as used needles become increasingly blunt (Ross et al 1994). Strathdee et al (1997) notes a connection between not sharing and drug treatment/methadone maintenance therapy and frequent HIV testing, demonstrating that some measures used with people who use injection drugs may be working. It is encouraging that greater awareness around disease transmission is reported among the reasons that people decide to use clean needles for the purpose of injecting drugs.

Canadian Context

This section will explore the trends in the injection drug community in Canada. New HIV cases in Canada in 2002 were estimated at 2800-5200, with about 30% being attributed to injection drug users (PHAC, 2004)[6]. Injection drug use is believed to be the cause of 80% of new HCV cases in Canada each year (PHAC). As with other countries the rates of infection are declining, however, they remain significant.

In a recent study of people who use injection drugs in Victoria, Regina, Sudbury and Toronto "24.5% of study participants reported injecting with used needles in the six months before the survey" (PHAC, 2004). It was found that similar to the rest of the world, people most commonly share with people they know, including regular sexual partners and friends. In a cohort study in Vancouver "19.1% of the participants reported that they had shared even though they did not report having difficulty obtaining new, sterile needles" and 27.6% of all those studied reported sharing in the previous 6 months (PHAC, 2004).

[6] This equals 840-1560 new HIV cases in Canada being attributable to injection drug use.

Recommendations From Literature

The literature offers a number of suggestions that may help in the reduction of needle sharing among people who use injection drugs. Many of them center on the need for greater access to needles at the time of injection. This includes having needles available 24 hours a day (Barnard, 1993) and enabling people who are withdrawing or attempting to quit increased access (Ross et al, 1994). The expansion of prison-based programs is also key in reducing the spread of disease in prison (CCSA, Dolan, Rutter, and Wodack, 2003).

Due to the gendered differences in needle sharing behaviour between men and women, they should be targeted separately by harm reduction services, with consideration given to the reluctance of women to use NEPs (Barnard, 1993). Peterson et al (1998) state that the first step to creating effective harm reduction programs for women who use injection drugs is understanding the social context and in which they inject. She recommends improving outreach to women injection drug users and tailoring drug treatment programs for this population. With a similar sentiment, Smyth, Barry, and Keenan (2001) suggest higher individualization in prevention techniques that take into consideration the social context in which each individual shares. Moreover, each individual's beliefs and attitudes around unsafe injecting need to be considered in interventions. The PHAC (2006) I-Track study suggests tailoring programs to each community as the drug cultures in all of the centres studied proved to be quite different. They also suggest directing services to injection drug users who do not yet have HIV or HCV and focusing on preventing

them from getting it. Strathdee et al (1997) agrees with others that AIDS prevention efforts need to be broadened with people who use injection drugs.

The Public Health Agency of Canada (2001) also suggests that access to NEPs needs to be expanded in rural areas, and that partnerships with police should be increased. The Canadian federal government has introduced increased funding for programs that include harm reduction strategies and education around injection drug strategies (Health Canada, 2003).

Chapter 3: Methodology

The study of people who use injection drugs is of great interest to me as a social worker. I have been working with people who experience extreme poverty since 1999. Due to the nature of my past employment I have had exposure to that segment of people in poverty who also abuse substances, including injection drugs. For the last two years I have been working in a homeless shelter that is a partner of the Ottawa Site Needle Exchange Program. We offer a drop box for used syringes and have clean equipment available for people who use injection drugs. It is through this work that I became interested in this research project. Often when exchanging syringes for people I would hear comments that lead me to believe that people were still sharing, regardless of the access to clean needles. For example someone may come in and ask for three needles because they just saw four people down the street that were all going to inject with same one. What always strikes me in this scenario is that they are less than a five minute walk from a needle exchange program. I began reviewing the literature surrounding needle sharing, which confirmed that the mere existence of Needle Exchange Programs has not stopped the sharing of needles and the spread of infectious disease among injection drug users.

A qualitative approach was chosen for this study as it promotes comprehensive findings and gathers in-depth information that cannot be gathered through quantitative methods. My aim was to gain a rich understanding of the experiences of the people in Ottawa around needle sharing. Through hearing stories from people who inject drugs, I was able to get a glimpse at what factors influence

the decision to share injection equipment in the moment that the decision to share is made.

The qualitative approach has specific limits, including limits to external validity. Qualitative study allows for a deeper understanding of the experiences of the individuals interviewed and does not look to generalize findings to other groups. A further limit is that, unlike quantitative research, during the qualitative research the researcher develops more of a relationship with the subject, and human interaction plays a role in the study. My personal and professional background plays into my research.

Participants were selected through a snowball sampling method, and 14 people in total were interviewed. Each participant was invited to tell their friends about the opportunity to be interviewed, and people entered the study as they came forward. The staff at the agency were also invited to inform individuals whom they felt might be interested in participating in the interviews, and in the end the majority of the referrals came through staff.

To set up the interviews I approached social service agencies that serve large numbers of injection drug users (i.e. Site, the Living Room, Centre 507 and Oasis). However, I was only able to conduct interviews at one agency. Reasons for not conducting interviews at other places included them having their own ethics review that would take upwards of 6 months to complete, or the agency feeling that too many studies or a study of a similar nature was taking place at their agency at that time. (One agency commented that their clients were beginning to feel like lab rats). Once a date for the interviews was set, a poster, along with my letter of introduction was sent

to the agency with the date and time that I would be conducting interviews. A copy of the letter of introduction can be found in Appendix C and a copy of the poster can be found in Appendix E. This research project was approved by the Carlton University Ethics Committee.

In the end I conducted open ended, semi-structured interviews with people who use injection drugs at the Living Room. The Living Room is an organization run through the Ottawa Aids Society for people living with HIV/AIDS. I conducted interviews on two separate occasions (June 15, 2006 and October 13, 2006). On each day I interviewed seven participants for a total of 14 (13 males and one female).

Interviews were done in a private area of the Living Room (the boardroom) where no one outside of the room was able to hear the answers given by participants. Anonymity is provided to the participants in my final report by use of a pseudonym. Anonymity could not be provided in the field as staff at the organization were able to see who was entering the room with me to be interviewed. However, the staff were not informed of what participants said nor should they be able to identify people in the final report. The raw data has been kept in a locked drawer at my primary place of residence, to which only I have access. I will retain the data for future research use, provided that research does not threaten confidentiality and anonymity. The tapes will be destroyed upon the completion of my Thesis for the Masters of Social Work Program at Carleton University. The consent form that all participants signed before being interviewed can be found in Appendix D.

I continued conducting interviews until I felt that the data obtained had given me a solid understanding of the experiences of people who use injection drugs in this

city. Interviews were approximately 15 minutes in length and participants were only requested to answer those questions they felt comfortable answering. The interviews were recorded, transcribed and analyzed by the interviewer. An interview guide with a sample of my questions can be found in Appendix B.

Participants received $10(Cdn) for participation in the study. The practice of paying injection drug users for participation in research studies has been debated as possibly unethical by researchers and ethics committees (Seddon, 2005). It is this researcher's opinion, confirmed by reading *Paying drug users to take part in research: Justice, human rights and business perspectives on the use of incentive payments* by Toby Seddon (2005), that it is preferable to pay injection drug users in cash as opposed to non-cash incentives. There are many arguments presented in Seddon (2005) impacting this opinion. It is common practice to offer incentives to social and health research participants for their involvement in research studies. Once the decision is made to offer an incentive for participation the question then becomes what this incentive should be. One argument often made for non-cash incentives is that they cannot be exchanged as readily for drugs. However, it has been found that non-cash incentives (food vouchers for instance) can often be redeemed for drugs at a lesser value, whereby the research participant loses some of the value of the voucher and the drug dealer receives a greater benefit from this exchange. The example presented in Seddon (2005) is that a voucher worth 10 British Pounds can be exchanged for 5 Pounds worth of narcotics. The dealer therefore makes an additional 5 Pounds profit from the transaction. From a human rights perspective Seddon (2005) argues that it could be seen as discriminatory to deny a population incentive payment

or offer them a different (less valued) incentive based on who they are as a group. Moreover, there is inherent judgment in stating that a certain group of people is unable to decide for themselves how to spend their own money. Although I am able to appreciate concern around giving cash payments to people who are being interviewed on the topic of injection behaviours, I feel that their time is as valued as any other research participant and should therefore be remunerated. As I would offer cash incentives to any other participant group, I feel it is my obligation to treat this population as I would any other and remunerate with cash incentives. Moreover, throughout my research I interviewed people who stated that they no longer used injection drugs, and it would have been unethical to withhold payment from some and not others or to "punish" people for past behaviour (i.e. not remunerate because they used to do drugs).

After collecting the data, interviews were transcribed by the researcher. Interviews were then loaded into Nvivo 7 database and organized into nodes by theme. The themes grew out of the collected data. As transcripts were read over, information was grouped together by theme. These themes then became subcategories of tree nodes. Tree nodes included "To Share or Not to Share", "Getting Started", "Starting/Stopping", "Alone or with Others", "NEPs" and "Views on Junkies". The quotes collected in these nodes were the starting points of each chapter and sub-heading.

