

INJECTORS AND THE INSIDE:
PRISONS, RISK AND HIV

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ABSTRACT

The spread of human immunodeficiency virus and other infection through drug injecting and sexual risk behaviour raises important considerations for social policy. The aims of this thesis are broadly two-fold. First, to explore and understand more about the influences on drug injectors' risk behaviour and how these influences might operate inside and outside prison. Second, to consider the impact of policy on drug injectors' lives and subsequent risk behaviour.

To examine these issues a qualitative approach was adopted. Four research methods were used: in-depth interviews, a vignette, small group discussions and diary field notes. Drug injectors were contacted in the community and a total of 24 drug injectors with prison experience participated. The empirical component of the research was underpinned by the development of a new theoretical framework towards conceptualising risk behaviour.

Inductive and deductive qualitative data analysis categorised perceptions of risk into three broad themes revolving around risky situations, influences on and mechanisms of risk reduction, and responses to risk behaviour. Drug injectors' views and experiences on three policy topics – the role and operation of prison drug and injecting equipment markets, mandatory drug testing, and substitute drug prescribing – were explored. This thesis raises important implications for the ways drug injectors' risk behaviour is understood and how policy responses can be better informed. Ultimately, there is a need for policies to reduce drug-related harm amongst drug injectors, especially when they spend time inside prison. That this is missing from current policy agendas results in people putting themselves and others at risk of infection

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– CHAPTER 1 –

INTRODUCTION

HIV IN PRISON AND BEYOND

It began in the seedy underworld of the prisons...it claimed its victims outside and inside the prison walls...it wasn't long before the tragedy began to strike at people outside of prison, it could strike in unpredictable ways (Boulton, 1997, television transcript).

In 1993 eight symptomatic cases of acute hepatitis B virus (HBV) and two cases of human immunodeficiency virus (HIV) were detected among the residents of Glenochil Prison. Reports from residents at this time pointed to drug injecting risk behaviour, including sharing injecting equipment, as a possible explanation for infection spread (Taylor *et al.*, 1995). Concerns prompted a public health initiative to investigate the problem and hence to inform strategies to minimise the spread of infections (Goldberg *et al.*, 1998).

Glenochil prison is a large male prison in Perth, Scotland. Whilst the site also holds a separate Young Offenders' Institution, the public health initiative was restricted to the main adult prison (Goldberg *et al.*, 1998). Between 1st January and 30th June 1993 when the cases of HBV and HIV were detected, 636 people had spent time in Glenochil. During the public health initiative 378 people were resident in the prison and all were offered voluntary and confidential counselling and testing for HBV and HIV. Counselling was received by 227 people and 162 people took a HIV test (Taylor *et al.*, 1995).

Taylor *et al.* (1995) found that 12 people were HIV positive and a further 12 people were in the 'window period' – the gap between transmission and detection of HIV. All 12

Box 1.

Selected Newspaper Headlines Following the Spread of HIV in Glenochil Prison

**Prisoner with Aids
virus may have
infected others***

HIV outbreak at

jail leaves 20

inmates infected**

**Prison HIV outbreak
may hit 50*****

Notes: **The Independent*, 8th August 1994, p.4. ***The Independent*, 3rd February 1995, p.9. ****The Independent on Sunday*, 16th March 1997, p.2.

people who were HIV positive had reported drug injecting whilst inside Glenochil. Two of them reported injecting for the first time inside prison. Overall, 76 people reported

injecting drugs at some time in their lives and 33 people reported injecting inside Glenochil. HIV prevalence amongst those who had injected drugs in Glenochil was high at 44 per cent. In addition, two other people previously known to be infected with HIV and who did not participate in the study also reported injecting in Glenochil. It was established that of the 14 people infected with HIV, six people had definitely contracted HIV within Glenochil, based on their time of entry into prison. A further two people probably acquired HIV in Glenochil but these infections could have occurred within another prison before transfer.

Yirrell *et al.* (1997) undertook a molecular investigation of the blood samples from the people infected with HIV in Glenochil and from other sources outside prison for comparison. They found that at the time of infection, 13 of the 14 people with HIV had been infected by an almost identical virus, from a single source, and over the same short period of time. People are particularly infectious shortly after exposure to HIV, which can help account for the rapid spread of the virus at Glenochil. These studies by Taylor *et al.* (1995) and Yirrell *et al.* (1997) demonstrate how HIV can quickly spread among groups engaging in risk behaviour.

The spread of HBV in Glenochil at around the same time was documented by Hutchinson *et al.* (1998). They report that eleven residents had acquired HBV between April and September 1993. From the date of entry into Glenochil it was established that seven transmissions definitely occurred within the prison. Co-infection with HIV was detected among six of the 11 people infected with HBV.

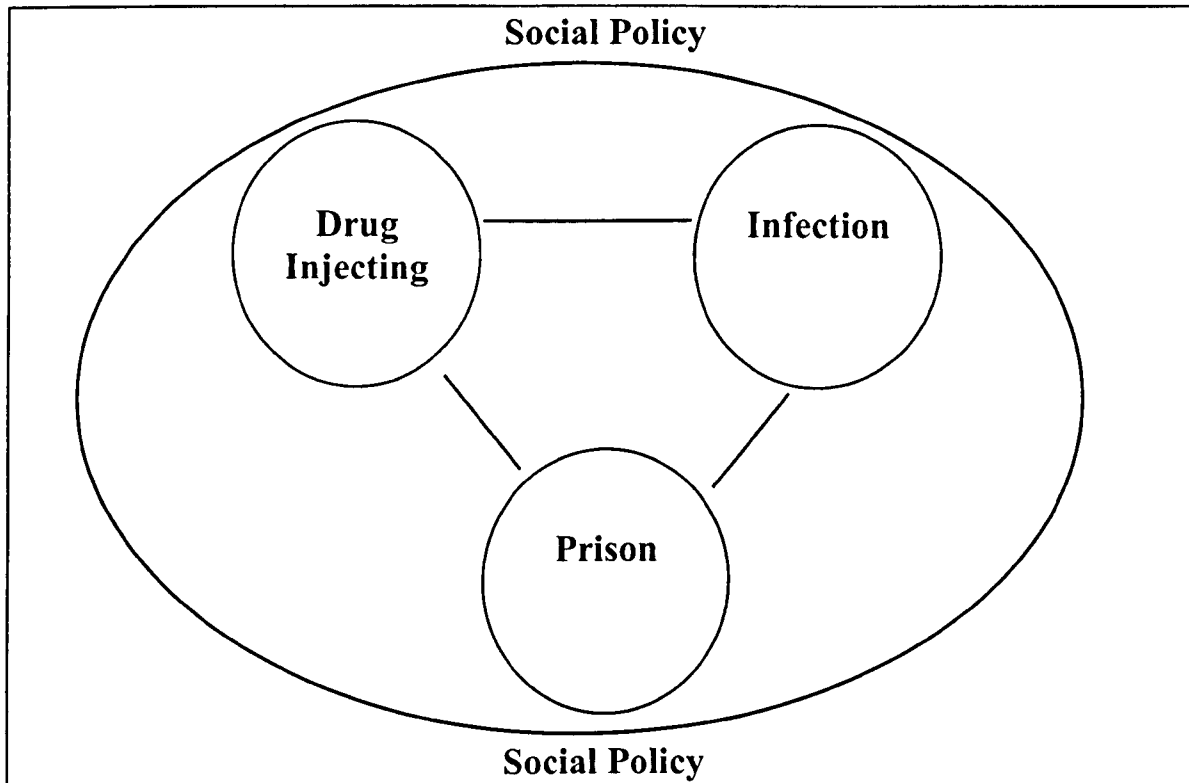
In 1994, a year after the outbreak of HBV and HIV in Glenochil, Gore *et al.* (1995a) conducted a follow up study using anonymous HIV and HBV testing of saliva linked to risk factor questionnaires. Gore *et al.* (1995a) reported proportions of drug injectors similar to those in the earlier study by Taylor *et al.* (1995). Around a third of those who had been in Glenochil during January to June 1993 had injected drugs. Gore *et al.* (1995a) also found that a year after being tested one of the 14 infected people in the original group had died of acquired immune deficiency syndrome (AIDS) through extremely rapid spread of the disease. Four remained in Glenochil, eight had been released and one person continued their sentence at another prison. They estimate that of the people who injected drugs in Glenochil between January to June 1993, 20 were infected with HIV.

The Glenochil outbreak of HIV is a pertinent reminder of the impact that HIV can have as the virus moves from its second decade (Aggleton *et al.*, 1993) into its third. Many of the issues that the Glenochil example raises have pertinence throughout this thesis. Particularly important issues that contribute to the central tenets of this work are represented in Figure 1. Notably, drug injectors spend time in prison and may continue to inject drugs inside. Drug injecting risk behaviour can lead to infection transmission, which raises important issues for social policy.

Risk behaviour that spreads infection has been well documented, as in Glenochil where the sharing of injecting equipment was directly implicated in the spread of HIV (Taylor *et al.*, 1995) and HBV (Hutchinson *et al.*, 1998). There are, however, geographical disparities in research on drug injectors' risk behaviour inside prison. Much of what is known on this topic originates from Scotland, with much less being known about the situation in other parts of the United Kingdom (UK).

Figure 1.

Drug Injecting, Infection, and Prison Located Within Social Policy



It is also important to recognise that there are a number of infections that can be transmitted through drug injecting risk behaviour, including hepatitis C virus (HCV) and bacterial endocarditis (Haverkos and Lange, 1990). HIV is only one of a wide range of risks that face drug injectors (Rhodes, 1995) but it is the focus of this thesis. The social aspects of risk behaviour have been afforded considerable attention. However, there are a number of critical unresolved issues (Bloor, 1995a), not least, drug injectors' perceptions of risk inside and outside prison. This thesis explores the ways in which influences on drug injectors' risk behaviour inside and outside prison might operate.

Perceptions of risk and associated behaviour do not exist in isolation. It is important to address the wider social context in which individual actions are both considered and acted upon. Recognising these 'wider life' issues is not new and has been expressed by others,

including Cornwell (1984, p.1), for example, who suggests that “there is a strong tendency for matters relating to health to be separated out as subjects that can be investigated from other aspects of social life”. Such considerations echo the sentiments of Mills (1959, p.8) who distinguishes between the “personal troubles of milieu”, representing perceptions of risk behaviour in this thesis, and “the public issues of social structure”, representing wider situational factors surrounding risk behaviour. As Mills (1959, p.8) argues:

Troubles occur within the character of the individual and within the range of his [sic] immediate relations with others; they have to do with his self and those limited areas of social life which he is directly and personally aware. ... *Issues* have to do with matters that transcend these local environments of the individual and the range of his inner life. They have to do with the organization of many such milieu into the institutions of an historical society as a whole, with the ways in which various milieu overlap and interpenetrate to form the larger structure of social and historical life. (Emphases in original.)

Exploring drug injectors’ perceptions of risk is the first aim of this thesis representing personal issues. However, as Mills argues (1959, p.10) “to understand the changes of many personal milieu we are required to look beyond them”. To achieve this within a social policy framework, the second aim of the thesis will be to explore some of the wider social policy issues that drug injectors face. In particular, the thesis explores the impact which recent policies aimed at tackling drug injection in prison have had on drug injectors’ lives.

THESIS COVERAGE AND SCOPE

As a point of departure this introductory chapter has used the Glenochil outbreak of HIV to highlight the significance of drug injectors spending time inside prison and the spread of infection associated with risk behaviour. Chapter 2 offers a brief appreciation of drug injectors’ lives. It then explains what HIV is and its modes of transmission. Following this a selective review of the types of drug injectors’ risk behaviour and some of the influences

on this behaviour is undertaken. Here drug injecting risks are considered first and sexual risks considered second. This chapter ends with an indication of infection levels among drug injectors.

Chapter 3 examines drug injectors' contact with prisons and discusses HIV risk behaviour within this setting. In contrast to the evidence presented in Chapter 2, much less is known about the constituents of risk behaviour inside prison. Chapter 3 engages with broader prison literature and, in particular, draws on two broad strands. The first suggests that individual behaviour is best understood in terms of an indigenous prison culture and the second perspective recognises that behaviour in prison will be influenced by people's lives both inside and outside prison. It is the latter perspective that is considered most useful in locating drug injectors' risk behaviour within a broader framework.

Chapter 4 examines selected policy responses to drug injecting, first outside and then inside prison. It begins by showing how HIV and AIDS became an important consideration for social and health policies and how some interventions, such as community needle and syringe exchange schemes (CNSES) and the prescribing of substitute drugs, became established strategies to help reduce drug-related harm. Considered then are responses to drug injecting inside prison. Inside prison great emphasis is placed on reducing the demand for and supply of drugs by disrupting drug markets, using mandatory drug testing (MDT) and substitute drug prescribing. There are conflicting responses to drug injection inside and outside prison and to locate these issues within a wider policy context prison health care debates are discussed. Finally, to provide a further and more specific example of some of the issues and debates at work with regards to drug injectors, the case for prison needle and syringe exchange schemes (PNSES) is reviewed.

Conceptualising HIV risk behaviour forms the focus of Chapter 5. The chapter begins by considering the range of individual and social approaches to understanding risk behaviour. This leads to an examination of the work of Schutz, which has been applied by others to understand better risk behaviour. To complement some of the weaknesses of this approach, the work of Giddens is combined with Schutz to provide a new theoretical framework towards a greater social understanding of risk behaviour.

Chapter 6 provides a shift in focus by detailing the design of the empirical research conducted for this thesis. It discusses the research methods and research topics, fieldwork issues, sampling and data analysis. A range of the data were generated and the analysis of findings are explored in the next five chapters. Analysis of data found that when drug injectors needed an injection of drugs and were experiencing drug withdrawal then they were more likely to take drug injecting risks. This was often discussed within an overall preoccupation with drug use. These findings are discussed in Chapter 7 as an example of the type of situations when drug injectors may put themselves at risk of HIV and the ways in which they may think about this.

In situations where drug injectors take risks, there are a number of influences on and mechanisms for risk reduction. Two examples form the focus of Chapter 8. First, the influence of social relationships provides an example of a subjective assessment of risk. Second, the cleaning of needles and syringes is examined as an example of a practical risk management strategy.

Having taken risks, drug injectors may consider it necessary to respond in some way. One of the main responses identified by data analysis surrounds the need to take an HIV test. Drug injectors' perceptions of HIV testing are discussed in Chapter 9.

Moving away from drug injectors' perceptions of HIV risk to broader social policy issues, Chapters 10 and 11 examine broader social policy issues. Chapter 10 looks at the role and operation of illicit drug and injecting equipment markets inside prison. Despite continued policy emphasis on reducing drug supply, these markets continue to operate inside prison.

Chapter 11 examines how drug use continues against the threat of punitive sanctions associated with MDT policy. Drug injectors did not receive treatment in connection with a positive MDT test result. This leads to the final consideration in this thesis, substitute prescribing inside prison. Here it is shown that inadequate and inconsistent drug treatment, in the form of provision of substitute drugs, ultimately continues to put drug injectors at risk of infection.

The concluding discussion in Chapter 12 draws together the evidence presented. The chapter focuses on why drug injectors consider risk behaviour in the knowledge of HIV risk, developing the theoretical model and demonstrating how the components of harm reduction, together with social policy, can inform the development of future policies.

It is noteworthy that throughout the thesis acronyms for people are not used – a disturbing habit that serves to depersonalise research participants. It does not label prison residents as 'prisoners' – vocabulary that again tends to shift the focus away from individuals, incorrectly reinforcing beliefs about the 'sameness' of people's lives. As others have

pointed out (Fitzgerald and Sim, 1982; Cavadino and Dignan, 1997) prisons are highly unsystematic in the way they treat people; the words 'prison' and 'system' are not used together in this thesis.

– CHAPTER 2 –

DRUG INJECTORS, HIV AND RISK BEHAVIOUR

INTRODUCTION

This chapter begins by providing an appreciation of drug injectors' lives. It then goes on to describe briefly what HIV is together with its modes of transmission. The main focus of the chapter is concerned with understanding the types of activities that allow transmission of HIV and the influences on these actions. Considered first is drug injecting risk behaviour and then, second, sexual risk behaviour. The chapter ends by indicating the levels of HIV and other infections among drug injectors.

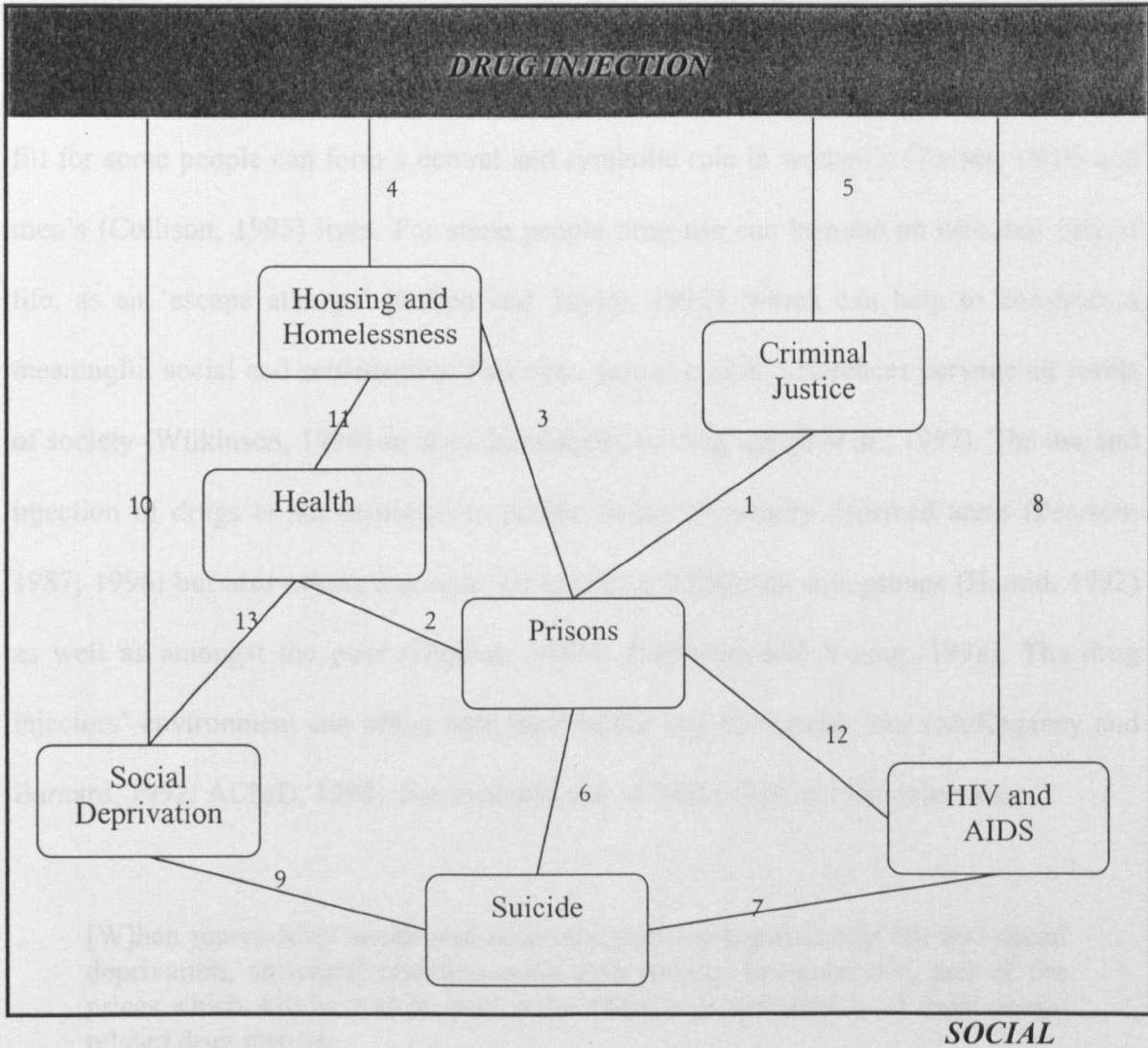
DRUG INJECTORS' LIVES IN THE TIME OF HIV AND AIDS

Social policy is proud of its multidisciplinary nature and the work it conducts on a range of subject areas, including housing, health, education, personal social services, social security, crime and the environment (Spicker, 1995). The lives of people that social policy research seeks to understand are characterised by a similar diversity of personal, social and economic circumstances that impact upon the individual, community and society. These considerations are all inextricably linked to the tenets of social policy. The lives of drug injectors, on which this thesis is focused, are no different. Some example studies are highlighted in Figure 2. It is important therefore for social policy, which impacts upon drug injectors, to consider the wide-ranging and multifaceted characteristics of their lives (Hughes, 1997a).

Figure 2.

Simplified Relationships Between Drug Injection and Selected Social Policy Issues

SOCIAL POLICY



POLICY

Selected References to the Literature on Particular Relationships

- 1) Advisory Council on the Misuse of Drugs (ACMD, 1996)
- 2) Bridgwood and Malbon (1995)
- 3) Carlisle (1996)
- 4) Flemen (1997)
- 5) Hough (1996)
- 6) Liebling (1992)
- 7) McKeganey (1990)
- 8) McKeganey and Barnard (1992)
- 9) McLoone (1996)
- 10) Pearson (1996)
- 11) Please and Quilgars (1996)
- 12) Taylor *et al.* (1995)
- 13) Wilkinson (1996)

The reported use of drugs is increasing (Harling, 1998) and a great deal of drug injection occurs in areas that are described as socially deprived (Pearson, 1996). Inadequate opportunities in people's lives can lead them to seek alternative lifestyles and drug use can provide a meaningful way for people to structure time. The social void that drug use may fill for some people can form a central and symbolic role in women's (Taylor, 1993) and men's (Collison, 1995) lives. For some people drug use can become an essential part of life, as an 'escape attempt' (Cohen and Taylor, 1992), which can help to construct a meaningful social and self-identity. However, just as health differences pervade all levels of society (Wilkinson, 1996) so does the ubiquity of drug use (6 *et al.*, 1997). The use and injection of drugs is not restricted to people living in socially deprived areas (Pearson, 1987; 1996) but also occurs amongst, for example, middle-income groups (Hamid, 1992) as well as amongst the poor (Hughes, 1997b; Buchanan and Young, 1998). The drug injectors' environment can affect both their health and their behaviour (McKeganey and Barnard, 1992; ACMD, 1998). For example, the ACMD (1998, p.115) points out:

[W]hen macro-level social and economic policies significantly fail and social deprivation, structural unemployment and poverty becomes rife, one of the prices which will have to be paid is the added cost and tragedy of deprivation-related drug misuse.

People have long used psychoactive substances for pleasure and solace, to induce different states on the mind and body (Cameron and Jones, 1985). In general, the reported use of opiates declined during the first half of this century but during the 1950s the reports of people taking a wider range of drugs began to increase. The 1960s and 1970s witnessed a sharp increase in levels of drug taking, reflecting changes in society's attitudes towards the use of drugs during this period (Bean, 1994). During the late 1970s and early 1980s an influx of cheap heroin became widely available in areas of the UK, such as in Merseyside

(Parker *et al.*, 1988) and Nottingham (Giggs *et al.*, 1989). A simultaneous burgeoning of social problems – income inequalities, unemployment, housing problems and widespread social deprivation – led to what Pearson (1987, p.66) calls an “accidental relationship” between increased injection of heroin and rising social problems. The key factor in the relationship was an effective drug distribution system that quickly evolved as drug injection filtered down from major cities into smaller towns and more rural communities.

Robertson (1990, p.97) notes that prior to the emergence of HIV and AIDS the drug injecting population enjoyed a “honeymoon period” of drug use. Drugs were readily and cheaply available with little law enforcement. Robertson (1990) notes that a large and inexperienced community of new injectors felt little need for support services. There had been little research or policy interest in drug injectors’ lives and risk behaviour was not at first an important concern (Bloor, 1995a). Drug injection increased at a time of widespread social deprivation and HIV began to move insidiously through drug injecting communities. One of the first cases to be noted was among a community of drug injectors in Edinburgh, including on the Muirhouse Housing Estate as shown in Photograph 1. Robertson *et al.* (1986) tested stored blood samples for HIV antibodies that had previously been obtained from drug injectors after an outbreak of HBV. They found that 51 per cent of their sample were HIV positive, and traced the first detected case in their sample back to September 1983. Reports such as these brought to light the potential impact that HIV and AIDS could have on drug injecting communities and the wider population. It sparked an unprecedented policy interest in selected aspects of the lives of drug injectors. The policy response to HIV and AIDS will be discussed later in this thesis. However, it is important to understand the wide ranging risk behaviour that can lead to the transmission of HIV. Before this, however,

the chapter provides a brief explanation of what HIV is and what its modes of transmission.

Photograph 1.

The Muirhouse Housing Estate in Edinburgh

(Source: Sturrock (1993, p.22-23). Reproduced with the kind permission of John Sturrock.)



THE BIOLOGY AND TRANSMISSION OF HIV

The human defence system consists of a number of lines of defence that protect the body from viral infections (Campbell, 1993). The body's primary defence mechanism is formed by skin and mucous membranes. Intact skin forms an impermeable barrier that cannot be penetrated by viruses. Mucous membranes in the respiratory, gastrointestinal and genitourinary tracts prevent infection by trapping and countering infectious particles. Viruses enter the body by very specific routes (Timbury, 1994) and the routes of HIV transmission have long been understood (Friedland and Klien, 1987). HIV has been isolated from many body fluids, although transmission has only been observed in blood, breast milk, pre-ejaculatory fluid, semen and vaginal secretions. HIV gains access to the human body during sexual activities that allow the exchange of body fluids and through other medical or social practices, including drug injecting, that result in the transfer of blood, tissue or organs. During sexual intercourse microtraumatic lesions and tearing may permit direct blood to bloodstream or secretion to bloodstream contact (Caceres and van Griensren, 1994). The risk of infection may be increased by the presence of sexually transmitted infections, including gonorrhoea, syphilis, and chancroid, which leave sores and lesions on the body (Kassler *et al.*, 1994).

Drug injecting with contaminated injecting equipment can lead to infection transmission. HIV (Wodak *et al.*, 1987; Chitwood *et al.*, 1990; Myers *et al.*, 1993; Cattaneo *et al.*, 1996; Rich *et al.*, 1998; Abdala *et al.*, 1999), and HBV and HCV (Cattaneo *et al.*, 1996; Heimer *et al.*, 1996) have been detected in needles and syringes used for drug injection. Although it is worth noting that in these studies HIV has not been detected on visibly clean needles (Chitwood *et al.*, 1990; Shah *et al.*, 1996). Needle tips have given intermittently positive results when tested for HIV, HBV and HCV although these viruses have been detected in

syringes for a number of weeks (Cattaneo *et al.*, 1996). HIV has also been detected in secondary drug injecting equipment and paraphernalia including filters, rinses from 'cookers' and the water used to clean needles and syringes (Chitwood *et al.*, 1990; Lishner and Look, 1994; Shah *et al.*, 1996). Needlestick injuries, which drug injectors can be at risk of (Hunt, 1997), can also lead to the transmission of infection (Hanrahan and Reutter, 1997).

Viral transmission can be influenced by other factors (Caceres and van Griensren, 1994). Concentrations of HIV in the body peak immediately after infection and during the development of AIDS, as the body loses its immunity from the increasing levels of HIV and decreasing levels of CD4 cells. Individuals are more infectious during these periods. A study by Carre *et al.* (1996) investigated the progression of HIV to AIDS amongst individuals who reported unprotected sexual intercourse with a severely immunodepressed partner and individuals whose partner was HIV antibody positive. They found that the progression of HIV to AIDS was far more rapid amongst individuals who had been infected by a severely immunodepressed sexual partner.

The effects of all viruses usually follow an asymptomatic incubation period, which can range from anything from a few hours to a few years. Viruses ultimately damage or kill living cells and this can cause disease in a number of ways (Timbury, 1994). First, the malfunction or absence of cells may cause disease in the organs which the cells service. Secondly, the immune system responds to infection by inflaming the affected area that may in itself cause tissue damage. Thirdly, viruses may disrupt the chromosomal balance in cells and this can lead to cancerous growth. Finally, and in the case of HIV, a virus can destroy the body's immune system leaving it open to a wide range of infections.

The time taken to progress to AIDS after the initial infection varies according to medical and social circumstances (Rump *et al.*, 1996). Some individuals develop AIDS within months of seroconversion (Walsh and Calabrese, 1992), whereas other individuals can appear clinically and immunologically healthy after 10 to 15 years (Buchbinder *et al.*, 1994). However, the average time taken to develop AIDS is 10 years (Hendricks *et al.*, 1993).

The actions of HIV on the immune system mirror its clinical effects on health. There is a spectrum of clinical conditions that reflect the progression of the infection (World Health Organisation (WHO), 1987). Immediately after infection individuals may suffer transitory flu-like illnesses, although at this stage these are not usually identifiable as seroconversion conditions. Following a relatively asymptomatic period, conditions such as swollen lymph nodes, fever and weight loss, cancers, neurological complications, physical difficulties and psychological and emotional difficulties signal the onset of AIDS Related Complex and ultimately fully developed AIDS (Adler, 1997). Early diagnosis together with improved medical and social care means that individuals with AIDS are living longer (Rump *et al.*, 1996).

DRUG INJECTORS AND HIV RISK BEHAVIOUR

Having briefly outlined the ways in which HIV can be transmitted and its effect on the body, the next section goes on to explore the types of drug injectors' risk behaviour and the influences on these actions. It examines first drug injecting risk behaviour and second sexual risk behaviour.

Types of Drug Injecting HIV Risk Behaviour

Shared infectious injecting equipment can lead to the transmission of HIV. However, what is considered as sharing is not straightforward and it has been noted that the term is imprecise (Stimson, 1996a) and may be easily misunderstood (Millar and Donmall, 1995). The meanings attached to drug injecting practices are far from homogenous and there are many different ways to share injecting equipment (Hunt *et al.*, 1994). The following five sections illustrate some aspects of wide-ranging drug injecting risk behaviour that can lead to HIV transmission. These include passing on and accepting injecting equipment, syringe-mediated drug-sharing, sharing through the process of drug injection and injecting equipment paraphernalia, cleaning injecting equipment, and the unsafe storage and disposal of injecting equipment. Also noted are the wider harms from drug injecting.

Passing On and Accepting Injecting Equipment

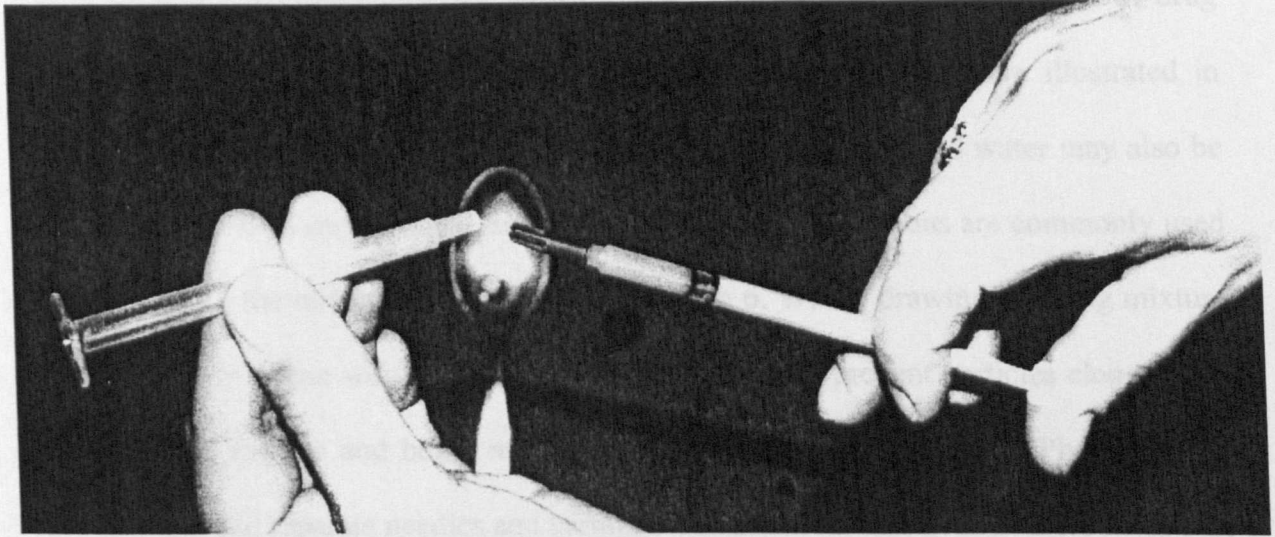
When considering the sharing of injecting equipment an important distinction needs to be made between people passing on and accepting. With regards to HIV transmission, passing on injecting equipment bears no risk to the lender unless the equipment is returned and re-used, whereas to the borrower this activity carries much greater risk (McKeganey *et al.*, 1989; McKeganey and Barnard, 1992). Studies have generally found greater numbers of drug injectors reporting passing on injecting equipment than accepting it (Hunter *et al.*, 1995; Gossop *et al.*, 1997; Peters *et al.*, 1998) although this pattern is not always consistent over time (Hunter *et al.*, 1995; Peters *et al.*, 1998). Furthermore, drug injectors report a greater future willingness to pass on than accept shared injecting equipment (McKeganey *et al.*, 1995). In addition, although drug injectors report being prepared to accept and pass on injecting equipment, the level at which they self-report actually doing so is lower (McKeganey *et al.*, 1996). That drug injectors are more prepared to pass on than accept

used injecting equipment may reflect wider social norms and etiquette, an issue to be discussed later in this chapter.

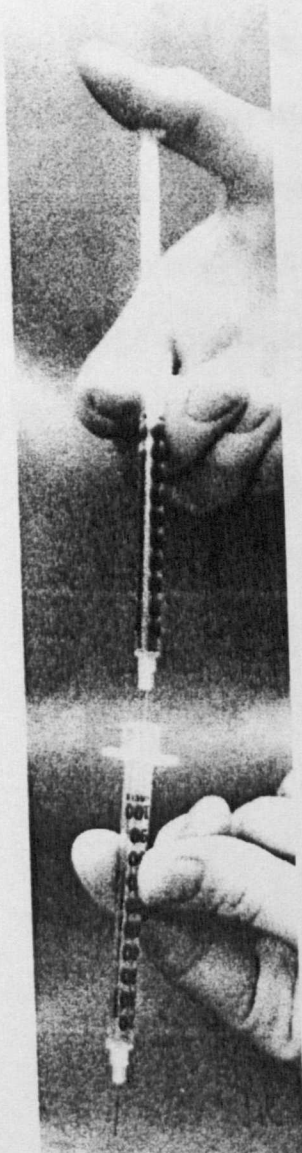
Syringe-Mediated Drug-Sharing

The practices of frontloading and backloading, or together collectively known as syringe-mediated drug-sharing (Jose *et al.*, 1993; Grund *et al.*, 1996), allow drugs to be mixed and accurately shared from one syringe to another. Syringe-mediated drug-sharing is described as an indirect sharing practice whereby one syringe is used to mix the drug solution, which is then accurately distributed to one or more other syringes. Frontloading refers to the drug solution being transferred through the front on the syringe once the needle has been removed, as shown in Photograph 2. Backloading refers to the drug solution being transferred through the back of the syringe after the plunger has been removed, as shown in Photograph 3. Thus, the solution in the syringe is the conduit for infection transmission rather than the direct sharing of injecting equipment (Jose *et al.*, 1993; Grund *et al.*, 1996). Syringe-mediated drug sharing in this way is not uncommon (Hunter *et al.*, 1995; Gossop *et al.*, 1997; Peters *et al.*, 1998). For example, the study by Hunter *et al.* (1995) with 495 drug injectors found 214 people reporting syringe-mediated drug sharing in 1993. In addition, of the 299 people who did not report sharing injecting equipment during this time 101 people reported syringe-mediated drug sharing. This could reflect more widely held beliefs that particular types of sharing behaviour, including syringe-mediated drug sharing, are not considered as sharing (Hunt *et al.*, 1994; Hunter *et al.*, 1995).

