

Blood borne virus risk behaviours among people who inject drugs in the UK: A Qualitative Exploration

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BACKGROUND

Among people who inject drugs (PWID) in the UK, prevalence of Hepatitis C (HCV) is 33-56%, HIV 0-1%, and Hepatitis B (HBV) 6-18%. Opiate substitution therapy and needle and syringe programmes (NSP) have reduced HIV and HCV infection among PWID, however psychosocial interventions which target risk behaviour may further reduce their spread.

Project PROTECT is a NIHR HTA-funded study which aims to develop and feasibility test an evidence-based psychosocial intervention to reduce blood borne virus (BBV) risk behaviours among PWID in the UK.

Most psychosocial interventions studied to date have been developed and tested out with the UK. Therefore, their applicability and acceptability to UK PWID, and feasibility within the UK drug treatment system, is uncertain. There remains a need to identify the key drivers of risk behaviour among UK PWID and the type of psychosocial intervention acceptable to and required by them to reduce vulnerability to BBV infections.

AIMS

To inform the development of a psychosocial intervention to reduce BBV risk behaviours among PWID in the UK, a qualitative interview study was conducted exploring:

- why PWID engage in BBV risk behaviours;
- the type of psychosocial intervention acceptable to and required by PWID to reduce BBV risk behaviours.

METHODS

In-depth interviews were conducted with a convenience sample of 60 PWID ≥ 18 years of age who had injected illicit drugs in the past 4 weeks (15 from London, Yorkshire, Glasgow and North Wales).

Participants were recruited from drug treatment and harm reduction centres, needle exchanges, sexual health clinics, and homeless hostels.

To ensure a variety of perspectives were accessed, including those most at risk, purposive sampling was used, stratifying by known BBV risk variables, including: gender, length of time injecting, drugs injected, involvement in sex work and homelessness.

Interviews were digitally recorded, transcribed and anonymised.

Data was organised using NVivo and analysed using Framework Analysis.

RESULTS

35 men and 25 women were interviewed. In this poster we present some of the main factors influencing injection and sexual risk behaviours, categorised under (i) individual, (ii) situational, and (iii) structural influences:

Individual Influences

Withdrawal, craving and intoxication

When participants were without their own injecting equipment, the pressures of withdrawal and craving influenced them to knowingly take risks by using other drug injectors' needles, syringes and/or injecting paraphernalia.

"when I have no needles and there's no, sort of, access to a needle exchange, it's after, like, sort of, six or seven o'clock in the evening and there's no way you feel you can get any fresh needles and you're starting to feel that, sort of, withdrawal and you know you want the heroin and the person has needles and so you take the risk."

Intoxication undermined participants' ability to manage risks. Alcohol, benzodiazepines and cocaine clouded judgement, leading to sharing of drug using equipment and also making condom use less likely in sexual scenarios.

"if...I'd been drinking all day, and I was with, well, a few of my friends in the hostel, I could be a bit lax in my way of thinking. I would never share a needle or that, but I could draw up from the same cook pot."

Cocaine was reported to increase sharing of needles due to frequent injection and reduced carefulness. Cocaine, crack and amphetamines increased libido, making casual sex without condoms more likely.

Mental Health and Psychological Well-being

Some interviewees reported poor mental health or psychological well-being, e.g. psychosis, depression and low mood, caused indifference to their health and reduced care around safe injecting.

"My sister died and I've been so depressed...that I've thought, you know, who cares?...I don't want to be here anyway...What does it matter if I use her set, her syringe, you know."

Knowledge

Participants reported that in the past they had unknowingly placed themselves at risk when sharing injecting paraphernalia.

"I thought if you did it with a new needle you were fine. Do you know what I mean? [...] I didn't think about the filter, the spoon, the water."

Current knowledge of hepatitis B was poor and some interviewees were uncertain how long the hepatitis C virus could live outside the body.

Values

Participants were concerned to protect others from onward transmission. However many reported being asked to lend their used needles and syringes to others. In doing so, they expressed the view that once they had disclosed their HCV status, it was the other person's responsibility if they took the risk.

"I try not to (share needles/syringes), but if they were pestering me and pestering me and...on and on and on and on at me and I just want to chill out, I tell them, I say, listen, I'm positive for Hep C, if you want to use it, it's your problem."

Situational Influences

Homelessness

Homelessness meant injecting often had to take place outdoors or in public places where unhygienic settings, lack of resources, and pressure to rush the injection led to intentional sharing of needles, syringes and paraphernalia as well as accidental BBV risks.

"it's more when we've got naewhere tae go. So we're doing out a' quickness...in car parks, in closes...You're trying no tae get caught. That's when you will just go into at least do it quickly, you know in and out...That's when you just go, 'fuck it, I'll share that needle with you'. You know, 'oh just give me yours.'"

Intimate relationships

Sharing of paraphernalia and needles, being injected and injecting others, and non-condom use were more likely within couples, based largely on trust and familiarity.

"I share with him (partner) but only because he's clean. Like we both got tested but I wouldn't share with anyone else."

Injecting in groups

Dominance and peer pressure in groups encouraged some participants, particularly younger, newer PWID, to go along with unsafe practices. When injecting with others, equipment could also become inadvertently mixed up.

"I've been in those situations where I've felt uncomfortable saying to the person about sharing spoons, because I don't know how they're going to take it, you know, they might be, like, well what are you trying to say, are you trying to say that I've got HIV or Hepatitis? And some of them are dangerous people, you know...it can be intimidating."

Sex work

Clients often offered more money for sex without a condom. Addiction and economic necessity made it difficult to consistently refuse. At times of withdrawal, intoxication and poor psychological well-being, vulnerability to sexual risk increased.

"I'd just got out of a police cell and I was ill, I was tired, I was broken really, broken, and this guy said he'd give me £60 to have sex without a condom, £60, I mean...I used to work as a lap dancer years ago, I used to earn £240 an hour so yeah, er, yeah I did it yeah, I was ill, all I wanted to do was get that horrible man away from me and get home."

Structural Influences

Access to injecting equipment and condoms

Participants were unable to access new injecting equipment at evening time and weekends. Some interviewees also felt there were not enough pharmacies offering needle exchange and not enough NSP in smaller cities. Access to free condoms (including femidoms), particularly at night, was considered inadequate by some interviewees.

CONCLUSIONS:

Homelessness, sex work, poor mental health, withdrawal and intoxication restrict PWID's abilities to manage BBV risks. Sharing of injecting equipment is influenced by relationship factors such as intimacy, trust, compassion and pressure. Preparedness and assertiveness training, along with extended access to injecting equipment and condoms are required.

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