Chapter 4: To Share or Not To Share...that is the question

The stated aim of this study is to compare through qualitative research if the self reported reasons for needle sharing among injection drug users in Ottawa are consistent with those that are reported in the English language literature from other developed nations. To this end, participants in the study were all asked questions about their own needle sharing behaviors. From their answers a number of interesting trends were identified. It is important to bear in mind that although all participants interviewed were at a drop-in for people diagnosed with HIV/AIDS, that there are many ways other than through the sharing of needles that this disease can be contracted.

Throughout their interviews some participants would comment that they never shared needles, however further in the interview they would tell stories about when they used to share or the rare occasion when sharing did happen, with the disclaimer that they did not consider it normal behavior for them. One participant, who stated several times during the interview that he had never shared a needle in his life, turned around at the door, after I turned off the recorder, to relay a rather lengthy tale about how he did share needles at one period of time in his injecting life. The Public Health Agency of Canada (PHAC, 2006) in the I-Track survey of 3031 injection drug users nation wide, report 14.5% of the study population report borrowing needles (most often from a friend or sex partner) and 18.2% report lending needles to others in the previous 6 months. Reports of equipment sharing are significantly higher, ranging from as low as 37% to as high as 76% depending on the city. In my study participants only identified if they had ever shared syringes/needles with another user. Moreover I

did not ask questions related to the last time they took part in sharing behaviour or stress any difference between injection equipment and needles.

Participants discussed sharing needles in a number of different scenarios. For some sharing took place the first time they injected, while they were being helped by a more seasoned injection drug user. Other participants discussed lending out their own used needles. Some participants stated they lost track of their needles while using in large groups, while for others sharing was based on trust, the person they used with insisting that they were clean, because there were no clean needles readily available or they wanted to inject and just did not care about the cleanliness of the needle they were about to use. The themes identified in this chapter with regard to needle sharing behaviours will be related to the literature and theoretical framework throughout.

Just Say No to Sharing

In this section I will discuss the information provided by those participants who state that they never share needles. Eight of the 14 research participants tell me that they have a strict policy against sharing needles with other people who use injection drugs. For some this has been the rule since they first began injecting, others have developed this practice after a period of injection drug use. Those that have developed this rule after a period of use did so for reasons including being diagnosed with HIV/AIDS. Some of the research participants discuss the impact that other people who are close to them have had on the decision to not share needles with other injection drug users.

David, a 47 year old male, discusses his introduction to using injection drugs with his uncle, at the age of seven. He tells me the biggest rule was that each person had their own needles and that there was to be no sharing between them.

"It was always...that was my uncle; that was one of the biggest rules when I first used with him."

David says he always kept a supply of syringes on hand when he was using so that he never had to share. He started using injection drugs when he was less than 10 years old and this lesson ingrained in him from his uncle, from the first time he used, seems to have lasted his entire life. It is difficult to believe, however, that his uncle's lesson was in anyway rooted in knowledge about HIV or Hepatitis as these diseases had not yet begun to receive the attention that they do today. Nonetheless he informs me that he has been clean now for 10 years, but in 27 years of injection drug use he always followed his uncle's advice and never shared a needle.

Another participant, Shaun, states that his lover insisted that he always use clean needles, and for the entire interview Shaun insists that he never shared with another injector. He credits his lover with this stating he always made sure Shaun had clean needles as he was worried about disease transmission. Shaun tells me after the interview that there was a period of time after the two of them broke up that Shaun did share needles because he did not have someone around to stop him anymore.

For some of the interviewees the decision to not share needles was a policy they developed later in their using life. Robert says he was not always as conscientious and knows that he got HIV from sharing a syringe. He tells a story of

being somewhere that other people were using injection drugs and seeing a bunch of syringes on the table:

"and I just picked one up and didn't really care at the time."

He says that in the moment it was more important to get high than it was to use a clean needle. Robert says now he is much more careful, as he learned through contracting HIV that sharing needles was a dangerous thing to do. Three of the participants comment that once they found out they were HIV or HCV positive they made the decision to stop sharing needles with other users, and two additional interviewees report that this was the reason that they stopped using injection drugs altogether.

Nathan makes a point of marking his needle in order to prevent others from using it. He began doing this after finding out that he had HCV. He describes the treatment as "not nice" and does not want other people to be subjected to it as well. Later in this chapter we will look at how some users cite an inability to differentiate between needles as a reason they might end up inadvertently sharing with others.

Other research participants comment that they do not share needles because they have easy access to clean ones. Derek tells me that he never shares needles; he and the people he uses with call the Site Van and have the drivers drop off clean equipment.

Samantha explains that since moving to Ottawa she shares fewer needles because they are given out for free from Site, in contrast to places she has found herself living in the past where needle exchanges were not available. Although she knows she is not sharing as often as she used to when clean equipment was not

readily available, she is still sharing at times when no clean needles are available at the time of injection. This trend will be looked at more closely later in the chapter.

The first time

People often report sharing needles the first time they inject drugs. Participants in my research answered questions regarding the first time they injected, including whether or not a clean needle was used. Themes from the first time they used that do not relate to needle sharing will be discussed in the next chapter. Six of the participants stated they had assistance the first time they injected.[7] For some the person who injected them used a clean needle, for others this was not the case.

Twelve of the interviewees answered the question "do you know if you used a clean needle the first time you injected?" Five people said that they know for sure the first time they used injection drugs it was not with a clean needle, with one other participant saying he had no idea if a clean needle was used or not. This is consistent with the existing literature that discusses trends that have been identified relating to the first time people use injection drugs. Several authors report that needle sharing often happens the first time people use (Roy et al, 2002, Smyth et al, 2001, Guydish et al, 2000, Peterson et al, 1998, Ross et al, 1994). Guydish et al (2000) note that through obtaining the help of a seasoned user, new users relinquish a lot of control over the injection process to the person actually sticking the needle into their vein. Roy et al (2002) add that the reason for sharing needles the first time may be due to lack of planning or ignorance as well. However, their study found that 84.3% of

[7] The participants were not asked specifically if someone else injected them the first time so it is possible that others had help the first time as well. One participant explains that everyone needs somebody to show them how to do it the first time.

participants did use a clean needle the first time they injected drugs. Smyth et al (2001) find that those individuals most likely to share injecting equipment are people who have been injecting for more than one year but have injected less than 1000 times. Although they can not say with any certainty why this is, it is suggested that as people become more comfortable injecting they may be less concerned with ensuring there is a clean needle, however they may still be relying on others to help them with the injection process. Chuck, a 26 year old male, tells me that one of the first times he injected himself he collapsed a vein. After this occurrence he had his partner inject him every time.

A couple of the participants state that they were very young when they used the first time or that it was a long time ago and clean needles were not readily available. The group of interviewees had a mean age of 15.7 at the time they first injected; the youngest was 7 years old and the oldest was 23 when they started using injection drugs. No age was repeated a significant number of times, however seven (or half) of the participants began injecting between the ages of 12 and 17.

Take it if you want

In this section I explore themes in lending out one's own needles, rather than using the needles of someone else. In a study of methamphetamine users by Darke et al (1994) reported in Tapert et al (1998) it was found that people lend their own equipment out at a slightly higher rate than they report borrowing from other people. Only one participant in my study made a distinction between using other people's syringes and allowing other people to use his. Alex, a 51 year old male, who has been

using since he was 23, discusses how he has allowed others to use his needles because he does not want to give up his clean needles and then not have any that are sharp the next time he wants to inject. He tells a story of someone injecting with him at his place and asking him for a new needle. He tells me

"and I said no, no, no, and I was saying no not because I didn't have any, but because I didn't want to share them ... because if I were to share them it's me at the end...because I knew I was going to shoot up again the next day."

Alex goes on to muse about how he shoots with such a heavy dose that another person could just add water to his syringe and they would be able to shoot up with just water and what is left over in his needle. He seems to think this is part of the reason someone else may want to use his needles.

Tricky Little Devils

There are a few participants who discuss how it can be difficult to keep track of their own needle while using in a group setting. While Nathan's tactic of marking his needle to prevent sharing was mentioned earlier, two other participants tell similar stories of there being a large number of people all using together and forgetting which needle they had been using.

Scotty, a 47 year old male who says that he always uses a clean needle, relays a story of times in which he might end up sharing accidentally. He states that sometimes there are a lot of people using with him and he is "cooking" for everyone.[8] He tells me that people will be grabbing needles as he prepares them, and he will

[8] This could include breaking down the drug (depending on what is being used) and heating it up with water so that it is in a liquid state that can then be pulled into a syringe and injected.

realize that he needs to take a hit before everything is all gone. With a number of needles lying around, if someone did not take the entire contents out of one of them when they used it and placed it back near the other needles, he says he can end up injecting with a needle that someone else has used and not realize it right away.

