

How are people assisted with their first injecting experience, and what information do they receive prior? A review of the literature suggests that peer workforces should be expanded and receive more support

1. Why are we interested in this topic?

In Australia, people who are new to injecting have the highest risk for hepatitis C transmission (1), and have been identified as priority populations in the Fifth National Hepatitis C Strategy. The progression from first injection to regular injecting is typically rapid, with research suggesting that the way in which a person first starts injecting is likely to influence future injecting practices and risk-taking behaviours (2). It is therefore important that these populations have access to accurate information prior to their first injection experience. Understanding whether people receive assistance with their first injection experience, and what information people are receiving prior to their first episode of injecting, will allow us to determine how to best reach these individuals and how their health literacy can be improved.

2. What does the research show?

2.1 How are people assisted with their first injecting experience?

The existing research shows that social networks and social interactions are instrumental in the transition to injecting drug use. These social interactions are typically categorised in terms of 'exposure' and 'promotion', with friends, family and intimate partners being particularly influential (3). Exposure generally refers to witnessing or observing other people injecting which (either intentionally or unintentionally) can generate awareness and curiosity (e.g., 'He would sit in the back [of the car] and start shooting himself. And I was watching him as he was nodding out, much more than I was, and I started getting jealous'; 3). Promotion involves the active encouragement of injection, which may involve enthusing about the benefits of drug injection linked to pleasure or cost-efficiency (e.g., 'people were telling me, "you're wasting it by sniffing"; 3), and can involve peer pressure, as well as coercion. Experiences of coercion seem to be uncommon however are more likely to be experienced by women. This is consistent with research that shows that females are more likely than males to report being injected by their partner and are less likely to be able to inject themselves (4).

Given the importance of social networks and social interactions in the transition to injecting drug use, it is not surprising that studies have found that most people will have a more experienced person present the first time they inject drugs. Indeed, drug injection is a learned skill and people will usually require help with their first injection/s. A review of the literature (up until October 2019), found that the prevalence of receiving assistance (i.e., help or guidance) at the first injection ranged from 74% to 100%, while the prevalence of being injected by another person at first injection ranged from 53%-95% (5). Friends were the most common people to provide assistance, followed by family

and intimate partners. For example, an Australian study of almost 400 people who inject heroin found that participants were mostly taught to inject by a friend (63%), followed by family members (14%) and partners (11%). Interestingly, there were some gender differences, with males more likely to have been taught to inject by a friend and females more likely to have been taught by their partner. Ten percent of this sample reported 'other', which was typically self-taught (6).

Summary

- **Most people who inject (74%-100%) report receiving assistance (i.e., help or guidance) the first time they inject drugs, mainly from friends, family and intimate partners.**

2.2 What characteristics are associated with assisting someone with their first injection?

The proportion of PWID who reported that they had ever assisted someone with their first injection varies considerably across studies (range: 13%-69%), however is mostly reported to be between 20-40% (5). It is important to note that studies suggest a strong reluctance or refusal to assist people with their first injection, however this was often overridden by the desire to reduce potential harms experienced by people new to injecting (who usually take an active role in seeking out their first injection). For more information about the motivations for providing (or not providing) assistance to someone at the time of their first injection, please see (7-13).

Regardless of the reasons for doing so, studies show that people who assist someone with their first injection are more likely to: be male; have been injecting for a longer duration of time and to inject more frequently; have a history of incarceration or law enforcement interactions; engage in sex work; and to receive income assistance or income from illegal sources. Further, they were more likely to: have injected in front of an injection-naïve person; describe, encourage or speak positively about injecting to an injection-naïve person; inject others (at times other than at first injection); and to have friends who provided assistance with first injections (5). Concerningly, several studies have also found that people who assist others with their first injection were more likely to report sharing syringes and injecting equipment, although one study did find that informing others about safe injection practices was associated with providing assistance (5). People who received injecting equipment from friends or a dealer were more likely to provide assistance, while those who received equipment from a needle and syringe program were less likely to provide assistance. Not surprisingly, two studies which examined future intention to provide assistance found that recently providing assistance to someone at the time of their first injection was associated with a higher likelihood of continuing to provide assistance in the future (5).

In contrast, older people, those who were recently employed, those had been injected by others at times other than at first injection (ever or recently) and those who had (ever or recently) received methadone or buprenorphine were less likely to provide assistance to someone at the time of their first injection (5).

Summary:

- The proportion of PWID who reported having ever assisted someone with their first injection varies across studies, however was typically between 20-40%.
- The main factors associated with providing assistance were: being male; having injected others (at times other than at first injection); sharing syringes and injecting equipment; having a longer injecting history; and injecting more frequently.
- Conversely, being older, recently employed and having received methadone or buprenorphine was associated with being less likely to provide assistance.

2.3 Do people seek/receive health information when they first start injecting drugs and what kind of information do they receive?

While most people report receiving assistance the first time they inject, there is very little research which examines whether people receive or actively seek out health information prior to their first injecting experience. The research that does exist suggests that people who have recently started injecting know that blood borne viruses can be transmitted through sharing needles, but that this knowledge rarely extends beyond 'common sense' and is 'barely adequate' (2, 14). For example, an Australian survey of 234 young people (12-20 years) who inject drugs found that although the majority (>80%) of people had heard of hepatitis C, specific knowledge about transmission routes, acute and chronic effects, and treatment options was very poor, particularly among young participants (14). Similarly, a survey of 300 young people (aged 12-22) who had started injecting in the past five years found that most people had heard of HIV (80%) and HBV (75%) before their first injection, and most of these (90%) knew they could be transmitted by sharing injecting equipment, however only half had heard of HCV (2). Media was identified as the most common source of information in both these studies. Interestingly, the latter of these two studies found that among those who had assisted someone else into injecting (47%), most reported sharing information about where to get clean needles (60%), but much smaller numbers (31%) reporting sharing information about the risks of HIV, HBV and HCV (2).