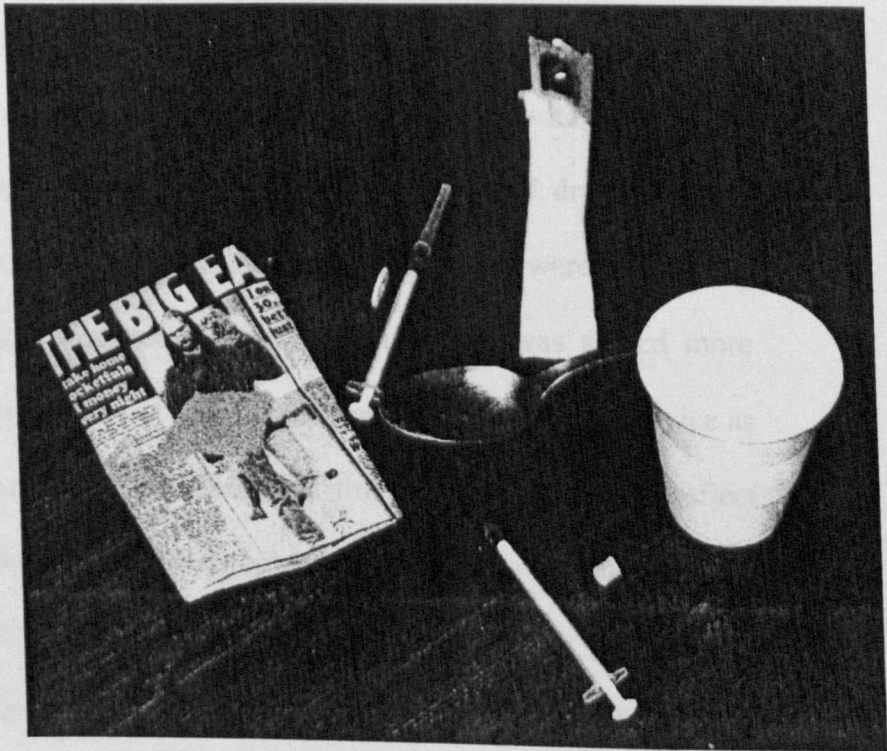
Photograph 2.
The Practice of 'Frontloading'



Photograph 3.
The Practice of 'Backloading'



Photograph 4.
Examples of the Range of Drug Injecting Equipment

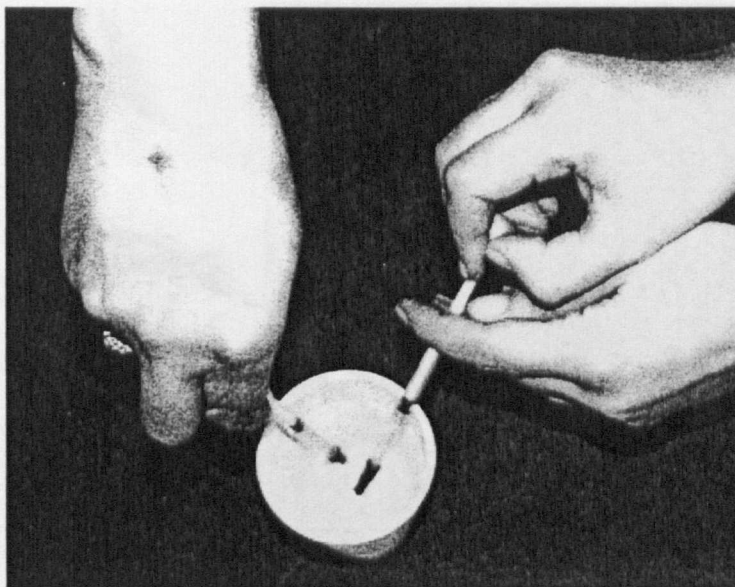


Sharing Through the Process of Drug Injection and Through Drug Injecting Equipment Paraphernalia

Whilst needles and syringes are the primary tools for drug injecting the process of drug injection also requires other secondary paraphernalia, some of which are illustrated in Photograph 4. Water is necessary to liquefy the drugs for injection and water may also be used to clean needles and syringes, as shown in Photograph 5. Spoons are commonly used when heating up the mixture, as shown in Photograph 6. When 'drawing up' drug mixture a filter, typically cotton wool or a cigarette filter, is used to prevent particles clogging up the needle and syringe and being injected into the body, as illustrated in Photograph 7. Even if sterile and separate needles and syringes are used for drug injection there is the risk of infection when secondary paraphernalia is shared (Koester *et al.*, 1990; McCoy *et al.*, 1998). This infection risk includes, for example, sharing water, as shown in Photograph 5, and 'drawing up' drug solution from a communal spoon and filter, as shown in Photograph 7. The process culminates with the injection of drugs, as illustrated in Photograph 8 and Photograph 9. A study by Gossop *et al.* (1997) on the shared use of drug injecting paraphernalia with 303 drug injectors revealed that needles and syringes were shared less often than secondary drug injecting equipment paraphernalia, which was shared more routinely. They found that the sharing of spoons and water containers was around twice as common as the sharing of syringes. As noted earlier in this chapter, this could reflect ambiguity surrounding the term sharing and that people have adopted safer drug injecting behaviour that demands not sharing but given its many different forms it still persists, albeit augmented from what was known when the risks of HIV were first identified.

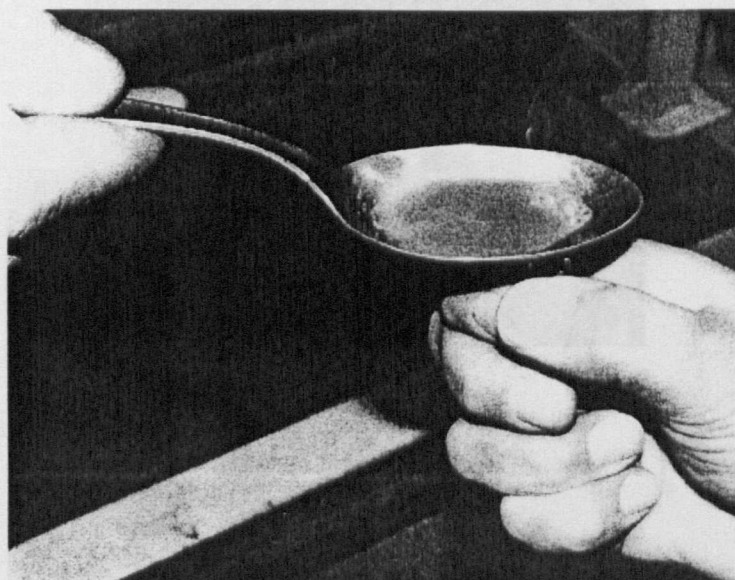
Photograph 5.

Water is used During the Process of Drug Injecting

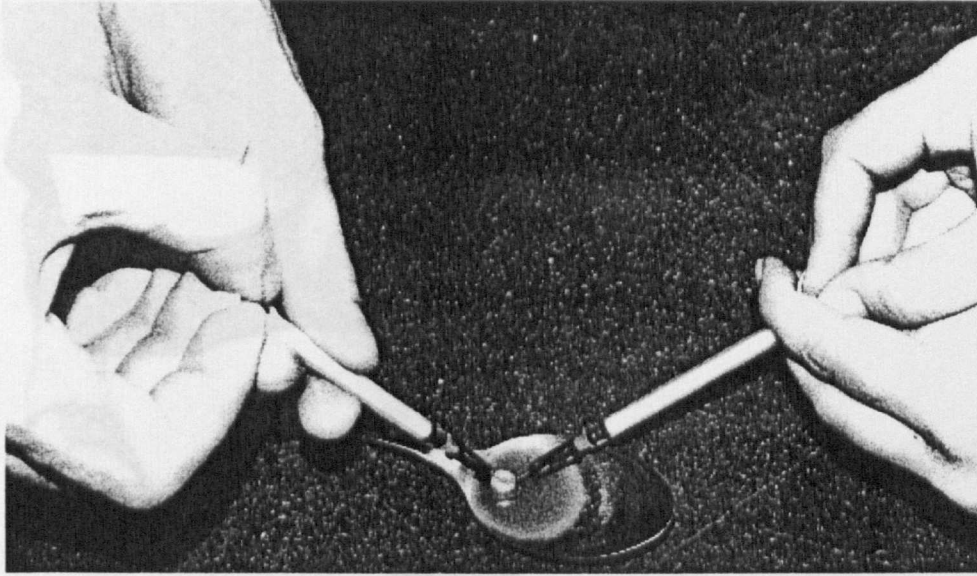


Photograph 6.

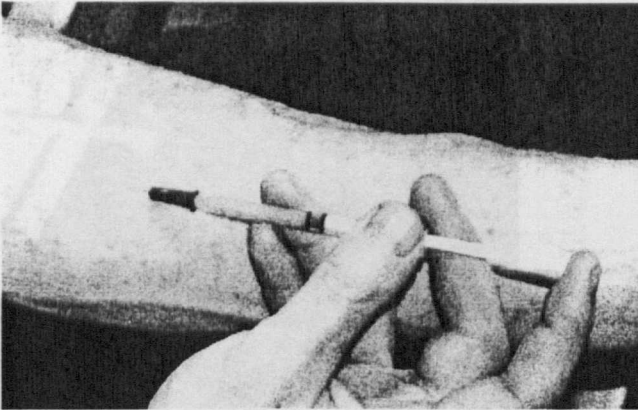
The Process of Heating Drugs



Photograph 7.
Drawing Up Drug Solution



Photograph 8.
Drug Injection in the Arm

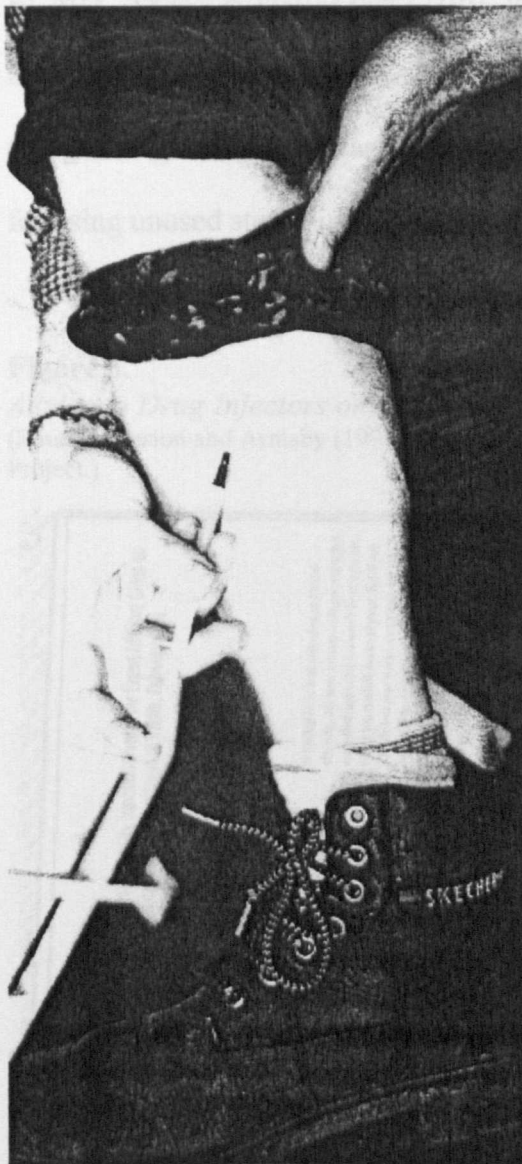


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Cleaning needles and syringes

The risk of infection from sharing needles and syringes can be reduced, although not eliminated, by cleaning. There are a number of methods by which unsterile injecting equipment can be cleaned, as illustrated in Figure 3. These techniques are important when people re-use their own injecting equipment and when people inject with needles and syringes previously used by others. Generally, the use of bleach is recommended as an

Photograph 9.
Drug Injection in the Leg



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Cleaning Needles and Syringes

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important part of the process of cleaning needles and syringes (Preston and Armsby, 1990; ACMD, 1993; British Liver Trust in association with LifeLine, 1997; Preston and Derricott, 1997). However, as the ACMD (1993, pp.29-30) point out it is important to recognise “that cleaning cannot offer full protection against infection and is no substitute for using unused sterile injecting equipment”.

Figure 3.

Advice to Drug Injectors on Cleaning Needles and Syringes

(Source: Preston and Armsby (1990, pp. 16-17). Reproduced with the kind permission of the Exeter Drugs Project.)

EXCERPTS FROM A NOTE AGREED BY REPRESENTATIVES OF THE EXPERT ADVISORY GROUP ON AIDS AND DISSEMINATED BY THE DEPARTMENT OF HEALTH, FEBRUARY 1989.

● If you find yourself in a situation where you feel you have got no choice but to share... use one of these methods of cleaning:

OTHER

● Boiling is the best and safest method of cleaning, but some syringes collapse when they are boiled, and often you won't be in a position where you can boil works anyway. But if you already boil your works, carry on using this method. The whole works should be taken apart, placed in a pan of boiling water and boiled for five minutes. Boiling for five minutes gives you the best protection from HIV infection. But these makes of syringe have been found to buckle if left in boiling water for five minutes, so don't boil them:

UNUSUAL

Syringe Transpacks Ltd
Syringe (or Gillette) all sizes
Monoject Insulin Syringe
Insulin

ALTERNATIVE

● Always try to clean works as soon as possible after they've been used. This makes it much easier to remove the blood. Try and get in the habit of always cleaning your works with cold water after use. This will help keep them in better condition. But remember to use bleach or washing-up liquid if you can if works are ever shared.

Put a generous squirt of washing-up liquid into a cup and add cold water. Draw the liquid right up the needle and into the syringe. Flush it all away (not back into the cup) then draw some more liquid in and flush that away. Then flush the works through with cold water two or three times.

Draw concentrated bleach (like Domestos) from a cup or other container up the needle and into the syringe, and then flush it away (not back into the bleach container). Do this again, and then flush the works through with cold water two or three times.

If you have not got washing-up liquid or bleach handy, then at least flush the works through with cold water three or four times.

No tests have been conducted on insulin syringes and until more information is available, they should not be boiled.

The practice of cleaning needles and syringes with bleach has been found to inactivate HIV (Newmeyer *et al.*, 1990; Shapshank *et al.*, 1993; Flynn *et al.*, 1994; Shapshak *et al.*, 1994). However, the strength of bleach may influence effectiveness (Flynn *et al.*, 1994). Studies have found that when bleach is used by drug injectors to clean needles and syringes it has not always prevented the spread of HIV (Titus *et al.*, 1994; Vlahov *et al.*, 1994; Taylor *et al.*, 1995). The types of cleaning practices employed may influence the effectiveness of cleaning needles and syringes. For example, Gleghorn *et al.* (1994) found that drug injectors did not always adequately clean needles and syringes. In particular, some drug injectors use only water, some did not ensure bleach remained in contact with the needles and syringes for long enough to inactivate HIV, and some did not agitate the injecting equipment during cleansing. However, when drug injectors have been informed of correct cleaning practices, these practices have increased (Rietmeijer *et al.*, 1996) and been maintained over time (McCoy *et al.*, 1997). Thus, when needles and syringes are shared, cleaning can help to reduce the risk of transmitting infections, although it cannot eliminate these risks. Cleaning injecting equipment can have other benefits for drug injectors. Cleaning can, for example, prevent a needle from becoming blocked and thereby ineffective, which can lead people to share further sets of injecting equipment (McKeganey *et al.*, 1995).

Studies examining the cleaning of injecting equipment have generally found high levels of cleaning practices among drug injectors (Gleghorn *et al.*, 1994; Hunter *et al.*, 1995; Davies *et al.*, 1996; Power, R. *et al.*, 1996; Gossop *et al.*, 1997; Klee and Morris, 1997; McCoy *et al.*, 1997; Peters *et al.*, 1998). Example studies are detailed in Table 1, which illustrates how drug injectors will use a number of cleaning methods including some that are more effective than other. Ineffective cleaning methods may be the result of few available

Table 1.

Example Studies of Drug Injectors' Sharing and Cleaning of Needles and Syringes Outside Prison

Study	Location	Years	Sample	Sharing*	Cleaning	Cleaning Methods			
						Bleach/ Alcohol Water	Cold/ Hot	Other	
Hunter <i>et al.</i> (1995)	London	1990	534	182	159	50	45	57	7
		1991	516	136	123	25	28	63	7
		1992	505	139	115	28	14	68	5
		1993	507	143	133	14	27	27	37
Peters <i>et al.</i> (1998)	Edinburgh	1992	233	55	48	22**			
		1993	232	71	54	35**			
		1994	169	40	28	12**			

Notes: *Sharing reported six months prior to interview. **Data refers to the use of bleach, alcohol and boiling.

cleaning materials (Nyamathi *et al.*, 1995), attitudes, social norms and perceptions of risk (Jamner *et al.*, 1996), together with the environment where drug injection takes place. For example, it has been noted that homeless people may have restricted access to water, quite apart from cleaning materials (Pym, 1998).

Storage and Disposal of Injecting Equipment

The unsafe storage or disposal of injecting equipment is an important risk behaviour. Drug injecting risk behaviour may occur when, for example, confusion arises as to who 'owns' injecting equipment resulting in inadvertent sharing (McKeganey and Barnard, 1992). Needlestick injuries may also be caused by unsafe storage and disposal of injecting equipment (Hunt, 1997). To avoid these situations drug injectors may hide injecting equipment to prevent others using it (Power, R. *et al.*, 1996). Neale (1998a) found that some drug injectors dispose of injecting equipment unsafely because they are unaware of the risks. This represents a serious health hazard to drug injectors and the wider community.

Wider Harms from Drug Injecting

The primary focus of this thesis is on HIV transmission. It is, however, important to recognise the wide-ranging harms associated with drug injecting. There are harms associated with the use of particular drugs, such as amphetamines (Hando *et al.*, 1997), as well as through the drug injection process, such as tissue damage, abscesses, deep-vein thrombosis, and bacterial endocarditis (Haverkos and Lange, 1990; Stein, 1990; Spijkerman *et al.*, 1996; Morrison *et al.*, 1997).

Influences on Drug Injecting Risk Behaviour

The previous section outlined some drug injecting practices that can lead to the spread of HIV. The focus now turns to some of the influences on drug injecting risk behaviour. Again this is a selective, rather than exhaustive, engagement with the literature to highlight the pertinent issues, some of which will be returned to later. The following influences on drug injectors' risk behaviour will be discussed: the availability of sterile injecting equipment; needing drugs, experiencing drug withdrawal, and intoxication; social norms and etiquette; socially close and distant relationships; cleanliness and dirtiness; and previous behaviour.

Unavailability of Sterile Injecting Equipment

The unavailability of sterile injecting equipment is an important determinant on sharing (Stimson *et al.*, 1988; McKeganey and Barnard, 1992). McKeganey and Barnard (1992), for example, found that the unavailability of sterile injecting equipment is partly influenced by drug injectors' lifestyles. This sometimes results in failure to plan ahead and drug injectors' refusal to halt the process of drug injection and secure supplies of clean injecting equipment. Some drug injectors do, however, also employ strategies to reduce the situations in which risks are taken in an effort to protect themselves (Burt and Stimson, 1993; Power, R. *et al.*, 1996). Power *et al.* (Power, R. *et al.* 1996), for example, found that some drug injectors minimised the risks of sharing injecting equipment by ensuring consistent supplies and re-using their own equipment when supplies were low. However, it is likely that when these strategies break down, drug injectors may share injecting equipment with others. Strategies may break down when people are in need of drugs, experiencing drug withdrawal and when intoxicated.

Needing Drugs, Experiencing Withdrawal, and Intoxication

For people dependent on drugs, the avoidance of the unpleasant experiences of drug withdrawal can play a significant part in their lives. Individuals can become physiologically, psychologically and socially dependent on the use of drugs. Drug users have described the physical and emotional pains associated with the need for drugs. For example, Connors (1994, p.47 and p. 48) revealed that drug withdrawal can be understood:

[A]s a chronic pain condition that bridges the physical and emotional experiences of pain, especially regarding feelings of rejection, shame, inadequacy, and isolation. ... The unique feature of withdrawal is that it collapses the emotional and physical realms of pain into one cataclysmic experience.

These experiences of pain can mean that HIV reduction strategies, such as avoiding sharing injecting equipment, can be difficult to implement because such strategies require individuals to tolerate the painful experiences of drug withdrawal (Connors, 1994).

Studies have identified the need for a drug injection as an important explanation in understanding why people share injecting equipment and risk HIV infection (Stimson *et al.*, 1988; McKeganey and Barnard, 1992; Power, R., *et al.*, 1996). For example, McKeganey and Barnard (1992) found that where sterile injecting equipment was unavailable but drugs were, people reported being prepared to share injecting equipment when in need of a drug injection. Craving may also influence the type of risk behaviour. Crisp *et al.* (1998) found that craving for drugs influenced the order of sharing injecting equipment. In particular, people experiencing craving were more likely to inject first with shared injecting equipment. However, Eklund *et al.* (1997) found that the predicted fear of the intensity of withdrawal exceeds actual experiences among a sample of dependent drug users. Notwithstanding this, Curran *et al.* (1999) report that increasing methadone dosages

resulted in greater craving for heroin. It is also important to recognise, as Merikle (1999) found, that individuals' craving for drugs are heterogeneous. Together these types of findings reflect the central and symbolic role of drug injection and, in particular, avoiding drug withdrawal in the lives of people dependent on drugs.

Social Norms and Etiquette

It is important for drug injectors' risk behaviour to be set against a wider social context (McKeganey and Barnard, 1992; Hartnoll and Hedrich, 1996; ACMD, 1998). McKeganey and Barnard's (1992) study demonstrates this, noting that the drug injectors' social environment in their study was characterised by social deprivation, which can have an impact upon behaviour. They found that one implicit response to poverty was the reciprocation of resources such as food, clothing, and tobacco. Within this context the authors note that it is not difficult to understand why injecting equipment was also shared. Similarly, Donoghoe *et al.* (1992) found that drug injectors who live together are more likely to share than people who live with their sexual partners, friends or parents, which could suggest that similar factors, as identified by McKeganey and Barnard (1992), to be in operation.

Other wider influences on drug injectors' risk behaviour include specific etiquettes that surround drug injection. As noted earlier the shared use of secondary injecting paraphernalia can spread infection. When people's houses have been used as a venue for drug injection Power *et al.* (Power, R. *et al.*, 1996) note that the filters may be left in people's houses. These can be reused to produce a second drug injection, which is weaker than the first. Social norms and etiquettes such as these can help to explain the high reports of sharing secondary injecting equipment paraphernalia as found by Gossop *et al.* (1997).

Socially Close and Distant Relationships

Social relationships are characterised by differing degrees of closeness and distance. Social closeness and distance can be related to a number of distinguishing features of interpersonal and social relationships. These features of interpersonal and social relationships include, for example, charisma (Shamir, 1995), stigma (Leiker *et al.*, 1995), trust (Goto, 1996), rejection (Lemaine and Ben Brika, 1997) and communication (Spiers, 1998).

Previous studies have found that social distance exerts a strong influence on the ways in which drug injectors behave in relation to the transmission of HIV. McKeganey and Barnard (1992, p.32), for example, found that social distance has a “direct bearing” on drug injectors’ risk behaviour. The closer people felt towards each other the more likely they would be to share injecting equipment. It was noted that sharing often occurs between close friends, sexual partners and family members including siblings. Quantitative studies, including the examples presented in Table 2, support these findings by demonstrating that self-reports of sharing injecting equipment occur amongst the socially close.

In addition to the studies detailed in Table 2, Gossop *et al.* (1997) examined the sharing of needles and syringes and other injecting paraphernalia by social distance. Sharing these items occurred more amongst the socially close than the socially distant. In this study it is interesting to note that the cleaning of needles and syringes was not found to be influenced by social distance. As will be addressed later in this thesis, this could imply that there are high norms surrounding the cleaning of injecting equipment.

Table 2.
Selected Studies of Drug Injectors' Sharing of Needles and Syringes by the Nature of the Relationship

Study	Location	Year	Sample	Total Numbers Sharing and Type	Sexual Partners	Close Friends	Family Members	Acquaint -ances	Others**
Klee <i>et al.</i> (1991a)	North- West England	1988	169	Accepting ***	12	27	****	30	****
		1989	169****	Passing on ***	8	29	****	60	****
Hunter <i>et al.</i> (1995)	London	1989	169****	Accepting ***	14	15	****	2	****
		1990	534	Passing on ***	9	19	****	36	****
		1990	534	Accepting 183	86	117	****	12	37
		1991	516	Passing on 201	84	129	****	46	39
		1991	516	Accepting 140	49	80	****	10	15
Peters <i>et al.</i> (1998)	Edinburgh	1992	505	Passing on 133	41	84	****	26	13
		1992	505	Accepting 141	46	79	****	18	18
		1993	507	Passing on 149	45	95	****	37	23
		1993	507	Accepting 144	85	85	****	12	22
		1992	233	Passing on 159	54	93	****	31	17
		1992	233	Accepting 55	20	27	1	****	15
		1993	232	Passing on 55	17	39	0	****	11
		1993	232	Accepting 71	24	49	8	****	16
		1994	169	Passing on 66	17	46	8	****	15
		1994	169	Accepting 40	13	27	3	****	8
				Passing on 30	10	21	1	****	7

Notes: *Sharing reported six months prior to interview. **Includes, for example, drug dealers, people in prison and discarded equipment. ***Recontacted sample from 1988.
 ****Data not available.

In general, studies have found that social closeness can result in greater drug injecting risk being taken between people, as shown in Table 2. One good example of this is sharing injecting equipment in sexual relationships where people may not fully consider the risk from sharing injecting equipment when sexual risks are already being taken (Donoghoe, 1992; McKeganey and Barnard, 1992; Barnard, 1993; Power, R. *et al.*, 1996). However, when individuals consider their relationships with others as socially distant, strategies to reduce infection risk may be employed (Power *et al.*, 1996).

Patterns of sharing needles and syringes by social closeness and distance have been found in drug injectors' future willingness to share injecting equipment. McKeganey *et al.* (1995) surveyed 505 drug injectors with a series of vignettes and examined their preparedness to lend and borrow injecting equipment between different types of relationships. It was found that drug injectors were more prepared to borrow injecting equipment from a sexual partner (65.6%) than from a very good friend (38.2%) or a distant acquaintance (12.7%). The preparedness to pass on injecting equipment was less related to social distance but nevertheless important. In these cases, people were more willing to pass on injecting equipment to sexual partners (73.3%) or friends (78.8%) rather than to someone not known well (65.6%). These findings are particularly valuable because existing studies, such as those detailed in Table 2, have generally relied on drug injectors' self-reports of their previous behaviour, which may lead to socially desirable responses. In a later study, McKeganey *et al.* (1996) compared vignette responses to drug injectors' self-reported behaviour. They found that considerably more drug injectors reported a future preparedness to take risks than was actually reported from previous behaviour, including borrowing (71 per cent compared with 32 per cent) and passing on (87.3 per cent compared with 57.2 per cent) injecting equipment. These data illustrate how, when compared with

vignette responses, self-reports appear to provide responses closer to what people consider they ought to do according to social norms.

Social distance is partly influenced by trust (Goto, 1996). Barnard (1993, p.807) suggests that drug injectors may find it more difficult to negotiate safer behaviour with people they know and trust because a refusal to share injecting equipment “could imply a lack of trust and the unwelcome assertion of separateness”. There are wide-ranging factors that influence social distance and people’s perceptions of HIV risk behaviour. One important consideration is gender. The experiences of drug injecting between men and women can be different (Taylor, 1993). Similarly, there are gender differences in perceptions of HIV risks (Buysse and Van Oost, 1997; Murphy, D.A. *et al.*, 1998a) and risk behaviour by social distance can also vary (Barnard, 1993; Rhodes *et al.*, 1994; Davies *et al.*, 1996; Buysse, 1998; Judd *et al.*, 1999). For example, a study by Davies *et al.* (1996) with 344 men and 136 women drug injectors found that sexual partners were the main source of borrowed equipment for women whereas men borrowed equipment from a close friend or from people whose HIV status they were unlikely to know. Furthermore, women were more likely to pass on injecting equipment to sexual partners whereas men were more likely to pass on to friends or share ‘indiscriminately’. Barnard (1993) suggests that the tendency for men to share with other men can be accounted for by men, in general, not having sexual relationships with drug injecting women (McKeganey *et al.*, 1989; Klee *et al.*, 1991a; Rhodes *et al.*, 1994; Davies *et al.*, 1996). As a result they spend more time drug injecting in the company of other men. In addition, the division of labour may be such that it falls upon men to secure money, drugs and injecting equipment for themselves and their partner, and these activities may be undertaken with other men (Barnard, 1993). Among a sample of women drug injectors Judd *et al.* (1999) report an increase in sharing injecting

equipment with sexual partners over recent years. This may reflect the relational aspects of risk behaviour becoming more important to drug injectors as part of risk taking and risk management strategies.

Cleanliness and Dirtiness

Allied to social closeness and distance is perceived cleanliness and dirtiness. Individual assessments of whether a person is considered clean or dirty can have an important influence on perceptions of HIV risk and on subsequent behaviour. For example, McKeganey and Barnard (1992) found that individual assessments of whether a person is considered clean or dirty can guide drug injecting risk behaviour. In this study injecting equipment was more likely to be shared with family members and close friends, who were considered clean, than with people less well known who were generally perceived as dirty. Balshem *et al.* (1992, p.156) suggest that maintaining a distinction between clean and unclean can help individuals to “maintain a feeling of personal worth and self-control”. This can be important for understanding the ways in which individuals perceive others and themselves, including previous behaviour.

Previous Behaviour

Previous behaviour is another important influence on risk behaviour. McKeganey and Barnard (1992) found that perceptions of cleanliness and dirtiness were related to other people’s previous behaviour and to how discriminating individuals were about partners with whom they shared injecting equipment. In addition, not experiencing health problems after sharing with particular individuals in the past also influenced perceptions of cleanliness. These qualitative findings informed the development of vignette methodology by McKeganey *et al.* (1995), which incorporated an analysis of previous behaviour on

perceptions of risk. Previous behaviour was found to influence both the borrowing and lending of injecting equipment. It was found that 55.6 per cent of people who did not report borrowing within the last six months were prepared to borrow injecting equipment in the vignettes. Of those that reported sharing in the past six months 95.1 per cent reported a preparedness to borrow. Similar patterns were found for lending. It was found that 70.8 per cent who did not report lending injecting equipment said they would be prepared to lend in the vignette, and this increased to 97.6 per cent among those who report previous lending in the last six months. Interestingly, statistically significant associations were found between a reduction in the preparedness to both lend and borrow injecting equipment within increasingly socially distant relationships. This highlights the interconnectivity of perceptions of risk. However, much more remains to be understood about the constituents of risk, especially in different environments.

Types of Sexual HIV Risk Behaviour

The previous section considered some drug injecting behaviour that can lead to the transmission of HIV together with some of the influences on this behaviour. This section will begin by exploring types of sexual HIV risk behaviour. It then goes on to address some of the influences on these actions.

Drug Injectors, Sexual Activity and Risk Behaviour

As shown above, the spread of HIV through drug injecting is one important part of risk behaviour. The other part is the spread of HIV through sexual activity. Sexual activities that lead to the spread of HIV include oral sex, vaginal sex and anal sex (Alexander, 1996). Some important considerations revolve around sexual risks engaged in outside established relationships (Wagner *et al.*, 1998), and the 'secondary' spread of HIV arising from drug

injecting risk behaviour being subsequently transmitted through sexual risk behaviour (Moss, 1987; Newmeyer, 1988; Donoghoe, 1992; Friedman *et al.*, 1993; Ronald *et al.*, 1993). The secondary spread of HIV is especially important given that some male drug injectors are in sexual relationships with non-drug injectors (McKeganey *et al.*, 1989; Klee *et al.*, 1991a; Rhodes *et al.*, 1994; Davies *et al.*, 1996). These sexual partners may be at risk of HIV infection from the drug injecting risk behaviour of their sexual partners.

The use of drugs has particular effects on the mind and body, including effects on sexual activity. There is evidence to suggest that the use of opiates leads to reduced sexual interest and activity (Mirin *et al.* 1980), whereas the use of stimulant drugs leads to enhancements in sexual interest and activities (Klee 1992). Klee (1992) found that among 200 amphetamine users, 61% reported the use of amphetamines as increasing sexual interests, whereas among 264 opiate users, 62 per cent reported reduced interest in sex. However, studies of drug injectors' sexual behaviour have found that the majority of people are sexually active (Mulleady *et al.*, 1990; Rhodes *et al.*, 1994; Davies *et al.*, 1996). For example, research on the sexual behaviour of 516 drug injectors by Rhodes *et al.* (1994) found that 20 per cent of their sample were not sexually active in the preceding six months.

Studies have found considerable numbers of drug injectors do not use condoms (Mulleady *et al.*, 1990; Klee *et al.*, 1991a; Rhodes *et al.*, 1994; Davies *et al.*, 1996). Whilst not using condoms can lead to the transmission of infection, infection may also spread when they 'fail' by tearing or slipping off during sexual intercourse. Mulleady *et al.* (1990) note that around 6 per cent of drug injectors had experienced condom failure, and qualitative research by Quirk *et al.* (1998, p.110) found that "many" drug injectors reported it. In addition, Quirk *et al.* (1998) report on two additional forms of 'unsafe protected sex',

which highlight other important considerations. First, people may use condoms for ejaculation only. In these instances the use of a condom was related to preventing pregnancy rather than as protection against infection, a finding also reported in other work (Hillier *et al.*, 1998; Kirkman *et al.*, 1998). Second, condoms would be used after limited unprotected penetration. This was related to the difficulties in negotiating condom use during the process of sexual intercourse and, as Quirk *et al.* (1998, p.110) note, as part of the process of “getting carried away”. This second practice differed from using condoms for ejaculation only as it was the act of sexual intercourse and penetration that was considered more risky by participants than ejaculation.

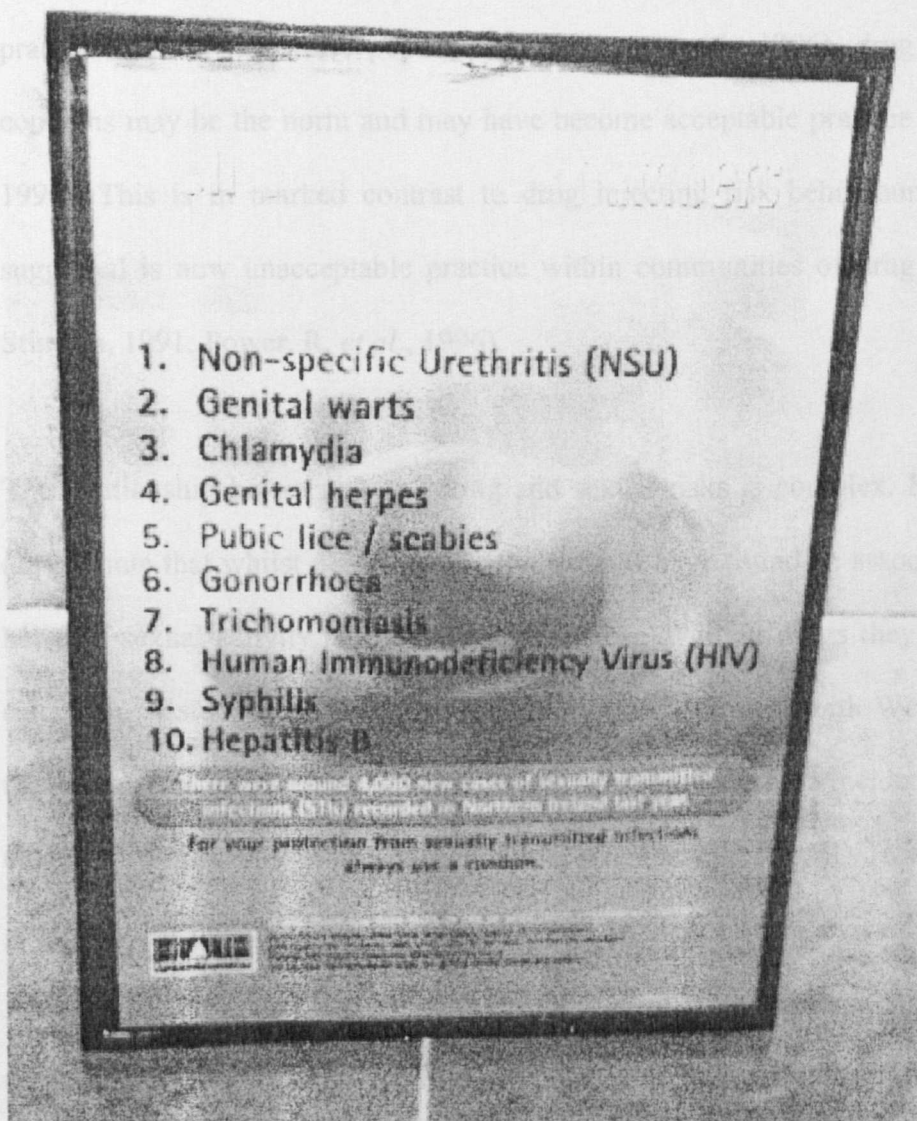
Before moving on to assess some of the influences of sexual behaviour it is important to recognise that there are wide-ranging sexual risks, outside of the spread of HIV. HIV is only one of a number of sexually transmitted infections, as illustrated in Photograph 10. Furthermore, sexual risk extends to wider issues and includes, for example, pregnancy (Hillier *et al.*, 1998; Kirkman *et al.*, 1998), sexual violence (Wood *et al.*, 1998), negative labels (Lees, 1986, 1993) and sullied reputations (Lees, 1986; 1993; Holland *et al.*, 1990; Hillier *et al.*, 1998), which are more commonly faced by women than men. As Singer (1993, pp. 67–68) argues:

What is particularly ironic and chilling about the campaign to market safe sex as the latest disciplinary innovation is the implicit assumption that circulates along with it, namely, that sex was safe before AIDS. Sex was safe, it seems, as long as it was mostly women who died for and from sex in childbirth, illegal abortions, faulty contraception, rape, and murder at the hands of their sexual partners. For men, sexual safety may simply be a matter of wearing a condom. For women, however, sexual safety is not so easily achieved because the risks for women who engage in sex with men or with other women outstrip the risks of contracting a sexually transmitted disease.

Photograph 10.

“Ten Catchy Little Numbers” Photograph in a Public Toilet Illustrates the Range of Sexually Transmitted Infections

(Reproduced with the kind permission of Marianne O’Loughlin.)



Influences on Sexual HIV Risk Behaviour

Drugs and Sex

The literature on HIV risk behaviour shows that whilst many injecting drug users are making the necessary changes to their drug using behaviour outside prison to avoid the transmission of HIV, their sexual behaviour may still put them at risk of infection (Mulleady *et al.*, 1990; Rhodes and Quirk, 1996). Rhodes and Quirk (1996) report that

many drug injectors have changed their drug injecting behaviour to avoid HIV. However, there has been little shift towards safer sex practices. This could imply that the risks associated with HIV through drug injection are considered more seriously than sexual practices. As in the wider population (Wellings *et al.*, 1994), drug injectors not using condoms may be the norm and may have become acceptable practice (Rhodes and Quirk, 1996). This is in marked contrast to drug injecting risk behaviour, which some have suggested is now unacceptable practice within communities of drug injectors (Burt and Stimson, 1991; Power, R. *et al.*, 1996).