Ted, talks about getting so high that he cannot remember which needle he used and then having to try to guess which one was his. Having two respondents explaining that they have difficulty keeping track of which needle they used and another one commenting that he marks his so as not to have that problem, I have started to ask the question "why are they all orange?" In Ottawa, syringes given out by needle exchanges are all the same colour. It would seem that if this is a common problem, one way to improve the effectiveness of NEPs could be to include some way of marking needles with the kits that are handed out. Most NEPs advocated a one time use policy, however people who use injection drugs report reusing the same syringe multiple times, even if they are not sharing with others.

Up to this point I have been discussing passive ways of sharing. People have either been confused as to which needle was theirs, having other people inject them while they were possibly more naive to the process or allowing others to take the risk of using their needle. Now I will move in to looking at times in which people are making the active decision to use a needle previously used by someone else.

"Trust Me. I'm Clean"

In this section I will explore two areas that involve an element of trust between people who are sharing needles. One situation involves sharing between

sexual partners; the other is between friends/acquaintances that tell each other they are clean. Strathdee et al (1997) and Barnard (1993) both discuss that people sharing primarily with sexual partners do not feel this behavior is worth commenting on. Also, Barnard (1993) discusses how people may feel awkward suggesting to someone that they have a disease, she states "refusal [to share] could be taken to imply a broad range of negative sentiments ...Between friends it could be taken to mean that the other person was dirty or possibly HIV infected. Between sexual partners it could imply a lack of trust and the unwelcome assertion of separateness" (p.807). In this context it is important to remember that people who share needles are still in social relationships with others and are being governed by a set of norms. Barnard (1993) frames this as a culture of sharing.

There is evidence that suggests people's decisions to share are not related solely to knowledge of disease transmission. Smyth et al (2001) report Darke's findings that needle sharing is "not predicted by knowledge regarding HIV or perceived vulnerability to HIV" (p.718). It is as if people choose to believe those around them are clean to accommodate their desire to shoot up as immediately as possible. Smyth et al (2001) discuss Festinger's theory on Cognitive Dissonance that suggests that people will adjust their perception of risk to better 'fit' with their behaviour. Two of the research participants discuss how there was a level of trust between them and the person/people with whom they were using.

Martin, a 37 year old male, explains that he only ever injected with his partner, and he trusted his partner was not using with anyone else. The two of them

were in a long term, committed relationship. Martin, who has not injected in seven years, tells me about his experience:

"I trusted him, and up until that point I thought he was being faithful, so on and so forth and I thought that he wasn't using with anyone else."

The PHAC (2006) I-Track study indicates that of people who reported sharing needles a national average of 44.6% indicated they shared with regular sexual partners in the last six months. Strathedee et al (1998) suggest that needle sharing behaviours among sexual partners has proven more resistant to change than other sharing patterns. When sexual partners (homosexual or heterosexual) are in long term committed relationships with each other sharing needles with each other can be a firmly rooted norm in their relationship. As there is a commitment and a relationship the individuals see sharing as less of an issue. Moreover, they point out that there is an increased risk of HIV transmission due to the dual risk behaviours they take part in. They also comment that male participants in their study who reported homosexual activity had "a three-fold increased risk of borrowing used needles" (p.1344) and attended shooting galleries more often.

Martin explains that his partner did the majority of the work involved with their drug activity. His partner purchased the narcotics and got the clean needles. Barnard (1993) discusses a division of labour between the genders in a heterosexual relationship where both use injection drugs. To be clear I am not suggesting here that there is a gendered difference between two homosexual males, but rather that the literature speaks of the division of labour in terms of a gendered difference; as this relationship had a similar division of work dynamic, the comparison becomes

applicable. Peterson et al (1998) note that there has been little research that explores HIV transmission in men who have sex with men and use injection drugs. In looking at this division of labour other themes emerge that need to be examined. Barnard (1993) states that men tend to do the "work" involved in setting up the injecting, and that in this respect they are more likely to share with multiple people. It is possible that because Martin's partner was taking care of the "work" involved with their injecting there were more opportunities for him to share needles with people other than Martin (people he purchased from, other users he met while obtaining narcotics), while Martin only ever used with him. Smyth et al (2001) link increased levels of association with other people who use injection drugs to have a positive correlation with increased sharing behaviors.

Another participant, Maurice, uses injection drugs with people who are not sexual partners, but has made the decision to share with different people on occasion because they have told him that they are not infected with HIV/HCV. People tell him that they are clean and generally he said that in the past that has been good enough for him. He states:

"you trusted the person, but really you just didn't care because you just wanted to get high."

He says that he sees a lot of people he shared needles with when he comes in to places like the Living Room (a drop in for people with HIV). When I comment to him it seems like it takes is a lot of trust for someone to say to you that they are clean and have you believe them, he replies

"well that or a lot of lies."

The PHAC (2006) I-Track study reports that almost 15% of people who borrow syringes nationwide report most often borrowing from people they do not know well or at all, demonstrating that Maurice is not alone.

Maurice also tells me that at times there were bleach kits around to clean the used syringes, however, he was never sure if he did that properly. Barnard (1993) states that even the cleaning of needles can be socially awkward among people who use injection drugs, as it insinuates a belief that the other person is infected with HIV. She states that injection drug users have suggested that it is embarrassing, and to avoid this situation people have reported sharing. Peterson et al (1998) report McCoy et al (1994) study results of injection drug users that were instructed on how to use bleach kits. Only 36% of those studied completed all the necessary steps to sanitize the syringe.

Social factors play a role in needle sharing behaviours. Both Martin and Maurice demonstrate a trust in other injection drug users and that this trust influenced their decision to share needles with others.

When You Ain't Got None

The largest number of people in my study who said that they have shared needles stated that it was due to the unavailability of clean needles at the time of injection. Several authors point to availability at time of injection as a factor in the decision to share (Smyth et al, 2001, The Canadian HIV-AIDS Legal Network, 1999, Ross et al, 1994, Barnard, 1993). Participants in my study offer the following reasons

for not having clean needles at time of injection: no access to needle exchange programs, confiscation by police, and technical difficulties with their syringe.

Many of the people in my study have been using injection drugs since before NEPs existed. They discuss how it used to be more difficult to get clean needles. Derek injected for the first time in the mid 1970s before the days of NEPs in Canada. He and his friends had to make their own syringes to inject with, by using either hair coloring bottles or Bic pens. After stating at the beginning of the interview that he never shares, Derek goes on to comment that he only shares when there is not a clean syringe available. He states:

"I'm not stupid. If there is a box there I'm taking a clean one...Believe me, it's a lot easier on you if it's sharp."

Although he states that he prefers to us a fresh needle, Derek says that he does not always clean the used syringe before using it. Greg, who quit sharing equipment when he was diagnosed with HIV, also discusses how hard it was to get syringes before NEPs. He comments in the 1960s through to the 1980s it was

"almost harder to buy syringes than it was to buy heroin."

Nathan also muses about when it was hard to get clean needles, stating they would trade drugs to diabetics for a few of their needles. He tells me that:

"...the problem was a bunch of us would pitch in to get whatever drugs for them and there would be at times...there would be 10 of us and at times because we didn't want to run out of the needles fast there would be like 10 of us on one needle."

Samantha also discusses sharing needles at a time when she lived somewhere that there was no NEP to go to:

"Because we used to go to the drug stores and buy the needles and that, and... there is no needle exchange, there's no needles, there's no rubbers, there's no nothin' down there. It sucks, but, it's true, but that's where we used to share."

She says that when she moved to Ottawa where there is a Needle Exchange Program she started using Site and sharing less. It is evident from these anecdotes that NEPs have made an impact in the lives of injection drug users in Ottawa. It has been proven time and time again that NEPs reduce sharing among injection drug users. Cities with an NEP have seen the HIV rate of infection drop, on average worldwide, 6% annually, while cities without NEPs have seen a 6% rise in HIV annually (CCSA). Although they have not been able to stop needle sharing altogether it is important to remember that NEPs have had a positive impact in reducing the harm associated with injection drugs.

Another reason people who use injection drugs may not have any clean needles on them at the time of injection is due to confiscation by the police or others. Samantha discusses that when the police confiscate her clean needles she is often forced to share with other people who inject drugs. The Canadian HIV/AIDS Legal Network (1999) reports a Vancouver study were two-thirds of the participants state that police confiscated needles from them. Samantha says that when needles are taken by the police and she is charged with possession of paraphernalia all it does is make her want to use more. She comments

"...and they piss you off and then your back out there...that's why, that's why the people are out there sharing the needles because this way here if I share my needle

with you then I don't have to bother going to the Site Van....It's sick to say that, but it's true"

She is explaining that when you use the mobile Site van the police are able to identify you as someone who uses injection drugs as they can see you picking up clean needles. In other studies people report not carrying needles on them to avoid hassles with the police, thus lowering the chances that they will have clean needles on them at the time of injection (Tapert et al, 1998, Ross et al, 1994). PHAC (2001) comments that at the highest levels there is police support for NEPs and other harm reduction strategies, however this support does not always get reflected in front line policing.