Another study of Australians aged 16 and 25 years of age (recruited between 2000-2002) who reported an injecting history of four years or less found that although there were good levels of knowledge of safer injecting practice and BBV overall, **this knowledge was acquired "well after initiation"** (15). That is, at the time of first injection, most participants described a low level of knowledge about HCV and safe injecting that rarely extended beyond common sense knowledge (e.g., to 'never share needles'). There were few reported incidents of detailed information being passed on, or sought out, either before or at the time of first injection. Overall, most participants reported getting their information from a combination of formal and informal sources (most commonly pamphlets, NSPs and friends), and 55% of participants reported passing this information on to other people who inject (15).

More recent studies have focused on people at risk of injecting (i.e., socially engaged with PWID), with the aim of characterising knowledge before injecting had commenced and have typically found similar results. For example, a survey of 210 young people (recruited in 2010-2011) found that

although the majority of respondents were aware that HCV could be transmitted via injecting drug use (79%) and via tattooing and body piercing (70%), more detailed knowledge was lacking (16). Specifically, few respondents were able to correctly identify that HCV was not sexually transmissible during heterosexual sex (14%) and was not transmissible via mosquitoes (32%) and only half knew that HCV has long-term health effects (54%), cannot be cured in all people (45%) and can be transmitted from a healthy-looking person to others (58%).

This same study also asked participants if they knew where to obtain sterile needles (17). They found that while a third (34.3%) of participants thought they knew where to obtain sterile needles, less than a quarter (24.3%) could correctly identify a service. The sources most commonly nominated by participants were hospitals (27.8%) and pharmacies (25.0%) – i.e., services that were not specifically needle distribution services – with only 15% nominating NSPs. Interestingly, there were no identified differences between those who could correctly identify where to get sterile equipment. Indeed, even participants who were currently receiving professional help for their drug use were no more likely to know where to obtain sterile needles (17).

Similar findings have been reported internationally. In New York City, a qualitative study of 36 people who had started injecting within the past 18 months found that while most participants made some reference to blood or sharing injection equipment as a means of transmission, their responses were often imprecise and incomplete (18). Respondents spoke of a variety of ways in which they received or came upon HCV information although they were rarely able to recall a specific source. Most often, respondents who had some understanding of HCV had received information from treatment programs and syringe exchange services, however **no respondents reported seeking information about HCV prior to their initial injection**. For the few respondents who acknowledged talking about HCV with their friends, conversations were described as casual, avoided serious discussion and often contained misinformation (e.g., that HCV can be contracted through sex/bodily fluids other than blood) (18).

It is important to note that most of the Australian studies outlined above are focused on young people (typically aged 12-early 20s) who had recently started injecting. However, it appears that the age of first injecting is increasing. Specifically, the 2016-2020 Australian NSP survey found that although the median age at first drug injection remained stable across 2016 to 2020 at 18-19 years, among people who had recently started injecting, the median age of first injection increased from 28 years in 2016 to 30 years in 2020. It is possible that people who start injecting at an older age have better levels of knowledge than those who started injecting at a younger age. Further, most of these studies occurred before the introduction of **direct-acting antiviral** therapies for HCV, which may have had some impact on people's knowledge of HCV. Further research is required.

Summary:

- **There is very little research which examines whether people seek out or receive health information prior to their first occasion of injecting.**
- **Further, research about HCV treatment knowledge was conducted prior to the availability of new treatments.**

- The research that does exist suggests that people who have recently started injecting, or who are at risk of injecting, are mostly aware that HIV and blood borne viruses can be contracted from sharing needles. However, more detailed knowledge regarding transmission routes, acute and chronic effects, and testing and treatment options is poor.
- Rather, this more detailed knowledge appears to be gradually built up after the transition to injecting has already occurred.
- One study, which examined knowledge about where to get clean needles (among people considered 'at risk' of injecting), found that only a minority of participants were able to correctly identify where to get clean needles.
- Knowledge regarding overdose, risk of injecting related injuries, and other safe injecting practices (e.g., use of filters, swabs) prior to first injection is unknown.

3. What does this mean?

Greater efforts are required to ensure that accurate information regarding safer injecting and BBV transmission reaches people who have recently started injecting, or who are at risk of injecting. Given that these individuals are typically not in contact with harm reduction services, it seems evident that peers have a crucial role in reaching this population and in making the transition to injecting drug use safer. Indeed, research shows that peer support and peer education are linked to positive health outcomes, with peer involvement now widely promoted as essential to effective responses to the [health, social, and political challenges faced by people who use drug](#). Research also shows that people who inject drugs share harm reduction information with each other (e.g., see 19, 20, 21), however as demonstrated in this review, this does not appear to be occurring either prior to, or at the time of someone's first injection. It is also important to ensure that the information that people receive when they start injecting is accurate, as the way in which a person first starts injecting is likely to influence future injecting practices and risk-taking behaviours. Combined, these findings suggest that: (a) the peer educator workforce should be expanded, to embrace the capacities and expertise of people who inject drugs; and (b) peer educators need to receive the support required to increase their engagement with people who have recently started injecting, or who are at risk of injecting, to improve health literacy and connection to care.

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