The relationship between drug taking and sexual risks is complex. Rhodes and Stimson (1994) note that whilst many quantitative studies have found an association or correlation between sexual activity, sexual risk, and the use of illicit drugs they do not demonstrate causation. A study undertaken by Klee *et al.* (1990) in the North West of England found that the use of temazepam was associated with an increased incidence of casual sexual contacts. Whilst this alone does not increase the risk of HIV transmission, a higher proportion of temazepam users compared to non-temazepam users did not use condoms. Klee *et al.* (1990) note that the effects of temazepam can result in loss of memory, which could include forgetting to use condoms as well as increasing lack of concern after taking the drug. In contrast, Leigh and Miller (1995) found that the use of alcohol and drugs did not result in riskier sexual behaviour. They cite their earlier study that found a positive association between the use of alcohol and safer sex practices. Therefore, in interpreting these types of data researchers can identify an association between the effects of drugs and behaviour but not causation. As Marx *et al.* (1991, p.94 – cited in Rhodes and Stimson, 1994, p.217) point out:

It is not known whether drug use is a marker for high-risk sexual behaviour, drug use leads to high-risk sex, high-risk sex leads to drug use, or some combination.

The Meaning of Sex and Safer Sex

Drug injectors, like the wider population, attach different meanings to risk taking activities. For example, what is considered a sexual act by one person may not be considered the same sexual act by another. Similarly, the identification of risk from certain activities will also vary between individuals. A longitudinal study, 'Socio-sexual Investigations of Gay Men and AIDS', investigated the different meanings attached to sexual encounters amongst 930 men who engage in sexual activities with other men (Hunt and Davies, 1991). People were asked what sexual activities have to take place for someone to be considered their sexual partner. The responses generally fell into two broad categories: answers that described sexual partners in physical terms were placed in one group, and responses that described sexual partners in emotional terms were placed in another. These two categories were not mutually exclusive and some responses were counted in both categories. It was found that just under half (48.2 per cent) of the sample described encounters with sexual partners as necessitating physical contact. In some instances the physical activities that contributed to sexual encounters were ordered hierarchically. Hunt and Davies (1991) suggest that sexual encounters are a staged processes that sometimes make it difficult to identify what sex is and when it has begun.

Safer sex refers to a range of strategies that prevent the exchange of bodily fluids during sexual activities. These may include non-penetrative sexual activities but are often considered to imply the use of condoms (MacIntyre and West, 1993; Rosenthal *et al.*, 1996; Hillier *et al.*, 1998). For example, Hillier *et al.* (1998) explored meanings of safer

sex among rural students aged between 15 to 19. In response to the question, “what does safe sex mean to you”, around half of their sample reported the use of condoms. Some people dislike the use of condoms, which was noticeable prior to the emergence of HIV (Weinstein and Goebel, 1979). They remain disliked among some drug injectors (Mulleady *et al.*, 1990). Objections to using condoms typically include reports that they de-sensitise a sexual encounter, are embarrassing to use, and difficult to negotiate with sexual partners. In addition, the use of condoms may also be influenced by socially close and socially distant relationships.

Socially Close and Socially Distant Relationships

Studies of drug injectors’ sexual risk behaviour have found social closeness and distance to influence sexual risk taking. The studies of drug injectors’ sexual risk behaviour selected for Table 3 demonstrate that drug injectors are more likely to report condom use with casual rather than established sexual partners. These studies also show how considerable numbers of drug injectors report ‘never’ using condoms in both regular and casual relationships. In addition, that the use of condoms is low in sexual encounters between men and women and is often stopped in most long-term relationships reflects patterns within the general population (Wellings *et al.*, 1994). Buysse (1998) describes two broad categories of sexual relationships. First, casual sexual relationships are characterised by their ‘body-centred’ emphasis, their non-exclusive nature and emphases on lust, physical release, fun and pleasure. Second, stable sexual relationships are characterised by their close, intimate and committed nature and are ‘person-centred’, focusing on emotional intimacy and expressions of love. As noted earlier, Barnard (1993) has commented on the difficulties in negotiating drug injecting practices among the socially close. Similarly, with regards to

Table 3.
Selected Studies of Drug Injectors' Use of Condoms by the Nature of the Relationship

Study	Location	Year(s)	Sample	Numbers Sexually Active*	Condom Use Among Regular Partners			Condom Use Among Casual Partners		
					Always	Sometimes	Never	Always	Sometimes	Never
Klee <i>et al.</i> (1991a)	N/West England	1989	169	148	5	20	65	17	12	29
Rhodes <i>et al.</i> (1994)	London	1991	516	397	44	53	206	54	54	55
Davies <i>et al.</i> (1996)	Edinburgh	1992-4	480	398	42	73	230	50	41	60

Note: *Data selected refers to heterosexual sex only reported six months prior to interview.

sexual behaviour Buysse (1998, p.56) notes that the use of condoms in stable sexual relationships “represents mistrust and formality”. Similarly, research with gay male couples by McNeal (1997) found that the more individuals ‘idealized’ their sexual partner and reported satisfaction with their relationship, the less likely condoms would be used. Condom use in these types of relationships may be understood to challenge the very notion of an ideal and satisfactory sexual partner and sexual relationship.

Cleanliness and Dirtiness

As noted earlier, social closeness and distance is related to perceptions of cleanliness and dirtiness with regards to HIV risk behaviour. Previous studies have examined the concepts of clean and dirty in sexual behaviour (Balshem *et al.*, 1992; Waldby *et al.*, 1993; Hillier *et al.*, 1998). These studies have found that individuals draw distinctions between others perceived as clean and those who are not, usually on the basis of whether people are believed or known to be infected with HIV and other infections. The ability to report an HIV-negative diagnosis is believed to enhance perceptions of sexual attractiveness and cleanliness (Lupton *et al.*, 1995). Studies of sexual behaviour have found that cleanliness is related to social closeness (Balshem *et al.*, 1992; Hillier *et al.*, 1998). In particular, an individuals’ perception of cleanliness of another person derived from a number of factors. These included the individuals’ degree of familiarity with another person; whether that person had a pleasant demeanour; whether that person had a good family background; whether their sexual history was known and the degree of trust between an individual and their sexual partners (Balshem *et al.*, 1992; Hillier *et al.*, 1998). Perceptions of cleanliness and dirtiness are clearly important to individuals and influence the ways in which they manage and negotiate their actions in view of HIV. This can be important for understanding the ways in which individuals perceive others (Balshem *et al.*, 1992; Hillier

et al., 1998) and themselves (Lupton *et al.*, 1995). Agostinelli and Seal (1998) found that individuals consider their own sexual behaviour as more responsible than close friends and, furthermore, close friends' behaviour was considered more responsible than people in general. This may perpetuate risk behaviour if people consider the socially close as more responsible and, therefore, are less likely to minimise the risks of infection transmission. Indeed, perceptions of cleanliness have been found to lead to greater risk behaviour (Balshem *et al.* 1992).

Negotiation

Studies have long examined personal relationships. Duck and Sants (1983) identified a number of problems with the ways in which the literature considers people's relationships. For example, they suggest that the literature considers relationships as the products of the people's responses to each other and the mixing of individuals' attributes, which incorrectly assumes that individuals do little 'processing' of their own. Similarly, they suggest that the literature has objectively defined relationships and that people conduct relationships with ubiquitous self-awareness. Duck and Sants (1983) reject these views and argue instead that relationships should be seen as processes. To achieve this requires an appreciation of negotiated roles.

Subtle and complex negotiations surround sexual activities, which are important influences on risk behaviour. Sexual activities are physical and symbolic acts that occur through both verbal and non-verbal communication. The negotiation of sexual activities is a delicate and complex process (McKeganey and Barnard, 1992; Lear, 1995). McKeganey and Barnard (1992, p. 62), for example, illustrate this:

The lead up to sexual relations appears to be one of an incremental process signposted by mutually understood if non-verbal signals which represent a gradual move towards a situation where agreement to sexual relations is taken to be consensual. By avoiding making explicit statements of sexual intent both parties may be able to avoid potential embarrassment or discomfort should the advances of either be rejected. Physical signs such as switching off the light or locking the door are often used to represent the wish to take things one step further. If the other person consents to this turn of events, this may be read as agreement to have sex. The overriding impression is one of a progressive move towards a situation in which sex 'becomes' the agenda, even if this is never explicitly acknowledged by those involved. It is almost as if a necessary fiction is created such that the actual consummation of the sex act is frequently represented as a spontaneous, unportended event, although it can be seen analytically as the result of a protected, careful and subtle process of negotiation.

One important factor with regards to the relational aspects of risk behaviour is the ways by which people determine the focus and boundaries of relationships (Cline, 1979) Among a sample of university undergraduate students, Lear (1995) found that friends were an important influence on safer sexual behaviour. The influence of risk or safer behaviour was guided by whether friends talked about sex and the ways in which it was discussed. For example, men typically talked about sex by joking whereas discussions amongst women were more explicit. Friends often monitored each others' behaviour such as "Did you use protection?" (Lear, 1995, p.1318), which support condom use. Similarly, Albarracin *et al.* (1998) found that the more condoms became a 'normal' feature of people's lives – by discussing them and having friends who used them – the more likely people would be to use condoms themselves.

These processual features of sexual activities and risk behaviour have also been illustrated by Rosenthal *et al.* (1996) with a group of 288 young people aged between 12 and 21 years. Their study used the 'Interpersonal Negotiation Strategy' interview which is designed to measure people's reasoning on interpersonal negotiation. The researchers used

vignettes depicting a couple on the way home or in the bedroom about to have sex. Examples of negotiation strategies that were suggested in response to the vignette include “talk to him before having sex about does he use them”, “tell her he wants to use a condom”, and “give him pamphlets on condoms to read” (Rosenthal *et al.*, p.95). The authors suggest that the negotiation of condom use may not be processual but intimacy and other aspects of sexual relationships are.

The processual nature of relationships also raises important temporal considerations. In particular the use and negotiation of condoms may be difficult to maintain and renegotiate over time (Lear, 1995; Lupton *et al.*, 1995). Such considerations can help to explain findings that show that condoms are not used in established sexual relationships (Table 3). There are very subtle and complex processes surrounding the negotiation of sexual encounters. Baxter and Wilmot (1985) found that sexual behaviour and previous sexual partners were taboo topics that when discussed led to unease and embarrassment. Individuals do not want to create negative image of themselves (Goffman, 1959) and people may not want others to think they have had a number of sexual partners, leading to these topics becoming taboo (Djamba, 1995). These issues resonate with studies reviewed by Wight (1992) who shows how young people expressed difficulties in talking about sexual activities and their relationships. Thus, taboo topics may lead to risk behaviour because safer behaviour cannot be managed effectively. However, this is not to suggest that people are unaware of the need to use condoms to reduce infection risk. Hillier *et al.* (1998) report that 69 per cent of their sample reported using a condom at their last sexual intercourse. Condoms were discussed by 68 per cent of the sample on this occasion. However, of the 69 per cent who talked about condoms 17 per cent did not use them. Of those who did not talk about condoms 37 per cent did use them. These findings could

reflect previously established practices being maintained or that negotiation was attempted but failed.

Discussed above are some of the subtle processes surrounding sexual behaviour and risk reduction. Sexual behaviour may also be discussed in more explicit terms, which Kippax *et al.* (1993, 1997) describe as negotiated safety. This term refers to the dispensing of condoms as being deemed safe when sexual partners are in a regular relationship, are not infected with HIV, are aware of each others' HIV-negative status, and have explicitly agreed about the nature of sexual activities that can be undertaken in and out of the relationship. A study with HIV negative homosexual men in established relationships by Kippax *et al.* (1997) examines the contexts in which men engage in unprotected anal intercourse and tests the negotiated safety agreement by the frequency of unprotected anal intercourse with casual partners outside the regular relationship. It was found that many men have unprotected anal intercourse with their regular sexual partners, especially when they both have the same HIV status. In these instances unprotected sex is not regarded as risky when sexual safety has been negotiated and the conditions of these negotiations are fulfilled.

Coercion and unequal power relations surround sexual discourses and sexual behaviour (Pollack, 1985; Holland *et al.*, 1990; Singer, 1993). For example, Pollack (1985) argues that women's sexual relations are a reaction to patriarchal sexual relations. Similarly, Holland *et al.* (1990) argue that women see sex as an activity to keep men happy or as a means to 'keep' sexual partners. They argue that women feel a reluctance to express sexual desires and needs and that women explain this in terms of superior male knowledge or

their own embarrassment. For Holland *et al.* (1990) women generally lack power in sexual relations and heterosexual intercourse is isolated within institutionalised heterosexuality where male dominance is the norm. The issue of negotiation of sex should be located within these realms. They point out, for example, that women have internalised negative views of condoms held by men and that women reporting beliefs such as that the use of condoms “breaks the flow” (Holland *et al.*, 1990, p.344) are a result of dominant male ideology.

Having considered some of the various types of risk behaviour and some of the influences on these, the final section of this chapter details the level of infections found among drug injectors.

LEVELS OF INFECTION AMONG DRUG INJECTORS

Statistics of the number of people infected with HIV and AIDS need to be interpreted with caution as there may be some underreporting (Bloor *et al.* 1991). Nevertheless, recorded numbers of people with HIV and AIDS can give a broad indication of the level of infection. Data from the Public Health Laboratory Service and the Scottish Centre for Infection and Environmental Health (1999) report that in the UK the total number of people infected with HIV was 20,050 and with AIDS 4,763 people of which drug injectors make up 2064 people and 301 people respectively. There are greater numbers of men infected with HIV (1,6026) and AIDS (3,927) than women.

In addition to the official recorded incidence of HIV and AIDS, community samples of drug injectors have been tested for HIV, as detailed in Table 4. Whilst HIV infection is the

Table 4.*Selected Studies of HIV, HBV and HCV Prevalence Among Drug Injectors*

Study	Location	Year(s)	Sample	Percentage of Drug Injectors Infected With		
				HIV	HBV	HCV
Waller and Holmes (1995)	United Kingdom	1994	2081			60
Gossop <i>et al.</i> (1997)	London	1994	286	0.7	30	
Rhodes <i>et al.</i> (1996)	London	1992	426/7* 491	7 6.9	52 48	
Peters <i>et al.</i> (1996)	Edinburgh	1992 1993 1994	233 232 169	21.4 18.3 22		
Lamden <i>et al.</i> (1998)	Northwest England	1992-96	773**	4.5	48	67

Notes: *426 saliva samples suitable for HIV testing and 427 saliva sample suitable for HBV testing. **34 participants did not report drug injection.

primary focus in this thesis, it is important to note the greater percentages of drug injectors infected with HBV and HCV. Furthermore, levels of HIV vary across the United Kingdom (Public Health Laboratory Service and the Scottish Centre for Infection and Environmental Health, 1999). Regional variations in HIV may reflect regional variations in sexual risk behaviour (Wadsworth *et al.*, 1996) and drug injecting risk behaviour (Bloor *et al.*, 1994), including regional variations in prison experiences (Stuart *et al.*, 1997). For example, Bloor *et al.* (1994) questioned why high levels of drug injecting in Glasgow has not translated into high rates of HIV. HIV prevalence remains considerably lower amongst Glasgow's injectors than in Edinburgh where there are fewer numbers of injectors but higher rates of HIV. Whilst there are a number of possible explanations, one of the most promising is drug

injectors' behaviour in Glasgow is less risky than those in Edinburgh. The differences in HIV levels illustrate how behavioural change can translate into lower rates of infection.

SUMMARY

This chapter began with an appreciation of drug injectors' lives, which was placed within a social policy framework. Further policy debates surrounding drug injectors will be considered in Chapter 4. Also discussed in the present chapter was the transmission of HIV, including microbiological considerations and particular practices that drug injectors may employ that allow HIV to spread. The issues presented are not an exhaustive review, rather they illustrate the range of research and some of the key findings. Some of the influences on drug injectors' drug injecting and sexual risk behaviour were also examined. The salient issues included here are, of course, not mutually exclusive and it is important to understand that influences on drug injecting behaviour, such as social distance, has also been shown to influence sexual behaviour. Finally, this chapter outlined the levels of infection among drug injectors and, as also pointed out in Chapter 1, HIV is only one of a number of infections that pose a risk to drug injectors. The next chapter follows a similar course by examining drug injectors' lives inside prison, including drug injecting and sexual risk behaviour. In addition, this chapter draws on some of the literature on prison life to illuminate understanding on the ways in which individuals behave in this environment.

– CHAPTER 3 –

DRUG INJECTORS INSIDE PRISON

INTRODUCTION

This chapter considers begins by considering drug injectors' contacts with criminal justice agencies and, in particular prisons, as a result of the illicit nature of some of their activities. The chapter then goes on to explore risk behaviour inside prison. It examines risk behaviour first with regard to drug injecting and, second, with regard to sexual activity. The focus of the chapter then shifts to examine studies of prison life. These studies can help to understand some of the wider influences on people's behaviour when they spend time inside prison.

DRUG INJECTORS, CRIME AND CRIMINAL JUSTICE

British criminal justice comprises a mass of institutions that respond in different ways to crime (Newburn, 1995; Davies *et al.*, 1998). Drug users have an established record of contact, often repeatedly, with criminal justice institutions (Hough, 1996). The ACMD (1996) point out that drug injectors are likely to come into contact with criminal justice in three main ways. First, by being caught through the use of drugs including for possession and supply. Second, for committing crimes in connection with drug use, such as acquisitional crimes. Third, for offences unrelated to drug use.

South (1997) considers two conflicting perspectives concerning drug use and crime. The first perspective considers that criminal activities lead to drug use. In particular, criminal activities lead people to encounter the use and supply of drugs, which result in drug taking.

In contrast, the second perspective suggests that drug use causes crime. Typically drug users commit acquisitional crimes to finance the pursuit of drugs. It is perhaps a mix of these two perspectives that shape drug injectors' lives and their contact with criminal justice agencies (South, 1994; Hammersley *et al.*, 1989).

High financial costs are associated with illicit drugs such as heroin, and regular users often require large amounts to sustain their dependency (Dorn *et al.*, 1994). Although possession of certain drugs is a criminal offence under the Misuse of Drugs Act (1971), not all drug injectors will engage in illegal money-generating activities. However, the high costs associated with drug dependency (Dorn *et al.*, 1994) can mean that together with other financial commitments such as the costs of bringing up a family, money can be a particular problem for dependent drug injectors. Thus whilst some people manage to maintain drug dependency on the income they receive, for example from welfare benefits, others may engage in illegal revenue raising activities when legal means of generating money are restricted (Hughes, 1997b).

Drug injectors' criminal activities are far from homogeneous. For some offences, such as drug supply, drug injectors usually serve time in custody. However, non-custodial sentences play a constructive role in sentencing policies (Worrall, 1997). When drug injectors commit minor offences they may receive community-based sentences such as probation orders. However, drug injectors may not be in a position to complete probation requirements because their priorities lie in the pursuit of drugs. As a result of this and other offences people may receive a custodial sentence (Hughes, 1997b). Thus, whilst criminal justice responses vary, for drug injectors it can often involve a custodial sentence.

Considerable numbers of people are held in prisons. In England and Wales the numbers are expected to rise from an average of 55,300 people in 1996 to 74,500 by the year 2005 (Turner *et al.*, 1997). At present, however, the prison population is consistently 1,500 people above the projected figures (Ramsbotham, 1998). The prison population as of 4th December, 1998 was 66,273 (House of Commons Hansard Debates for 10th December 1998, Part 16). The number of drug offenders has also risen in recent years and in 1996 a new 'record' was set with 8,800 people being given immediate custodial sentences for drug offences (Corkery, 1998). Reconviction rates however, have remained relatively stable over recent years with just over half of the people discharged from prison being reconvicted within two years. The majority of people are reconvicted for different offences, the exception being drug offenders who are usually reconvicted for the same offence (Kershaw and Renshaw, 1997). In addition to these official indicators, studies have found large numbers of people dependent on drugs inside prison (Kennedy *et al.*, 1991; Maden *et al.*, 1992; Mason *et al.*, 1997; Brooke *et al.*, 1998) including considerable numbers of drug injectors as detailed in Table 5. Drug use, especially dependent drug use, can transcend individuals' movements through prison. Furthermore, the lack of opportunities that people faced before they entered prison – which may or may not have contributed to their use of drugs or criminal activities – often remain and may even have been exacerbated upon release. It can mean that repeated movements characterise some drug injectors' contacts with criminal justice services including prisons.

Table 5.

Selected Studies of Self-Reported Drug Injection and Injecting Equipment Sharing Inside Prisons

Study	Location	Year	Sample	Injectors in Prison	Injected in prison	Shared in prison
Carvel and Hart (1990)	London	1982-89	50*	50	33	26
Dolan <i>et al.</i> (1990)	Britain	1988	183*	139	32	24
Kennedy <i>et al.</i> (1991)	Glasgow	1990	81*	56	14	6
Dye and Isaacs (1991)	Edinburgh	1990	123**	43	29	22
Covell <i>et al.</i> (1993)	Glasgow	1990	503*	262	41	30
Turnbull <i>et al.</i> (1991)	England	1990	452*	168	45	32
Bird <i>et al.</i> (1992)	Edinburgh	1991	363**	66	31	***
Taylor <i>et al.</i> (1995)	Perth	1993	227**	76	33	32
Turnbull <i>et al.</i> (1996)	England	1993	44*	44	16	9
Bird <i>et al.</i> (1995)	Glasgow	1994	928**	327	162	***
Gore <i>et al.</i> (1995a)	Scotland	1994	284**	75	44	***
Edwards <i>et al.</i> (1999)	Oxfordshire	1994	376**	76	44	33
Gore <i>et al.</i> (1997)	Scotland	1995	414**	140	101	***
Mason <i>et al.</i> (1997)	Durham	1995-96	548**	101	***	***
Bellis <i>et al.</i> (1997)	Liverpool	1996	921**	260	36	20

Notes: *Sample recruited in the community. **Sample recruited in prison(s). ***Data not available.

DRUG INJECTORS AND HIV RISK BEHAVIOUR INSIDE PRISON

Typically, prisons are considered a greater risk environment than outside (Turnbull *et al.*, 1991). Studies have found, however, that most residents in Scottish prisons consider the risk of HIV to be greater outside prison than inside prison (Power *et al.*, 1994; McKee *et al.*, 1995). In contrast, prison staff consider the risks of HIV to be greater inside prison than outside (McKee *et al.*, 1995). Upon closer examination of these issues Power *et al.* (1994) reveal that among a sample of 550 known HIV-negative residents from eight Scottish prisons, approximately 20 per cent of participants perceived their risk of HIV infection to be greater inside prison than outside. The characteristics of people reporting this include, for example, individuals who had been charged with drug offences, injected drugs both

inside and outside prison, and had a test for HIV. Thus, whilst prison is not regarded as a high risk environment for the majority of residents, for an important minority – including drug injectors – the reverse was found to be true. In a later study Power *et al.* (Power, K.G. *et al.*, 1996) found that those who are most likely to perceive themselves to be at risk of infection are also the most knowledgeable about HIV and AIDS. This could suggest that people assess their own vulnerability to HIV infection based on their knowledge of the virus. However, it is important to recognise that perceptions of risk do not translate into actual risk reduction.

Between 1996 and 1997 the Prison Service Directorate of Health Care (1998) report that 4,143 HIV tests were carried out, of which 123 new cases were found positive. During the same period the average number of acute HBV cases were 6, chronic HBV cases were 72 and the total number of HCV cases was 234. Studies of HIV prevalence in prisons, as detailed in Table 6, have generally found higher levels of HIV than was known to the prison authorities. Of the people identified with HIV in these studies, most reported a history of drug injection and the prevalence of HIV among drug injectors is considerably higher than among the wider prison population. There is a high prevalence of other infection inside prison, including HCV. Gore *et al.* (1999) found that approximately 20 per cent of prison residents in five Scottish prisons were infected with HCV. For drug injectors the prevalence of HCV was around 50 per cent. To understand further the spread of infection inside prison, the following two sections report on risk behaviour inside prison, first with regards to drug injecting and second, with regards to sexual behaviour.

Table 6.
Selected Studies of HIV Prevalence in Prisons

Study	Prison	Location	Year	Sample*	Number of People Infected with HIV	
					All	Drug Injectors
Bird <i>et al.</i> (1992)	Saughton	Scotland	1991	375**	17	17
Bird <i>et al.</i> (1993a)	Saughton	Scotland	1992	236**	8	6
Bird <i>et al.</i> (1993b)	Polmot	Scotland	1992	421**	0	0
Taylor <i>et al.</i> (1995)	Glenochil	Scotland	1993	162**	12	12
Gore <i>et al.</i> (1995b)	Glenochil	Scotland	1994	293**	7	7
Bird <i>et al.</i> (1995)	Barlinnie	Scotland	1994	978**	9	9
Edwards <i>et al.</i> (1999)	Bullingdon	England	1994	388**	1	1
Gore <i>et al.</i> (1997)	Perth	Scotland	1995	304**	6	6
	Cornton Vale			134***	0	0
Bellis <i>et al.</i> (1997)	Liverpool	England	1996	905**	1	–
Weild <i>et al.</i> (1997)	Various****	England & Wales	1997	2100** 410***	6 5	– –

Notes: *Samples chosen include only those suitable for HIV testing. **Men. ***Women. ****Representing combined data from 8 prisons.

Drug Injecting Risk Behaviour Inside Prison

There are a number of risk factors surrounding the imprisonment of drug injectors. One study, for example, by Bird *et al.* (1995) found that multiplicity of prison experience, being under 30 years old, having been tested for HIV, and having injected drugs inside prison were all important characteristics of drug injectors inside Barlinnie prison. As shown earlier in Table 5, considerable numbers of people inject inside prison. In addition, significant numbers of people have been found to report starting to inject inside prison (Gore *et al.*, 1995a, 1995b; Bird *et al.*, 1995; Taylor *et al.*, 1995; Bellis *et al.*, 1997). For example, the study of risk behaviour in Glenochil prison by Taylor *et al.* (1995) found that

76 people had previously injected drugs and of these seven had started to inject during their current sentence. Two of these people were subsequently found to be HIV positive. Similarly, using data obtained from Barlinnie and Glenochil prisons, Gore *et al.* (1995b) found that one in 60 men started to inject inside prison during their first sentence. From 7000 new admissions each year, they estimate that over 100 men may start to inject drugs, and subsequently share injecting equipment, in Scottish prisons alone.

Risk behaviour may be enhanced in prison (Crofts *et al.*, 1996) because of the physical environment and the limited and different service provision for drug injectors compared to what is received outside prison. Injecting equipment in prison can be scarce and some people use blunt and broken injecting equipment (Taylor, 1996; Seamark and Gaughwin, 1994; Turnbull *et al.*, 1994; Rutter *et al.*, 1995; Crofts *et al.*, 1996; Goldberg, 1997). Moreover, when injecting equipment is shared, the number of people having previously used it may be unknown. For example, one person in the study by Kennedy *et al.* (1991, p. 1507) remarked:

When you hide your needle, someone else might find it and it gets used in their circle, so you can't say how many get to use it.

Estimates of the number of people with whom injecting equipment was shared give an indication of the extent of risk that drug injectors face. Estimates of the number of people sharing one set of injecting equipment range from one to 14 (Covell *et al.*, 1993), one to 40 (Dolan *et al.*, 1990), and between five and 100 (Kennedy *et al.*, 1991).

In an attempt to reduce risks, drug injectors may clean needles and syringes inside prison, which, as noted earlier, is an important measure to reduce, although not eliminate the risks

of infection. Studies of drug injection in prison have found that when shared equipment is used it is usually cleaned, as the example studies in Table 7 illustrate. However, the methods used to clean needles and syringes outside prison are generally less effective when used inside prison.

Taylor *et al.* (1995) found that the majority of people who reported sharing 'always' cleaned needles and syringes before use. However, one person who reported 'always' cleaning shared needles and syringes with bleach before use was found to have definitely contracted HIV inside prison Glenochil. In response, the Scottish Prison Service implemented a number of harm-reduction measures throughout Scottish prisons in December 1993, which include the provision of decontaminants to help clean needles and syringes (Goldberg *et al.*, 1998). The use of these tablets has been examined by Bird *et al.* (1997) in two Scottish prisons. They found that in both prisons people regularly used the tablets to clean injecting equipment. In Lowmoss prison drug injectors estimated 207 injections and 258 uses of sterilising tablets, and in Aberdeen prison 229 injections and 221 uses of sterilising tablets. These data highlight how drug injectors feel a need to clean injecting equipment when shared and that they respond positively to harm reduction interventions. However, problems have been identified with the provision of decontaminants. It has, for example, been noted that drug injectors may be reticent to request decontaminants from prison officers for fear of recrimination (Crofts, 1997; Goldberg, 1997). Similarly, the ACMD (1996) has remarked on the inherent difficulties in providing harm reduction materials to drug injectors at a time in which MDT emphasises the control and punishment of drug use. In Australia, Crofts (1997) notes that requests for bleach by prison residents to staff could be followed by urine tests, to detect the use of drugs.

Table 7.
Example Studies of Drug Injectors' Sharing and Cleaning of Needles and Syringes Inside Prison

Study	Location	Year	Sample	Injectors in Prison	Injecting in prison	Sharing in prison	Cleaning	Cleaning Methods			
								Bleach/ Alcohol	Boiling Water	Cold/Hot Water	Other
Dolan <i>et al.</i> (1990)	Britain	1988	183*	139	32	24	20	1	5	14	—
Covell <i>et al.</i> (1993)	Glasgow	1990	503*	262	41	30	30	10	0	11	9
Taylor <i>et al.</i> (1995)	Perth	1993	227**	76	33	32	31	3	1	17	7

Notes: * Sample recruited in the community. ** Sample recruited in Glenochil prison.

Some drug injectors stop injecting when they spend time inside prison (Shewan *et al.*, 1994a; 1994b; 1995; Turnbull *et al.*, 1994). For example, Turnbull *et al.* (1994) identified a number of reasons why people stop injecting inside prison. These reasons include: personal decisions not to use drugs, the fear of infection, unavailability of drugs and injecting equipment or the resources to pay for these, fear of being stigmatised and because of lower levels of drug consumption inside prison.

Sexual Risk Behaviour Inside Prison

Sexual activity in prison has long been a contentious area within prison policy. The law on same sex activities defines them as illegal when they do not occur in a 'private' place. There has been some confusion as to whether a prison cell constitutes a 'private' place. However, the former director of prison health care clarified this by stating that consenting sexual acts between adults "are not automatically unlawful and that a prison cell is in many circumstances capable of being deemed a private place under the terms of the 1967 Sexual Offences Act" (Wool, 1996 – cited in Flynn 1998, p.85). However, condom provision is restrictive:

Prison doctors are able to prescribe condoms to individual prisoners, on application, where, in their clinical judgement, there is a known risk of HIV infection. We have no plans to make condoms more freely available to prisoners... (House of Commons Hansard Written Answers for 9th July 1998, Part 7).

Sexual behaviour in prison is also an important issue when considering risk behaviour inside prison (Dolan, 1994). Studies, including those detailed in Table 8, have found that small numbers of people, including drug injectors, engage in sexual activities inside prison. These are usually encounters with members of the same sex, although there have been

reports of sexual activities with members of the opposite sex inside prison (Turnbull *et al.*, 1991; Rotily *et al.*, 1998). Turnbull and Stimson (1993, p.168) note that sexual activity in prison has an important heterosexual as well as homosexual dimension, which is particularly important with regards to HIV:

Prisons are environments in which some individuals engage in HIV risk behaviours which they would otherwise not do outside. Prisons displace individuals from their usual environments, practices and behaviours, and sexual and drug taking behaviour can alter as a result. For example, some ostensibly heterosexual men may have sex with men in prison since they desire sexual pleasure. So prisons not only contain a disproportionate number of people with pre-existing risk exposure, but they may also be conducive to novel behaviours for those with no pre-existing risk behaviours.

Table 8.

Selected Studies of People Reporting Sexual Activities with Others Inside Prisons

Study	Location	Year	Sample	Reported Sexual Activity	
				Non-Drug Injectors	Drug Injectors
Carvel and Hart (1990)	England	1982-9	50	–	4*/1**
Dolan <i>et al.</i> (1990)	Britain	1988	183	–	8*/1**
Turnbull <i>et al.</i> (1991)	England	1990	452	26*/16**	–
Power <i>et al.</i> (1991)	Scotland	1990	559	1*/3*	–
Bird <i>et al.</i> (1993)	Scotland	1992	404	3*	–
Taylor <i>et al.</i> (1995)	Scotland	1993	227	1*	–
Bird <i>et al.</i> (1995)	Scotland	1994	28	0	3*
Gore <i>et al.</i> (1995a)	Scotland	1994	284	1*	1*
Edwards <i>et al.</i> (1999)	England	1994	378	2*	–
Gore <i>et al.</i> (1997)	Scotland	1995	282	0	3*

Notes: *Men. **Women.

There is a lack of condom provision inside prisons, despite Prison Service ‘approval’ of such provision (Flynn, 1998). Nevertheless condoms may be used in some sexual

encounters. Turnbull *et al.* (1991) found that of the men found to be sexually active in prison the majority were involved in penetrative sex, including anal sex, but condom use was low. Turnbull *et al.* (1991) also found that women reported a higher level of sexual activity in prison than men, and that most women engaged in oral sex.

Prison can be deemed a higher risk environment than in the community. Whilst for some people there will be little, if any, risk behaviour, for others who do take risks these are undertaken in a riskier way than outside prison. This can, in part, be attributed to policy responses aimed at reducing risk behaviour inside prison, together with individuals' perceptions of risk and actual behaviour when in this environment. Whilst there have been studies examining risk behaviour inside prison, these tend to focus on the type and frequency of risk behaviour resulting in a paucity of knowledge on drug injectors' perceptions of risk. Given the risk behaviour that does occur, and has the potential to occur in prison, important issues are raised for policy. These issues are returned to in the following chapter. The final section of this chapter examines some studies of prison life, which can help to further understanding of the ways in which people behave when they spend time in prison.

UNDERSTANDING BEHAVIOUR IN PRISON FROM PRISON LIFE STUDIES

The substantial literature on prisons dates back to the work of early prison reformers during the eighteenth century, including Howard (1777) and Fry (1847). Since then, a number of classic studies on the lives of prison residents and staff have emerged. These studies are valuable as they can be used to inform understanding on contemporary social problems in prisons, including drug use.

This section engages with the prison literature and in particular draws on work that can lead to better understanding of people's behaviour. It does so by drawing on what are classed into two broad strands of the literature for the purposes of this chapter. The first suggests that individual behaviour is best understood in terms of an indigenous prison culture that shapes people's behaviour whilst inside prison. The second recognises that behaviour in prison will be influenced by features of people's lives both inside and outside prison. These two perspectives are considered in an attempt to inform understanding about drug injectors' behaviour in prison.

The Indigenous Prison Culture and Prison Behaviour

Clemmer's (1940) pioneering organisational study of a prison during the early 1930s demonstrates the ways in which individual behaviour can be understood within the context of a distinct prison culture. The prison culture consisted of, for example, traditions, habits, customs and rules. Clemmer (1958) developed the concept of 'prisonization' which is a subtle, secondary form of socialisation where all people in prison – although to differing degrees – learn to adapt and behave.

The process of prisonization occurs as people's lives are reshaped to suit the workings, both formal and informal, of prison. Formal aspects of the process include, for example, daily routines, the wearing of prison clothing, and the assignment of a prison number. On the other hand, informal aspects include the adoption of vocabularies, attitudes, beliefs and actions characteristic of prison life. The concept of prisonization is highly influential and remains in use. Its degree and nature have been explored in relation to, for example, the use of drugs (Winfrey *et al.* 1994; Peat and Winfrey, 1992; Thomas and Cage, 1977), violence (Stevens, 1994), the coercive prison environment (Thomas, 1977) and people's

transitions from prison to the wider community (Goodstein, 1970). For example, Thomas and Cage (1977) found that drug users report higher levels of prisonization than others. This was reflected in their opposition to the formal aspects of prison. However, Winfree *et al.* (1994) found that drug use was not related to increased prisonization when compared with other groups within prison. This study found that 'hedonistic' drug users, compared with people who use drugs for medication, rejected prison staff more than other groups, which could reflect some degree of prisonization.

Sykes (1958) identified the pains of imprisonment, referring to the difficulties people face in prison: the deprivation of liberty, of goods and services, of heterosexual relationships, of autonomy, and of security. The pains of imprisonment influence and shape the ways people cope and behave. People cope in a number of different ways and Sykes (1958) found certain behaviour characteristic of particular groups. 'Gorillas' for example cope with the deprivation of goods and services by stealing from others, whereas 'merchants' or 'peddlars' trade goods and services. 'Ball busters' on the other hand respond to the loss of liberty and autonomy on their lives by disobedience and assaults on prison staff and by creating regular disturbances.

It is important to recognise that people's behaviour in prison is heterogeneous as individuals in prison do not think and behave in the same way. Morris and Morris (1963) demonstrate that prison experience is far from uniform and varies considerably between individuals. They note, for example, that some people become prisonized in certain aspects of prison life, but few are wholly prisonized. Their work differs from previous studies by suggesting that some people learn to cope in prison by resisting attempts to make them conform to certain behaviour.

Prison Behaviour and Personal Identities

The studies presented in the previous section generally view behaviour as indigenous to and shaped by the prison environment. However, the approach is problematic as it depersonalises people's lives in prison. It treats individuals as lacking personal identity and autonomy, and with attitudes and behaviour generally 'cleansed' from outside influences. Clearly this is not the case. The people that make up prisons – both staff and residents – constitute a prison community (Worrall, 1996). They arrive from and return to the wider community which prisons serve (Roberts, 1994). It is, therefore, important to gain some understanding of people's lives as they move inside and outside prison.