Samantha continues to discuss her distrust of the Site van, saying that it is the prostitutes and the homeless who get picked up for exchanging needles at it. The users of NEPs have been identified as belonging to categories of people who lead high risk lifestyles, including being homeless and working in the sex trade. From a structural perspective it is interesting that these two marginalized groups are recognized by Samantha as having a harder time with the police due to their use of NEPs. Lundy (2004) states "a social worker who utilizes a structural approach in responding to an individual's problems and needs considers not only the material and social conditions of clients but also social relationships and institutional formations which may be contributing to the client's problems and acting as barriers to meeting their needs" (p.59). In this situation the police, through confiscating clean syringes, are preventing people from being able to inject safely. The structural perspective takes into consideration how multiple attributes impact individuals. For example

injection drug users often report feeling marginalized, however, in the example of Samantha, who is also a female sex-trade worker as well as an injection drug user, she may feel marginalized as a women or as a sex-trade worker. In the next chapter I will examine more closely the impact of being female and being an injection drug user.

Finally, a third reason is offered for not having a clean needle at the time of injection. Ryan believes he got HIV through sharing a needle due to "technical" difficulties with his. Ryan explains:

"[m]y...ahh...needle got clogged up and the only one that was available was one that had been used by someone else, so I used it."

While some of these stories point to the days before needle exchanges as the reason there were no clean syringes available, others suggest that if there is no clean needle readily available people are willing share rather than put in the effort needed to inject more safely. The next section looks more closely at the importance of having clean needles available at the time of injection.

"I just don't care"

This section looks at the reason frequently stated for not ensuring that a clean needle was available at the time of injection. Six participants discussed how the desire to get high at times will overrule the desire to have a clean needle and inject more safely. Several of them used the words "I/You just don't care" when talking about the desire to use as quickly as possible after obtaining narcotics. Barnard (1993) discusses an injection drug user salivating with anticipation at the moment of

purchase, so much that they were unable to wait to inject. This theme came out strongly in my research.

Remember that Maurice was willing to trust people because he cared more about experiencing the high than about ensuring he had a clean needle. He, like Derek, tells me that he would also not take the time to wash used needles before using. Maurice states that:

"ya, and even at my own place, like certain people would be like can I use your needle you've got the sharper one and all this...and it's like as long as you give me a hit it's not a problem."

His primary concern is not with disease transmission, but rather on experiencing the effects of the drugs to the point he is willing to share needles in a trade for more drugs. Maurice relays to me how he contracted HIV from someone who told him that she was HIV positive:

ya, and it's somebody really close to me and they went to, ahh, to go get more dope and they took too long coming back and they hadn't finished their hit and it was sitting in the cupboard and there was blood in it and I figured well it's been out in the open for hours so it's going to be dead so I played with the loaded gun and I ended up catching it...I'll never tell the person that that's how I got it, because I'm not going to make them feel responsible, because it wasn't their choice it was mine...like I was high when she left and I started coming down and I knew her rig was up in the cupboard and the first thing she asked when she came back was where is my hit...and I said you did it. And she said oh, OK.

He simply could not wait any longer for his friend to come back with more narcotics and decided to use a loaded syringe that was mixed with the blood of a person that he knew had HIV. His story really demonstrates the powerful effects of addiction. He understood there was a risk of contracting HIV through using that syringe, yet talked himself into it anyway. He was aware enough of the risk that to protect the person who he contracted HIV from he lied to her upon her return and told her she took the rest of the hit before she left. It is interesting because if he had truly convinced himself there was no risk of HIV transmission, he may not have felt the need to lie, and may have rather explained that he got tired of waiting.

Other participants suggest that they too have shared needles because they did not think about the consequences. Take Shaun, who turns around at the door to tell me that he did share after he and his lover broke up, when no one was there to stop him from sharing needles anymore. He was obviously aware of the risks as his lover had often expressed concern to him regarding disease transmission, to the point of having him vaccinated against Hepatitis B. After Shaun was left to make his own decisions around sharing he would take the risk. Robert states that he learned his lesson about sharing by contracting HIV because he used a previously used needle. He said that he just did not care at the time and wanted to get high, there were needles on the table so he used one.

Ted comments that he gets so high he does not care if he is using a clean needle. He also talks about how if there are needles and drugs available, even if the needles are not clean the effort involved in calling the Site van seems a lot:

"nah...some...when you're at somebody's place and there is so much dope and so much supply I know you know you don't really want to go out and make a phone call and get out and use a pay phone and hey I need some rigs or something right."

This comment suggests that unless availability can be increased to the point that syringes are always readily available at the moment of injection there will still be users that share needles.

Barnard (1993) discusses a 'culture of sharing' in *Needle Sharing in Context: patterns of sharing among men and women injectors and HIV risks*. Sharing needles with other drug users can be thought of as a norm with in the injection drug using community Samantha comments:

"I know there are times, whatever and that, when we all go... [and it] was nothing for four or five of us to share that needle...It was like there was no fear, there was no nothing there."

Samantha discusses sharing needles as though it is something that people do not even think about. Needle sharing is something they are so accustomed to that they do not even think about it.

Research participants discuss a number of situations in which they have shared needles. These include the first time they injected, allowing others to use their needles, losing track of which needle they previously used, trusting the people that they use drugs with, not having a clean needle available at the time of injection or wanting to get high and not caring that the needle had been used by someone else.

The Appendix A explores other themes that were identified through my research that did not relate directly to needle sharing behaviour.

Chapter 5: Conclusion

Needle exchange programs (NEPs), despite having significant success in reducing the spread of deadly and costly blood borne diseases, have not been able to completely prevent people who use injection drugs from sharing syringes. In 1993 Barnard introduced the concept of a "culture of sharing" among people who use injection drugs. While stating that availability of clean needles at the time of injection remained a factor, she described highly organized rules and social norms that govern the occasions in which needle sharing happens among injection drug users. This culture has been explored by many researchers over the last 13 years and the concept more fully developed. In a study of injection drug use in Canada PHAC released findings in August of this year that injection drug cultures vary significantly from city to city in Canada. Through this thesis, I have completed a qualitative study of injection drug users in Ottawa at the Living room, a drop-in for people living with HIV/AIDS. This study brought forth similar themes as those presented in the existing English language literature. My analysis began by exploring the reasons that people presented for sharing needles, and then moved into exploring other aspects of the drug culture in Ottawa.

Participants in my study report sharing needles most frequently because there are no clean needles available at the time of injection. Reasons that they stated for not having needles when they went to inject include limited access to NEPs, police confiscation of needles, or having a technical difficulty with the syringe with which they had planned to inject.

Research participants also reported sharing the first time they used injection drugs. By needing the help of a more seasoned user, first time injectors relinquish a lot of control over the process. Although participants were not specifically asked if they had assistance the first time they used, many offered this information anyway. One participant stated that you need someone to show you how to inject properly, before being able to do it on your own.

A third reason interviewees offered for sharing needles was that they were losing track of needles while using as a group. To combat this, one participant reported marking his needle when using with other people as he does not want anyone to contract HCV from him.

Two participants discussed their sharing behaviour as being part of 'trust' relationships. For one of these individuals the trust was placed in a sexual partner, who, unbeknownst to him, was sharing needles with other injection drug users. The other participant described wanting to trust the people around him in order to have peace of mind when using another person's needle. He states that ultimately you trust them because you do not care about the risks; it is more important to get high.

Finally a significant number of people interviewed said that they shared needles with other injection drug users because they wanted to inject and "just didn't care" that there was no clean needle available. One participant tells a story about how he got infected with HIV through the needle of someone he knew was HIV positive, because he simply could not wait any longer to inject. In his words he "played with a loaded gun".

In my research other themes emerged that did not relate directly to needle sharing behaviour. These themes are discussed in Appendix A and are related back to the literature and theoretic framework. I will provide a brief overview of these themes here.

Participants described their first experiences with injection drugs including how old they were and who they were with the first time they injected. The mean age at first injection in my study was 15.7, slightly younger than the national average. Many participants discuss having assistance the first time they inject. The people they were with can be categorized as friends, family or other, with other being referred to twice as a 'drug dealer'.

In the next section themes surrounding people starting and quitting injection drug use are analyzed. A number of the participants in my study have stopped using injection drugs, and others discuss attempts to quit. Some participants discussed why they started using injection drugs, through telling me what was going on in their life at the time.

Themes surrounding who participants used with most often are discussed. Some prefer to use by themselves, in a group setting or with their significant other. Issues of isolation felt by the injection drug using community were analyzed in this section.

Regardless of whether or not participants were willing to share needles with other people who use injection drugs, they overwhelmingly stated that they felt comfortable using NEPs. Some reported preferring the Site van as it delivers clean

needles when needed, while others expressed concern that the police would be able to identify you through use of that program.

Finally at the end of each interview, participants were asked to discuss if they felt society had a different perception of men who use injection drugs and women. Although participants did not agree on whether the genders were viewed differently from each other, they did agree strongly that society has an overall negative view of injection drug users.