Irwin and Cressey (1962) use three categories – thief subculture, convict subculture and legitimate subculture – to make explicit some of these considerations. First, they suggest that people in prison bring their own culture into prison with them. They term this the thief subculture although, of course, not everyone convicted of a crime will belong to a thief subculture. Second, the authors postulate convict subculture, which refers to beliefs and actions prevalent within prison. Third, a legitimate subculture refers to people who have rejected prison norms and remain generally isolated within prison. Irwin and Cressey (1962) argue people's behaviour in prison cannot be seen as arising solely from the prison environment but will be also be affected by other influences. For example, the prison vocabulary described in a number of prison studies – such as don't inform on another person and don't interfere with other people's activities – exists both inside and outside the prison. Jacobs (1977), for example, notes that when a number of gang members were imprisoned the prison culture changed. Similarly Hunt *et al.* (1993) found that the influence of new 'gangs' outside prison affected life inside prison leading to, for example, conflict and violence between these groups. Just as people's lives inside prison are

influenced by factors outside, people's experiences in prison will affect their lives upon release. Stevens (1994) addressed the question of whether prisonization would influence violent behaviour upon release from prison. These findings suggest prison experience does increase people's violent tendencies regardless of previous violent behaviour and could influence such tendencies both inside and outside prison. On this point Sim (1994a, p.116) argues that violence and domination occur in prison not as a product of the institution itself – although prison will shape people's behaviour – but, for example, in the case of men as part of a wider culture of masculinity:

[Prisons] are linked to that society by the umbilical cord of masculinity where similarities between prisoners and men outside may be more important than the differences between them in explaining sexual and other forms of violence against women.

Cohen and Taylor's (1972) study adds a further dimension to these arguments. They argue that the key to understanding adaptation to prison and its associated behaviour is to engage with individuals' biographies and ideologies. In contrast to earlier studies, Cohen and Taylor (1972) demonstrate how people employed a number of resistance techniques to 'make out' and 'fight back': self-protecting, campaigning, escaping, striking and confronting. They present a model that links these factors together, leading them to suggest that confrontation behaviour, manifest in a crime such as armed robbery, will be linked to an ideology of 'romantic anarchism' and similar aggressive tactics will be used in prison. In contrast, in less confrontational relationships that are more 'symbiotic', (people in this group typically being convicted for organised crimes), campaigning activities that aim to subvert the prison authorities will be engaged in. 'Outflanking' techniques as used in professional theft, will manifest themselves in cool hedonist ideology. Finally, the 'private

sin' of, for example, people convicted of sexual offences, will lead to withdrawn and retreated behaviour in prison characterised by an 'inner worldliness' ideology.

An approach that takes account of the history of the prison, the biographies of the residents and staff and their personal ideologies can help to understand, for example, risk taking where there are influences both inside and outside the prison environment. Cohen and Taylor (1972, p.125) quote Chris, one of their participants, who makes this explicit:

The lynchpin of this ideology is an ethic based on courage and the commitment to test it by risk taking in the quest for prestige and self-esteem, ranging from epitomizing gladiator virtues to challenging authority. ... The madness of all these institutions is that prisoners are allowed to operate on the same anti-social values that power crime outside. With no logical exploitation such as thieving or gangsterism available this largely revolves around the cult of toughness and prestigious rebel displays. The natural power struggle for social dominance that any group exhibits hots up in prison because the habitual outlets are blocked.

SUMMARY

Drug injectors come into contact with prisons for a number of reasons. Their risk behaviour within this environment raises important issues. Studies have sought to examine these issues but little is known about the ways in which people construct their ideas about risk within the prison setting. The short exploration of the prison literature demonstrates the importance of considering people's lives as processes as they move inside and outside prison. Some studies point to distinctive characteristics of prisons as an influence on people's behaviour. This perspective is valuable in recognising the ways in which prisons play a particular role and have influence on individual behaviour. For example, inside prison it was noted that, in contrast to people's previous behaviour outside prison, some people start or stop injecting drugs. Similarly, some men may engage in sexual encounters with other men inside prison but not in the wider community. Furthermore, these

behaviour are underpinned by some people, including drug injectors, perceiving behaviour within prison to be riskier than in the wider community. Thus, with reference to this indigenous prison culture and prison behaviour perspective it is clear that the prison environment influences, to differing extents, the ways in which individuals view and engage in certain forms of behaviour. However, this perspective does not recognise fully the fluidity of individuals' behaviour that transcends the prison and wider community environments. Emphasising these explanations can assist a fuller appreciation of people's behaviour inside prison. For example, many drug injectors enter prison each year and some continue to inject drugs whilst inside. As discussed in Chapter 2, previous behaviour is an important influence on continued drug injecting and, in particular, continued HIV risk behaviour. Inside prison it is clear that the prison environment influences types of behaviour but also, as discussed above, this behaviour can be distinctively more riskier than outside. For example, extremely poor quality injecting equipment is used inside prison much more than outside prison. This is a result of particular policy responses, which will be discussed in the following chapter.

Overall an emphasis should be placed on people's lives as they transcend both the prison and wider community settings and this emphasis can assist a fuller appreciation of people's behaviour inside prison. In this way, drug injectors' perceptions of risk outside and inside prison will be returned to later in this thesis. In the meantime, the following chapter examines the differing policy responses directed towards drug injectors outside and inside the prison setting.

– CHAPTER 4 –

RESPONSES TO DRUG INJECTING

INTRODUCTION

This chapter begins with an overview of policy responses to drug injecting and the risks of HIV outside prison. It then goes on to examine prison responses to drug injecting. To locate these issues, the chapter then goes on to explore some of the debates surrounding current health care policies and practices. The focus here is at an abstract level of analysis including the ‘prisoner or patient’ health care debate. To locate these issues further a policy case example, on PNSES, is used to highlight some of the inconsistencies in health care provision for drug injectors inside prison compared to provision received outside prison.

RESPONSES TO DRUG INJECTING OUTSIDE PRISON

In Britain, the first main response to HIV and drug injecting came from the Scottish Home and Health Department (1986). It recommended that individuals unable or unwilling to stop injecting should be provided with sterile injecting equipment together with the necessary support and counselling to enable them to reduce the risks from drug injecting and sexual behaviour. In England this was followed by a series of reports on HIV and AIDS by the ACMD (1988; 1989; 1993). In its first report the ACMD (1988) had no hesitation in supporting the Scottish recommendations. Recognising that HIV poses a greater threat than drug use *per se* the ACMD (1988) recommended a hierarchy of goals to deal with drug injection – primarily pursuing drug abstinence, then switching from drug injecting to oral drug administration and finally to avoid sharing injecting equipment. This reflects the adoption of some of the principles of harm reduction (O’Hare *et al.*, 1992;

Riley, 1994; Saunders and Marsh, 1999; Riley *et al.*, 1999). Riley *et al.* (1999, p.21) define harm reduction as:

A policy or program directed toward decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use. (Emphasis in original.)

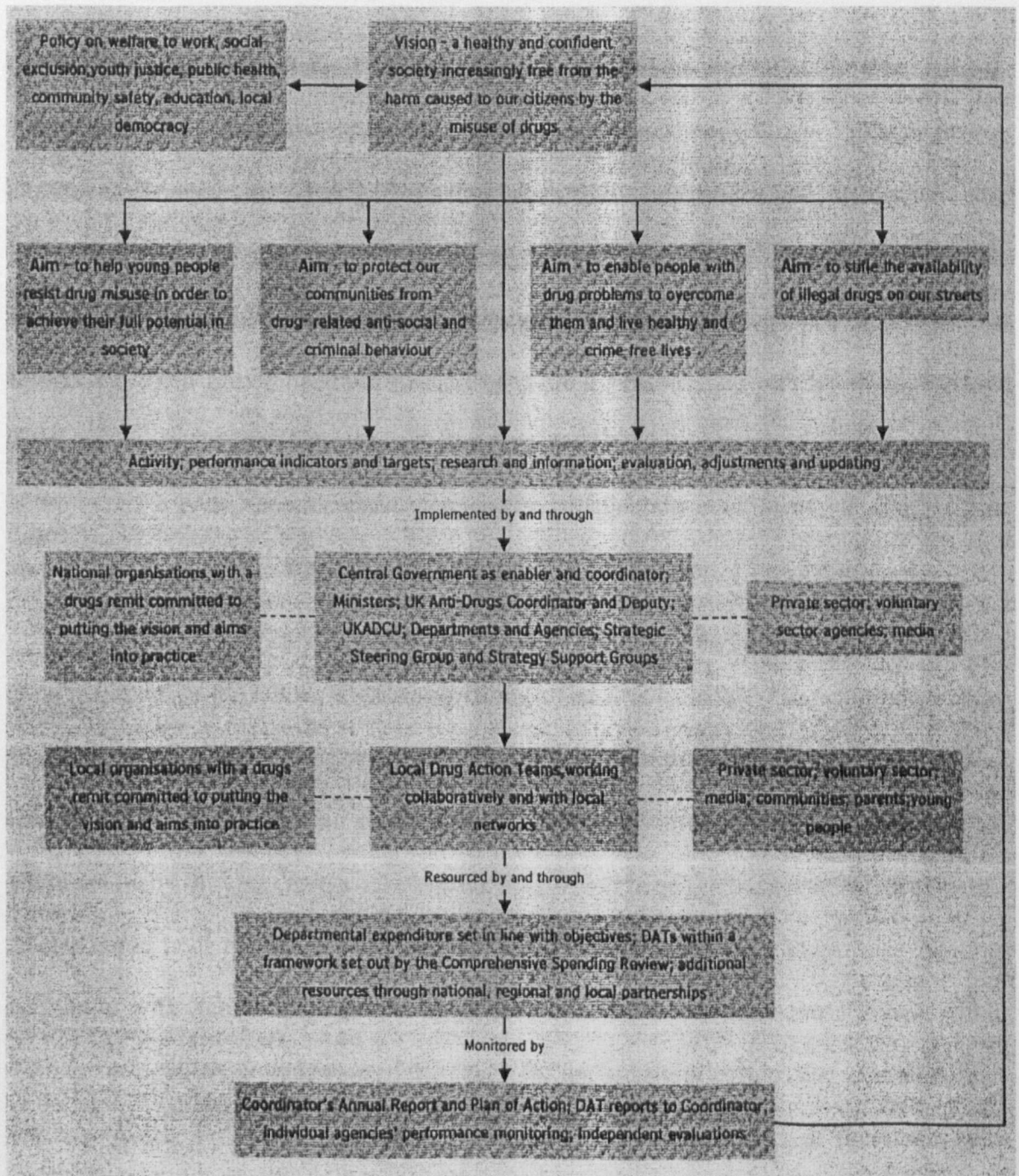
As a result of the emergence of HIV, support services for drug injectors increased, most notably in the development of CNSSES, substitute prescribing and HIV testing (ACMD, 1993). Reducing the spread of HIV and AIDS among drug injectors (Stimson, 1995) and the wider population (Berridge, 1996) became an important focus for policy.

To further reduce the spread of HIV and AIDS one of the main targets for health services specified in the 1992 White Paper 'The Health of the Nation' was to reduce the incidence of needle and syringe sharing among drug injectors and to reduce the incidences of sexually transmitted infections (Department of Health, 1992). Three years later the Government launched its White Paper 'Tackling Drugs Together' (Lord President on the Council and Leader of the House of Commons *et al.*, 1995). The 1995 strategy continued to emphasise the need to reduce the health risks associated with drug use, but also encompassed steps to reduce drug-related crime by enforcing the law on drug supply and trafficking and by introducing education and prevention initiatives in schools and the wider community (Prison Service, 1995a). In 1998 the Government launched a ten-year drug strategy (Cabinet Office, 1998). The new strategy recognised some of the weaknesses of the first strategy, noting, for example, that "it treated drug misuse largely in isolation from other social and environmental factors" (Cabinet Office, 1998, p.9). As shown in Figure 4 the drug strategy has four elements: first, to prevent drug use; second, to protect

communities from the consequences of drug use, including criminal activities; third, to treat people with drug problems; fourth, to reduce the availability of drugs.

Figure 4. *The Government's Ten-Year Drug Strategy*

(Source: Cabinet Office (1998, p.5). Reproduced with the kind permission of the Controller, Her Majesty's Stationery Office.)



Stimson (1992) reflects the ACMD (1988) hierarchy of goals by noting that HIV prevention strategies can aim to discourage certain types of risk behaviour (such as injecting equipment sharing) by providing sterile materials or by discouraging the injection of drugs, for example through substitute prescribing. It is perhaps a combination of these interventions that work best in practice.

CNSES offer freely available sterile injecting equipment in return for used equipment. They were established in 1986 when a pilot of the schemes and an evaluation was introduced (Stimson *et al.*, 1988). Since then schemes have expanded and are available in a wide range of community settings including through drug services, pharmacies, mobile projects and outreach workers. CNSES, however, do much more than exchange injecting equipment, often providing more general social and personal support for drug injectors (Stimson *et al.*, 1991). Whilst not all attenders of CNSES adopt risk reduction strategies (Klee *et al.*, 1991b), the increased availability of injecting equipment via CNSES has assisted drug injectors to adopt safer injecting practices (Stimson, 1995; 1996b).

Drug treatment in the UK is diverse (MacGregor and Smith, 1998). For people dependent on illegal drugs, the prescribing of substitute drugs is an important component of harm reduction that has become an integral part of drug treatment strategies (Willis, 1991). There are many different forms of substitute drug prescribing (Department of Health *et al.*, 1999). These help to reduce drug dependence and the effects of withdrawal symptoms associated with heroin dependence. Two main forms of substitute prescribing include maintenance, which provides substitute drugs for an indefinite period, and detoxification, which regularly reduces the amounts of drugs given. In both types of prescribing the alleviation of withdrawal symptoms do not produce the 'high' that might be experienced

from the use of illicit drugs. Methadone has been the main drug used to relieve withdrawal symptoms (Marsden *et al.*, 1998). However, there are other drugs such as buprenorphine (Kosten *et al.*, 1992) and lofexidine (Bearn *et al.*, 1996) that are also used in place of methadone. The prescribing of methadone has reduced the harms associated with drug injection. For example, it has been found to reduce infection-related risk behaviour and drug-related crimes (Marsch, 1998). However, the prescribing of drugs is controversial and not without its problems (Ricklin, 1996). For example, it raises a number of dilemmas for prescribers (Bond *et al.*, 1999) and methadone has been implicated in a high number of deaths (Newcombe, 1996).

For people who have taken risks HIV testing has been widely available in the UK since 1985 (Wellings *et al.*, 1994). As a HIV reduction strategy testing will work when individuals take the test and make appropriate changes to their behaviour as a result. Considerable importance is attached to HIV testing, as the ACMD (1993, p. 51) point out:

We consider that in view of the possible clinical benefits of early diagnosis of HIV infection, people who think they have been at risk should be encouraged to consider having a test. (Emphasis in original.)

Early and appropriate interventions, in the UK at least, to reduce the spread of HIV and AIDS are understood as some of the crucial factors in averting the spread of HIV and AIDS (Stimson, 1995; 1996b). Stimson (1996b) notes that there has been a positive shift in drug injectors' risk behaviour resulting in low levels of HIV nationally and averting an epidemic. In rejoinder to Stimson (1996b) however, McKeganey (1996) argues that the success of harm reduction strategies has focused, rather narrowly, on levels of HIV infection. Responses have not fully recognised, or understood, the extent to which behaviour is liable to change, within and between drug injecting communities over time.

Thus, any aversion of risk behaviour and subsequent levels of HIV infection may not be permanent. As McKeganey (1996, p. 1993) goes on to argue:

The scenario we may witness, then, may be one of small pockets of endemic HIV infection, rather than the national epidemic of HIV among UK injectors that was once feared.

As hinted at by McKeganey (1996), a 'place' dimension of HIV risk behaviour may well become of paramount importance in the future. The importance of 'place' and health has been recognised (Blaxter, 1990; Macintyre *et al.*, 1993; Smoyer, 1998). Similarly, there are, for example, existing reports on geographical variations in drug use and levels of HIV and AIDS (Bloor *et al.*, 1994). Important for this thesis is the way one particular place, namely prisons, responds to drug injectors.

RESPONSES TO DRUG INJECTING INSIDE PRISON

Prison health care is important for all people in prison but there are individuals and groups with particular needs. The Government White Paper, 'Custody Care and Justice', identified certain groups as having specific health care needs and these groups included drug users and people at potential risk of being or already infected with HIV and AIDS (Home Office, 1991). The health care needs of these important groups are reflected in policy documents such as the Prison Service Directorate of Health Care's 'Health Care Standards' (1996) and the 'Report of the Director of Health Care' (1998). Concerns have been raised that the health care needs – whether acute or chronic – of drug users (Turnbull *et al.*, 1994; Polkinghorne, 1996) and people with HIV and AIDS (Thomas, 1990; Turnbull *et al.*, 1991; Thomas and Costigan, 1992; Young and McHale, 1992; Turnbull *et al.*, 1993) are not

always met inside prison. One way of understanding these issues is by considering the 'prisoner or patient' debate, which will be dealt with later in this chapter.

Generally the use and injection of drugs inside prison remained off the policy and political agenda until 1993. At this time drug use in prison was subjected to increased political attention, which Seddon (1996) suggests emerged from reports pointing to high levels of drug taking in prison. Political attention was most notable when in 1993 the then Home Secretary, Michael Howard, gave his 'prison works' speech to the Conservative Party Conference in October. This sparked a series of policies aimed at 'toughening' criminal justice (Seddon, 1996). These changes coincided with financial cutbacks for work, welfare and education programmes inside prison (Mills, 1995a), which MacDonald (1997) argues was not the most appropriate time to make changes to prison drug policy.

The national strategy on drug use began to satisfy the political agenda, in which one of the Government's objectives was "to reduce the level of drug misuse in prison" (Lord President of the Council and Leader of the House of Commons *et al.*, 1995, p.1). A separate Prison Service (1995, p.2) strategy drawn up in line with the overall strategy gave more details, which were aimed at:

- reducing the supply of drugs
- reducing the demand for drugs in the prison and rehabilitating drug misusers
- measures to reduce the potential for damage to the health of prisoners, staff and the wider community, arising from the misuse of drugs.

Supply control measures include increased perimeter security; the searching of visitors and the provision of lockers for visitors' hand luggage; the use of sniffer dogs increased surveillance, including closed circuit television during visits; the searching of people after

visits before they return to the prison wing; and the imposition of 'closed visits' for people found to have committed a drugs offence in prison. To reduce the demand for drugs inside prison, strategies include the identification of individuals using drugs and the provision of treatment, counselling and support.

Commissioned evaluations of prison drug services (Farrell *et al.* 1998; Mason 1998) informed 'The Review of the Prison Service Drug Strategy' (Prison Service, 1998a). This review was commissioned in September 1997 by the Prison Service and conducted by its staff and reported in May 1998. The central recommendation made by the Prison Service (1998a, p.24) was that "the basic structure for tackling supply, demand and health consequences should remain *intact*" (emphasis in original). During April 1998 the Government had launched its ten-year drug strategy that continued to tackle drug use in prison (Cabinet Office, 1998). Taking on board the recommendations from the review and again constructed around the aims of the overall Government strategy, in May the Prison Service (1998b, p.1) published its new drug strategy which:

[R]emains *wholly committed* to the reduction of illegal drug use in prisons, to promote a safe and healthy environment for those who live and work in them.
(Emphasis in original.)

As in the overall government drug strategy (Cabinet Office, 1998), the health risks associated with drug use inside prison were afforded some attention by the Prison Service (1998b). However, these were packaged within other concerns and a much stronger emphasis on tackling drug supplies, punishing and, in departure from the earlier Prison Service (1995a) strategy, on 'rewards' for remaining drug free, notably in the provision of incentives and privileges. The Prison Service (1998a, p.11) review was also positive about the strategies used to reduce the supply of drugs in prison, noting, for example:

Recent years have seen increased emphasis on security procedures and some real benefits have been evident in tackling the problem of drugs entering prisons.

To continue these efforts one particular aim of the present Prison Service (1998b, p.7) drug strategy is to “disrupt the distribution networks for illegal drugs in prisons”. In January 1999 a further attempt to curb drug supplies was announced with the automatic ban of visitors caught smuggling drugs into prison (Travis, 1999). The Anti-Drugs Co-ordinator published the ‘First Annual Report and Action Plan’ in May 1999 and future policy objectives include “improved security procedures in prisons to detect drug smuggling” (Hellawell, 1999, p. 18). Furthermore, prisons will:

[P]ut in place more dogs trained to detect drugs; and more CCTV [close-circuit television] in prison visits areas; obtain better information about supply routes and availability of drugs to prisoners; discourage families from smuggling drugs. (Emphasis in original.)

The supply and availability of drugs in prison have raised important concerns for the government (Lord President of the Council and Leader of the House of Commons *et al.*, 1995; Cabinet Office, 1998), the Prison Service (1995, 1998a; 1998b) and its advisors (ACMD, 1993; 1996; Ramsbotham, 1998; Hellawell, 1999; Woodhead, 1999). Substantial resources have been targeted towards tackling drug use inside prison. The comprehensive spending review for 1999 to 2002 in England and Wales provides a total of £76 million (House of Commons Hansard Debates for 19th May 1999, Part 17). The methods people use to introduce drugs and injecting equipment into prisons together with associated policy responses are frequently given media attention, albeit contentiously, as illustrated in Box 2.

Box 2.

Selected Newspaper Headlines Concerning the Prevention of Drugs and Injecting Equipment Entering Prisons

PROBATION OFFICERS REJECT JAIL SEARCHES*

Babies stripped in jail drug searches**

Union acts over jail searches***

Jails to step up security on phones****

**1,300 held taking
drugs into prisons*******

**Jail ban for visitors
who carry drugs*******

Notes: **The Independent on Sunday*, 3rd October, 1996, p.2. ***The Independent*, 14th September 1996, p.5. ****The Independent*, 28th December 1996, p.8. *****The Independent*, 27th November 1998, p.14. ******The Guardian*, 19th June 1997, p. 12. ***** *The Guardian*, 26th January 1999, p. 9.

In recent years the number of prison visitors arrested for smuggling drugs into prison has increased, as shown in Table 9. Similarly, the number of sentenced prison residents proved

to have committed drug-related offences in England and Wales (excluding fine defaulters) has also risen. In 1994 3,483 people were caught, in 1995 4,729 people were caught and by 1996 6,100 people were caught (House of Commons Written Answers for 22nd May 1997, Part 1).

Table 9.

Prison Visitors Arrested for Drug Related Offences, 1993 to 1998.

(Source: House of Commons Hansard Written Answers for 17th December 1998, Part 58.)

Year	Number of Prison Visitors
1993	310
1994	921
1995	1410
1996	1270
1997	1130
1998*	831

Notes: *Data refers to January to September only.

There is a range of drug offences, the most common offence proved against prison residents is the unauthorised use of drugs, including detection through MDT (House of Commons Hansard Written Answers for 17th December 1998, Part 58). Of the drugs found in prisons, cannabis resin, followed by heroin, are the most common, as detailed in Table 10.

Table 10.

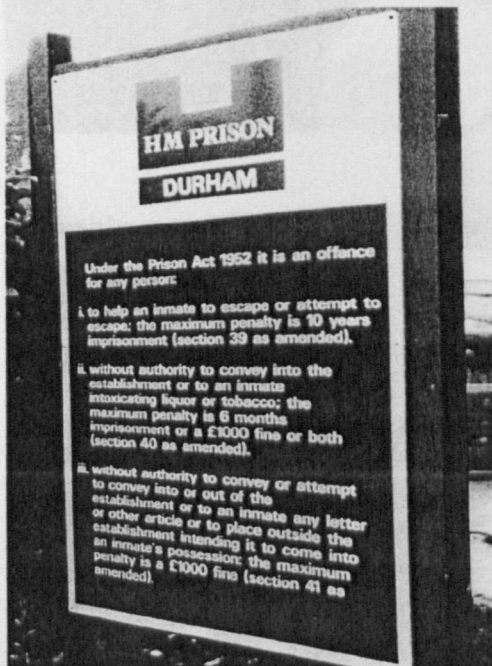
Types of Drugs Found in Prisons, 1994 to 1998.

(Source: House of Commons Hansard Written Answers for 28th June 1999, Part 18.)

Type of Drug Found	Number of Drug Seizures				
	1994	1995	1996	1997	1998
Amphetamines	120	242	197	161	152
Barbiturates	70	82	56	41	23
Cannabis Resin	4,859	6,442	4,897	4,093	3,054
Cannabis Herbal	252	288	223	240	188
Cocaine	108	143	97	98	86
Crack Cocaine	0	12	21	32	39
Heroin	350	678	1,034	992	1,079
LSD	49	28	18	11	11
Other	406	643	673	548	454
Total	6,214	8,561	7,216	6,216	5,086

Photograph 11.

Selected Extracts from the Prison Act are Displayed in Prison Grounds



Photograph 12.

At a Visitors' Entrance Notices and Newspaper Cuttings Warn People not to Bring Drugs into Prison



Arguably, one of the most highly contested policies contained within the Prison Service (1995; 1998b) strategies is MDT. This policy requires, by law, people resident in prison to provide a urine sample or other type of specimen (non-pubic hair, sweat or saliva but not blood or semen) for the testing of illicit drugs. From the outset MDT was formulated to satisfy a particular political agenda and reflects the political rhetoric of 1993 (Seddon, 1996). As Travis (1996, p.26) suggests, MDT was an “official admission” to drug use. However, the policy was not based on evidence (Gore and Bird, 1998). On the contrary it was regarded as an information generating device, as the Prison Service (1995a, p.7) explains:

It [MDT] will also provide, for the first time, objective management information on the scale, nature and trends of drug problems in each prison establishment, which can be used to guide both central and local drug strategies.

MDT was part of 'demand reduction' which aims to "re-enforce the message to all prisoners that if they misuse drugs they will now run an increased risk of being caught and punished" (Prison Service, 1995a, p.7). The Criminal Justice and Public Order Act (1994) provided amendments to the Prison Act (1952) which confer power upon prison officers to require people to produce a urine or other form of sample for drug testing. Samples are tested for opiates, cocaine, amphetamines, methadone, benzodiazepines, cannabis, barbiturates, and a small number of samples are tested for LSD (the latter are restricted due to expensive testing procedures).

Random MDT was undertaken each month on ten per cent of residents in each institution. However, not all prisons fulfilled their quota of the tests (MacDonald, 1997). There are additional forms of MDT. People may be tested as part of a risk assessment before being considered for certain activities such as release on temporary licence. People can be required to provide a sample for drug testing on reception, although no disciplinary action can be taken for a positive test result on reception because the use of drugs would have occurred outside prison. Prison officers who suspect individuals of using drugs, for example, because they are found to possess injecting equipment, can require people to provide testing samples outside the random procedures. The Prison Service (1995a, p.8) recognises explicitly that these additional procedures "help to concentrate measures on those prisoners who misuse drugs". People who continually test positive for drugs can be tested more frequently on a separate testing programme in an effort to "concentrate further anti-drug measures on persistent offenders" (Prison Service 1995a, p. 8). An important,

although arguably overlooked (Prison Service, 1998a), element of the policy was to identify individuals in need of drug treatment. People can voluntarily enter into drug treatment programmes and be placed on 'drug-free' wings where testing occurs more frequently and the maximum penalties for testing positive on these wings are much harsher.

A change to the Prison and Young Offender Institution Rules means that people can be disciplined for refusing to provide a sample, or for providing adulterated or substituted samples. People unable to provide a sample can be segregated and held for up to five hours until they do so. People who refuse to provide a sample will lose 28 days loss of remission.

The maximum penalty for testing positive for cannabis was the imposition of 14 additional days to a sentence with the detection of Class A drugs, including heroin, adding up to 21 days to a sentence. In addition to these measures, people testing positive can lose privileges or home leave opportunities. People may be fined, segregated and put on closed visits.

The evaluation of MDT by Farrell *et al.* (1998) informed the Prison Service (1998a) review, which made a number of recommendations in line with the stated objectives of MDT. First, to allow prison establishments flexibility in the level of random MDT undertaken (from between 5 per cent to 15 per cent of the prison population). Second, to promote more flexible penalties for positive tests including the need to shift penalties away from people serving additional days, especially for the use of cannabis, to incentives and earned privileges. Third, to promote mandatory frequent testing for people testing positive to Class A drugs. Taking on board the recommendation from the Prison Service (1998a) review, the current Prison Service (1998b) drug strategy continues to employ MDT.

As part of the 1995 Prison Service (1995a) strategy, other health care interventions for drug injectors are also included, namely substitute drug prescribing and the provision of decontaminates to clean needles and syringes. These two issues are briefly outlined below and will be returned to later in this thesis.

Substitute drug prescribing needs, as a health care intervention, should remain an important consideration inside prison (Dolan and Wodak, 1996). Some studies have found prescribing in prison to be inadequate (Carvell and Hart, 1990; Kennedy *et al.*, 1991; Turnbull *et al.*, 1994; Brooke *et al.*, 1998). In the community, unequal policies and practices can affect who receives methadone (Bell *et al.*, 1992; Daunno and Vaughn, 1992) and the same can apply inside prison (Ross *et al.*, 1995; Polkinghorne, 1996; Simpson, 1999). Where adequate substitute prescribing is available to meet people's needs it has been found to reduce drug injecting harms in, for example, Australia (Dolan *et al.*, 1996a; 1998), Switzerland (Nelles *et al.*, 1997) and Germany (Meyenberg *et al.*, 1997). In England the Prison Service (1995a, p. 22) recognises that medical discretion based on individual assessments of need should determine the type and amount of substitute drugs prescribed:

[C]ontinuity of care in methadone treatment [between prison and the wider community] will be of particular benefit to remand inmates and those serving short sentences but methadone treatment should not be restricted to these groups if there are sound clinical reasons for its use.

However, the Prison Service (1995a, p. 21) places emphasis on drug detoxification rather than maintenance prescribing by considering it inappropriate to prescribe methadone “on a longer term basis in a prison setting”. The emphasis on drug detoxification rather than maintenance is supported by the ACMD (1993; 1996) and is also reflected in the Prison

Service Directorate of Health Care (1996) 'Health Care Standards'. The British Medical Association (1997) note that outside prison short-term detoxification (with short-term referring to a time period of between three and six months) was a feature of prescribing policy and practice during the early 1980s. Since then there has been a move back towards maintenance prescribing, which is more characteristic of the 'British system' of drug prescribing (MacGregor and Smith, 1998).

Inside prison, however, the Prison Service Directorate of Health Care (1996) states that opiate users, for example, can expect a detoxification programme to help achieve abstinence. They consider that lethal doses of methadone can be administered and note the dosages at which methadone in prison should be prescribed. These begin between the range of 20mg and 40mg, with the duration of the detoxification between 10 to 14 days and daily reductions not exceeding 5mg. These are conservative measures in the detoxification of dependent drug users. The amounts of drugs prescribed and the type of treatment are crucial determinants to successful prescribing (Hartel *et al.*, 1995; Ward *et al.*, 1996). For example, Ward *et al.* (1996) identify methadone as being most effective when prescribed at dosages of between 60 to 100mg per day and when long-term maintenance rather than detoxification is the aim. In Australia, Dolan *et al.* (1998) found that prison methadone maintenance reduced drug injectors' risk behaviour when prescribed at moderately high dosage and prescribed during the entire period of imprisonment. Good clinical practice should, of course, establish medical history before prescribing any drug. This is particularly important with regards to methadone to prevent fatal drug overdose (Ward *et al.*, 1996). Deaths have been attributed to prescribing methadone in prison without checking medical history (Dyer, 1999). This could reflect wider relational

problems between the NHS and HCSP, where contact between the two has been noted to be rare (Woolf and Tumin, 1991).

As discussed earlier, when people share injecting equipment it is important that it is cleaned. This is especially important as sterile injecting equipment is not formally provided in British prisons, which will be discussed later in this chapter. Advisory groups have endorsed the provision of decontaminants in prison (ACMD, 1988; AIDS Advisory Committee, 1995; ACMD, 1993; 1996). In 1993 the CoE (1995, p. 10) recommended that decontaminants should be made available to prison residents “not only to protect them against transmissible diseases, but also to enable them to observe the rules of hygiene”. The Prison Service (1995a) drug strategy ‘Drug Misuse in Prison’ introduced the availability of disinfecting tablets. It stated:

As a measure towards improving hygiene generally, and reducing the possible spread of hepatitis and HIV in particular, disinfecting tablets are to be made available to all prisoners/young offenders together with information leaflets on their use.

This is supported by advice to individuals in Prison Service (1995b; 1995c) health promotion packages that provide information on how to clean needles and syringes with disinfecting tablets and bleach. However, it was later reported that decontaminants had not been made available due to concerns about their safety (House of Commons Hansard Written Answers for 25th June 1998, Part 9; Prison Service Directorate of Health Care, 1998).

Past and current policies targeted at drug injectors inside prison have, therefore, been preoccupied with preventing and punishing drug use rather than reducing the HIV risks

associated with drug injection. In addition, there are conflicting responses to drug use inside and outside prison. One means of understanding and locating these issues within social policy is by turning to broader prison health care debates.

‘PRISONER OR PATIENT’?: PRISON HEALTH CARE POLICIES

Prison can provide a key role in providing people with health care that they might not otherwise receive in the wider community (Levy, 1997). In the UK this is supported by, for example, free prescriptions (at the point of delivery) to all. People in prison who are physically ill and require transfer to the National Health Service (NHS) or need to see a consultant spend less time waiting for appointments and admissions than people in the general population (Hall, 1997). This section of the chapter engages with the ‘patient or prisoner’ debate to help contextualize issues presented earlier as well as to contextualize the policy case example in the following section.

Prison disturbances in April 1990 and the subsequent inquiry report (Woolf and Tumin, 1991) prompted the White Paper ‘Custody, Care and Justice’ that “charts a course for the Prison Service in England and Wales for the rest of this century and beyond” (Home Office, 1991, p, 3). It is noted that “prisoners should expect the same standards of health care as those provided by the National Health Service” (Home Office, 1991, p, 62). These comments reflect long held principles that prison health care should be similar to that provided in the community. The United Nations (1955), for example, set minimum rules for the care and treatment of people in prison. These were later revised by the CoE (1973) and point to prison health care being organised in close relation to health care in the wider community. However, barriers to effective prison health care exist, notably in the ambivalent relationship between the community and prison (Roberts, 1994). Yet in prison

where there are, for example, large numbers of people suffering from poor physical (Bridgwood and Malbon, 1995) and mental (Birmingham *et al.*, 1996) health it is vitally important that prison health care meets fully the needs of all its inhabitants who, as noted earlier, include a considerable number of drug injectors.

A CoE report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1991) expressed concern as to the quality of health care that people in English prisons received. They found, for example, that during reception procedures where people must be medically examined, the conditions were not private and this compromised confidentiality. In addition, the poor working conditions of the staff, coupled with time pressures to complete examinations quickly, compromised good health care delivery.

An inspection of 19 prisons in England and Wales by Reed and Lyne (1997) found that the Prison Service Directorate of Health Care (1996) standards were not always being met. They found that some health care in prison was good and of similar quality to that expected from the NHS, despite prison medical staff working in quite poor conditions. But the provision of health care was variable. Whilst recognising that medical staff are fully trained to undertake their work they note that staff are not sufficiently trained to deliver the same quality of care that would be provided in the NHS. Again working conditions prevented effective medical examinations in some busy prisons where up to 100 new people could arrive each day. In addition, prisons were not conducting needs assessments and often did not know their overall budgets for health care. Considering that since 1992 governors have been responsible for purchasing health care Reed and Lyne (1997) remark

that it is difficult to see how effective purchasing decisions are made if health care decisions are not based on an understanding of health care needs.

The provision of health care in the wider community is, of course, also problematic (Willman, 1998). Provision can vary from authority to authority and between individual providers. The belief that the NHS provides the 'gold standard' of health care is clearly not the case (Hall, 1997). There are also concerns about the disparities in provision for individuals as they move in and out of prison. These concerns have been expressed for people with diabetes (MacFarlane, 1996) people with mental health problems (Hargreaves, 1997; Pierzchniak *et al.*, 1997) and drug users (Turnbull *et al.*, 1994; Polkinghorne, 1996) and, no doubt, could be extended to other groups of people. Polkinghorne (1996, p.40) found inconsistent drug treatment for people as they move in and out of prison:

We fully acknowledge that the Prison Service faces difficult control and management problems. However, written evidence to the Task Force and some evidence from our own visits have caused us to be very concerned about the treatment of some drug misusers within the prison system. There is a lack of consistency of treatment also between prisons, and between prison and the community, leading to a lack of continuity for drug misusers passing from one to another. Where drug treatment is provided within prison, arrangements for continuity of care on release are often sadly lacking. Prison offers an important opportunity to address the problems of drug misuse which at present is largely missed.

The Prison Medical Service (PMS) has a long history (Sim, 1990). In the past discourses on less eligibility, that is health care inside prison being set lower than outside prison, operated because of an overriding emphasis on discipline, control and punishment. Sim (1994b) argues that these discourses continue to influence prison health care. To redress this there have been calls for a closer alliance between prison and community health services. Some commentators have argued for the fusion between these two services.

Smith (1984) notes that when the NHS was founded in 1948 it presented policy makers with an opportunity to fuse the PMS with the new NHS. It did not happen but rather the PMS was set within the Home Office (Ralli, 1994). In 1964 a Home Office (1964) working party considered how PMS and NHS relations and organisation might be improved. A number of professional associations called for the merger of these two services but the recommendations were not taken up. In 1972 a committee was established to examine health care for people with mental health problems in prison (Home Office and Department of Health and Social Security, 1975) and in 1978 a Home Office (1979) inquiry reconsidered proposals for the merger of the two services with the support of major healthcare bodies. But on both these occasions the proposals were rejected. Radical reform of the PMS was expected (Squires, 1996) after a Home Office (1990) scrutiny in 1990. This did not occur, but the PMS was renamed as the Health Care Service for Prisoners (HCSP) to reflect the fact that health care in prison needs to emphasise health promotion and preventative health care whilst remaining part of the Prison Service (Home Office, 1990). Wool (1994) reflects this, noting that it places greater emphasis on individuals to take responsibility for their own health.

There are many arguments for and against the assimilation of the HCSP by the NHS (Smith, 1984). An important issue is whether people in need of health care in prison are treated as patients or as 'prisoners'. This has been addressed in a discussion paper by Ramsbotham (1996), the Chief Inspector of Prisons. The arguments centre on the fact that health care in prison does not match that provided by the NHS. The paper argues that few prison establishments have trained health care managers with an understanding of how health care should be provided, managed and linked with the NHS. It maintains that people in prison requiring health care should be seen as patients and given the same care as

provided in the community. The paper recommends that a timetable for reform should begin immediately with the NHS taking responsibility for the commissioning and provision of care. It notes that it is unsound for the prison service to replicate the function of the NHS and that when competing for scarce resources the smaller prison service will inevitably lose out. Furthermore, Ramsbotham (1996, p,7) acknowledges that people in prison are part of the community and will return to wider society:

Prisoners were members of the wider community before their reception into prison and their health care was the responsibility of the NHS; the vast majority will return to that community and to the NHS on their release. It is illogical that, during the time that they are prisoners, their health care is provided through separate channels. It is also necessary to recognize the interdependence of health care in prisons and wider health care.

Smith (1992) argues for integration on three grounds. First, NHS purchasers have developed purchasing skills that the prison service cannot match. Second, NHS purchasers have access to a wide range of public health skills lacking in prisons. Finally, NHS purchasers can purchase for prisons at the same time as for the rest of the community, which could lead to a broad range of skills being made available at better prices, than if prisons were to do purchasing on their own.

As in the past (Smith, 1984), arguments for the assimilation of the NHS with the HCSP have been rejected. In Ramsbotham's (1996) discussion paper Longfield, the then Acting Director of Prison Health Care, was provided with the opportunity to respond, and rejected the recommendations. A list highlighting the potential bureaucratic, technical and practical difficulties that would arise from such reform was used as a basis for this rejection. The position of the Prison Service was further reinforced by a mention in a later annual report, which stated that "we do not consider it essential for prison health care to become part of

the NHS in order for standards to be improved” (Prison Service Directorate of Health Care, 1997, p, 1). This has been supported by others working within prison healthcare. Hall (1997) points to a range of benefits that people in prison receive that are not available in the NHS – for example, people can be seen by a prison medical doctor with full access to medical records at unusual working hours. Recently a report from the Prison Service and NHS recommended a formal partnership to be established between the NHS and HCSP (Joint Prison Service and National Health Service Executive Working Group, 1999). However, the joint partnership did not recommend the assimilation of the HCSP by the NHS that continues to be argued for (Smith, 1999).

Since 1992 there has been a greater emphasis on prisons contracting-in health care services (Home Office, 1992). Wool (1994) argues that the NHS is not in a position to meet fully the needs of the HCSP and considers contracting-in as an important means of improving prison health care. Reed and Lyne’s (1997) inspection also supports contracting-in, noting that health authorities are keen to play a role in purchasing health care for prisons. Some large prisons have full time medical officers whilst others contract-in services to general practitioners. Reed and Lyne (1997) found that health care provision was of a particularly high quality when it was contracted-in locally to an NHS general practice. They report, for example, that additional clinical services were provided at no extra cost. However, Sim (1994b) considers contracting-in with caution. Sim (1994b) argues that contracting in fails to confront the principles of less eligibility operating inside prison. In addition, contracting-in places greater emphasis on individual rather than collective health care that can lead to unequal provision, especially for the most vulnerable people inside prison. For groups, such as drug injectors, and issues, such as the spread of HIV, the principles of individual (Wool, 1994) health care may fail. This is because essential and established

components of harm reduction strategies in operation outside prison are not available to people spending time inside prison.

The 'patient or prisoner' debate is a long-standing one and highlights implications for health and wider social policies as people move in and out of prison. Prisons are not physically or psychologically healthy places, which as Sim (1990; 1994b) argues is because of dominant discourses on discipline and control. Similarly, as Squires (1996, p.1161) points out, it is important not to ignore the host of wider structural factors that prison health care policies need to take account of:

No matter how high the quality of healthcare offered to prisoners, if the regime and conditions within prisons cannot be influenced then any benefits from health services will be rapidly lost when the patient, when well, again becomes a prisoner.

Thus improvements to prison regimes more generally (Tumin, 1993) are integral to providing people with a healthy environment in which to live when they spend time in prison. To improve health care, policies inside prison need to be consistent with those outside. People in prison have a wide range of health care needs and there is evidence to suggest that these needs are being met inconsistently. The organisation of health care in prison has long been a contentious issue and in England, at least, there are strong arguments for the reform of prison health care. The fusion of the HCSP and the NHS which has been considered here would go some way to redressing the unequal balance of health care for people inside and outside prison. This is one of a number of proposals that have been considered in the past and remain as pertinent now as they did then. These discussions are not new and this reflects the historical roots of prison health care and highlights how the problems of the past can be perpetuated. People in prison are part of the

wider communities that prisons serve; it remains inappropriate that health care is provided differently in each.

The focus of this section has been to locate prison health care within wider social policy debates. Attention now turns to one particular strategy – needle and syringe exchange schemes – as an illustrative policy case example of drug injectors’ special needs as regards HIV risk reduction inside prison. The topic of PNSES is an important topic that has been neglected from serious UK policy development.

THE CASE OF NEEDLE AND SYRINGE EXCHANGE SCHEMES

Harm reduction and drug prevention are important both inside and outside prison (Uchtenhagen, 1997). The WHO (1993) and CoE (1995) recommend that harm reduction measures inside prison should be broadly equivalent to those provided in the wider community. However, it does not necessarily follow that interventions that were appropriate outside prison will be appropriate and effective inside prison (ACMD, 1996; Turnbull *et al.*, 1996; British Medical Association, 1997). Nevertheless, there are gulfs between these two settings, notably in health care provision for drug users (Polkinghorne, 1996).

Very few countries operate PNSES. Sterile needles and syringes for drug injection were provided in 1988 by a medical officer at the female prison of Hindelbank in Switzerland. However, a prison inspector discovered this practice and prohibited its continuation (Paget, 1998). Further acts of ‘medical disobedience’ (Nelles and Harding, 1995) occurred in Switzerland during 1992 when a medical officer working within the male prison of Oberschöngrün began distributing sterile needles and syringes (Nelles and Harding, 1995;

Paget, 1998). In 1994 the Swiss Government established a pilot PNSES in Hindelbank prison (Nelles and Fuhrer, 1995; Nelles *et al.*, 1997; 1998; Paget, 1998). Since then PNSES have expanded to other prisons in Switzerland but are not available in all prisons (Nelles, 1997; Paget, 1998). Portuguese prisons began distributing needles and syringes in 1995 (Gaspar de Almeida and Encarnação, 1998) and in 1996 two prisons in Northern Germany were involved in a two-year pilot of the schemes (Meyenberg *et al.*, 1997).

In Switzerland needles and syringes were first distributed by medical officers in face-to-face contacts on a strict one-for-one basis (Nelles and Harding, 1995). The subsequent pilots in Switzerland (Nelles and Fuhrer, 1995; Nelles *et al.*, 1997, 1998) and also in Germany (Meyenberg *et al.*, 1997) have used automatic dispensers to exchange one sterile set of injecting equipment for one used set. Whilst some countries including Canada (Hankins, 1998) are beginning to consider piloting PNSES, most countries do not formally provide sterile needles and syringes for drug injection inside prison (Jürgens, 1996).

A number of political, ethical and practical considerations are raised by the practice of supplying drug injectors with sterile needles and syringes in the community (O'Brien, 1989; Loue *et al.*, 1995). Similarly, PNSES are controversial and noted by Nelles *et al.* (1997, p.41) as "highly disputed everywhere". The PNSES debate generally centres on a number of main issues, many of which are similar to those rehearsed on CNSES, which have wider resonance with debates on the supply of condoms in prisons (Cregan *et al.*, 1996). The questions addressed in this chapter section are by no means exhaustive but are selected to represent the range of general and specific issues that surround PNSES debates. The following six questions will be considered: are PNSES unrealistic and unpopular?; do PNSES conflict with the duties and principles of the prison service and its staff?; do

PNSEES affect levels of drug use and drug injection in prison?; would PNSES affect levels of infections?; will drug injectors use PNSES?; will PNSES affect safety and security? The focus is on UK policy development and draws on international sources to achieve this. However, the issues explored will have wider international resonance.

Are PNSES Unrealistic and Unpopular?

The fact that few PNSES operate around the world has been used to suggest that they are unpopular (Eyland, 1996; Goldberg, 1997; Goldberg *et al.*, 1998). In Australia, for example, Eyland (1996, p. 59) asserts that “it is clear that prison authorities around the world share the NSW [New South Wales] view that such a program is of questionable value”. In response to this however, Dolan *et al.* (1996b, p. 59) argue that this “is to ignore the resistance most prison authorities have to HIV prevention measures in prisons”. The study that sparked this particular debate between Eyland (1996) and Dolan *et al.* (1996b) was the result of a feasibility study of PNSES in Australia (Rutter *et al.*, 1995; Dolan *et al.*, 1996c). They found that former prison residents generally regarded PNSES as a popular idea. Not only was it considered as an important means to reduce risk behaviour and infection spread but would also help to reduce other risks that surround drug injecting and prison drug markets. In this study, however, professionals’ views of PNSES were mixed. In particular a prison officers’ union was against the idea. One prison officer, for example, commented “In my gaol I have 200 members who are totally and unequivocally opposed. If it’s ever implemented, I will take my people out” (Rutter *et al.*, 1995, p.24).

Whilst there is evidence to suggest that prison authorities and prison officers are opposed to PNSES it would not appear that this represents all views. For example, a needs assessment in an English prison by Huby and Hamer (1994) found prison residents and

staff support the idea of PNSES and residents reported being prepared to use a scheme if implemented. The introduction of PNSES has been generally well received by staff and residents in Swiss (Nelles and Fuhrer, 1995; Nelles *et al.*, 1998) and German (Meyenberg *et al.*, 1997) prisons. For example, during the piloting of the schemes in Germany, staff considered PNSES as part of the prisons' daily routines. Staff believed that the PNSES enabled drug injectors to talk more freely and honestly about their drug use – topics considered taboo before the introduction of PNSES – thus helping to facilitate drugs education and prevention (Meyenberg *et al.*, 1997).

Do PNSES Conflict with the Duties and Principles of the Prison Service and its Staff?

It has been argued that PNSES would send symbolic messages to prison residents, visitors and staff that drug use in prison is acceptable (ACMD, 1993; AIDS Advisory Committee, 1995; ACMD, 1996; Goldberg, 1997; Goldberg *et al.*, 1998). For example, the AIDS Advisory Committee (1995, p.30) suggest:

[S]uch an approach would be fraught with difficulty and would fit uneasily with the duty of prison authorities and staff to detect the smuggling of drugs into prison and to prevent drug misuse during custody. The conflict between encouraging prisoners to use an exchange scheme and detecting illicit drug use would have no easy resolution.

Inherent contradictions involving PNSES are compounded by mandatory drug testing policies in UK prisons as the ACMD (1996, p.103) point out:

It is very difficult to see how possession of a syringe could be condoned when both possession of injecting equipment and testing positive for drugs are disciplinary offences. Moreover, there are very great legal as well as practical problems in setting them [PNSES] up in an era of mandatory drug testing.

As King and McDermott (1995) suggest, mandatory drug testing was a disappointing policy because it responded to drug use as a criminal rather than a medical health issue. Whilst this is unsurprising, the criminalisation of drug use in prison has been a notable failure (Frommel, 1997). However, in both Germany and Switzerland urine testing to detect illicit drugs was undertaken alongside PNSES. In Germany, whilst prison residents were concerned that drug control measures including urine testing would increase, no changes in drug control practices were identified as a result of PNSES (Meyenberg *et al.*, 1997). However, in Switzerland, Nelles *et al.* (1999) note that during the pilot study drug-related sanctions correlated with people's use of the PNSES. However, these sanctions were later changed to place more emphasis on rewards for remaining drug free than the previous punitive measures.

The Prison Service's (1995a, 1998a; 1998b) intent to restrict the supply and use of drugs through control and drug detection measures may be considered diametrically opposed to PNSES and harm-reduction more generally. By introducing PNSES prison authorities may be seen to collude with the use of drugs, thereby throwing doubt on procedures that aims to stifle drug distribution networks. It is argued that PNSES would send messages that drug use is acceptable and, in effect, decriminalised inside prison (Goldberg, 1997).

As noted in the previous section long-established discourses on discipline, control and punishment within prison undermine health care interventions (Sim, 1990; 1994b). Opposing perspectives can impede pragmatic approaches to harm-reduction measures inside prisons. As Nelles *et al.* (1997, p.41) point out:

This might be due to the fact that, particularly in prison, narcotic laws prohibiting drugs on the one hand and health care claiming harm reduction on

the other hand are more likely interpreted to contradict each other, thus resulting in a dilemma of none acting.

Critics of PNSES point to the contradictory position in which PNSES would place the prison service and its staff. How can prison officers involved with security, control and discipline – especially with regards to drug taking – be put in a position where they encourage the up-take of harm reduction measures, namely PNSES? However, these dilemmas appear to be resolved when harm reduction measures other than PNSES are considered within prisons. A crucial consideration when implementing harm reduction strategies is who will administer them. Harm reduction measures are essentially health care orientated tasks and both proponents and opponents of PNSES generally agree that qualified staff should undertake these interventions; usually, although not exclusively, trained health care workers. Prison officers still have a role to play in PNSES, notably encouraging residents who inject drugs to participate, and to tolerate the operation of the schemes.

In the UK some harm-reduction measures will be tolerated and supported more than others. For example the rejection of PNSES is usually framed within support for other harm reduction measures including the provision of chemicals to help decontaminate unsterile injecting equipment (ACMD, 1993; AIDS Advisory Committee, 1995; ACMD, 1996; Goldberg 1997; Goldberg *et al.*, 1998). Where these harm-reduction measures are favoured over PNSES practical solutions to minimise the perceived contradictions between different approaches are suggested. For example the AIDS Advisory Committee (1995) note that the provision of decontaminants raises similar issues to PNSES and suggests that these are provided in the form of a ‘health and safety’ pack. The AIDS Advisory Committee (1995, p.31) suggest:

The packs would be issued by health care, not discipline staff, and instructions would explain that replacement contents could be obtained on (confidential) application to the health care centre.

What prison service staff are expected to tolerate in connection with conflicting principles and duties is ultimately a political decision (Brewer and Derrickson, 1992). However these political decisions have consequences, notably the spread of infections within prisons and the wider communities that prisons serve. HIV and AIDS prevention can be impeded (Wasserfallen *et al.*, 1997) or improved by political will. Gore and Bird (1993, p.147) argue that limiting the spread of infection inside prison must come first from politicians and legal reforms:

A prison sentence, prohibiting access to clean needles for injectors, may become a death sentence. If politicians had the humanity to grant prisoners the same rights to reduce their risk of HIV infection as the rest of the population then prison services could help inmates to stop endangering each other, and they could deliver those rights without risking disorder in the prisons. Practical initiatives are impeded for lack of political will and legal reform.

These changes require an acceptance of the levels of drug injection inside prison regardless of whether it will be condoned. As Hart (1990, p.138) notes, the introduction of CNSES over a decade ago was “an example of government stomaching one ‘evil’ – distribution of needles and syringes to drug injectors – in order to obviate others”.

Do PNSES Affect Levels of Drug Use and Drug Injection in Prison?

PNSES would undoubtedly alter informal prison drug markets. At present, injecting equipment has a ‘marketable’ value inside prison and typically can be lent in return for drugs (Turnbull *et al.*, 1996). PNSES could minimise the trading of injecting equipment that can result in unsafe sharing practices, together with the risks associated with the

operation of injecting equipment markets inside prison, as will be discussed in chapter ten. For example, a participant who had spent time in prison, reported in Rutter *et al.* (1995, p.23), commented “You wouldn’t get people [relatives or visitors] risking their visits to drop clean syringes at the side of the gate”. However critics of PNSES argue to the contrary and Goldberg (1997, p.226), for example, suggests that PNSES would lead to prison residents, visitors and staff taking a more active role in the operation of prison drug markets:

The ingenious means through which drugs are smuggled into prison would likely become even more ingenious and there would be the danger of intense drug trafficking. Pressure on relatives, friends and others to ‘deliver the goods’ would increase, as would the severe consequences of failure. An unequivocal message indicating that drug use was acceptable in prison would be perceived by staff, and a prison officer who, hitherto, would have been motivated to eliminate drug use might become involved in drug racketeering.

The ACMD (1993) suggest that the introduction of PNSES would result in drug users, who had previously smoked drugs including heroin, turning to injection as a method of drug administration. However, as established earlier in this thesis, there are already considerable numbers of drug injectors inside prisons, some of whom continue to inject drugs, usually with shared injecting equipment. Some evidence suggests that people begin to inject drugs for the first time inside prison (Bird *et al.*, 1995; Gore *et al.*, 1995b; Taylor *et al.*, 1995) and, therefore, PNSES could help people to establish safer injecting practices. This is especially important given that previous behaviour has an important influence on drug injecting practices, as noted in Chapter 2. However, the Prison Service draws on evidence that suggests that people may stop injecting inside prison to refute the arguments for PNSES (Connor, 1995). The Prison Service has been reported to suggest:

It is a question of balancing the risk of increasing injecting within a prison by providing needles against the risk faced by a small number of inmates who continue to inject (Prison Service quoted in Connor, 1995, p.6).

In Switzerland, Nelles *et al.* (1997; 1998; 1999) found that drug users were still able to locate drugs after the introduction of PNSES and as such the schemes do not prevent drug use. However, Nelles *et al.* (1997; 1998; 1999) found that drug use did not appear to rise and PNSES did not appear to influence drug taking patterns, notably switching people to heroin or cocaine use. People who report using drugs had used them before spending time in prison. Nelles *et al.* (1997; 1999) note that uptake of the sterile needles and syringes was closely related to availability and the use of drugs; PNSES participation increased the week after residents had received their monthly wages suggestive of increased amount of drug acquisition. Similarly in Germany, Meyenberg *et al.* (1997) found that PNSES did not appear to encourage people to use drugs.

A low rate of drug injecting inside prison is one good reason for not providing sterile injecting equipment. A Dutch study of drug injecting risk behaviour in prisons by Van Haastrecht *et al.* (1998) found that drugs were widely available and used in prisons but there were low (3%) levels of drug injecting with no-one reporting sharing needles and syringes. They conclude that providing drug injecting equipment may increase the amount of drug injecting inside prison and may be “counterproductive from a public health viewpoint” (Van Haastrecht *et al.*, 1998, p.1423). The authors note that where prison residents have private cells they are less likely to circulate injecting equipment than where two or more people share a cell.

Would PNSES Affect Levels of Infections?

A number of studies that have examined risk behaviour and levels of infections in prison have recommended the introduction of PNSES; for example in France (Rotily *et al.*, 1994), Australia (Dolan *et al.*, 1996d; Dolan and Wodak, 1999; Dolan *et al.*, 1999), Canada (Dufour *et al.*, 1996) and Greece (Malliori *et al.*, 1998).

Eyland (1996, p.59) argues that levels of infections are low and stable in New South Wales prisons and attributes this to the success of prison service interventions. Goldberg (1997, p.225) argues that inside prison there is evidence of minimal transmission of HIV, some transmission of HBV, and considerable chance of HCV transmission in prison. However, the fact that “there is little proof that transmissions are occurring” (p.225) is one reason why Goldberg (1997) and others, including the ACMD (1993), argue against PNSES. In contrast Crofts *et al.* (1995, p.288), for example, recommend that harm reduction strategies should be introduced urgently “without awaiting such final clarification”. Furthermore, Dolan *et al.* (1996b) argue that low levels of infection inside prison are due to community HIV prevention rather than to any prison efforts. Mahon (1997, p.2) develops this point by arguing that the absence of harm reduction inside prison will “undercut community-based programmes by creating a gap in prisoner harm reduction practices”.

Studies have found that when the feasibility of PNSES have been assessed in relation to reducing infection transmissions within prison, both staff and residents believe that risk behaviour and infections could be reduced (Huby and Hamer, 1994; Meyenberg *et al.*, 1997). However as with CNSES (Klee *et al.*, 1991b), PNSES do not eliminate drug injecting risk behaviour that can lead to the spread of infections. For example Meyenberg *et al.* (1997) found that injecting equipment remained an object of trade in the men’s

prisons because not all drug injectors, in this case people being prescribed methadone, could participate in the PNSES and as a result injecting equipment continued to be traded and shared. In Switzerland Nelles *et al.* (1998) found that reports of sharing injecting equipment reduced and was reported by very few people after the introduction of the PNSES. Thus whilst PNSES do not eliminate the sharing of injecting equipment it can reduce the number of people who take these risks. The reasons why people share injecting equipment are mixed and complex and the availability of sterile injecting equipment has been identified as an important influence on drug injecting risk behaviour in the community (Stimson *et al.*, 1988; McKeganey and Barnard, 1992). The introduction of CNSES in the UK achieved this outside prison over a decade ago.

In the Swiss pilot PNSES at Hindelbank prison it was found that no new infections with HIV, HBV or HCV were detected (Nelles and Fuhrer, 1995; Nelles *et al.*, 1998). Although given the timing of these tests, within five months of each other, it has been noted that the results should be treated with caution (Nelles and Fuhrer, 1995). It is important to recognise that, at present, there is very little evidence from which to assess the potential contribution PNSES can make on the reduction of infection in prison. To do so requires a thorough assessment of the prevalence of drug injecting, the prevalence of associated risk behaviour, and the prevalence of infection followed by the introduction and evaluation of PNSES.

Will Drug Injectors Use PNSES?

A needs assessment in one English prison by Huby and Hamer (1994) found that residents reported being prepared to collect sterile needles and syringes from prison authorities if provided under the right circumstances. They note that individuals would need to feel

confident in the schemes and that unrestricted use would be needed for them to work most effectively.

In Germany Meyenberg *et al.*, (1997) note that anonymity of PNSES participants was important and residents were concerned that participating in PNSES would have a negative effect on their relationships with staff. Women in particular wanted automatic dispensers to be privately located where the exchange could not be observed. The automatic dispensers were considered to provide more privacy than face-to-face distribution by staff. However, this must be offset against the associated counselling and support, necessary components to encouraging safer drug injecting practices, which could be offered if contact was made with harm-reduction professionals. This study reported that pre-conceived worries concerning the effects of the PNSES on prison-staff relationships were unfounded.

Will PNSES Affect Safety and Security?

A deliberate stabbing of a prison officer by a HIV infected resident with a needle and syringe containing blood in Australia was reported by Jones (1991). In the UK prison residents have also held prison staff hostage with blood-filled syringes (Murdock, 1997). Young (1996) argues that HIV has become criminalised through the potential for blood-filled syringes to be used as a threatening weapon towards others. These concerns have been used to argue that the increased availability of needles and syringes will also increase the likelihood that they are used as weapons against prison residents, visitors and staff (ACMD, 1993; 1996; Goldberg, 1997; Darke *et al.*, 1998). For example, a prison officer reported in Rutter *et al.* (1995, p.16) asked, “what’s to stop him from walking up behind anyone even another prisoner and jabbing em?”. During 1998, the Prison Service for

England and Wales considered piloting PNCES (Abrams, 1998). However, the Scottish Prison Service were against, on the grounds of safety:

“If a prisoner fills a needle with blood and takes a member of staff hostage, that is a very serious situation” (Scottish Prison Service quoted in Abrams, 1998).

Dolan *et al.* (1995) suggest that PNCES should operate on a strict one-for-one basis and only exchanging the syringe barrel and not the needle will enable the risks of HIV transmission to be reduced. However, this latter suggestion may undermine the effectiveness of PNCES in reducing other injection-related harms outwith the spread of infections including, for example, tissue damage. In addition the introduction of PNCES would send symbolic messages that harm-reduction measures inside prison are considered important and are taken seriously by the prison service. To introduce PNCES in half measures would serve to undermine the principles of harm-reduction.

In view of concerns about safety, evidence from both Switzerland (Nelles *et al.*, 1997; 1998; 1999) and Germany (Meyenberg *et al.*, 1997) found that injecting equipment had not been misused as weapons since the introduction of PNCES. Some prison staff reported by Meyenberg *et al.* (1997) help to put these issues in perspective. They note that whilst some staff were worried that injecting equipment could be used as weapons, this could happen with injecting equipment previously in circulation within the prison. Relationships between prison staff and residents were dominated by mistrust and precaution and this was maintained following the introduction of PNCES. Prison staff noted that it was important to work on the staff-prisoner relationship to prevent any threatening situations occurring and not just within the context of PNCES. Violence within UK prisons tends to involve a lot more than a needle and syringe (Scruton *et al.*, 1991; Woolf and Tumin, 1991).

An important safety issue in the operation of both CNSES and PNSES concerns the ways in which used equipment is disposed of. Outside prison, injecting equipment may be disposed of unsafely (Neale, 1998a) and similarly PNSES could potentially increase rather than reduce the risks of infections (Huby and Hamer, 1994). However in Switzerland Nelles *et al.* (1997) found no problems were incurred by discarded injecting equipment. In addition, Rihs-Middel (cited in Rutter *et al.*, 1995, p.8) suggests that the Swiss PNSES may have decreased the possibilities of injury through the permitted storage of injecting equipment in the toilet areas of cells. Similarly, Meyenberg *et al.* (1997) found that prison staff believed that the introduction of PNSES made injecting equipment more easy to control.

The current position in many countries, including the UK, on PNSES means that valuable opportunities to reduce the harms from drug injecting are lost. Wide-ranging political, practical and ethical issues are raised by PNSES, some of which have been discussed in this chapter. Relatively little evidence is available from which to assess fully the feasibility of PNSES or the impact they can have on harm-reduction within prisons. It is a political anomaly that certain measures are tolerated more than others, despite there being very little information available to inform harm-reduction debates within prisons. In the wider community these schemes are not without their problems and critics have rightly warned of the difficulties that surround PNSES.

Ideological and practical problems also beset PNSES. Ideological difficulties arise from the conflict of interests between the duty of prisons to control drug use and their health care duties, which include reducing the spread of infections. These ideological conflicts should be located within prison health care debates more generally. For example, Sim

(1990) argues that historically prison health care was shaped by discourses on less eligibility, which operated because of an overriding emphasis on control and punishment. These discourses continue to influence prison health care (Sim, 1994b). Thus, as discussed earlier, meeting the health care needs of drug injectors in prison should be located within the wider policy changes that are necessary to improving prison health care.

This section has also discussed a number of practical considerations that surround PNSES debates. These practical problems are often considered insurmountable by those who argue against PNSES. However, in countries where the practical costs and benefits of PNSES have been considered, their impact has been found to make a positive contribution to harm-reduction within prisons. In Switzerland, for example, Nelles *et al.* (1997, p.47) argue that operating PNSES “do not provide any arguments against the continuation of the distribution of sterile syringes”.

PNSES ultimately constitute a political issue that is highly symbolic. The discourses that have led to drug injectors being denied a formal supply of the means to inject drugs more safely send particular signals which, at present, demonstrate with what little regards drug injectors are considered.

SUMMARY

This chapter has demonstrated how, in the UK, drug injecting and the risks of HIV transmission have been responded to. Early interventions have been implicated in the relatively low levels of HIV infection among some groups of drug injectors. However, as shown earlier in this thesis, it is important not to neglect the wider harms, such as HBV and HCV, and tissue damage, which are also associated with sharing injecting equipment.

That infection may become endemic amongst particular groups and in different places highlights the need to consider responses to drug injection inside prison. Responses inside prison focus on reducing the supply and demand for drugs, which is associated with the controversial policy of MDT. The provision of substitute drugs is inadequate in prison and the delayed introduction of providing decontaminates contributes to, as was noted earlier as, prison being a riskier environment for people who inject drugs. The risks are apparent not only with regard to HIV transmission but also in relation to the quality of drug injectors' lives inside prison generally.

Whilst some of the problems that drug injectors face inside prison are specific to the use of drugs and drug injection, the issues raised have much wider resonance with prison health care debates. Lower health care standards were set in prison than for the rest of society. Less eligibility for the health care needs of people in prison, together with an over-riding emphasis on control and punishment, has continued to operate, which is particularly apparent for the most vulnerable groups. For dependent drug users in prisons, substitute drugs are prescribed at lower levels than those generally prescribed outside prison. The policy of MDT was introduced to provide information on drug use in order to control and punish drug use, rather than to treat it. Needle and syringes with which to inject drugs with are unavailable. Despite policy documents pointing to the contrary, drug injectors are not provided with the means to decontaminate needles and syringes. There have long been calls for radical reform. However, health care for drug users, and people in prison more generally, will only be seriously addressed when the principles that have shaped it – less eligibility and control and punishment – are abandoned in favour of high quality and consistent health care for all and, as discussed in the final section of this chapter, this includes needle and syringe exchange.

The perspective adopted in this thesis very much concerns drug injectors. This has been particularly apparent in this chapter with regards to the types of policy responses adopted and how these should be improved. It is, however, important to recognise that policy responses are also influenced by wider social values both inside and outside prison. Historically, health care inside prison, for example, has been set at a lower standard than outside prison. In this respect there have been calls for integration of community and prison health care services. Furthermore, health care directed towards drug injectors both outside and inside prison is sometimes delivered inconsistently and at a level that is not comparable with the delivery of health care for other problems. Of course, not all policies are based on humanitarian grounds and are ultimately influenced by wider societal values. With regards to drug injectors, for example, policies may be shaped by society's implicit view that individuals' problems are self-inflicted and thereby worthy of provision set lower to that set for the wider population. These issues shall be returned to in Chapter 12.

– CHAPTER 5 –

CONCEPTUALISING HIV RISK BEHAVIOUR

INTRODUCTION

A sociological perspective on AIDS is critical for research and policy because the transmission of HIV infection occurs through intimate social activities, successful intervention strategies are based on changing the behaviour of large groups of people, and effective treatment programs require detailed knowledge of the social worlds of persons with AIDS.

(Albrecht, 1992, p. 1 – cited in Bloor, 1995a, p. 130.)

The concept of risk has become increasingly central (Carter, 1995; Skolbekken, 1995) to analyses of society (Schwing and Albers, 1980; Giddens, 1991a; Beck, 1992; Adams, 1995) and, in particular, analyses of health (Bunton *et al.*, 1995; Gabe, 1995a; Heyman, 1998). Risk has been noted to “fuse in relation to HIV and AIDS” (Scott and Freeman, 1995, p. 151) and risk has also been a central concept in related research with drug injectors (Rhodes, 1995).

This chapter begins by considering some of the different approaches that have been used to understand HIV risk behaviour. Individual and social approaches will be examined before an exploration of the ways in which social conceptualisations of risk can provide a more complete framework to understand risk behaviour. It will be shown how the work of Alfred Schutz can be practically applied to an understanding of HIV risk behaviour. However, no conceptual approach is without problems and the work of Anthony Giddens is drawn upon to address some of these weaknesses. Following this a preliminary statement on conceptualising risk behaviour is elaborated.

CONCEPTUALISING RISK: INDIVIDUAL AND SOCIAL PROCESSES

Risk can be conceptualised in a number of different ways, including individuals' perceptions and statistical assessments (Schwing and Albers, 1980; Royal Society, 1983; 1992). In discussing the concept of risk Blaxter (1999, p. 23) notes, "there is a considerable risk in the assumption that we are all talking about the same thing". Historically, risk was understood in mathematical terms with risk analysis centring on probabilities, losses and gains (Lupton, 1993; Fox, 1998). Within the social sciences, the Royal Society (1992, p. 89) note that perception is central to analyses of risk, offering a useful framework to understanding risk that:

[I]nvolves people's beliefs, attitudes, judgements and feelings, as well as the wider social or cultural values and dispositions that people adopt, towards hazards and their benefits. ... What is clear is that risk perception cannot be reduced to a single subjective correlate of a particular mathematical model of risk, such as the product of probabilities and consequences, because this imposes unduly restrictive assumptions about what is an essentially human and social phenomenon.

The concept of risk has been disputed (Dowie, 1999a; 1999b) and as noted by Fox (1998, p. 66), "risk is in the eye of the beholder". In discussing the approaches to understanding risk in health, Gabe (1995b) draws on the work of Mills (1959, p. 8) to distinguish between the "personal troubles of milieux" and "the public issues of social structure". Gabe (1995b) shows how micro studies of health risks, referring to personal aspects, have been used to explore the meanings people attach to risk concentrating on, for example, perceptions. In contrast, macro studies, relating to public concerns, demonstrate the role social institutions play in framing risk. As noted in Chapter 1, this can include health and social policy responses. With regard to institutional responses directed at risk behaviour, Scott and Freeman (1995, p. 161) show how the focus has been on "the individualisation of risk management" and how "health education has passed from the level of the social to that of

the individual". Asymmetries between individuals' knowledge of risk and behaviour highlight problems with individualistic understandings of risk behaviour. Whilst responses to HIV risk behaviour have focused on individual actions (Scott and Freeman, 1995), there remains an important social dimension to HIV transmission, not least because it is a dyadic or group occurrence (Bloor *et al.*, 1992). It is important, therefore, for conceptualisation of HIV risk behaviour to take account of both its individual and social aspects.

Individualistic conceptualisations of risk behaviour are most common (Rhodes, 1997). Examples of individual approaches are the social cognition models that are used to predict health behaviour in psychology (Conner and Norman, 1996a). They have been applied to HIV risk behaviour and generally assume that risk behaviour is managed by calculated choices based on, for example, the perceived costs and benefits of actions or levels of perceived vulnerability and susceptibility. Conner and Norman (1996b) show how the value of these models lies in their ability to provide a clear theoretical basis for selecting particular variables for examination that, when combined, can help to predict health behaviour. However, proceeding with a particular theoretical approach can determine the strict choice of certain types of variables at the exclusion of others. Important factors, such as the embeddedness of emotions in behavioural decisions, are therefore lost (Williams, 1998a; 1998b). Conner and Norman (1996b) also note that while social cognition models provide a description of the cognitive processes that determine individual motivation to perform, they do not consider how these cognitions may be altered to affect change.

Burton-Jeangros (1998) argues that these models present a static analysis and suggests how perceptions may be built after risks have been taken in order to justify actions or, going further, that the relationship between perceptions and behaviour may evolve over time as

each adjusts to the other. Such considerations are not incorporated into social cognition models of behaviour. Similarly, research with drug injectors on risk behaviour has demonstrated the complexities surrounding constructions of risk, which are influenced by processual factors such as social distance, previous behaviour, and negotiation (McKeganey and Barnard, 1992; Rhodes, 1997). Criticisms have been levelled at social cognition models when applied to understanding HIV risk behaviour (Bloor *et al.*, 1992; Ingham *et al.*, 1992; Bloor, 1995a; 1995b; Rhodes, 1994; 1995; 1997; Loxley and Davidson, 1998). One such criticism is that the meanings and social context surrounding individual and group actions, such as routines or cultural norms, are neglected. Bloor (1995b, p.20), for example, describes the problems with individualistic approaches, thus:

[T]heories of risk behaviour which conceptualise risk behaviour as a volitional and individual act are inappropriate where risk behaviour involves two parties, not a lone individual, and where practice may be characterised by constraint, rather than by free choice.

Health risk has an important cultural dimension (Bunton and Burrows, 1995; Tansey and O'Riordan, 1999). Cultural theory provides some improvement to individualistic understandings of risk behaviour (Douglas and Wildavsky, 1982; Douglas, 1986), when applied to HIV risks (Douglas and Calvez, 1990; Calvez, 1995; Calvez, 1998). For example, Douglas and Calvez (1990) describe four types of culture, in the form of a two by two matrix, of which members of different cultural types can be understood to behave in particular ways in view of the threat of HIV. The central arguments of cultural theory suggest that risks are not homogenous but vary systematically according to particular cultural biases.

Bellaby (1990) is critical of cultural theory for failing to acknowledge the movement of individuals or groups between cultures. Similarly, the Royal Society (1992) notes that there is an inherent difficulty in classifying people into particular groups, which may oversimplify important differences in risk behaviour. Bloor (1995a) reflects similar concerns as to the placement of drug injectors, for example, as isolates. This contradicts prevailing research on drug injectors' lifestyles and the influences on their HIV risk behaviour, which have been found to transcend particular group affiliation.

Critiques of individualistic approaches to risk behaviour and cultural theory have supported arguments that point to the importance of social explanations of risk behaviour. These explanations show, for example, the varying symbolic meanings attached to risk and the importance of the wider social environment (Bloor *et al.*, 1992; McKeganey and Barnard, 1992; Bloor, 1995a; 1995b; Rhodes, 1995; Rhodes, 1997). Rhodes (1997) demonstrates how individual and social constructs of risk are competing and, like Bellaby (1990), points to the need for 'socially situated' understandings of risk behaviour. As Rhodes (1997, p. 211) suggests:

If theories of risk behaviour are to envisage risk as a socially interactive enterprise, where risk behaviour is shaped by the constant interplay between individuals' perceptions and the ways in which these are organised through the process of social interaction itself, then what is needed are 'socially situated' theories of risk epidemiology.

However, Bellaby (1990, p. 476) notes that 'socially situated' aspects of risk behaviour are elusive and often only the residues of socially situated actions can be explored. Thus, whilst criticisms have been levelled at the individualistic models of risk behaviour and cultural understandings, very rarely has a suitable, and practical, alternative been developed.