Recommendations

Through the process of analyzing the interviews I have come up with a number of recommendations, many similar to those that have been put forth by other researchers in this area.

Participants discussed difficulty keeping track of their needles while injecting in groups, two stated that they know they have shared because they forgot which needle was theirs and another participant discussed marking his needle to prevent this from happening. The idea of marking your needle really stood out in my mind, and I recommend that needle exchange programs look in to providing a system of marking needles that can be given to injection drug users when they pick up new clean needles. It could be something as simple as stickers for example in different colours/shapes or with their initials on it, which would allow people using them to identify which needle they had used.

Access to clean needles at the time of injection remains an important factor in needle sharing. Reasons reported by participants in my study for not having clean

needles include access to NEPs, confiscation by police and technical difficulties. Many of my participants who discussed not having access to clean needles were referring to the time before needle exchange programs in Canada, or living in communities other than Ottawa that did not have an NEP. There is a need to ensure that all injection drug users have access to needle exchange services nation wide. Moreover, NEPs need to continue to work with police forces to ensure that support that is offered to NEPs from the leaders in this community filters down to front line officers.

As people often report sharing needles the first time they inject, first injections take place at a young age and injection drug use is significantly higher among street involved youth than the general youth population, education programs should be geared towards informing high risk youth of the dangers involved with injection drug use at early points of contact with them. The public school systems 'anti-drug' policy does not equip people with the knowledge that they need to remain safe at the time of first injection.

Many people agree that programs need to be created that specifically target female injection drug users since they experience drug use differently from their male counterparts. Women suffer increased marginalization and isolation due to their reproductive capabilities and maternal roles. Environments and outreach programs that are safe for women who use injection drugs need to be created to overcome these barriers.

Finally there is a need for increased study on homosexual male injection drug users as well as men who have sex with men and use injection drugs. These men are

at an increased risk of disease transmission if they are having unprotected sex and sharing needles, and may feel additional barriers to accessing services due to sexual orientation.

Limitations

I will now shift my focus to the limitations of my study. In addition to the limitations with the qualitative approach, already discussed in the methodology, there are additional limitations to this research project.

There is a possible bias in my sample as I interviewed solely at a drop-in for people living with HIV/AIDS. A side effect of this was that all of those interviewed reported receiving Ontario Disability Support Program (ODSP) or "disability insurance" as their primary source of income. As all of those interviewed were at a drop-in for people diagnosed with HIV/AIDS, it is reasonable to assume all those interviewed are living with HIV/AIDS and accessing this financial assistance program for this reason (although I should be clear here that I do not have direct information about the screening process of service users at the Living Room). By not interviewing at other locations I was unable to use the information I gathered regarding the income of the participants, as all participants had the same income. Following from this is that interviews only took place in one city in Canada, making it difficult to generalize findings to other locations, even if the type of agency remains consistent.

I interviewed a sole female client, preventing me from conducting a gender based analysis. On the two dates that I conducted interviews only one female came

forward to be interviewed. I noticed that when in common areas of the agency the vast majority of the service users were male, which may have led to this unevenness in my sample. I consider this highly unfortunate as themes in the literature on needle sharing behavior among injection drug users demonstrates marked differences between how the genders experience injection drug use.

Moreover, not all of my interviewees are current injection drug users so I may have received information that was out dated. Indeed many of those who discussed difficulty in obtaining needles as being the reason they shared did so in the context of telling me stories about times before the advent of NEPs in the place that they lived.

Appendix A: Additional Themes

In addition to questions surrounding needle sharing behavior, research participants were asked questions regarding other aspects of their injection drug use, in order to better understand the culture of injection drug use in Ottawa. The following explores themes in the experiences participants had the first time they used injection drugs, with attempting to quit, who they use injection drugs with, their views on needle exchange programs (NEPs) and their beliefs on how society views them. The themes in each of these categories will be related back to the literature and placed within the context of my theoretical framework.

Lets Get it Started in Here

Research participants were asked questions about the first time they used injection drugs, including who they were with and whether or not a clean needle was used. In the last chapter needle sharing behaviors at the time of first time injection was explored; this section will shift focus to who interviewees were with and the experience of the first time.

The mean age of participants in my study the first time they used injection drugs was 15.7 years old with the youngest being 7 and the oldest 23 at the time of first injection. Half of the participants were between the ages of 12 and 17 when they first injected. This mean age is slightly younger than the average age of first injection discussed in the literature. CCSA states that in Canada the first injection takes place typically in late adolescence or the person's early 20s. In the Public Health Agency of Canada (PHAC, 2006) I-Track survey 74.2% of males started injecting after 16

years of age, for females it was 70% that were older than 16. The age at first injection is significant in that Guydish et al (2000) link young age to an increased likelihood of equipment and needle sharing.

I was with Friends

Research participants report being with one of three categories of people the first time they injected. Some were with friends, others with family or significant other and others were with people they did not classify as friends or family. Roy et al (2002) found in her study of street youth in Montreal that the majority of people (64.8%) were with a close friend the first time they injected. This was followed by an acquaintance, a lover, someone unknown and the youth being alone – in that order.

Five of the interviewees were with friends the first time they used injection drugs. Greg tells me a bit about his first experience:

"...I was the youngest. I was always kind of the youngest in the crew, we were all fairly young. I think the oldest was you know...you see, I was the only one 12, but 13, 14, 15."

He goes on to tell me:

"*Well it was the 60s and...drugs were like...drugs were kind of cool at the time...But ah, injecting drugs wasn't, but ah, but ah, I was always, I had problems when I was a kid and so I ahh, always wanted to go that extra step."*

Greg states that because societal attitudes have changed he thinks that young people today are less likely to fall prey to drug use.

I was with Family

Two of the people interviewed were with family members the first time they injected. Interestingly these two did not share needles at the time of their first experience. Three others discuss having their partners with them when they tried injection drugs for the first time.

David discusses how his Uncle that he used with the first time influenced him to never share a syringe.

"It was always, that was my uncle that was one of the biggest rules when I first started with him."

Maurice too used with a family member the first time. It was his older sister. He says that when he used with his sister they always used clean rigs.

Three of the males interviewed discuss having their partners with them at the time of first injection. Chuck describes being nervous and needing his partner to help him. Strathdee et al (1997) report on the increased risk that homosexual male injection drug users have; she states "these men appear to represent a subculture which is doubly marginalized within both the IDU and gay communities" (p.1344). They are not only marginalized from society for being injection drug users they are also marginalized within that sub-culture for being homosexual. Coming from a structural framework, it is important to take in to consideration how people's sexual orientation impacts their experiences.

I was with Others

Five interviewees do not categorize the people they were with the first time as either friends or family. Alex describes the person he used with the first time as the cousin of his pusher. He explains that neither of them could snort coke anymore due to the damage that they had done to their noses and the cousin of his pusher shot up with coke and injected him with it, changing him forever into an injection drug user. Nathan too describes the person he was with as a drug dealer, explaining that he was a runaway and did not know what he was getting himself into. It seems to be a common theme that the first injection is not a planned event. CCSA states in a 1998 Canadian study that many first time youth injectors did not think the first time injecting was a big deal. They also reference an Australian study where a third of the youth interviewed said their first injection "just happened" and was an unplanned event. Other research participants state they were with a variety of other people. For Robert it was with his boss, who was paying him with drugs rather than money, and Samantha was working as a prostitute and used with some of the other girls on the street the first time.

I'm Hooked on a Feeling

Two of the participants discuss feeling as though the high they experienced from injecting drugs was so amazing that they were 'hooked' from the very first time they injected. Although I remember clearly from the "drugs are bad" education that I received in elementary school, people are rumored to be addicted to drugs that are

often injected (cocaine and heroin) from the time of first injection. However, I was not able to find any scholarly source stating people can be addicted from the first injection. This could be due to most first time injectors having used drugs before the time of first injection. PHAC (2006) finds that the majority of people who inject cocaine have used cocaine in other forms prior to the first injection and that many people who inject heroin have used it in a non-injection way previously as well. Alex tells me:

"I looked at him and I said is that coke, fucking coke?...he said he poked...and I said "ahhh ya" I said "I wanna try that" so he went and he poked me once...and I took the syringes, and he just poked me once and it was a tiny little shot that he gave me, I just took the syringes out of his hands and I said "from now on I'm poking for the rest of my life"...Just like that..."

Shaun too was hooked from the very first time. He tells me about being injected by a friend of his the first time:

"I have such a fear of needles...and just this one time I was out at his place with his ahh...with his boyfriend...And he says "just try it", he says "you'll like it" it was MDA, I said "ok" I said, but I couldn't look; I turn away and my friend thought I was going to like freak out and...because it was my first time and it was like the best thing. Everything was sparkling...everybody looked beautiful. And friend said "whatever you do don't look in the mirror" and I said "why?" And I looked in the mirror and I looked awful...but it was like totally; it was really weird. And then after that I was...I continued for about 8 months like very strongly."