CONCEPTUALISING RISK: TOWARDS GREATER SOCIAL

UNDERSTANDINGS

In the previous section the dominant individualistic explanations for HIV risk behaviour were outlined and subsequent critiques briefly highlighted. It has been noted that the dominant individualistic paradigms have shaped interventions addressing risk behaviour (Rhodes, 1995; 1997). But limited attention has been directed towards constructing *practical* theoretical models to understand HIV risk behaviour from a social perspective. This reflects the dominance of highly abstracted sociological perspectives to risk that have limited connection and application to empirical research (Tierney, 1999). It is within this context that concerns with HIV risk behaviour remaining undertheorised can be better understood (Bloor, 1995b; Scott and Freeman, 1995). Furthermore, as Hart (1999, p.9) points out, “without a fully social dimension the concept of risk will never achieve its potential”.

Recently, however, there has been a call for the renewed interest in the work of Schutz to aid understandings of the social world (Lengermann *et al.*, 1995). In particular Schutz’s systems of relevances has been used to explore health behaviour (Dingwall, 1976) and HIV risk behaviour amongst drug injectors (McKeganey and Barnard, 1992) and male prostitutes (Bloor, 1995a; 1995b). The following section will overview Schutz’s systems of relevances and illustrates its value with respect to Bloor’s (1995a; 1995b) application of the approach to understanding HIV risk behaviour. That some criticisms have been levelled at Schutz’s analysis leads to the examination of the work of Giddens, notably on consciousness and ontological security, to expose the ways in which the potential weaknesses of Schutz’s work can be addressed using the work of Giddens to provide a theoretical framework with practical implications.

Systems of Relevances

The breadth of Schutz's work is considerable (1962; 1964; 1966). Schutz's analysis of the everyday world is widely recognised (Wagner, 1983; 1984; Esser, 1993; Prendergast, 1993; Lengerman *et al.*, 1995; Hermida-Lazcano, 1996; Crossley, 1996). Central to this work is the taken-for-granted aspect of everyday routines and the ways in which problems are considered and assessed. The taken-for-granted refers to "that particular level of experience which presents itself as not in need of further analysis" (Schutz, 1972, p. 74). This is particularly important given that "good theorising in the risk-taking areas needs to take account of the commonness of certain situations" (Moore *et al.*, 1996, p. 70).

Schutz (1970) understood that fields of consciousness are located at the horizon, referring to distant consciousness or theme characterised by "now" (p. 4). Routine behaviour can possibly be understood as horizontal. Take, for example, the process of injecting drugs by a regular drug injector. The heating of the drugs, drawing the solution through a needle and into a syringe, finding and locating a vein and, finally, injecting can be understood to be horizontal. The process is regularly and routinely carried out and necessitates little conscious effort. On the other hand, the inability to locate a suitable vein for injection may be thematic. As an unusual occurrence, for some people at least, this requires immediate conscious efforts. A focus on themes and horizons is used to understand individuals' reasoning. Whilst it may be understood that some issues are horizontal and far removed, Schutz (1970, p. 11) points out that they are, in fact, "constituted as thematic, requiring and receiving our full attention if only momentarily". Furthermore, the relationship between theme and horizon is simultaneous because "in order to make something thematic and another thing horizontal we have to assume an artificial split of the unity of our personality" (Schutz, 1970, p.12). Recognising the interconnectivity between horizon and theme leads

Schutz to develop three forms of relevances: topical relevances, interpretational relevances and motivational relevances (Schutz, 1970; Schutz and Luckmann, 1974).

For Schutz, familiarity is built upon previous behaviour and perceptions of similarity with previous behaviour. The reproduction of familiar routines makes up, in part, the taken-for-granted social world. Topical relevances are formed when unfamiliarity is encountered in everyday life. This leads to its separation from routine as issues are no longer taken-for-granted. For example, drug injectors have been found to keep stocks of their own sterile or personally marked injecting equipment to avoid situations in which they may be called upon to share injecting equipment (Power, R. *et al.*, 1996). In such a situation, a topical relevance may be formed when these supplies are absent, perhaps the supply having been borrowed by someone else. Here a topical relevance includes the lack of injecting equipment. Schutz recognises that topical relevances are constantly being formed and may be superimposed by other connected topical relevances resulting in the enlargement of a problem. A related topical relevance may be formed on the worry of drug withdrawal from the inability to inject or a concern about HIV if injecting equipment is shared. Alternatively, two or more unrelated topical relevances may be formed by, for example, *any* other concern that is brought about at the same time.

Whilst topical relevances surround issues that demand attention against the background of everyday taken-for-granted routines, the confronting of these issues depends on interpretational relevances. Interpretation is a continuing process and new topical relevances may be formed or new interpretations evolve. Interpretational relevances will inform any action that is or is not taken. The prevention of HIV may be topically relevant to individuals, but such relevances need to be interpreted in context. For example, it has

been found that there are a number of different meanings attached to drug injecting risk behaviour. Typically, sharing injecting equipment may not be considered as risky when undertaken with a sexual partner or with a good friend. In these cases the *interpretation* of the topical relevance of HIV risk may lead to behaviour which ignores the risk. Motivational relevancy constitutes 'in order to' and 'because' motives. In the example, 'in order to' take drugs an individual shares with a sexual partner or good friend. Motivational relevances will depend on individual's interest and will, therefore, also be important in determining what is topically relevant.

In this system, relevances are characterised by their interconnectivity, constant shifting and fluid operation. They are self-perpetuating and one relevance is not privileged over and above another. Any particular relevance may become the starting point for a change in others. As Schutz (1970, p. 66) asserts:

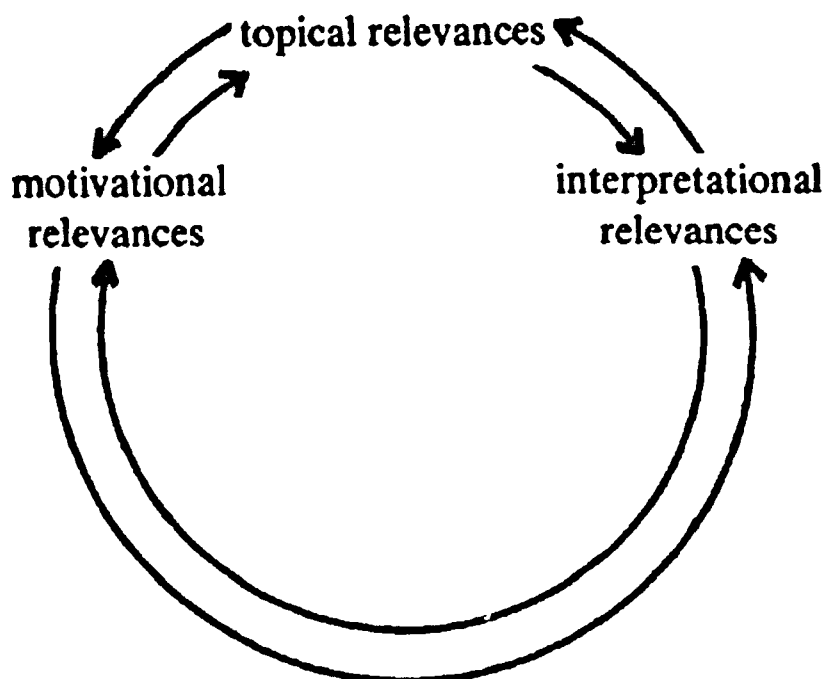
These interrelationships among the types of relevances should not be taken as chronological, that "first" the one, "then" the other, "then" the last type become established. All three types are concretely experienced as inseparable, or at least as an undivided unity, and their dissection from experience into three types is the result of an analysis of their constitutive origin.

It is important to recognise that Schutz distinguished these relevances by their imposed and intrinsic characteristics. Relevances may be imposed, for example by others, or through awareness raising campaigns, as in the case of HIV, or may be intrinsic relevances emanating from within the individual. The interdependency between relevances and the ways in which they are understood to be constantly influenced by one another is represented in Figure 5.

Figure 5.

The Interrelationships Between Schutz's Systems of Relevances

(Source: Schutz (1970, p.70). Reproduced with the kind permission of Yale University Press.)



Bloor (1995a; 1995b) has used Schutz's systems of relevance to inform practical explanations of risk behaviour amongst male prostitutes. This research centred upon the constraints that prostitutes encountered when attempting to practice safer sex and, in particular, the control clients exerted over them (Bloor *et al.*, 1992; Bloor 1995a; 1995b).

Bloor (1995b, p. 27) explains:

[T]he schema embraces a range of activities previously reported – the routinisation of risk behaviour through daily repetition where safer commercial sex is no longer a topically relevant pursuit, the imposed adoption of risk behaviour, motivational relevances which give greater or lesser urgency to the topic of safer commercial sex, and the strategic choice of performable recipes for action which countervail clients' preferences for unsafe sex.

Bloor (1995a; 1995b) shows how the value of the approach lies in its ability to capture the volitional aspects of behaviour together with individuals' constraints on behaviour. Similarly, the 'automatic' and calculative aspects of decision making are combined, in

contrast to individualistic understandings of risk that emphasise a “step-wise” progression.

Bloor (1995b, p. 27) suggests:

In the world of routine activities this step-wise cognitive sequence is collapsed as cognition occurs monothetically, in a single flash.

However, Schutz does place greater emphasis on the calculating, rather than the volitional, aspects of decision making (Bloor, 1995a; 1995b; Crossley, 1996). Crossley (1996) argues that these calculating aspects are overstated and, consequently, there is less recognition of the *embodiment* of actions that are not directly planned or discursively realised. For example, coping is a state that individuals do not plan or think about. Furthermore, Schutz makes a clear distinction between action and behaviour. Crossley (1996) is critical of this:

Experience teaches that some of the things we do in life are planned and some aren't. The distinction is difficult to sustain, however, for two reasons. Firstly, plans relate to acts (in Schutz's sense) rather than actions. They deal with ends rather than means and means can't be completely planned for. They are spontaneously produced as a response to conditions of execution and exigencies which cannot be foreseen. Plans lay out landmarks but they leave the navigation between those landmarks to spontaneous innovation... (Crossley, 1996, p. 80).

Crossley (1996) notes that Schutz's analysis has a high level of abstraction and presents a small world view with regard to social interaction. As a consequence Schutz does not account for wider factors. Dependency, for example, represents an embodied influence on decision making rather than a calculating one, Crossley (1996, p. 96) suggests that Schutz:

[I]gnores all but the most basic interdependencies which function within and bind groups of various sorts. Schutz fails to consider emotional dependencies, physical dependencies and financial dependencies, for example, all of which have been shown to be central to the construction of solidarity and dynamism of social life...

Dependencies are important considerations with regard to HIV risk behaviour. Similarly, domination in the form of power and control, together with its negotiation, has important influences on HIV risk behaviour (Holland *et al.*, 1990; McKeganey and Barnard, 1992; Lear, 1995). Client control and domination was found by Bloor to be important in understanding male prostitutes' risk behaviour. Lengermann *et al.* (1995) found a paucity of attention afforded to domination within Schutz's work. They show how the taken-for-granted aspects of the world are not problematised for Schutz and, with regards to domination, argue:

The subordinate...is expected to do the work necessary to maintain the world without calling attention to either the act or the actions of maintenance. The calling of attention makes the world less taken-for-granted, more subject to intrusions of the problematic, because the very statement of what is done implies the possibility that things could be otherwise (Lengermann *et al.*, 1995, p. 32)

In applying the work of Schutz to risk behaviour, Bloor (1995a; 1995b) suggests how such potential difficulties can be minimised by recourse to the distinction between imposed and intrinsic relevances, which give the approach wider applicability. With regard to Bloor's findings on male prostitutes, client control on risk or safer behaviour can be understood as an imposed relevance, whereas prostitutes' pursuit of safer behaviour can be understood as intrinsic. Bloor (1995a, p. 100) concludes:

Schutz's analysis of the complex interplay of topical, interpretative and motivational relevances represents a series of cross-cutting continua where different ranges of risk phenomena may be located – from unconcern to militant determination, from inattention to weighted deliberation, from habituation to innovation, from the immediate to the culturally determined, and from the volitional to the constrained.

This section has discussed Schutz's systems of relevance with regard to understanding risk behaviour. Bloor (1995a; 1995b) has shown how the approach is valuable in grasping the complex and interrelated influences on HIV risk behaviour. However, Schutz's analysis is located at a high level of abstraction and places greater emphasis on particular issues, such as calculated decision making, over others, including volition, unthinking and dependency. These latter factors are recognised by other social perspectives, including those of consciousness and ontological security to which this chapter now turns.

Consciousness and Ontological Security

Within a wider framework of structuration theory Giddens (1993; 1984; 1991a) can help to understand more about risk behaviour. One particular element of structuration theory concerns everyday practices that are not *directly* motivated. This is explained by individuals' self-reflexive monitoring of actions at particular levels of consciousness. Giddens addresses three modes of consciousness. The first level is unconsciousness, which is recognised as playing no role in explaining behaviour. Second, discursive consciousness refers to the ways in which people have to think about activities in order for them to be carried out. Giddens (1984, p. 45) explains:

'Consciousness' in this sense presumes being able to give a coherent account of one's activities and the reasons for them.

Third, practical consciousness is non-conscious rather than unconscious and refers to aspects of life that are known but that are not discursively realised. Practical consciousness allows individuals to sublimate or ignore thoughts about or possible interpretations of an action. The action is taken for granted and not subjected to the same kind of conscious

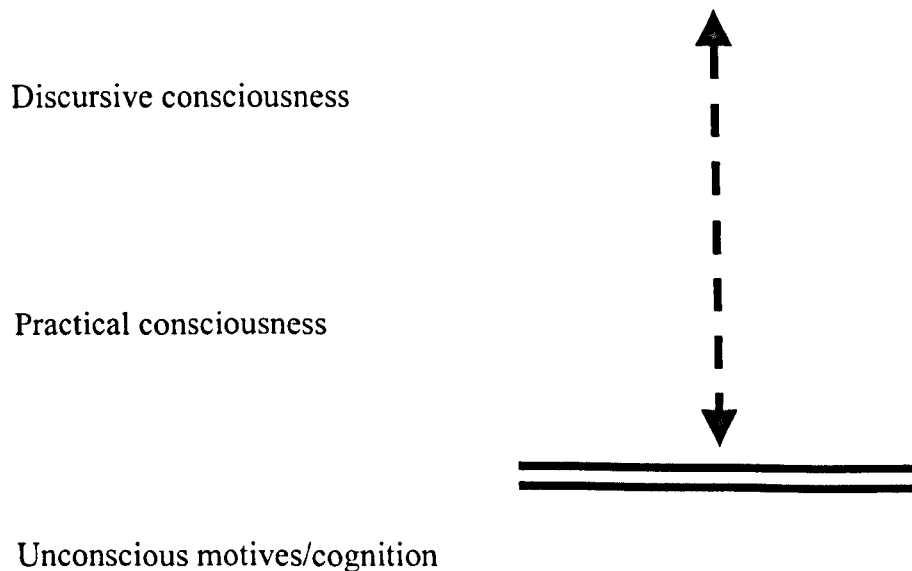
thought or scrutiny which might be given to a new or unfamiliar type of action, in ways in which discursive consciousness operates.

The division between practical consciousness and discursive consciousness is not rigid but constantly moving and permeable. The difference is between what is discursively realised and what is done. The barrier that does exist is between the discursive and practical consciousness and the unconscious and cognitive elements of the mind. This framework is represented in Figure 6.

Figure 6.

The Schematic Interrelationships Between Giddens's Concepts of Practical Consciousness, Discursive Consciousness and Unconscious Motives

(Source: Giddens (1984, p.7). Reproduced with the kind permission of Anthony Giddens.)



Practical consciousness is *central* to ontological security, a concept first developed by Ronald Laing and referring to the emotional fulfilment of the self. Laing (1959, p. 41-42) describes:

The individual, then, may experience his [sic] own being as real, alive, whole; as differentiated from the rest of the world in ordinary circumstances so clearly that his identity and autonomy are never in question; as a continuum in time; as having an inner consistency, substantiality, genuineness, and worth; as spatially co-extensive with the body; and, usually, as having begun in or around birth and liable to extinction with death. He thus has a firm core of ontological security.

Giddens (1991a, p.129) uses the concept of ontological security to demonstrate how feelings such as anxiety, mistrust and shame are “pushed to one side” during practical consciousness to enable individuals to ‘go on’. Giddens (1991a, p.130) suggests:

The dangers they present, in other words, are thought of as too far removed from a person’s own practical involvements for that individual to seriously contemplate them as possibilities.

For Giddens, ontological security is founded on the predictability of practical routines; and ontological security provides a “protective cocoon” in order to ‘screen off’ problems to enable people to ‘go on’ with everyday life. Giddens (1991a, p.127) elaborates:

The simplest action, such as walking without falling over, avoiding collisions with objects, crossing the road or using a knife and fork, had to be learned in circumstances which originally had connotations of fatefulness. The ‘uneventful’ character of much day-to-day life is the result of a skilled watchfulness that only long schooling produces, and is crucial to the protective cocoon which all regularised action presumes.

Laing (1959) describes how ontological *security* can break down to ontological *insecurity* during periods of ‘anxiety’, ‘engulfment’, and ‘petrification’. Similarly, Giddens (1984, pp. 50-51) refers to the disruption of ontological security in problematic situations:

Ontological security is protected by such devices but maintained in a more fundamental way by the very predictability of routine, something which is radically disrupted in critical situations. The swamping of habitual modes of

activity by anxiety which cannot be adequately contained by the basic security system is specifically a feature of critical situations.

However, critical situations pass, if only temporarily, and Giddens suggests that individuals readjust and, crucially, that ontological security is *re-built*.

The concept of ontological security and insecurity has been discussed within an analysis of wide-ranging subject areas within the social sciences (Silverstone, 1993; Saunders, 1990; Seale, 1996; Riggs and Turner, 1997; Cohen and Metzger, 1998; Higate, 1998; Nettleton and Burrows, 1998; Walklate, 1998). One important study by Riggs and Turner (1997) on intimacy and emotional satisfaction during the ageing process found that Giddens's understandings of self-reflexivity was in contrast to their findings. Riggs and Turner (1997) found that the construction of self identity develops *throughout* the life course and can be understood to operate within the boundaries of ontological security.

Giddens (1991b) is aware of the limitations of his development of the concept of ontological security and Riggs and Turner (1997) point out how, on self-reflexivity, his work occupies middle-class intellectual boundaries. Furthermore, Riggs and Turner (1997, p. 232) argue

The self-reflexive nature of Giddens's interpretation of self-identity denies the centrality of the self as a social being. The participants in this study have a very strong notion of themselves as a product of social processes.

HIV risk behaviour is characterised by processual features (Rhodes, 1997) and Riggs and Turner's (1997) work is important in demonstrating how people can be aware of the influences of these processes.

This section of the chapter has drawn on Giddens's conceptualisation of consciousness and, in particular, discursive consciousness and practical consciousness. Ontological security is closely linked to practical consciousness, which can be understood to represent non-discursive and embodied influences on behaviour. These constructs can be used to assist explanations of risk behaviour and, in particular, the ways in which they can *complement* Schutz's systems of relevances. The next section brings these two perspectives together in a tentative theoretical framework to further understandings of HIV risk behaviour.

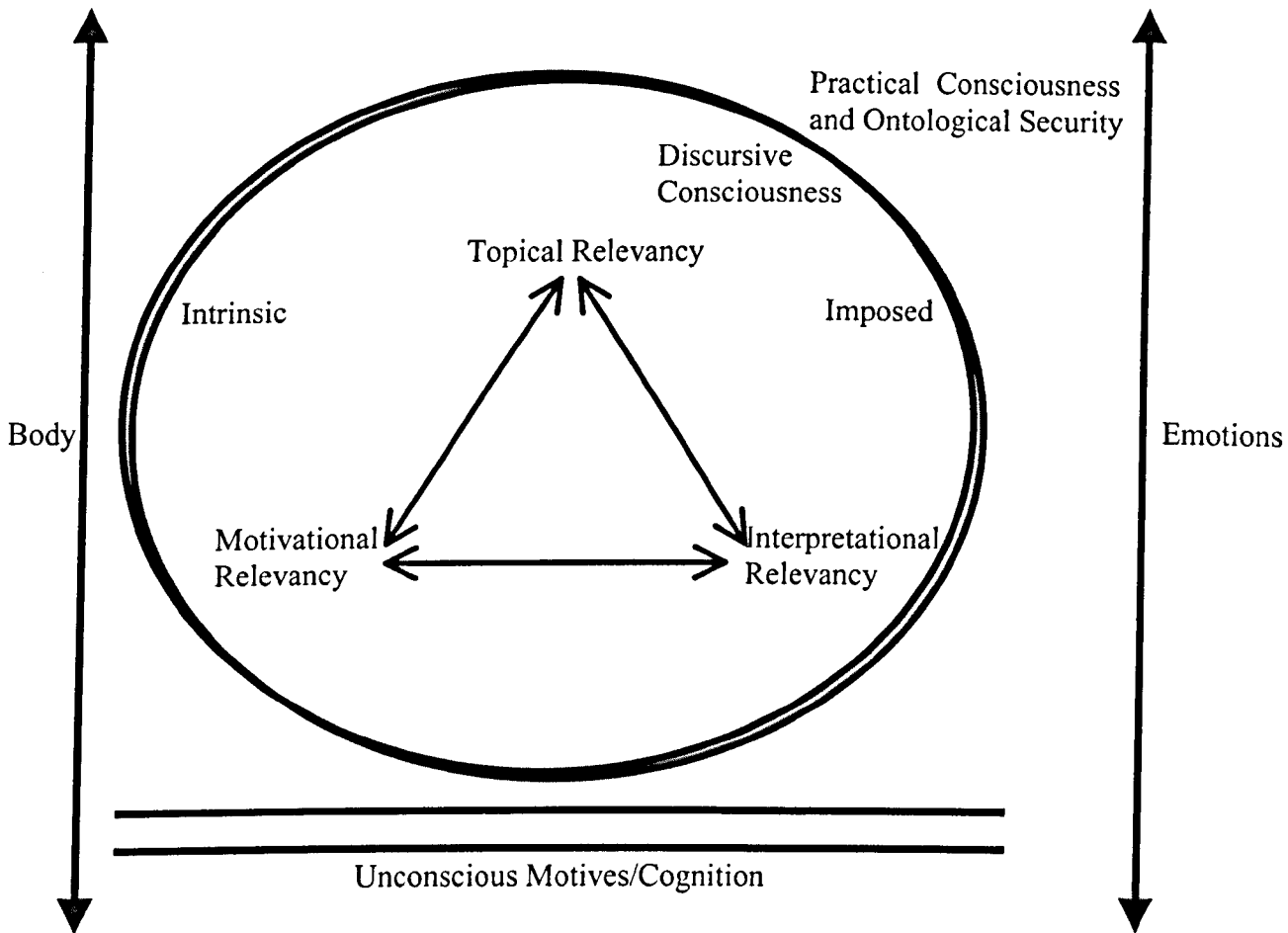
CONCEPTUALISING RISK: A THEORETICAL FRAMEWORK

Schutz's systems of relevances and Giddens's ideas on varying levels of consciousness and ontological security are pursued in this section of the chapter to develop a theoretical framework towards understanding HIV risk behaviour. As Moore *et al.* (1996, p. 70) point out, theoretical frameworks are summarising tools and "few theories can (or do) incorporate all situational possibilities". The value of combining two theoretical approaches reflects wider debates in social theory that focus on the need to maintain flexibility when examining issues at the conceptual, and more abstracted, levels of social enquiry (Layder, 1998). Furthermore, theory should be used to best suit the needs of particular topics (Stanley and Wise, 1993) and the theoretical synthesis presented in this section of the chapter can assist the development of further *practical* models of understanding risk behaviour.

This section of the chapter will explore some areas in which Schutz's and Giddens's analyses are in concert and there are, of course, divergent areas. Developments in contemporary social theory afford attention to the body and emotions. In the theoretical

framework these factors are brought together in order to understand HIV risk behaviour, as shown in Figure 7.

Figure 7.
Conceptualising HIV Risk Behaviour: A Theoretical Framework



At the outset it is important to recognise that both Schutz and Giddens emphasise the fluid characteristics of their conceptualisations. These recognitions are valuable, not least, because less recalcitrant conceptualisations can assist the development of a more flexible framework towards understanding risk behaviour.

A topic common to both Schutz and Giddens is the attention given to routine actions. Schutz's understandings revolve around the reasoning that occurs when routines are

broken and, subsequently, systems of relevances are formed. These systems of relevances can help to explain decision making processes. In this respect, Schutz's approach is limited by the ability to conceptualise wider processes, such as how routine behaviour are *sustained*. On the other hand, Giddens's approach emphasises the continual reproduction of practical consciousness and ontological security, which is not directly motivated. This can help to explain further taken-for-granted behaviour. This approach can assist the conceptualisation of wider influences over and above Schutz's understanding of reasoning as espoused through systems of relevances. Combining the approaches of Schutz and Giddens in this respect can capture discursive reasoning together with unconsidered actions. Whilst the Schutz model marks a significant advancement from individualistic approaches on decision making there is, nevertheless, a sharper focus on rational and calculating aspects. Giddens's conceptual approach can go further by recourse to actions which are not always directly motivated. Giddens's conceptualisation is at its weakest when explaining the calculating elements of behaviour. Hence the strengths of Schutz in this respect are complementary.

Schutz's relevances may have imposed or intrinsic characteristics. With regard to HIV risk, for example, imposed influences may stem from the power and control exerted by others upon decision making, whereas intrinsic influences may refer to the self-identified need for drugs. Giddens recognises how the conscious and non-conscious realms are constantly moving and, furthermore, that the protection of ontological security may be lost to a state of ontological insecurity. However, there is less recognition of what may prompt such occurrences. In this respect Schutz's imposed and intrinsic conceptualisations are valuable in providing a more holistic appreciation of behavioural influences.

Contemporary social theory can illustrate some of the inherent weaknesses that pervade both Schutz's and Giddens's conceptualisations of action, including the attention afforded to the body (Nettleton and Watson, 1998) and emotions (Bendelow and Williams, 1997) within recent debates.

Shilling (1997), for example, argues that Giddens's structuration theory, of which ontological security is a constituent, accords the body some position in conceptualising the embodied aspects of behaviour. However, Shilling argues that the emphasis on the body is weak and insufficient. For Shilling, Giddens is unable to account fully for the embodiment of action because of the overriding emphasis on the monitoring of individual actions through reflexivity. Shilling argues that structuration theory:

[S]ays little about how embodiment is *itself* a force for the structuration of knowledge or how our emotional modes of being actively participate in shaping the social system (Shilling, 1997, p. 747).

The embodied aspects of behaviour which may include factors such as drug dependency, requiring drugs and so on are clearly important when considering risk behaviour. The implication of this, for a theoretical framework, is to recognise tentatively such constructs as having some influence on risk behaviour.

Related debates within social theory pay attention to the emotional realm. Williams (1998a, p. 749) argues that emotions and reasoning are not antithetical to one another and "are central to the 'effective deployment' of reason". Williams (1998a, p.761) goes on to argue:

Without emotions, social life, including our decision-making capacities and our ability to make informed choices amongst a plurality of options, would be impossible.

Campbell (1996, p.157) notes that while individuals will be able to maintain a degree of control over bodily and emotional processes, there are limits to this control:

Impulses and emotional reactions which adults find that they can control most of the time, will inevitably, under some circumstances, be experienced as uncontrollable.

Shilling's (1996) argument supports the need to recognise the unmotivated aspects of human behaviour and can be located within the lower portion of the theoretical framework, as presented in Figure 7. Following Giddens, the mind will 'go on' unthinkingly, but inextricably bound within these processes are the corporeal and emotional influences over action.

Turning to the theoretical framework presented in Figure 7, the outer portion of the illustration highlights features that are non-discursive, embodied and emotional. More discursive and reasoned thinking is represented in the inner portion of the framework. Thus, when issues arise outside everyday routines they may be pushed to the back of the mind through practical consciousness to maintain individuals' ontological security and reducing topical relevance. As noted earlier, these concerns may be intrinsic or imposed. However, ontological security can break down to ontological insecurity, which can lead to the discursive consideration of issues and recognition systems of relevances. In the realm of discursive consciousness concerns can then be located within Schutz's topical relevances. Such a theoretical framework may work, not least because some of the weaknesses of the two approaches are collapsed by the respective strengths of the other.

Common to both Schutz and Giddens is the emphasis on the moving interrelationships between constructs, characterised by fluidity, which is equally important to the theoretical framework.

To illustrate the theoretical framework in action consider, for example, the scenario of a dependent drug injector in need of drugs. Experiencing drug withdrawal is an unpleasant emotional and physical experience. For people who regularly inject drugs the preparation of the drug is a routine activity and such activities may take place several times a day. As a consequence and, following Giddens's thinking, it can be understood to operate at the level of practical consciousness closely linked to ontological security. However, as Giddens recognises, the boundaries between practical consciousness and discursive consciousness are constantly moving and fluid in operation. Thus, activities may be discursively realised and with Schutz the breaking of routines prompts systems of relevances. At the discursive level Giddens is unable to conceptualise fully the reasoning behind people's behaviour. Here the value of Schutz's systems of relevances can clearly be seen. Discursive consciousness may be imposed or intrinsic and can lead to imposed or intrinsic systems of relevances. This may occur when something out of the ordinary happens during the process of injecting drugs, for example the blocking of injecting equipment. This can lead to problems becoming topically relevant – the needle is blocked. The problem will require interpretation – is the blocked needle important? If so, it will lead to motivational relevances which serve as a guide to understanding behaviour. In the example of a blocked needle further topical relevances may be formed such as concern with drug withdrawal. Interpreted as important, motivational relevancy may lead to the sharing of injecting equipment depending on the interplay between topical and interpretational relevances.

The constant interplay of these systems of relevances can be important when seeking to understand risk behaviour. Similarly, reasoning underlying systems of relevances may move back to unthinking, practical consciousness. If for example, risks are taken to allow the drug injector to be able to go on with the task in hand, concerns with HIV may need to be pushed to the back of the mind.

SUMMARY

This chapter has examined approaches to conceptualising HIV risk behaviour. There are numerous models that have been used to achieve this. However, this chapter has generally considered them within the over-arching themes of individual and social perspectives of risk. To be useful in aiding understanding, concepts used should relate to the purposes of the research topics under investigation. The work of Schutz has been shown to have a practical use in explaining HIV risk behaviour. The distinctions between varying levels of consciousness as developed by Giddens also have value in assisting these explanations. Both approaches have their weaknesses but taken together they can assist in the *conceptualisation* of HIV risk behaviour as demonstrated by their synthesis in a new theoretical framework.

Social theory is not, of course, disembodied from empirical focused research (Stanley and Wise, 1993; Layder, 1998). The theoretical framework discussed in this chapter underpins the research questions and methods that will be discussed in the following chapter. Thus, the analysis and presentation of findings from the empirical work should be located within this theoretical backdrop. The theory will inform the broad analytical categories of data that form individual chapters. Similarly, the theory will assist explanations of individual

sets of findings. Before the findings are presented in Chapters 7 through to 11, the next chapter discusses the research methods adopted.

CONDUCTING RESEARCH WITH DRUG INJECTORS

INTRODUCTION

Conducting research with drug injectors using quantitative (Turner *et al.*, 1992) and qualitative (Lambert *et al.*, 1995) research methods gives rise to a number of ethical and practical considerations (Wright *et al.*, 1998). At the outset it is important to recognise that many aspects of the research process are mixed and complex (Stanley and Wise, 1993) and are rarely reported in the manner or sequence in which they were experienced (Aldridge, 1993). The outline of this study is presented in the following sections for the purposes of discussion: research objectives; methods of investigation; research topics; sampling strategy; contact, recruitment and fieldwork with drug injectors; the sample achieved; and the process of data analysis. The chapter ends with a brief outline of the following empirically led chapters.

RESEARCH OBJECTIVES

Earlier chapters in this thesis have highlighted current understanding of drug injectors' HIV risk behaviour. Broadly, quantitative investigations have helped to establish the frequency and extent of risk behaviour whereas qualitative studies have described types of behaviour and explored the influences underlying them. Although there have been quantitative assessments, the qualitative dimension of risk behaviour in prison has been subject to much less attention. This thesis explores the ways in which influences on drug injectors' risk behaviour inside and outside prison might operate.

It is important that risk behaviour is located within a wider social and policy context. McKeganey and Barnard (1992, p.12) note that individual actions “do not occur within a vacuum, but as part of a much wider context of human relationships”. Their work explores the influence of the wider social environment on risk behaviour. They argue that the study of drug injectors’ risk behaviour too often “gives the impression that these individuals are somehow entirely separate from other people, and subject to quite unique pressures, norms and beliefs” (McKeganey and Barnard, 1992, p.12). Similar concerns have been raised by others including, for example, Polkinghorne (1996, p.84) who argues for the need to “address wider life context issues” when tackling the issues raised by drug use. To capture some of these social policy considerations a second aim of the thesis is to explore the impact which recent policies aimed at tackling drug injection in prison have had on drug injectors’ lives. This chapter now details the methods best suited to pursuing these broad research objectives.

METHODS OF INVESTIGATION

To best address the objectives of the research a qualitative approach was adopted. As Bryman (1988, p.61) describes, there are a number of characteristics of qualitative research of which an important feature is “to penetrate the frames of meaning” of participants. Qualitative research is understood to play an important role in research with drug users and risk behaviour (Lambert *et al.*, 1995; Power, 1998). For example, Power (1998, p. 687) notes its value in understanding the “subtlety and complexity of HIV-related behaviours and the importance of lifestyles and culture in determining crucial factors, such as risk and negotiation”.

People's views and experiences on social policy topics can have a real value in influencing policy debates. However, few empirical policy-oriented studies have engaged with drug users' views and experiences (Neale, 1998a; 1998b; 1998c). Neale (1998c, p. 309) notes that research has mainly considered the perspective of service providers rather than drug users themselves while "drug users' views remain distinctly peripheral within the existing literature". This is a particularly striking observation given the importance attached to eliciting people's views and experiences within social policy, which has gained increased prominence in recent years (Forbes and Sashidharan, 1997). There are exceptions to this, however, including studies of young people's feelings towards drugs (Wibberley, 1998), studies of drug injectors' views and experiences of HIV and AIDS and their carers (Carretero *et al.*, 1998) and Neale has assessed drug users' views on disposing of injecting equipment, substitute prescribing, and service providers (Neale, 1998a; 1998b; 1998c).

Considerable value can accrue from combining research methods (Jick, 1979; Fielding and Fielding, 1986; Mason, 1994), especially in research with drug users (Dennis *et al.*, 1994; Barnard and Frischer, 1995; McKeganey, 1995). No single research tool can truly reflect people's real life. The rationale for 'complementary' research methods stems from the idea that each method has its own strengths and weaknesses.

[E]ach method implies a different line of action toward reality – and hence each will reveal different aspects of it, much as a kaleidoscope, depending on the angle at which it is held, will reveal different colors and configurations of objects to the viewer. Methods are like the kaleidoscope: depending on how they are approached, held, and acted toward, different observations will be revealed (Denzin, 1978, pp.292-293).

Sharing the strengths and weaknesses of two or more techniques within an overall methodological approach can, as Jick (1979, p.603) argues, help to "capture a more

complete, *holistic* and contextual portrayal of the unit(s) under study”. (Emphasis in original.)

Following this reasoning, four qualitative research techniques were chosen: in-depth interviews, a vignette, small group discussions and diary field-notes. In-depth interviews were used to allow participants to interpret issues and voice their own understandings. Interviews were allowed to proceed in a relatively unstructured fashion, to provide an opportunity for participants to raise issues not prompted by the researcher and to talk about issues at length (Murphy, E., *et al.*, 1998). There are a number of important practical and ethical considerations that surround qualitative interviewing (Mason, 1996; Murphy, E., *et al.*, 1998). Cornwell (1984) illustrates some of these by distinguishing between public and private accounts. Drawing on a series of interviews about people’s health, initial interviews were characterised by public accounts of their lives. Public accounts refer to selective, polite and socially desirable descriptions. They are not a form of deception but do mark the social distance between participants and the researcher, together with the participants’ tendency to seek the approval of the person to whom they are talking. However, as Cornwell got to know the participants in her study and as topics were repeatedly discussed she notes that later interviews contained more private accounts that reflect richer and more detailed descriptions. When it is difficult to interview people repeatedly, especially ‘hard-to-reach’ people such as drug injectors, a range of research methods can help to reduce the likelihood that data will be limited to public accounts.

In this study, in-depth interviews were complemented by the use of a vignette in an attempt to elicit more private accounts of people’s lives. Projective techniques, of which vignettes are a form (Finch, 1987), have a long history, notably in social psychology (Anderson and

Anderson, 1951). Vignettes can be described as narratives about individuals and situations, which make reference to important points in the study of perceptions, beliefs, attitudes and behaviour. Written vignettes, of varying lengths, are perhaps one of the most common applications of the vignette technique. Participants are typically asked to respond to a narrative, which constitutes a 'snapshot' of a given situation. They are asked what they would do in a particular situation or how they think a third person would respond. Thus, vignettes are not employed in an attempt to match real life experiences, rather to provide an interpretation of the 'real world' and present it in a way that gives people a situated context in which to respond. As McKeganey *et al.* (1996, p. 562) point out in their comparison of vignette generated and self-reported HIV risk behaviour:

In directly asking an injector about any sharing in the recent past there may be an implied assumption that the risk behaviour has been voluntarily entered into and thus that the individual has been guilty of a serious disregard for his or her own health and the health of others. In the vignettes, by contrast, there is an implicit recognition of the potential for the injectors' behaviour to be constrained by the social context within which the drug use is occurring. Thus the individual may feel less culpable in reporting sharing in response to the vignettes than in response to the direct questions.