Help Me Out Man!

Six of the participants report that they had assistance the first time they injected, however they were not asked specifically about this, so it is possible that others had assistance as well. Roy et al (2002) state that just over a quarter of youth in their Montreal based study of 505 young injectors report injecting themselves the first time, leaving close to 75% having the assistance of someone else. As previously stated many new injectors require the assistance of more seasoned users while learning to inject. Guydish et al (2001) state "the person being injected has reduced control of the injection process, including whether steps are taken to prevent blood-borne infection" (p.138). Maurice discusses that it takes time to learn how to inject on your own. He said after a while he got tired of waiting for someone to give him a hit, so he started trying to do it on his own. Chuck describes not being able to inject himself as he collapsed a vein one of the first times he tried it on his own and needed help with injecting after that.

All of the participants started using injection drugs before they were 25 years old; however, they all had different experiences the first time injecting. Many of them had someone help them with the first time they injected: some were with friends, others were with family or significant others, while still other participants classified the people they used with the first time as drug dealers or people from work.

Starting/Stopping

This section includes discussion around the reasons that participants report they first tried injection drugs, how they feel about quitting, and in the case of some,

what made them decide to stop injecting. Roy et al (2002) list the following reasons (in this order) offered by research participants for why they started injecting drugs: curiosity, peer pressure/influence, to get high/have fun, so that the drug would have a stronger effect, depression or sadness, the opportunity presented itself, or injecting was cheaper and less wasteful (p.1007).

I Need a New Drug

All of the participants told me how old they were and who they were with the first time they injected. A number of them went on to describe what was happening in their life at the time. The following is a brief recap of some of the more interesting stories.

As previously discussed, Alex explains that his nose was burned out from snorting cocaine and he was no longer able to ingest it this way. He saw someone else injecting and decided that he wanted to try to consume cocaine intravenously. He said from the very first time he injected he was hooked for life on that method. Roy et al (2002) reports that 80.4% of the people in her study who inject with cocaine the first time have used cocaine by a different method previous to that. Alex had already snorted enough cocaine to permanently damage his nose.

Greg explains that it was the 60s and drugs were popular, although injecting was not, he says he had problems as a kid and always had to go a bit further. Nathan's story sounds a bit similar:

"The first time I did it was with the drug dealer. But that's also because I was a runaway um from um home and you know and I wanted to experiment and I didn't know what I was getting into..."

Both of these men sound as though their adolescent years were not a good time for them, and so they turned to drug use.

Robert's story sounds unique. He was working for someone who paid him by injecting him rather than with money. Whatever the reason for starting was, the participants seem to agree that it is difficult to quit.

Hard to Quit

Seven of the participants discuss attempts to quit or what is stopping them from being able to quit. There are discussions on physical pain and on the relationship that they have with their habit.

Alex refers to the injection drugs as being like a wife to him. He has been using intravenously for 30 years. He would like to quit but he states

"it's kind of like I am to say to my wife take the door and go away. I don't want to see you no more. Because cocaine is too...kind of a woman; to say to my wife...(he trails off)"

It is difficult to imagine how this tears him up. He began to cry a bit when he spoke of how long he has been using and the conflict within him that is created by his desire to quit a very old habit.

For others the difficulty in quitting is the due to physical pain or illness. David discusses the physical pain that he was in when he started using injection drugs on a

regular basis. He had been in a motorcycle accident and he says that after they took him off the pain medication the pain did not go away, so he started taking care of it through injecting. Derek too talks about being sick and says that:

"even if there is a policeman in the room"

that would not stop him from using if he is sick. He tells me that he is on the methadone program, so he has to be careful not to get caught and does not inject very often because of this. He expresses concern that if he gets caught he will be kicked off the methadone program, yet this is still not enough incentive to overrule his desire to inject.

Samantha is also struggling to stay away from injection drugs. She tells me that she had been clean for three years and then injected again recently:

"you can't really judge anybody on that because it's like you can bring yourself up there, but you can also bring yourself back down...but it's still in the back of your mind, because of the fact that when you get upset or if you got a lot of problems on your mind, if you can't deal with certain things or...it seems like that's the only way out or something. It, but, it's not the way out, because I don't want to go back down that road."

Samantha explains that this time she ended up injecting near her vagina and is worried about the damage that she has done to herself with this injection. It is clear from her statement, and from the fact that she spent three years clean, that she really would like to live free of the drugs but that it is really difficult to not give in to her addiction. She goes on to tell me:

"I said that I wouldn't go back to the needles and now today it's like you are better off saying nothing...I got dragged back in with the old crowd again, I had three years in clean...and then when you think that you are out there doing something and bang-o it's like, it doesn't take them long to drag you back into it, it's like here's the needle again, here's the prostitution again, these doors are all opening again...they do close if you want to have them close behind you it's there."

Shaun too has been clean for awhile and says that the drug still calls to him sometimes. It is very hard to stay away from. He tells a story of someone else using around him:

"The drug is just overpowering. Like just two weeks ago I had someone over at my place...I smoke crack occasionally. And we were smoking crack and he pulled out a syringe on my table and I didn't realize it because I went to change the station on the radio. I came back and I saw him injecting it and I felt the urge...and then the urge turned to anger because I told him "OUT" I said... "Hey get this 'guy' out of here" He said "what's the problem?" I said "I used to do that" I said "I've got a craving for it" I said...I had a craving for it "and now it's just turned into anger. I said get this 'guy' out...I don't want him fucking shooting in here"...I said "You can smoke here, but that's it"

These two very powerful stories suggest that even after they have quit there are still triggers that pull people back to injection drug use. Samantha goes on to tell me that she ran in to a friend she used to shoot up with recently and had to ask someone to stay with her so she would not feel the urge to go use with him. Both of them discuss that it is difficult to see others using or to see people that they used to use with. Shaun

describes the drug as being overpowering, and although he has no problem with people smoking crack around him, he does not want to go back to injecting it.

All seven of these participants present the struggles that they have had attempting to quit injecting. It would seem that sometimes the desire to quit is simply not enough. Through these stories one can hear the need for programming that understands how difficult it is for injection drug users to quit injecting.

The Public Health Agency of Canada and Marlatt (1998) discuss the differences between high threshold and low threshold programs. Low threshold programs are viewed as having a greater harm reduction impact because they have fewer requirements of the participants. They encourage clients to continue program enrollment rather than set up barriers to client success, for example, they are open at convenient hours or they are accepting of some drug use among participants. Through listening to people discuss how difficult it is for them to stop using injection drugs it is apparent how programs that understand this struggle are valued by those attempting to clean up. NEPs and particularly mobile needle exchange vans are examples of low threshold programs that we have looked at and will continue to look at further in this chapter. Some methadone maintenance programs are low threshold programs while others are not. Some allow the use of non-injection drugs among clients, or are understanding of 'slip-ups' while other programs are more strict (Marlatt, 1998).

Relating to the difficulty of quitting injection drugs is the concept of 'needle habits'. CCSA discusses the concept of a strong needle-habit, where people become addicted to the act of sticking a needle in their arm. They characterize these people as

having difficult times with methadone programs as they prefer to inject narcotics and as enjoying the act of injecting so much that at times they will inject water when no drug is available. The association is made between the act of injecting and the injection itself to the point that other items associated with injection can become pleasurable as well (tourniquets, swabs etc). People with strong needle habits have a harder time quitting injection drug use than others.

I'm Done with that Shit

As hard as it is to quit injecting five of the participants talk about how they were finally able to give it up. Some quit because they did not like what it was doing to their life, for others it is related to illness.

David says that he just sort of lost interest in it. He said he saw himself deteriorating and did not like what was going on in his life

"I was no longer a functioning...citizen, I was a ... sliding into the gutter then really fast and I simply left Ottawa"

It was after he left Ottawa that he cleaned up.

"I went from Ottawa... and I got into a program and got into school and got back on track again."

He is proud to have graduated from school and started a career.

For Martin it was finding out that he had HIV that made him decide to quit, and leave his partner at the same time.

"Right before I found out I was sick, I got sick, he found out his diagnosis, full blown, and I basically got sick and tired of watching him basically...well I basically watched

him OD several times and come back and I got sick of it...and then he found he was... he was full blown...He was injecting his morphine, he was crushing it up, and one day, one day I just snapped and I said "I can't handle this"...I told him he had to choose me or the drugs, because I am not doing this shit anymore, and he made his bed and lied in it...and I left him."

Unable to cope with his own illness, his partner's illness and their lifestyle he decided he needed to make changes in his life. He tells me his ex-partner has been dead for seven years now. There are others that tell me that HIV diagnosis convinced them to stop using as well. For Maurice too, it was the HIV diagnosis that made him realize that he needed to make some changes in his life:

"I found out I was HIV positive and I wasn't going to do something, Lord that's when I thought I was dying in a month...I wasn't going to do something that was killing me, I'm not going to do it no more, so I just stopped, but I got into prescription drugs."

Participants all have different stated reasons for starting to do injection drugs, however, for many attempting to quit remains difficult. The Needle Exchange Programme website from Christchurch, New Zealand states "The world is full of ex-users and they all got clean the same way – the hard way", making the point that detoxing and staying clean is very difficult.

Alone or with Others

The focus will now shift to the people who participants in this study report using with and whether or not the participants prefer to use alone. Four of the participants said they use alone sometimes and with others at other times, and had no

real preference one way of the other. In the PHAC (2006) I-Track study more than half of the participants reported injecting with friends, while a nation wide average of 10.6% reported injecting alone all the time, and 41.5% reported injecting with no one in particular and alone at times. In addition 32.1% indicated that they injected with their regular sexual partner, in the last 6 months. PHAC (2006) offers the disclaimer that people who frequently inject alone may not have been captured in their survey, due to social isolation.

I use alone

Three of the participants stated that they preferred to inject by themselves. Alex stated this was due to his behavior while under the influence. He says:

"not, phobia no. But habit, habit ya that I have, and I don't want to share that habit with no one because the...this is no fun to say to someone, because if I say the ghost of someone...Ya because I look for someone and there is nobody in the room."

He describes how he looks for a female in the room that he thinks is there, even though the door is locked and there is no way that she could have got in. He says that this hallucination is the side effect of long term cocaine use.

"And my brain...coke did that to my brain...So I think that there is a woman behind me"

He continues to tell me that he masturbates while searching for this woman and so he is not comfortable using with other people.

Scotty discusses how he gets irritated with other people and feels like throwing them out a window. He describes what it is like when he uses with other people

"Oh ya, but now I started to use by myself, some of these guys they'll do a whack...they'll do a half a gram and a whack and you know they'll do the funky chicken on the floor and then they'll expect to do another one right after they get up off the floor."

However, even though it is Scotty's preference to use alone at times he does use with other people. Using injection drugs alone habitually can be very isolating. CCSA discusses how the illegal nature of injection drug use is marginalizing to people who inject. Dave too says that he prefers to use alone because he does not want people to know that he does injection drugs. PHAC states "people who use injection drugs are under-represented in population surveys, and many have unstable lifestyles that revolve around drug use and marginalize them from mainstream society." Injection drug users who use alone may feel even more marginalized because they are removing themselves from people with similar habits (injection drug use) as them as well as removing themselves from society.

<u>I use with others</u>

Three people commented that they prefer to use with others. Nathan talks about how he is worried about using by himself.

"Because I notice that if I end up injecting alone, um I end up wanting to do it more and more and more...and so ah I guess um hide from the world that way um...And then the next thing you know that's all my world has become."

He seems to be worried about there being a separation between him and other people. In a competitive society driven by the market people can become separated from each other in general (Rice and Prince, 2000). Moreover if a person is addicted to an illegal substance (s)he are marginalized further. CCSA discusses that people who use injection drugs often have issues in their interpersonal relationships and can feel quite isolated because of their drug use. Nathan's words sound like he is trying to remain connected to other people.

Always with the same person

Two participants commented that they had only ever injected with their partners. Chuck and Martin say that the only way they would use is if they were with their respective partners. While Chuck says that he and his partner always used a clean needle, Martin comments that he and his partner always shared equipment including syringes. As stated earlier, there have been few studies done on homosexual men or men who have sex with men and use injection drugs (Peterson et al, 1998). This is an important area for further study.

Some participants prefer to use alone, while others prefer to inject with other people, some preferring it to be their significant other. For all of them, however, there are potential issues of isolation attached to injection drug use.

Needle Exchange Programs

In this section the research participants discuss their level of comfort with using needle exchange programs. The literature suggests that many people who use needle exchange programs still share injection equipment (Strathdee et al, 1997). All of my participants say that they are comfortable with some form of needle exchange service, either at one of the stationary locations or using the Site Van.[9] Some participants preferred to use the van while others felt that the van attracts the attention of police.

I'm down with NEPs

Ten of the participants state that they are comfortable using NEPs while four others state that they prefer the Site Van as it travels to the people in need of clean syringes (making it a low threshold program). While all of the participants are comfortable exchanging syringes you will recall from the previous chapter that there is a large number of them that still share syringes in different situations. This supports the literature in this area as it is believed that while NEPs reduce sharing among injection drug users that use them, they do not prevent it all together. World wide cities that have NEPs boast a HIV infection rate of -6% while cities without NEPs see increases in HIV by 6% annually (CCSA).

Nathan talks about how he is glad that there are needle exchange programs now because he has a place to bring his used needles. He explains that he use to throw them in the garbage and then when he did not have a needle he would go back and dig

[9] One participant stated he stopped using injection drugs before NEPs were available, but he would use the services of one now if he was still injecting.

for ones that he had thrown out. He says he stopped doing this after meeting someone whose father was a garbage man that had contracted HIV through a discarded used syringe. He likes that he can get biohazard containers from NEPs to put his used needles in.

David talks about how he has always used the van and even remembers the names of the people that worked on it years ago. He says he likes it because they come right to his building, and then he was also able to get clean needles for other people that were sharing syringes in the same building as him, enabling him to encourage them to use clean needles as well. Other interviewees echo these sentiments, that the convenience of having clean rigs delivered is something they appreciate. As there is less effort required from the addict to reduce the harms associated with their habit, they are more likely to use the program.

The van is trouble

On the other hand two participants commented that they associate the Site Van with the police and that it can make people a target.

Maurice discusses how he used to worry that the police were watching the van.

"I always thought the police were watching and stuff like this and then they would know who you are. Like it's pretty obvious you know, it's a hundred degrees out and your walking around with a long sleeved sweater....and they will put two and two together with the Site van and stuff."

Samantha too says that she does not like to use the van because she thinks it attracts the attention of the police. She says that the prostitutes and street people often get "pinched" by the police because they are seen using the Site Van. Samantha goes as far as to say she would rather share needles than use the site van and risk getting picked up by the police. Ross et al (1994) discuss how people report not keeping syringes on them to avoid hassles with the police, which places them in the position that they may not have clean needles on them when they need them. As mentioned previously, PHAC reports that officially the police forces in Canada support NEPs in all their forms, however the support from the leaders in the policing community does not always translate to support from front line officers.

Views on Junkies – From the Mouths of Junkies

Finally, all participants were asked the question "do you think society views female users differently than male users?" Participant's answers have been categorized based on whether or not they believed there was a different view of females and males. A significant number of participants, whether they thought there was a difference in perception between male users and female users, commented that all injection drug users are viewed in a negative light by the rest of society.

Women got it rough

Five of the male participants felt that women were viewed more negatively than males, most commenting on the female reproductive role as the reason behind why society would look down more on female injection drug users. Peterson et al

(1998) state that studies done on female injection drug users highlight the structural and personal difficulties women face in reducing their risk for HIV. Barnard (1993) discusses how women in the injection drug using community can be seen as in "breach of their proper feminine role, particularly where childcare is concerned" (p.808). She goes on to say that the women in her study were aware of their poor public image and attempted to keep their drug habit a secret. Through being looked down on as "bad" women as they are not the typical picture of maternal femininity they become increasingly marginalized within the larger community.

Some of the users seem to feel that the different treatment of female users is just part of society. Greg comments

"That's one of the things about society is that there is always a different view of men and women... Umm ya, you know it's ya, women are second class citizens."

This ranking of 'second-class' that women in our society may feel is reflected in the injection drug community. Greg shows some hope for the future though:

"You know in a whole bunch of ways, I mean, it is getting better, but very, very slowly." Women in other arenas of society have been fighting for equality for generations; however women in the injection drug using community face additional struggles for equality.

Alex comments that

"Female users are looked at harsher, like they treat them like piece of ...well they treat junkies as a piece of shit."

There is recognition that even when you belong to a member of a group that society looks down upon there is still a gendered difference and it is preferable to be a male than a female. He links this to the female reproductive role

"So you know like, I know society is like that, but when you're a woman and you use you are a piece of shit, but they will tell you 'don't have any more babies'... and a woman is more than a piece of shit because you never know if she is going to get pregnant or not."

Alex goes on to say that he saw a woman get beat up just because she was a junkie, and he was too stoned to stop it. Ryan also links the negative view of female injection drug users to their reproductive abilities:

"Because females well...I know that in my past I've seen pregnant women shooting up...I've seen a woman in her 9th month shooting up into her jugular... you can't stop someone from doing it, if they're going to do it pregnant or not."

CCSA states that women who inject drugs may be more reluctant to access services out of fear of having their children taken away.

A number of people also commented that women who use injection drugs often obtain the drugs through prostitution at the behest of their significant other. There is recognition that this particular social arrangement is harder on the female than on the males who often benefit from it. Maurice comments:

"I don't know really, I never though about that. Like I know a lot of us will use a female users like... because I know, like their boyfriends are users and like their boyfriends make them go out and work to support their habit."