There is much debate surrounding the use of vignettes, and some of the issues in relation to the application of the technique in this study have been discussed more fully elsewhere (Hughes, 1998). These debates generally centre around the differences between real life and vignette responses; the selectivity of vignettes that can never cannot match real life situations; and that differences arise between what people consider *should* happen in a vignette and what people consider *would* occur.

As part of the data generation strategy small group discussions were also employed. Much has been written on the ways in which interaction between group members can be a

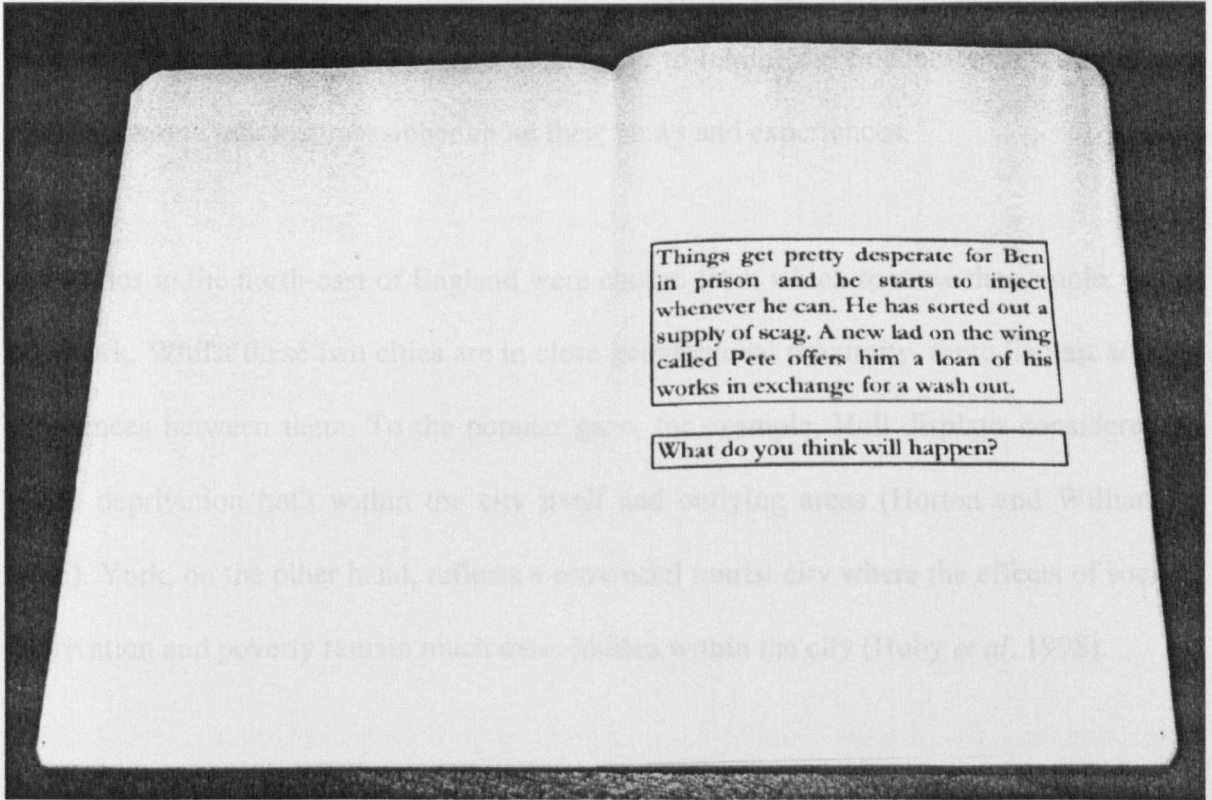
valuable source of data within focus group research (Kitzinger, 1994; Morgan, 1997). The similarities and differences between participants' views and experiences can help to highlight attitudes, priorities and the use of language. It can also identify group norms and provide an insight into the processes underlying the articulation of knowledge (Kitzinger, 1994). This interaction, particularly when it is spontaneous, can be especially useful for stimulating and exploring new research topics and it is this feature of group interaction that is harnessed for focus group methodology (Morgan, 1997). In their formal sense, focus groups are difficult to implement when conducting research with drug injectors due to the difficulties in contacting and recruiting drug injectors. Thus, for the purposes of this study adaptive small group discussions were employed. An important consideration when conducting group discussions is whether groups should consist of people known to each other or even whether they should be formed from pre-existing groups. The use of pre-existing groups has been criticised as participants may present well-rehearsed statements, the discussions may be based on assumptions and certain topics among close friends may be taboo (Tritter, 1997). However, these are features of inter-personal relations more generally. There is some value in moving away from focus group convention to using pre-existing and 'natural' groups (Kitzinger, 1994; Beckerleg *et al.*, 1997). In the AIDS Media Research Project, Kitzinger (1994, p. 105) recruited participants who were living, working or socialising together and argues that these groups were able to "tap into *fragments* of interactions which approximated to "naturally occurring data" as participants challenged each other's views about what they "were *professing* to believe and how they actually behaved" (emphases in original). In this respect, the small group discussions held with existing groups in the present study may be less likely to attract public accounts.

Field-notes are usually an integral component of ethnographic fieldwork (Hammersley and Atkinson, 1995). In the present study recorded field-notes were employed to record data generated in other ways. For example, the point at which an interview or group discussion begins is usually marked by taking the notepad out and turning on the tape recorder. This can signify a 'formal' beginning. However, recording only subsequent data neglects the events and negotiations that lead up to this point, together with the expressions and non-verbal gestures occurring throughout the interview or group discussion. Observational field-notes complement the more 'formalised' data collection methods and have been useful, for example, in recording why people may not participate in research (Hughes, 1999).

RESEARCH TOPICS

Topic guides were designed for use in interviews to explore how drug injectors perceive risk behaviour inside and outside prison, and to learn more about drug injectors' views on social policy topics, as shown in Appendix 1. In addition, a vignette was written to incorporate some of the important aspects of risk behaviour inside and outside prison and was employed within the context of in-depth interviews. The vignette, seen in Photograph 13, is detailed in Appendix 2. Small group discussions were used to explore 'wider life' issues inside and outside prison as shown in Appendix 3. The topic guides and vignette were piloted with colleagues and a small number of drug injectors. During the main body of the fieldwork there was considerable overlap between the topic guides in practice. Notably people would discuss risks within the context of prison life in the in-depth interviews and during small group discussions the topic of prison life would often lead to the issue of drug injection and subsequent risk behaviour.

Photograph 13. *'Injectors and the Inside' Vignette Storybook*



SAMPLING STRATEGY

Sampling strategies are an essential and integral component of qualitative research (Mason, 1996). In qualitative studies on drugs and risk behaviour, commentators have argued for more rigour, especially with regard to sampling (McKeganey, 1995; Power, 1998). In the present study, the initial sampling strategy aimed to recruit people in the community who had injected drugs and spent time inside prison.

People in the sample were to be recruited from outside rather than from inside prison partly because prison-based research encounters practical problems including negotiating access and ethical issues such as the possibility of identifying drug injectors to prison authorities. Whilst these considerations are also apparent in community studies they are far less

marked. In addition, the timing of the early stages of the fieldwork coincided with the piloting and introduction of mandatory drug testing inside prison and the introduction of other drug policies. This would have been likely to inhibit the freedom with which drug injectors would talk to a researcher about their views and experiences.

Two cities in the north-east of England were chosen from which to draw the sample: Hull and York. Whilst these two cities are in close geographical proximity, there lie vast social differences between them. To the popular gaze, for example, Hull displays considerable social deprivation both within the city itself and outlying areas (Horton and Williams, 1996). York, on the other hand, reflects a provincial tourist city where the effects of social deprivation and poverty remain much more hidden within the city (Huby *et al.* 1998).

It was envisaged that these two cities would allow access to a larger number of drug injectors with prison experience than one city alone and provide a wider range of responses from participants. Due to the nature of the study, and the transient nature of the drug injecting population, the responses are not used for comparing responses between these two cities.

Attention was paid to sampling strategies designed to “encapsulate a relevant range of units” (Mason, 1996, p.92). Thus, a range of demographic characteristics was sought and the intention in sampling was to recruit roughly equal proportions of men and women, and to achieve a good range on other basic demographic characteristics and experiences.

CONTACT, RECRUITMENT AND FIELDWORK WITH DRUG INJECTORS

The activities of some drug injectors can lead individuals and groups to conceal aspects of their behaviour from 'interested' groups, including researchers. This has led to drug injectors being characterised as a 'hard-to-reach' or 'hidden' group (Lambert, 1990) and because of this there can be no 'representative' sample of drug users (Wiebel, 1990). However, to help understand the difficulties that arise during recruitment it is important to recognise that individual researchers have particular relationships with participants characterised by differing degrees of social distance. The ubiquity of drug use, and therefore drug users, indicates that it is not these individuals themselves who are 'hard-to-reach'. Rather, being 'hard-to-reach' is the product of a particular relationship researchers have with participants. Drug injectors' lives in the present study were characterised by disadvantage and, therefore, it is their position within society *vis-à-vis* a researcher's that can make them 'hard-to-reach'. Furthermore, as Balslem *et al.* (1992, p. 157) point out:

Being hard to reach is not an attribute of a target population; it is an attribute of an interaction in which one group unilaterally targets another.

Innovative research techniques have been developed in response to the issues that surround research with drug users, especially on the topics of HIV and AIDS (Ostrow and Kessler, 1993; Boulton, 1994). Drugs research methodology has developed a range of innovative techniques to overcome some of the difficulties in contacting and recruiting drug injectors (Power, 1995). It has included drug users themselves performing a number of roles in the research process including contacting, recruiting, and interviewing other drug users (Griffiths *et al.*, 1993; Power, 1995). Access to drug users has also involved individuals and organisations which have a particular relationship, usually as a helping and assisting relationship with groups of drug users. Ethnographic approaches have used these methods

with, for example, drug agencies (Power, 1989), a pharmacy (McKeganey and Barnard, 1992) and a detached drug worker (Taylor, 1993). Contacts established from these sources can then enable researchers to extend their contacts to other groups, sometimes as part of a 'snowball' sampling strategy (Birnacki and Waldorf, 1981).

The following section discusses first, the ways in which, in order to reach a sample, access was negotiated with services in contact with drug injectors and, second, the methods used to contact and recruit drug injectors themselves. A more illustrative account of these processes can be found in Hughes (forthcoming a).

Negotiating Access With Services in Contact with Drug Injectors

The starting point for the fieldwork was to contact a range of helping services in touch with drug injectors. Those approached included CNSSES, drug-counselling services, young people's projects, residential drug treatment centres, probation services, drug teams operating inside prison and various types of hostels. From the outset these were chosen to represent a wide range of services in touch with drugs injectors and different client groups. It also had the practical benefit of avoiding an over-reliance on any particular service (Power, 1989).

A series of letters, telephone calls, and face-to-face meetings established contact with key members of staff within these services. The purposes of these contacts were two-fold: first, to ask professionals for their advice and input into the research. This included inviting feedback on the research instruments and discussing strategies to recruit drug injectors with prison experience. Second, professionals were asked whether they could help recruit participants.

Research that involves the co-operation of services demands a number of important considerations (Power, 1989). At the outset it is important to note that the majority of services contacted over the course of this study responded positively to the research, most agreeing to co-operate. However, one important factor that influenced the readiness of services to co-operate was the extent to which the research would take up time and resources. When services were unable to help, this was usually due to the conflicting pressures facing staff and the services.

Contacting and Recruiting Drug Injectors

Having been granted access to recruit via community services, the next stage of the project was to make contact with eligible drug injectors and invite them to participate. To highlight awareness of the study and the researcher, three complementary strategies were used. First, introductory letters, with attached pre-paid envelopes were distributed within services centres. In some locations, letters were placed in communal areas and in others staff gave them out. Second, posters were put up in services centres. Third, over a number of weeks an advertisement was placed in the Big Issue, a magazine sold by homeless people. These briefly outlined the purposes of the research and invited eligible people to contact the researcher.

Some, although relatively few, contacts were made directly through these awareness-raising strategies. The most successful technique for contacting and recruiting drug injectors into the study was spending time with them. In this respect, meeting people in 'low-threshold' services such as 'drop in' centres or in the common rooms of hostels enabled the researcher and potential participants to get to know each other, building up confidence in the research relationship. However, it is important not to underestimate the

value of the awareness strategies that *facilitated* contact with people. By reference to the advertisements conversations about the research could be quickly sparked. These helped the researcher to ascertain whether individuals were eligible to be invited to participate.

Recruitment from other services was facilitated by staff acting as gatekeepers, who introduced participants to the researcher. In addition, snowball sampling techniques and time spent getting to know people outside service centres typically 'on the street' and 'hanging out' at meeting points frequented by drug injectors allowed the researcher to reach people not in touch with services.

A difficulty regularly encountered during the fieldwork concerned the recruitment of women. Some, although not many contacts were made with women inside and outside service settings, and they generally responded positively to the research. Yet it remained difficult to recruit women. To help deal with these problems, the end of the fieldwork period focused solely on recruiting women. It involved spending more time in settings such as hostels which housed women, and in service before 'women only' sessions. Whilst, as a man, it was not possible to spend time during the 'women only' sessions, some women would arrive early and provide an opportunity for the researcher to meet them. Such strategies helped to recruit additional women into the study. Ultimately however the extent to which special groups can be contacted and recruited for research relies heavily on the timing and resource constraints of the study (Lee, 1993). In this study fewer women than expected were recruited. This may reflect the existence of fewer numbers of women drug injectors than men, especially those using drug services (Vogt, 1998). It could also be due to the gendered dimension of the fieldwork (Padfield and Procter, 1996), in which the researcher was a man, trying to recruit women as participants.

The Use of Incentives and Rewards

The effect of using incentives and rewards to help recruit participants in social research has been debated (Wineman and Durand, 1992). These debates often centre upon the extent to which incentives may be coercive and enticing, thereby unduly influencing individuals' participation (Macklin, 1981) especially amongst hard-to-reach groups (Cottler *et al.*, 1995; Melrose, 1996). In previous research drug users have been offered a range of incentives including food vouchers (Cottler *et al.*, 1996), food, drink and cigarettes (Spooner and Flaherty, 1993; Spooner *et al.*, 1997), health care information, condoms and needles and syringes (McKeganey and Barnard, 1996), and cash payments (Loxley and Davidson, 1998; Merikle, 1999). The use of incentives in social research raises a number of ethical and practical questions (Huby and Hughes, work in progress). In the present study a decision was taken to provide some token of appreciation for participating. Whilst not always made explicit during fieldwork negotiations, although stated on some of the awareness raising techniques, a hand-written 'thank you' card and a letter together with a £5 high street stores gift voucher was offered to participants at the end of each in-depth interview and small group discussion. In addition, some people were bought a meal or snack. A snack bar or restaurant could provided a suitable venue for the meeting, but may also have formed an incentive or reward. These were all offered as some token of appreciation for participating, rather than *quid pro quo* exchange. The incentives and rewards used in the present study sometimes influenced people's readiness to participate but were not the sole motivators for taking part.

Understanding Drug Injectors' Reasons for Participating in Research

There are a host of reasons why people agree or decline to participate in social research activities (Holden *et al.*, 1993) but few studies have directly addressed people's motives.

As Lee (1993) notes, what is known often comes from researchers' own reflections, which can lose sight of participants' perspectives. Drug users have been noted to participate in research as a relief from loneliness, boredom and isolation (Taylor, 1993), from a feeling that their contribution will help society (Bowser and Sieber, 1993), and with the hope that they will make a positive impact on public policy (Balshem *et al.*, 1992). Participation can also have costs which, as Spooner *et al.* (1997) suggest may be because drug users are suspicious or apathetic towards research and because of the time it takes to participate. Similarly, non-response in drug using surveys has been attributed to the potentially 'sensitive' and 'threatening' topic of individual's drug use (Caspair, 1992; Witt *et al.*, 1992). As part of the present study, drug injectors were asked about their reasons for participating in the research. These findings are reported in more detail elsewhere (Hughes, 1999) but the key reasons given are summarised in Box 2.

The Sample Achieved

The achieved sample reflected the methods used to contact and recruit drug injectors. The following sample description includes those who 'formally' participated in in-depth interviews or small group discussions and excludes data generated from 'informal' contacts and conversations held in other settings. In all, 17 people were interviewed in-depth. Two early (pilot) interviews were conducted with two vignettes that were later revised and one interview was conducted without a vignette. These three interviews were used in the analysis but only using the data generated from in-depth interviewing techniques. Thus, vignette generated data was obtained from 14 people.

Box 3.

Drug Injectors' Reported Reasons for Participating in Research: An Illustrative Summary

Interesting, relevant and worthwhile research:

“It sounded quite interesting...it is something I know a bit about and I have got points of view on the things we talked about”(in-depth interview).

Timing of the research and participants' concerns and priorities:

“It passes the time in here [hostel] to be honest” (in-depth interview).

Research benefits participants:

“Assisting you in your research would also help me in the long-run I believe” (letter to the researcher).

Research benefits others:

“If one person in authority reads it and makes a little change it has got to be worth it for the people who come behind me” (in-depth interview).

Influence of gatekeepers:

“Through a friend. He said he'd spoken to you and, I don't know, any help I can give from my experience I don't mind doing it” (in-depth interview).

Confidentiality:

“I was assured ... that it would be confidential” (in-depth interview).

First impressions:

“If you'd been some fucking bloke with a whistle and flute and that, stuck up, and who's gonna be judgmental and all I don't think I would have done it” (small group discussion).

Incentives and rewards:

“You said about the token and you said you would take me out for a meal like and I thought I would help you out” (in-depth interview).

Ten people participated in three group discussions comprised respectively of two, three and five participants. The group discussion with five people included one individual who had not spent time inside prison and these responses were excluded from analysis. In addition two people who had participated in in-depth interviews later helped to set up a group discussion and also participated in the group discussion.

All participants had previously injected drugs. At the time of interview 19 people reported 'currently' injecting drugs. Individuals had been injecting drugs from between 9 months to 19 years. Heroin was the first drug of choice for most participants, as shown in Table 11, and this was also the drug mainly used by participants, as detailed in Table 12.

Table 11.
Participants' First Drug of Choice

First drug of choice	Number of participants
Heroin	19
Cannabis	3
Methadone	1
Ampetamine	1
Total	24

Table 12.
Drugs Mainly Used by Participants

Drugs Mainly Used	Number of participants
Heroin	20
Methadone	18
Cannabis	10
Amphetamine	1
Total*	49

Note: *Totals exceed number of participants as most participants used more than one drug.

The sample achieved had also spent time inside prison. A number of offences had been committed resulting in being sentenced to custody. These offences typically include trespass, burglary, criminal damage, firearm offences, shoplifting, breaching bail, fraud

and deception, driving offences, possession of drugs and drugs supply. The number of times people had spent in prison custody, either on remand or as a sentence ranged from one to 18 occasions, although these figures were often given as estimates. Similarly, the time served on the last occasion ranged from 1 day to 5 years. Contact was made with participants between 1 week and 4 years after release.

Of the 24 total participants, 18 were men and 6 were women. Thus, the sample did not achieve equal numbers of men and women. Men's ages ranged from 22 to 36 years with a mean age of 27 years, and women's ages ranged from 17 to 30 years with a mean age of 23 years. The sample also represents a range on other basic demographic characteristics. The housing circumstances of people included living in trailers, with others on a temporary basis, and in hostels to living in more permanent accommodation including flats and houses. The first contact with participants was made from services in touch with drug injectors in 17 cases and 'on the street' and in communal meeting places with 7 participants. Eleven contacts were made with participants in Hull and 13 contacts in York. Summary profiles of participants are provided in Appendix 4.

Interviews and Small Group Discussions: Set and Setting

Interviews and small group discussions were held in a variety of settings including service establishments, participants' homes, cafés, pubs and restaurants. Ideally service establishments would provide the most suitable venue to interview people. Quiet interview and counselling rooms provide a comfortable environment. As with many services, however, these rooms would be well used and may be available for limited time periods. In these situations and when contact was made with people outside of services centres, commercial establishments also provide a suitable venue for meeting. However, this is not

without its problems. For example, whilst an attempt to secure a 'quiet corner' was made these could become busy within short periods of time with the associated noise being picked up in the recordings. Furthermore, the tape recorder and notepad of the researcher could be understood to draw attention to the meeting. On some occasions the setting did not *outwardly appear* to bother participants although on other occasions the reverse was documented in the fieldwork diary.

Other problems when conducting in-depth interviews and small group discussions included interruptions of which one of the most common was the search for cigarettes. In addition, whilst the timing and participants' other priorities could affect participation they could also affect the 'quality' of responses. For example, when contact was made with Big Issue sellers taking time to speak to the researcher led to a potential loss in sales. This meant that some interviews were much shorter than others and sometimes interviews would be cut short, sometimes without prior warning. Similarly, responses could become increasingly rushed if participants had other things to do.

In contrast, however, in other settings people had much more time available to speak including when meeting in hostels and in people's homes. In more relaxed settings such as these other factors could also be understood to affect the 'quality' of responses. For example, the injection of heroin and its associated affects on people were sometimes not conducive to satisfactory research interviews in the present study.

Discussed in this section is a selection of the sorts of issues encountered during the fieldwork. As some of the research topics centre on particular policies it is important to note that the fieldwork was undertaken during 1997 when the previous government (Lord

President of the Council and Leader of the House of Commons *et al.*, 1995) and associated Prison Service (1995a) drug strategies were in force.

THE PROCESS OF DATA ANALYSIS

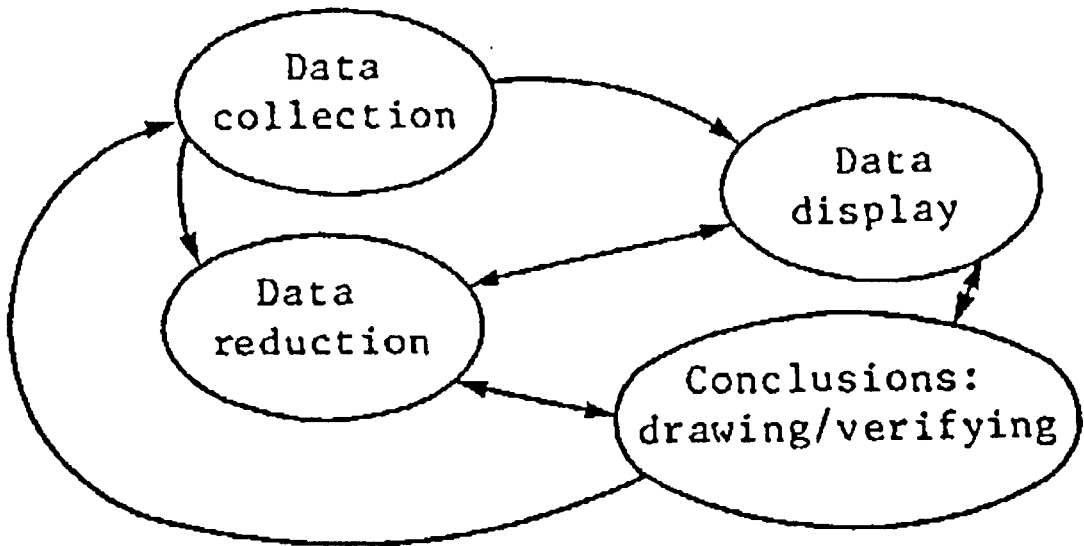
At the onset of the interviews and group discussions participants were asked whether a tape recorder could be used for the purpose of transcribing. No one objected to its use and all in-depth interviews and group discussions were recorded. The tape recorder was not used during other contacts. There are a number of issues that researchers face when transcribing (Poland, 1995; Mishler, 1991) and in this study some consistency was maintained by one person, the researcher, fully transcribing the material. Decisions were made during transcription, to exclude vocabulary such as “ums” and “ers” and “hms” from the conversations.

Transcribing the tapes allowed familiarisation with the data as did the reading and re-reading of transcripts. Established qualitative data analysis procedures were followed, as described by Miles and Huberman (1994) and were facilitated throughout by the computer software package, Non-numerical Unstructured Data Indexing Searching and Theorizing or NUD*IST (Qualitative Solutions and Research, 1997; Gahan and Hannibal, 1998). Procedures focused on the reduction of data, its retrieval and display, and conclusion drawing and verification. Such procedures are interactive, as Figure 8 illustrates, and are also iterative. Coding and analysis was kept flexible in order to combine prior theoretical knowledge and assumptions with the inductive generation of original concepts and theories (Layder, 1998).

Figure 8.

The Components of Data Analysis: Interactive Model

(Source: Miles and Huberman (1994, p.12). Reproduced with the kind permission of Sage Publications.)



The aim of the analysis was to examine the influences on drug injectors' HIV risk behaviour inside and outside prison and to explore the impact of recent prison policies on drug injectors' lives. Theoretical and empirical constructs are closely allied and it is important to recognise that the analytical approach adopted was underpinned by the theoretical framework as discussed in Chapter 5. With regards to the findings on perceptions of risk behaviour, three broad analytical headings capture, albeit to differing degrees, some of the main constituents of the theoretical framework. First, risky situations focus on experiences of the need for drugs and the ways in which people think about HIV risks. Second, influences and mechanisms on risk reduction, as identified by drug injectors, explore social distance and the cleaning of needle and syringes when shared. Third, drug injectors will respond in some way to risks taken and perceptions of HIV testing are examined. The findings presented will also draw on the theoretical framework to assist explanations of the issues under study.

Following analysis of data on drug injectors' views and experiences, three policy topics are reported. These include the role and operation of illicit drug and injecting equipment markets in prison, MDT and substitute prescribing. These policy topics are often neglected in current agendas and serve to inform contemporary policy debates by fostering an appreciation of the issues from drug injectors' perspectives.

The following chapters draw on the words of participants, as transcribed. The vocabulary of distinct social groups, including drug injectors, can be esoteric. Details of the source of these quotations, including the geographical location, are detailed in Table 13. In addition, the vocabulary of distinct social groups, including drug injectors, can be esoteric especially when transcribed verbatim. Clarification of drug injectors' vocabulary, as used in the quotations in this study is detailed in the Glossary.

SUMMARY

Empirical research raises a host of methodological considerations. Discussed in this chapter are some of the issues raised when conducting research with drug injectors in the present study. The objectives of the research are broadly two-fold. First, to explore drug injectors' perceptions of risk inside and outside prison and second, to explore the impact prison drug policies have on their lives. To achieve these objectives qualitative in-depth interviews with a vignette, small group discussions and diary field-notes were employed with drug injectors contacted and recruited in the community. Inductive and deductive data analysis procedures established three broad themes enabling a better understanding of drug injectors' perceptions of HIV risk inside and outside prison. These themes constitute the following three chapters in this thesis. Following these analyses the fourth and fifth

empirically-led chapters examines drug injectors' views and experiences on three prison drug policies.

Table 13.
Location of Contact with Participants and Type of Data Source

Name	Location		In-depth Interview	Group Discussion		
	York	Hull		One	Two	Three
Adam		•		•		
Amy	•				•	
Colin		•	•			
Craig	•		•			
Dan		•	•			
Dave		•				•
Don	•		•			
Jake	•		•			
Jane	•		•			
Karen	•		•			
Keith		•	•			•
Kieran	•		•			
Lewis		•	•			
Lorna	•		•			
Mark		•	•			
Martin		•				•
Mike		•		•		
Natasha	•		•			
Nick	•				•	
Phil		•		•		
Robert	•		•			
Sharon	•		•			
Terry		•	•			•
Tim	•		•			
Total	13	11	17	3	2	4

RISKY SITUATIONS

INTRODUCTION

Drug injectors are faced with situations that sometimes provoke risk behaviour. Risky situations can occur when the means to use risk reduction materials, including sterile injecting equipment and condoms, are unavailable. The unavailability of shared injecting equipment, for example, exerts an important influence on drug injectors' risk behaviour or safer behaviour. Inexorably bound with this, is the fact that risk behaviour is also more likely to occur when individuals feel the need and desire for drugs, which can be part of the process of drug withdrawal (Stimson *et al.*, 1988; McKeganey and Barnard, 1992; Connors, 1994; Power *et al.*, 1996). To understand more about drug injecting risk behaviour, this chapter begins by briefly contextualising drug injectors' experiences of drug withdrawal. It then examines the influence of the need and desire for drugs on risk behaviour.

Individuals' thinking about risk in these situations has been afforded little attention. Within the broad area of risk analysis, thinking about risk has largely been explored using quantitative research methods (Gerrard *et al.*, 1996; Sjöberg, 1998). There is also scope for a much richer appreciation of the influences underpinning the ways in which people think about risk. Furthermore, empirical research is not disengaged from theoretical constructions (Stanley and Wise, 1993; Layder, 1998) of risk and this chapter will also assist in the illumination of the tentative theoretical framework (Figure 7) presented in Chapter 5.

“GETTING SICK”: EXPERIENCES OF THE NEED AND DESIRE FOR DRUGS AND WITHDRAWAL

Drug injectors contacted in the present study were mainly heroin users who required regular amounts of heroin to stave off drug withdrawal. Both outside and inside prison the pursuit of drugs was one of a number of priorities in people’s lives. During the pursuit of drugs – from financing and locating supplies to the injection of drugs – people reported a preoccupation with drug use and injection. The use of drugs can help people to feel normal, enabling them to get on with their everyday lives. Jane explained:

I never want to become ill and poorly. It’s like as soon as you’ve had that hit you can get up and do all your housework and the washing and go out and get dressed up and you don’t think nothing about it. But if I’m poorly I can’t seem to do anything.

It is important to recognise that drug withdrawal are heterogeneous experiences (Merikle, 1999). In the present study people used words including “sick”, “ill”, “poorly” and “pain” to describe drug withdrawal. These words are used to describe the physiological and psychological features of the need and desire for drugs. Experiences of drug withdrawal are physically and psychologically unpleasant, as Lewis says:

It’s like weird. It’s like having icy sweat on your back, when you start sweating you’re freezing and I’ve hallucinated sometimes off turkeying because I’ve not had sleep for that long and that you end up seeing things and all sorts. You’re just tired but you can’t sleep, you’re in bed but you can’t get comfy in your bed. You’re laying this way you’re laying that way tossing and turning all night. Your back starts, diarrhoea, sickness. It’s the mind games as well when you’re turkeying. It’s mostly up there as well, I’m thinking I’m not going to get through this, I need a hit. But if you stop thinking about it for a while and keep occupied it seems to go away, till you stop doing that and you’re sat there and it starts up again.

These experiences occur in any environment. However, when people spend time in prison they may undergo enforced withdrawal, especially when, as will be demonstrated in Chapter 11, the substitute drugs to relieve drug withdrawal in prison are inadequate. In the community, deliberate drug withdrawal can be alleviated by using other drugs or it can generally be avoided because supplies can be easier to finance and procure. However, inside prison there may be shortages of drugs, thereby making drug withdrawal more difficult to avoid. The effects and experiences of drug withdrawal in prison were reported to last from a matter of days to considerable periods of time. Martin describes his experience in prison as:

I rattled for three and a half month when I went to gaol last year. Three and a half months of sheer hell.

With these considerations as backdrop, the next section examines the influence of the need and desire for drugs on perceptions of risk behaviour.

“CLUCKING FOR A HIT”: THE NEED AND DESIRE FOR DRUGS AND HIV RISK BEHAVIOUR

Drug injectors may share injecting equipment to help others who are in need of a drug injection. If individuals empathise with other people's need for drugs, including identifying with the feelings of drug withdrawal or feeling guilty when they are in a more favourable position than someone else, then injecting equipment may be lent out. Robert considered that a vignette character would lend out injecting equipment in these sorts of situations:

Because Vicky was desperate, the works were gone and she needed an injection and Sarah's been in that same situation herself and wouldn't want anybody else to be in that same situation.

In this example, Robert suggests that drug injectors would not like others to be in need of drugs and, consequently, injecting equipment may be lent. However, as explored in Chapter 8, such factors may also be influenced by other perceptions of risk including individuals' relationships.

When drug injectors need and desire drugs in situations where sterile injecting equipment is unavailable it is often considered necessary to share. In response to many of the possible sharing scenarios contained within the vignette it was reported that individuals would share injecting equipment because of the effect of the strength of the need to inject and the effect of drug withdrawal on risk perception. Jane reflects this finding with reference to the vignette:

They are both scag heads, they are obviously desperate for a hit otherwise they wouldn't have gone on the burglary. I think they'd share works, they definitely would share works.

Similarly, Tim's experiences of sharing outside prison point to a combination of drug withdrawal and unavailability of sterile injecting equipment:

I've been turkeying, you know, wanting it there and then it's been like desperation. ... There's been no other way of getting needles and it's been night-time and unable to pick them up.

Whether people do or do not share depends, at least partly, on the strength of need they feel for a drug injection. Situations in which people need drugs immediately were found to compound the desire for drugs and, subsequently, a willingness to take risks. Furthermore, the events and situations that build up to the injection of drugs, together with the need for

drugs, can also result in risk behaviour being considered and then pursued. Terry, in response to the vignette, said:

There is no way you're going to say in that situation, "oh, we'll wait till the morning until we can get to the chemist". 'Cos it's there and again it's like oh it's there I want it and I'm not going to wait for it because I've gone through all this to get it and you're all ready waiting for the hit.

In turn, these factors depend on other physical and psychological factors. One such factor was that the longer drug dependency had been maintained the greater its influence on the need to use drugs and take risks. As Karen said in response to the vignette:

If you've really been on it a long time and you're really really desperate for a fix you'd do anything to get it.

In contrast, when individuals are less dependent on drugs the opposite can apply. Kieran, reflects on his own behaviour:

Now I ain't got a habit, I don't need the hit so much, so I can take the time getting clean needles. I don't have to share.

Thus, the need for drugs can be understood as a guiding influence on drug injectors' perceptions of risk and their actual behaviour. Importantly safer behaviour may be adopted when people feel less need for drugs in their lives. These findings support other studies, including Merikle (1999), who found that drug users reported fewer and less intense craving for drugs when attempting to remain abstinent. On the basis of the present study, the lower the need and desire for drugs the less likelihood of risk behaviour. However, other factors can influence the need and desire for drugs, which can hinder safer perceptions of behaviour. Curran *et al.* (1999) found the use of methadone increased

craving for heroin. Thus, whilst methadone may reduce drug injecting (Strang *et al.*, 1997) and associated risk behaviour (Marsch, 1998), it also has the potential to increase risk perception and subsequent risk behaviour when increasing the desire for heroin.

Having established the conflicts between the need for drugs and risk behaviour, it is important also to examine how the conditions faced by drug injectors in prison may also shift the balance of decision making from a concern with risk behaviour to needing drugs and sharing. Examined here are some of the influences on risk behaviour within this environment.

Perceptions of risk behaviour transcend movements inside and outside prison. In response to the prison-based vignette scenarios, people recognised that the vignette characters would be in need of drugs, especially upon first entering prison. As a result, enforced withdrawal may lead some people to change their patterns of drug use, leading to a reduction or cessation in drug use. This can help to understand why prison may assist some drug injectors to break patterns of drug injecting (Shewan *et al.*, 1994a; 1994b; 1995). Tim offers a personal illustration of the ways in which this situation may come about:

I'd done a five-day lay down at [name] police station. ... So really I had gone through the worse of me rattle, you know. I'd done the worse of it there. ... The first time I did enquire to see if there was anything on the wing and someone filled me in on the size of the bags in prison. Thought about it, then thought it is not worth bothering with. Got me head into thinking well I'm here now I may's well, you know, stay away from it all. If I get a visit then it is all good but if not I'm off it.

Whilst limited supplies of drugs and injecting equipment may result in a reduction or cessation in drug injection, the need and desire for drugs can transcend the prison setting

and continue to influence risk behaviour. The need and desire for drugs are important reasons for sharing injecting equipment. Robert describes his own experiences as:

I just wanted it, you know, I just wanted to get myself feeling right that night and to tell you the truth I've done it [shared injecting equipment] twice on two separate occasions.

Such findings can help to understand why people inject inside prison (Table 5).

Furthermore, it is important to recognise the combination of influences on risk behaviour.

For example, the need for drugs combines with availability inside prison. The interplay between these two factors is illustrated by Keith in response to the vignette:

It depends whether she's got any gear. If she ain't got any gear and she's clucking and that persons got gear she gonna lend them it for gear. If she's got gear she's not clucking she's gonna say no.

In turn this impacts upon other features of the prison environment. For example, closely allied to availability is the exchange of drugs and injecting equipment, as will be explored in Chapter 10. These exchanges may be more likely when people are in need of drugs. As

Keith goes on to say:

She is going to give her the phone card for the hit. She's clucking for a hit she's gonna give her, she's gonna give her whatever she's got.

That drug injectors in the present study understood risks to be taken when they need and desire drugs is not a surprising finding. However, given the 'obviousness' (Gage, 1993) of the topic, also noted by Power *et al.* (Power, R. *et al.*, 1996, p.100) as an "almost predictable" situation, this topic has been left relatively unexplored with regards to risk behaviour, especially with regards to the prison setting. The findings presented here

broadly concur with others (Stimson *et al.*, 1988; McKeganey and Barnard, 1992; Connors, 1994; Power, R. *et al.*, 1996), which together demonstrate the need and desire for drugs as an important influence on risk behaviour. The present study has gone further by providing an insight into the operation of these factors both inside and outside the prison setting. Within these two environments there are similarities in the ways drug injectors construct their ideas about risk. In both settings people recognised the need and desire for drugs as an influence on risk taking, namely when situations arise where there is no sterile injecting equipment available so that it was often considered necessary to share injecting equipment. Differences also emerge as a result of the enforced withdrawal some people were forced to endure inside prison. These findings have a close relationship with inadequate substitute prescribing inside prison, which will be discussed in Chapter 11.