He says that this makes society look down on the women more. Peterson et al (1998) state that often women will need to pay the same price for drugs, but will also be required to perform sexually in addition to this. Through this women who use injection drugs are sexually exploited by their male counterparts. Ryan agrees stating:

"maybe there are some male users that get the female to go out and work so they can both use you know the story...It's just pimpin' and slavery"

Derek comments that he feels the female junkies are worse than the male counterparts:

"I'll tell you I live right at the Salvation Army. Right beside that walk that line where there's 50 people every day and them woman are far worse than the men."

He does not elaborate on this so I could only speculate what he means.

We are all the same

Nine of the participants stated that they thought all injection drug users were viewed the same, although after discussing it for awhile one decided that it was possible that women may be viewed more negatively than males. Interestingly the only female that was interviewed did not think there was a different perception of female users than male users. Samantha says:

"No, I think its equal, it's the same."

She also states in contradiction to the literature that she is comfortable using NEPs. Bernard (1993) reports that due to stigma within the injection drug community, women feel uncomfortable going into NEPs. Since I only interviewed one female, it is difficult to comment on this and draw any conclusions. Many of those who think

society views them all the same do not feel society has a very positive view of them. Chuck puts it very simply when asked if there is a different perception between male users and female users

"No...We're all nothing."

We are all Trash

Six of the research subjects stated that society views all users negatively. Some seemed to agree with this opinion themselves, one going as far as to call himself an animal when he uses. Others seemed to think this was an unfair label from the rest of society. One commented that there are lawyers and other professionals that inject drugs. PHAC points to public perception of injection drug users as a reason for lack of political support for some harm reduction programs. It also state that no 'official' study of Canadian opinion has been done, but that the topic tends to bring out strong emotions in people.

Alex says:

"...all the junkies are a piece of shit. I saw that in my family...We were six children in my family, and five of them...those five left, think that I'm a piece of shit"

and although this is how he feels labeled by his family, he does not feel it fits

"I can say "OK I am a piece of shit" but I am only a piece of shit when I use. When I am clean I am not a piece of shit so you have to respect the person who you are though. When I am using it's OK, I am a piece of shit, I agree with that"

He goes on to say:

But there's two weeks during the month that I know I am not smoking a joint, I am not taking pills, I am not taking drugs I know that there's a few weeks during a month that I don't do nothing...That I eat, take care of my body...try to take care of, of my mind...To be able to, to just be able to say that I'm a human being...Otherwise I would be an animal. I am when I use though.

Martin comments that it bothers him when people look down on junkies around him, as he himself is an ex-junkie.

"it just makes me pissed off when I hear all these people talking about 'fucking junkies' I'm like "ex-junky HELLO!'"

He also states

"Users in general just get shunned upon no matter what...Which is pretty stupid, because they are people too"

A number of participants offer very descriptive images of how they feel they are viewed by society. Ryan states that users are viewed as pariahs. Nathan talks about how not all junkies are living on the street and some people you would not think of are junkies too

"I think that society on a whole views addicts as like scum of the earth sort of thing you know...Which is surprising because I know some other addicts you know which are professionals and I mean you wouldn't know...That they're using and mean while they're lawyers or you know stuff like that."

I agree with him that I know a small business owner that is an injection drug user and he comments

"And its funny you know how society seems to think that you know junkies are slotted a certain way you know."

David says he finds injection drug use disgusting because of the effect it had on him:

"I find it all totally disgusting, like even the thought of someone doing that I have to turn around and walk away...I can't, I just find it very dirty in the sense that I know how bad I took it...and I don't ever want to see anyone else there."

Participants overwhelmingly feel that society has a negative view of injection drug users; indeed some of them have negative views of themselves. Women can be particularly marginalized in this community, often relating to their reproductive role. They can be sexually exploited, viewed as bad mothers and afraid to access services out of fear of having their children apprehended. Regardless of whether or not participants felt women were viewed more negatively by society, overwhelmingly they felt society did not have a positive view of injection drug users.

Conclusion

The previous is a discussion of the information gathered through my interviews that did not relate directly to needle sharing among the people who use injection drugs. Topics included who participants were with the first time they used and what that experience was like, why they started using injection drugs and their struggles with quitting, who they typically use with, their thoughts on needle exchange programs, and their thoughts on how society views them.

Appendix B: Interview Guide

How old are you?

Gender:

What is your primary source of income?

How old where you when you first used?

Who did you use with the first time?

Can you tell me a bit about that?

Was a clean needle used?

How often do you inject?

Do you generally inject alone?

How often do you use with someone?

Is it generally the same person or couple of people?

When you are with someone do you share cookers, water, swabs etc?

Have you ever used the same needle someone else has used?

Can you describe a typical situation in which you would use a needle already used by another person for me?

How would you describe your relationship to the people with whom you share needles?

Would you say you share needles and equipment more or less often now than you have in the past?

Have you ever used the NEP?

Do you feel comfortable going into NEP?

Do you think male users are viewed differently than female users?

Appendix C: Letter of Information

This letter is to inform you about the research I am undertaking, and provide you with information regarding the process and the goals or the research. My name is Erica Braun, and I am a Masters of Social Work student at Carleton University. Professor Adje van de Sande and Professor Therese Jennissen, are supervising my research.

Each person who volunteers to be a member of the study will be asked to do an interview of approximately half an hour with me at the Living Room, and will be given $10 for their participation in this research. The interview will consist of questions regarding your injection drug use, as well as information such as age and income. The questions are aimed at better understanding injection drug use in Ottawa. You are free at any time to refuse to answer a question or leave the interview altogether without penalty. Each interview will be audio recorded for accuracy. No one else will hear the audio recordings. To protect the anonymity (so no one knows your name) you will be identified by another name in my final report. People at the agency that the interview is conducted may know that you are participating in the research, however they will not have access to any of the answers that you provide. All materials from the interview will be kept in a locked boxed that only I have access to. All tapes will be destroyed by June 2007, however transcriptions of the tapes will be held by me for possible future use. Transcriptions will not include your name, only initials. If you would like to request a copy of the final report one will be delivered to you. The final report will be published as a public document.

I have an ethical obligation to report any disclosure or threat of harm to yourself or others to the appropriate authorities. Illegal activity directly related to injection drug use will be kept confidential and no disclosure of information will be made without your knowledge. By this I mean that if I need to report something you tell me to another person, I will inform you of that before I tell anyone else.

If you have any questions please feel free to ask me. If you would like to contact one of the research supervisors you may, or you may speak to the Carleton University Research Ethics Chair. The phone numbers are listed below.

If you are interested in being interviewed by me I will be at The Living Room.

Thank you

Erica Braun

Adje Van De Sande (Research Supervisor):	520-2600 ext 6692
Therese Jennissen (Research Supervisor):	520-2600 ext 4390
Antonio Gualtieri (Carleton University Research Ethics Chair):	520-2517

Appendix D: Letter of Consent

This letter is to inform you about the research I am undertaking, and provide you with information regarding the process and the goals or the research. My name is Erica Braun, and I am a Masters of Social Work student at Carleton University. Professor Adje van de Sande and Professor Therese Jennissen, are supervising my research.

Each person who volunteers to be a member of the study will be asked to do an interview of approximately half an hour with me at The Living Room, and will be given $10 for their participation in this research. The interview will consist of questions regarding your injection drug use, as well as information such as age and income. The questions are aimed at better understanding injection drug use in Ottawa. You are free at any time to refuse to answer a question or leave the interview altogether without penalty. Each interview will be audio recorded for accuracy. No one else will hear the audio recordings. To protect the anonymity (so no one knows your name) you will be identified by another name in my final report. People at the agency that the interview is conducted may know that you are participating in the research, however they will not have access to any of the answers that you provide. All materials from the interview will be kept in a locked boxed that only I have access to. All tapes will be destroyed by June 2007, however transcriptions of the tapes will be held by me for possible future use. Transcriptions will not include your name, only initials. If you would like to request a copy of the final report one will be delivered to you. The final report will be published as a public document.

I have an ethical obligation to report any disclosure or threat of harm to yourself or others to the appropriate authorities. Illegal activity directly related to injection drug use will be kept confidential and no disclosure of information will be made without your knowledge. By this I mean that if I need to report something you tell me to another person, I will inform you of that before I tell anyone else.

I, _____, agree to voluntarily participate in the research project with researcher Erica Braun. I have read the above information and understand all parts of this letter.

Participant _____ Date _____

Researcher _____ Date _____

Appendix E

PARTICIPANTS REQUIRED FOR INTERVIEWS ON INJECTION BEHAVIORS

You may be eligible
for compensation

PLEASE SEE STAFF FOR INFORMATION ON A RESEARCH PROJECT STARTING (INSERT DATE AND TIME)

Appendix F: Abbreviations

AA: Alcoholics Anonymous

AIDS: Acquired Immune Deficiency Syndrome

CCSA: Canadian Centre on Substance Abuse

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

IDUs: Injection Drug Users

NA: Narcotics Anonymous

NEP: Needle Exchange Program

ODSP: Ontario Disability Support Program

PHAC: Public Health Agency of Canada

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