Turning to the conceptual ideas presented in Chapter 5, it is clear that the need and desire for drugs can feature routinely in some drug injectors' lives. The routine aspects of everyday life are important to both Schutz and Giddens. However, Schutz departs from Giddens by emphasising the calculating aspects of decision making. These calculating aspects can be seen from some drug injectors' responses. For example, when sterile injecting equipment is unavailable, which represents an imposed relevancy, some individuals subsequently decide to share. However, the findings presented in this section of the chapter also illustrate other influences on risk behaviour. There are also embodied and emotional influences on risk behaviour. For example, the longer an individual has been drug dependent the greater the perceived need for drugs. At the emotional level, when people identify with others in need of drugs, feeling a sense of altruism or guilt may lead to injecting equipment being shared. In these respects, the theoretical framework enables

conceptualisation of both the embodied and emotional influences together with the more calculating aspects of perception.

This thesis can move beyond these understandings to expose the ways in which people think about risk and, in particular, the temporal dimension. These findings are grounded within drug injectors' need and desire for drugs. Whilst pursuing this focus, these findings may have wider resonance to risky situations more generally.

“THINK ABOUT THAT LATER”: EXPLORING THE WAYS DRUG INJECTORS THINK ABOUT HIV RISKS

This section explores how risk behaviour may be enhanced by need and desire for drugs together with the sublimation of concerns about HIV, which can result in risk behaviour being considered more likely. However, drug injectors do express concerns about HIV, which leads to a consideration of the management of these risks by thinking in the short and long term. Also examined are the resurfacing of HIV concerns that are broadly classed as imposed and intrinsic.

Drug injection occurs in very drug orientated situations, which are accompanied by a build up to the use of drugs. As a consequence, drug injection can preoccupy people's minds. Natasha's personal experiences exemplify this finding with regard to drug injecting outside prison:

By the time you've been grafting and sold your stuff and got your money together, scored and you're rattling you just don't think about anything else.

When drugs are being pursued, drug injectors reported not being able to see past drug injection and everything else is sublimated. Drug injectors sometimes framed these responses with not caring about risk at the time of drug injection. Sharon describes a risky situation when she did not care about the risk of sharing injecting equipment:

It's been late at night, we've only just managed to sell the shoplifting and stuff, had some gear and there is only one set of works. ... Just banged it in my arm. I didn't give a shit at the time.

Similarly, inside prison drug use was a response to the "boring and demoralising" nature of prison life that in turn was also attributed to a lack of concern about HIV and not thinking about risk. Robert exemplifies some of these issues in response to the vignette:

He'd not be concerned about, you know, if he's going to catch anything or how he's feeling and, you know, he's just been put in prison for two years I don't think he'd care. I think he'd do it and worry later.

Similarly, Tim's observations of another person's behaviour:

This guy was a cat A. He was looking at doing a life. You know a serious offence and he literally wasn't bothered about anything. He was the type if he got a needle to use, yeah, bomf, he'd do it straight away. ... It is a lot of boredom being locked up.

Not caring about HIV risk could be used as an explanation for not thinking about risk. Furthermore, the immediate need to alleviate drug withdrawal can mean that thoughts about risk are entirely subsumed. Kieran illustrates this issue as an explanation for sharing injecting equipment inside prison:

I was still rattling and all I wanted was a hit so I didn't really think about catching those diseases, it didn't even come into my mind.

When drugs are the main preoccupation, Mark describes the “tunnel vision” associated with the need and desire for drugs:

I think a lot of it is the drug. You sort of, how can I put it, when you're like rattling it is like tunnel vision you're not feeling of nothing but feeling OK and by having that hit you're going to be all right and forget about everything else, you can't, it [HIV] just doesn't seem to come into it.

Not thinking about HIV risk can be explained by findings that suggest how any concerns with HIV and AIDS are pushed to the back of the mind during periods of drug injecting and subsequently forgotten. For example, “when you're using gear you put it to the back of your mind and forget about it”. A distinction was made between putting thoughts to the back of the mind to temporarily forget and thoughts which “go out of your mind”. Terry, makes this point:

It goes out of your mind, well it doesn't go out of your mind completely it goes to the back of your mind.

Lorna suggests that HIV is always an issue in people's minds, but at the time of drug injection the consequences of risk behaviour, notably HIV, are forgotten. Lorna says:

But it [HIV and AIDS] is there in everybody's mind but like when at the time you are having drugs you just tend to forget about the future and you just think about that hit and that is really what happens all the time.

Whether risk is pushed to the back of the mind or out of the mind, together these distinctions serve to illustrate deferment processes at work. Gerrard *et al.* (1996) support the notion of risk deferment in their three-year longitudinal study of adolescents' risk behaviour, namely reckless driving, drinking and smoking. They note that these risk behaviour were engaged in despite individuals being aware of the risks and go on to

suggest that risks can be managed by not thinking about them. Rather than denial of risk, these processes, as Gerrard *et al.* (1996, p.350) assert, enable people's minds to work "in what appears to be a "Scarlett O'Hara strategy" in which they say to themselves "I won't think about this now"".

These findings resonate with other studies that suggest how individuals consider other people to be more at risk than themselves (Weinstein and Klien, 1995) or individuals underestimate the risks to themselves in an optimistic fashion (Weinstein, 1987; Rothman *et al.*, 1996; Weinstein and Klien, 1996). The findings from the present study illustrate the complexity of some of these issues and show that risks may not be 'denied' (Sjöberg, 1998), but rather are considered in ways that enable people to go on with their intended course of action, which may be part of the process of risk deferment.

A preoccupation with drugs and the effects of drugs on the mind and body can also assist these deferment processes, which illustrates the importance of embodied influences on behaviour. Karen illustrates some of these issues:

You think, yeah, we'll go back to the thing, have a couple of E's, do a couple of digs, and stuff like that. All you think about is getting smashed out of your head. You don't think about anything else. All the concerns, 'are we're doing this right?', 'is this clean?', and all that. All you think about it getting stoned and when you do get stoned you're like all over being drunk and that. At the end of the day you can do virtually anything without knowing. And then in the morning you can't even remember half of what happened from the night before. So at the end of the day you don't really think about it.

These thought processes that enable people to go on with their actions can be understood as elements of practical consciousness and ontological security. In order for drug injectors to inject a lack of consideration of the range of risks involved is necessary. This can be

especially important given the immediacy surrounding the need for drugs. In such cases sharing injecting equipment may be more likely because of the build up surrounding drug injection, and reinforced by the need and desire for drugs. In these situations, whilst people were aware of the risks, drug injection was considered the primary concern. Typically people reported, “think gear, crank, fuck what I get after that” and, similarly, “the hit, everything else takes second place, there’s no worrying ‘oh’, you know what I mean, ‘I might have AIDS’”. This results in a tipping of balance between people’s concern with HIV and concern for drugs being weighted towards the latter. However, this is not to say that drug injectors are not concerned about sharing and the risk it entails. As noted above, these explanations may also represent accounts of practical consciousness and ontological security that enable people to inject drugs. However, risk cannot be deferred indefinitely, which as Dingwall (1976) notes is partly because of the embodied nature of health. Thus, at the level of discursive consciousness and systems of relevances these issues may be afforded more direct attention.

The need and desire for drugs is one of a range of risky situations drug injectors may encounter. As Connors (1992) suggests, drug injectors’ risk can be understood hierarchically and, as Rhodes (1997) points out, the everyday risks that drug injectors face may be given greater priority over HIV risk. However, it is important, when considering individuals’ perceptions of risk, to recognise that risk behaviour and the possible transmission of HIV is not always a priority and is bounded by other concerns. Jane’s extract, with reference to the prison environment, emphasises some of these concerns, including risk behaviour:

He’s like off the methadone, yeah, and he’s sort of like doing his turkey what he’s going to be worried about now is where he’s going to get his next hit from

sort of thing and instead of just letting himself doing the turkey and getting over it he's gone back and had a hit of scag, which is only going to last him six hours, make him feel better for six hours. He's going to worry about how he's going to feel after the six hours and where he's going to get his scag from. Not having any money and, you know, not having any clean works.

In this example, the interplay between Jane's varying concerns identified from the vignette could represent the fluidity between practical consciousness and ontological security as they move in and out of discursive consciousness. The routine of methadone dependency inside prison being broken represents a break from practical consciousness and ontological security to discursive consciousness. Furthermore, the resulting need for drugs reflects an intrinsic embodied topical relevancy. Interpretational and motivational relevances result in the use of drugs. As Schutz recognises, there is the constant formulation of relevances, in no particular order, and also topically relevant here is the need for further drug supplies and the lack of sterile injecting equipment. The interplay between these issues will come together to influence perceptions of risk behaviour.

As noted earlier, a preoccupation with the effects of drugs can influence perceptions of risk. The embodied and psychological aspects of drug taking can also help to relieve people, albeit temporally, of concerns and worries. For example, "once you get that gear into your arm you're not concerned" and, similarly, "cos he is out of it he ain't gonna be worried about it at all is he?". This can help to explain an apparent disparity between people thinking of the consequences of risk behaviour before taking drugs including "for the first ten minutes before I had the hit", with little attention being given to risk when experiencing the effects. Importantly, however, drug injectors do become concerned with risk behaviour.

Issues that have been pushed to the back of the mind or out of the mind may be understood as part of practical consciousness and ontological security. However, findings also suggest that concerns with HIV can re-emerge. This represents a shift from practical consciousness and ontological security to discursive consciousness and systems of relevances. When concerns are topically relevant and understood to be at the forefront of people's minds they are more likely to result in behavioural change through associated motivational relevances. This is in contrast to the state of practical consciousness and ontological security. These processes can be made easier by a disjunction between short term concerns of pursuing drug injection and the long term effects of contracting HIV. This is borne out by an analogy by Mark in response to the vignette:

I think they are thinking short term. It's just, 'I want a hit I've done all that, I've been out robbing and I want a hit and fuck it I'll wash it out'. It's just taking a chance. The chances are it will be all right but there is that slight chance that it won't. ... It's the long term effects, you don't, all you're thinking when you're into the gear and that is just gear, 'I want a hit. I've been out and got the money and I want a hit now. Fuck the consequences think of that later'.

This short and long term analogy is useful. In general, it reflects the risks associated with drug injection. Many of the consequences of risk associated with drug injection are generally long term – such as drug dependency, tissue damage, and HIV and AIDS – with the exception being more immediate harms such as drug overdose. In contrast to long term effects the act of drug injection is an activity that can immediately alleviate the need and desire for drugs. Short term issues such as, “gear, that's all he'll be thinking about”, will be paramount because people did not, in general, report thinking about the long term effects and consequences of their actions during the process of drug injecting. To illustrate the influences of short term thoughts on action, the following two examples come from prison-based responses.

First, the less immediate a risk manifests as being the more likely that it will be pushed to the back of the mind. Short term concerns will be focused on the use of the drug and not on the risk of HIV, which as a long term effect is associated with death. That, “you don’t think about dying”, and, “they think about [HIV] when it happens”, reflects the topicality of one relevance over another. In response to the vignette, Keith says:

They won’t be thinking about AIDS or dying. The only thing they’d be thinking about is getting that hit. You know so HIV, AIDS never come into it.

Second, short term concerns may influence behaviour more than long term concerns. An immediate short term concern with drugs can be compounded by the situation in which drugs are injected in prison. For example, a hurried drug injection to avoid being caught and to alleviate the need for drugs can be the priority over and above other risks. Craig illustrates this in response to the vignette:

It [HIV/AIDS] is not the first thought that comes into your head when you’re in gaol. The first thing that comes into your head is getting a score and getting sorted out for some. You’re absolutely poorly by that time and you really are hanging out and the last thought in your head is catching something. It’s just getting it in before lights are out. If they come round and you are still trying to do it you’re fucked aren’t you? So he’s just going to be thinking about getting it in and getting back to his pad and being sorted out. It is bad though because when you are in gaol you don’t think about the AIDS and that, you just think about your hit.

Thus, short term concerns may influence people’s actions far more than the long term. However, it was also reported that some people do become “a bit more worried” about risk behaviour and this can be influenced by a range of factors.

Thoughts that are temporarily pushed to the back or out of the mind will resurface. However, drug injectors said, “you don’t realise that you’ve done something really serious

until it's too late". Moreover, "by then it could be too late". This realisation came after risk behaviour had been engaged in and was described in questioning terms, such as "what have I done?". In this way Mark reports:

Afterwards you not so much worry about it, you think about it because you do think, 'could I'?

Whilst "the choice is always going to be have the hit and worry about it afterwards", the re-emergence of HIV risk concerns can occur at different times. Drug injectors reported that thoughts and concerns about risk behaviour can re-occur soon after an injection of drugs "once you've had that hit", "when you're relaxed again", the "morning after" and "about a week later when it's all come back then you start to worry". Surrounding all these factors was the embodied influence of the effects of drugs and when they are "wearing off". When individuals are feeling relaxed, which for dependent drug injectors will not be when they need and desire drugs, then concerns about HIV may be raised. These features of individuals' thought processes, that "you only worry afterwards" was described as "a mechanism" and "because this is how people are isn't it?". Craig illustrates some of these findings when questioning his sharing of injecting equipment inside prison:

Afterwards when I went to my pad and thought, 'fucking hell I didn't, I can't believe I didn't clean it out and that. ... What if that? What if that?'. That's all I thought about that night. Then next day that thought's just gone again and it was back to square one. ... I started to rattle again. That's why the thought went away because you thought more about getting another hit. You didn't try and worry about I shared bla bla bla. I was more worried about getting another hit. That wasn't the first problem on your mind, worrying about AIDS, I was more worried about getting sorted out for next time. So that's why, once you've been sorted out you've got time to relax that's when you do start to think.

The points in time when people think about risk are likely to depend on each individual and their particular circumstances. However, reports also suggest that behaviour will be contemplated, often through questioning, for considerable periods of time after. Lorna reflects on her own experiences, which further illustrates the disjunction between short and long term concerns:

I can sit for hours, why do I do this? Why am I like this? And I think about the future and I do and I don't but it's, I can't really think of any answers. You're just more bothered about now and you can't seem to see past now.

Whilst some people would question risk behaviour, and some would continue to take risks, others reported considering the effects of risk behaviour when a problem occurs. This can also be understood as not thinking about risk. Karen's comments exemplify this finding:

I don't really think that you think about that risk [of HIV and AIDS] until you find out that you've actually caught it. Because you think, 'it's never going to happen to me, I won't catch this. You think, 'oh yeah, so and so down the road has got it, got it from someone I don't know, maybe some other way or something'. But you don't think it is going to happen to you until you actually catch it yourself. So I don't think really you think about that.

That risk behaviour is not considered until a problem arises resonates with McKeganey and Barnard's (1992) study. This study found that having shared and not experienced health problems with particular individuals in the past influenced drug injectors' assessment of the perceived cleanliness of other people that, in turn, contributed to further risk behaviour.

Prison-based responses found that individuals identified thinking about risks upon release. This may be because inside prison people were pre-occupied with other concerns, including what was described as the pressures of prison life. In response to the vignette, Tim comments:

I reckon when he gets out that is when it will hit him. 'Fuck what did I do in there'. Go and find out that he has got hep C, AIDS or whatever and that is when it will hit him.

Prison-based responses revealed that people will spend their time differently during protracted periods of imprisonment than they might do outside prison. Notably, people generally reported that they have more time to think in prison. Protracted periods of contemplation can mean that people think about the risks far more than outside prisons. This could also lead people to consider risks differently. Karen describes how these periods of contemplation can encourage the adoption of safer behaviour:

There is people who come in with diseases and as you come to get to know a few more people in prison you maybe find out that so and so has got this. And maybe you're sharing with them, you think, "am I at risk from getting that?". Because when you're in prison you've got more time to think about things. And you just think, "am I going to take the risk of catching it or am I, you know, just going to leave it?".

Story telling can inform the periods of contemplation that can occur between some groups of people in prison. Sharon comments:

You realise if you have long enough you do realise what you've done, what can you do right to make it better. ... 'Cos you realise sitting in prison listening to their stories and that. You know some of them have got AIDS and how they got it, how they find it and everything and that puts you off a bit. And if you are in there long enough you will hear lots of people's stories but if you're only there a day you might only be padded up with someone and hear their story but the more stories puts you off a bit more. You've got time to think about what they have said and that.

Furthermore, thinking about the consequences of risk behaviour on sexual partners and family was something people considered should happen. However, in practice, "you don't worry about your girlfriend and your Mam and your Dad and HIV and all that you're just worried about getting that hit". As noted earlier, the process of drug injection demands that

extraneous concerns are put out or to the back of the mind. Subsequent questioning of previous behaviour occurs after the event. Moreover, for some people their previous behaviour may concern them for considerable periods of time. Robert said:

It is a worry, you know, knowing that you have done it before. ... It's, yeah, always there in the back of my mind.

Having extended periods to think about risks or hear about people's stories could lead people to reconsider their actions and engage in safer behaviour inside prison. However, these processes can also work in reverse inside prison. It is important that people have enough time to think about the risks, but the need for drugs can obscure such reasoning. For example in response to the vignette, "he's been having time to think and that but he ain't had long enough because he is still feeling poorly off his methadone so I don't think he would think twice".

Having increased periods of contemplation may also lead to risk behaviour. For example, it may lead people to believe that sharing injecting equipment might not be as risky as first thought. Terry illustrates this finding when responding to a prison-based vignette scenario:

He'd be sat there looking at the works thinking, 'well he might have AIDS', and the longer the period gone on, the longer he would start reverting backwards to, you know, 'well he might have been moved off to another prison or whatever'. So then, he'd like, it's a tempting thing, you know, it is there it is tempting kids with goodies, you know, you do this and then you come to me come to me. It's there, you know, 'what shall I do?'. I'll leave it for another day and then you're looking at it the next day and you've got the gear and you can't get the works. Eventually he'll turn round and I know he would pick it up on heroin.

Analysis, informed by the theoretical framework, broadly identified two types of concerns: those that are imposed by others; and those which are intrinsic. Imposed concerns may take

the form of health promotional interventions such as information on reducing the risks of infections, knowing someone who is infected or, as Lorna demonstrates within the wider community setting, it can be from others voicing their concerns:

When I've gone to get the works off Nigel [fellow drug injector] he goes, "no don't 'cos remember he's been in prison and shared, it's not worth it, might as well go to the chemist and get some". Which I did. It's just that you tend to forget.

Imposing concerns – through whatever method – can potentially lead to behavioural change. However, just as it can lead to safer behaviour it can also lead to risk behaviour. Imposed concerns, understood as topically relevant, may lead people to think twice about their actions. However, in Kieran's experiences, the intrinsic need for drugs can be understood as motivationally relevant:

When I went into prison this time everyone was saying, 'don't use the needles, you're going to get hepatitis don't use it', so it made me think. But at the end of the day I still used them.

However, as Kieran goes on to show in this example, the need for a drug injection and the belief that he would not become infected – as short term concerns – exert a stronger influence than awareness alone of the longer term consequences of his actions. Kieran also said:

I shared one with my pad-mate. I didn't really think about catching anything, AIDS or anything, I knew it was full of hepatitis, I know when I went into gaol they give me my jabs for it, for hepatitis, so I didn't really think about catching anything. I thought I'd be all right.

Focusing on short term concerns may lead to a questioning of behaviour, before it is adopted. For example, "you say, 'have you got anything'". However, these questions were

sometimes described as part of the process of putting thoughts about HIV and AIDS to the back of the mind. Sharon comments in response to the vignette:

He'd most probably go through his head, 'what if he's got something what if he's got something'. But then, shove that, not bothered, it's a dig isn't it, that's all he'll say, he won't be bothered.

Prompted behaviour change, notably risk reduction strategies, can also be understood as a means of enabling individuals to pursue their actions when concerns are raised about the risks of HIV and AIDS. However, these may be ineffective in reducing risks. For example, Keith illustrates this finding with regards to vignette characters negotiating the order of sharing between people:

If she's a bit more worried about it then he'd say well you use it first because it is your works. ... When you've used it I'll have it if that is going to get them through till the morning.

In this way, risk reduction strategies were understood as a method to help people bridge the disjunction between short and long term concerns.

SUMMARY

This chapter set out to explore further the influences on drug injecting risk behaviour. The analysis presented here is broadly located under the theme of risky situations. First, the experiences of the need and desire for drugs and drug withdrawal were described, which can help to understand the impact that drugs have on the lives of the people contacted in this study. It is clear that in describing these unpleasant experiences of needing and desiring drugs, including drug withdrawal, then any action to relieve the pain may be considered a real possibility.

Second, the need and desire for drugs influences risk behaviour both outside and inside prison. Findings highlight emotional influences on sharing behaviour and, in particular, lending injecting equipment was related to identifying with others in need of drug injection. As will be explored in the following chapter, these findings resonate with those on social closeness and distance. It could be, for example, that these feelings may be more strongly felt amongst the socially close than the socially distant. When the need and desire for drugs are combined with a lack of sterile injecting equipment then it becomes a very risky situation. Furthermore, the exchange of drugs and injecting equipment inside prison may be more likely to occur in these situations. These drug and injecting equipment exchanges are returned to in Chapter 10.

The third and final section of this chapter sought to explore the ways drug injectors think about HIV risks. Findings suggest that the build up surrounding drug injection can result in drug injection becoming a priority to such an extent that everything else takes second place. When people described these feelings, they were located within descriptions of not caring about risk inside prison and of the boredom people faced. People's physical and psychological state when in need of drugs can result in risk behaviour being engaged in quickly, with little apparent thought to associated risk. These thoughts were related to putting concerns to the back of the mind, out of the mind or being forgotten – all variations on a similar theme, which are inexorably bound with the effect of drugs on the mind and body.

With reference to the theoretical constructs, it is clear that the findings may reflect actions occurring at the levels of practical consciousness and ontological security. If people were to think about these issues discursively then they may not be able to go on with their

intended course of action. There are a number of concerns that drug injectors may encounter during drug injecting, of which HIV risk remains a part. Drug injectors manage these concerns by recourse to thinking about issues within a short term and long term framework. Notably, the effects from sharing have long term consequences whereas the alleviation of drug desires is far more immediate. Anxieties with risk behaviour resurface later. These anxieties may be prompted by a general awareness of previous behaviour, as problems arise, upon reflection of a period of imprisonment, and through concerns for others. These anxieties may be imposed, including by others, or may be intrinsic, including as a result of long periods of contemplation especially inside prison. Within each of these cases it was found that whilst imposed and intrinsic effects may result in safer perceptions of behaviour they could equally result in riskier perceptions.

Ultimately there is no easy or guaranteed resolution to these dilemmas which result in risk or safer behaviour among drug injectors. This exploratory set of findings has provided a richer understanding of some of the influences on drug injecting risk behaviour together with the ways in which they are considered. The present chapter has provided a starting point for future research within this area and also illustrates the usefulness of the theoretical framework.

In revealing the processes permeating drug injectors' thoughts about risk behaviour, it is important to recognise the value of this application of the vignette technique. The vignette allowed individuals to voice what they considered a vignette character would do and what individuals personally would do, which was usually informed with reference to aspects of their own lives. It would be more difficult for in-depth interviewing techniques alone to elicit discussions on the thought processes underpinning perceptions of risk behaviour.

This application of the vignette technique was also beneficial in eliciting data on other perceptions of risk, not least the influence of social relationships on drug injectors' perceptions of HIV risk behaviour. In the next chapter the influence of social relationships on risk behaviour is explored as a subjective influence on risk management. This is followed by the strategies to clean needles and syringes as a practical mechanism used in reducing risk.

– CHAPTER 8 –

RISK REDUCTION: INFLUENCES AND MECHANISMS

INTRODUCTION

In Chapter 7 the ways in which drug injectors think about risk behaviour were discussed. These issues are important in understanding why drug injectors may put themselves at risk of infection. Furthermore, when individuals recognise that engaging in certain behaviour may put them at risk of HIV, risk reduction may be employed to minimise the chance of infection spread. There are, however, wide-ranging influences on risk behaviour and equally wide-ranging risk reduction strategies (Chapter 2). To examine these issue this chapter does two things which are covered by a broad umbrella theme of risk reduction.

First, there are countless influences on drug injectors' risk behaviour, and social closeness and distance is one important issue (Chapter 2). In the present study, data analysis revealed social closeness and distance to have a strong influence on drug injectors' perceptions of risk within sexual relationships and drug injecting relationships. In an attempt to capture the broad-ranging spectrum of social closeness and social distance, as it influences risk behaviour, sexual relations in the community and drug injecting relations within prison are examined. This focus represents a continuation and development of the tradition of examining the social aspects of HIV risk behaviour within the context of social relationships, particularly as they vary by closeness and distance. Moreover, it extends the discussion of risky situations, presented in Chapter 7, as the need and desire for drugs together with the ways people think about risk will also be determined by the nature of the relationships with those with whom risks are being taken.

Choosing who to share injecting equipment with or who to have sexual relations with on the basis of social closeness can be understood as a subjective method of risk reduction. There are also a range of practical mechanisms that drug injectors may employ to reduce risk. These mechanisms include using condoms during sexual relations and cleaning needles and syringes before sharing (Chapter 2). As noted at the end of Chapter 7, practical mechanisms for reducing risk may be employed to enable individuals to go on thinking about the pursuit of drugs, separate from any wider concerns with HIV and AIDS. It is important that these practical mechanisms are subject to interrogation because if, as suggested in Chapter 7, risk reduction is employed to enable people to cope with risk taking then the methods used may not be wholly effective in reducing HIV transmission. Thus, this chapter provides an analysis of two very different strategies that drug injectors may employ to reduce risk, beginning with the examination of the influence of social closeness and distance on drug injectors' risk behaviour.

“FRIENDSHIPS ARE A BIG PART OF IT”: THE INFLUENCE OF SOCIAL CLOSENES AND SOCIAL DISTANCE ON HIV RISK BEHAVIOUR

Social relationships are characterised by differing degrees of closeness and distance (Chapter 2), which have been found to exert a strong influence on drug injectors' drug injecting and sexual risk behaviour. Social closeness and distance should be understood as related concepts along one continuum. Individual perceptions of risk at particular points on the continuum, and in particular situations, are likely to influence perceptions of risk behaviour. To augment current understanding on the influence of social closeness and social distance on risk behaviour the next section explores these issues within sexual relationships. The subsequent section explores these issues within drug injecting relationships inside prison.

Drug Injectors' Perceptions of Sexual Risks Outside Prison

In the present study, the need for sexual risk reduction, including the use of condoms, was influenced by particular features of sexual relationships. These include trust, love, seriousness with the relationship, and the length of the relationship. Previous studies have found that condoms are used less often in established sexual relationships (Table 3). In the present study, drug injectors felt that individuals in established relationships should protect sexual partners against the transmission of infections. A typical quotation illustrating how seriousness in a relationship should influence behaviour was, "if he's really serious about her then he shouldn't put her at risk". Protecting partners against the spread of infections was considered necessary when, for example, in the vignette, one partner was a drug injector and the other was not. As Karen reports in response to the vignette:

There's always a risk 'cos he's injecting. There's always a risk he could be carrying something so they've got to be careful of that, so their best bet [is] to take precautions.

Taking precautions in sexual relationships included the use of condoms and having an HIV test. Undertaking these was sometimes considered necessary so that individuals did not put their sexual partners at risk of HIV. For some people, condoms were considered more necessary in close relationships than in distant relationships. A discussion with Tim highlights this:

Tim: It would be Durex if that would be if I was Ben, should I say, it would always be a Durex.

Rhidian: Do you think that is what realistically happens to other people in general?

Tim: If they are a couple and they have been together for a while and it is not just someone you have picked up is it then, yeah. Me, that is what I would do, have done.

It is noteworthy that this extract also suggests that, conversely, safer behaviour may not be adopted within more distant sexual relationships.

Some of the constituents of social closeness, including trusting, caring and loving another can reinforce social closeness. When people are in close relationships they do not wish to harm their partner through passing on infection. This helps to explain why some people in longer term relationships use condoms, despite the problems that have been identified with their use, including desensitising sexual encounters. However, the duration of the relationship can be an important influence on sexual risk behaviour. In some instances the longer the relationship has been formed the less likely risk reduction strategies would be used. Craig said:

When you're with a partner you feel like you're going to be with them for however long so you don't worry about that [HIV and AIDS].

The lack of condom use in closer relationships could reflect condoms not being topically relevant, perhaps the influence of other conflicting topical relevances including trust and love deeming such actions contrary to the premise of the relationship. When condoms are interpreted as less important, motivational relevances influence risk behaviour. Practical consciousness and ontological security, as emotionally fulfilled states, can help to explain why condom use is not sustained in closer relationships because of overriding emotional influences. Furthermore, not using condoms may also help to foster particular emotions such as trust.

For some drug injectors in the present study the use of condoms stopped when longer sexual relationships had been formed, a finding also reported in other work (McKegancy

and Barnard, 1992; Lear 1995). These findings may also be explained by the fact that condoms are often considered prophylactics against pregnancies rather than infection (Kirkman *et al.*, 1998). In addition, being HIV tested can be seen to obviate the need to use condoms in close relationships (Lupton *et al.*, 1995a; 1995b) as also reported in the present study by, for example, Mark:

With Ben using he should use condoms. That is what I always done with my girlfriend until we, before we had the blood tests with me using and, you know, sharing before in the gools. ... I loved her so I had it for her.

Emotional influences were important in constructing risk perceptions in close sexual relationships. When individuals were trusted and considered clean from infection there was an increased likelihood of risk behaviour. As Sharon explained in response to the vignette:

When you're in a close relationship you think you can trust them or you don't think they have got owt because it is your boyfriend.

These perceptions may self-perpetuate risk behaviour – more and greater risks are taken between individuals as relationships become closer. Furthermore, the influencing features of close relationships that may lead to risk behaviour are often inextricably linked. Lorna's personal perceptions illustrate some of these including the interconnectivity of care, love and trust:

Like my boyfriend he doesn't use drugs at all. The whole situation is more or less the same and I've shared works in the past. ... Maybe he sleeps around a lot while I'm here [hostel], I don't know. But I suppose I don't take any protection apart from the pill. But as I've been with him a year now, I wouldn't share works, I wouldn't put him at that risk. I do care about him I love him a lot and I wouldn't do that to him. And I hope he wouldn't do that to me. ... I wouldn't be seeing Wayne if I didn't I'd probably ask him to use a condom.

That's the way at the end of the day. ... But I've got to be really careful at the minute, you know, being with Wayne [boyfriend].

Lorna's extract also shows how perceptions of risk may also be built upon assumptions of other people's behaviour. In this case she hopes that her partner would not behave in ways that will put her at risk of infection. Barnard (1993, p.810) remarked that risk taken in close sexual relationships can be based on "an article of faith" when the behaviour of sexual partners is assumed to be safe or, in Lorna's case, is hoped to be safe.

Some drug injectors consider that they know the previous risk behaviour of their sexual partners, especially within closer relationships. It was sometimes recognised that knowing or establishing previous behaviour gave no indication of whether people were actually infected with HIV. However, when individuals were considered clean from infection, sometimes by virtue of closeness between individuals, then risks were more likely to be taken. Craig reports on his own sexual experiences:

I just never have [used condoms]. I don't like them. Never really. I haven't slept with birds who have slept around, they are usually all right, were in my eyes. I know you can't say whether they have or not but you usually know them, you know, I usually know them, you know, whether they have slept around whether she is a slut or what. I didn't really go with sluts so I thought I was all right again.

Related to these findings was the perception that drug injectors are considered less likely to be free from infection than non-drug injectors. As a consequence some people may be more prepared to take sexual risks with non-drug injectors than they would with other injectors. Sharon explains why she doesn't use condoms with Peter, her sexual partner:

Peter here he doesn't inject or fuck all so I know he ain't got nowt 'cos like well I think he ain't got nowt, because the people he's been with hasn't touched drugs.

Perceptions of cleanliness and dirtiness and their influence on behaviour can be self-reinforcing. For example, having taken risks with other people perceived as clean can mean that individuals also see themselves and their previous behaviour as clean. As a result they may not take steps to reduce risk in the future. In this way Terry reflects:

The people I've shared with I know they are clean so there is no need to bother with Durex or anything like that because I know my mates.

The concept of reciprocity (Gouldner, 1960; Sahlins, 1965) is important to understanding risk taking (Zule, 1992; Gerrard *et al.*, 1996; Jacobs, 1998). In the present study, reciprocity was an important factor in understanding sexual risk behaviour in close relationships. Some people understood that if one partner was infected with HIV the other person would also be infected, albeit rather deterministically. For example, in response to the vignette it was reported that "if she's got something he's got something" and similarly "maybe he'd think if I've got it, give it to her maybe". These beliefs were reported by men. Craig shared injecting equipment inside prison and upon release reports:

We still slept together because she said, "if you've got it I'm gonna have it" and that's how it is because we're together and that's how it was so it [HIV/AIDS] didn't seem a problem when I got out of gaol.

Whilst some drug injectors may not wish to spread HIV knowingly (McKeganey, 1990), such forms of reciprocal infection may be influenced by the relationships with the person with whom infection is being shared. In Craig's case, the nature of the relationship was clearly important, including expressions of togetherness. These findings support Leclerc-

Madlala's (1997) study on responses to HIV and AIDS where people wanted to face the consequences of being infected HIV and AIDS with others and did not wish to die from AIDS alone.

Moving along the socially close and distant continuum, the final portion of this section examines the influence of social distance on sexual risk behaviour. Within more distant sexual relationships drug injectors considered that condoms should be used, reflecting similar perceptions on their use within some closer relationships. The application of the vignette technique for this study generated data that is particularly conducive to highlighting differences between what people perceive should happen and what would happen (Hughes, 1998).

Social distance and the immediacy surrounding sexual relations are two factors that influence why condoms are not used with the socially distant or, put another way, "someone you have just picked up". This also could reflect discourses on sexual drive (Hollway, 1984), which for some people in the present study centred upon the desire for sexual relations, sometimes bounded with great immediacy. Keith exemplifies this finding in response to the vignette:

A one night stand, you normally don't say fuck all to them anyway. See what I mean, normally you don't even know their second name and you're gone in the morning, so it [safer sex] don't matter. It's just sexual gratification and then you're off so it doesn't make no difference.

The nature and immediacy of sexual relations with the socially distant together with the build up that surrounds sexual encounters can influence risk behaviour. Jane points out:

It's like you're with a girl, say, and you haven't got any condoms and you're really getting it on together, yeah, and the lass is turned on, you're turned on and you suddenly say, "oh I haven't got any condoms", just say, "forget it, lets get on with it", sort of thing and that's how it happens really isn't it?

An interesting finding here lies in the 'sociobiological' factors that drive risk behaviour, as recognised by the embodied influence on risk in the theoretical framework. In Chapter 7, the physical and psychological need and desire for drugs were identified as important influences on risk behaviour. This resonates with the findings presented above on the immediacy surrounding sexual desires and their influence on risk behaviour. With regard to sexual behaviour it is noteworthy that these findings were apparent within the context of more distant sexual relationships. This may reflect the role of sexual encounters in close and distant relationships. For example, sexual activity in close relationships may be more to do with love, intimacy and emotional fulfilment. Whereas in more distant relationships, where these feelings may be less apparent, the need for sexual gratification comes to the foreground.

On a related issue, a finding associated with less close sexual relations upon release from prison further illustrates the importance of immediate sexual relations. When sexual activities are the primary pursuit it can result in concern about HIV and AIDS taking second place. As Keith explains:

When you come out obviously the first thing is being locked up for a while you wanna get your rocks off. And that and that's it. It doesn't make no difference, no difference at all HIV.

Clearly this reflects findings based on drug injecting risk behaviour (Chapter 7). In the previous chapter the physical and psychological need and desire for drugs can mean that people put thoughts with HIV and AIDS to the back of their minds. The findings presented

in the present chapter support this and lead to some tentative support for the processes outlined in Chapter 7. Furthermore, whilst supporting some of the more calculating elements of decision making, including putting thoughts to the back of the mind, there is also recognition of the physical and emotional role of sexual encounters.

People who were considered distant were likely to be perceived as carrying infection because their moral character and previous behaviour could not be established or, perhaps, perceptions of closeness, including trust and knowing people, had had less time for assessment to be made and perceptions of cleanliness to be developed. When sexual relations occur within these types of relationships the risk of HIV was considered an integral part of engaging in sexual relations with the socially distant which were more likely to be seen as a game. Terry illustrates the influence of these factors in distant relationships:

The sex would just not be bothered about a condom, 'cos you're both on that same line. Even though you might not have anything and she could be riddled with it and vice versa. It's you both play the same game, that Russian roulette.

These features of distant relationships can be understood to be particularly apparent features of distant sexual relations. Vocabulary such as 'game' and 'gamble' were less likely to be attributed to closer sexual relations.

This section of the chapter has illustrated how within closer relationships, trust, love, caring for partners, and the length of the relationship can influence why condoms are used to protect others. Distinctive findings stemming from risk behaviour in distant sexual relationships can be identified. Notably, the need and desire for sexual relations, especially upon release from prison can lead to risks in distant sexual relationships being described in

gambling terms. Social closeness and distance are also important in illuminate drug injecting risk behaviour.

Drug Injectors' Perceptions of Drug Injecting Risks Inside Prison

Generally the closer a relationship the more likely people are to report sharing injecting equipment (Table 2). Whilst a number of studies have examined drug injecting risk behaviour in prison (Table 5), the influences on sharing have been afforded much less attention. This section begins by exploring first the influence of close relationships and second distant relationships on drug injecting risk behaviour inside prison.

As some people recognised that social closeness could not affect infection transmission in sexual relationships, the same pattern was identified in drug injecting relationships. Tim made the point:

I know it doesn't mean just 'cos you're mates it doesn't mean you won't catch owt off them.

However, there were contradictions between these and other responses. Physical proximity with others inside prison, including sharing a cell for anything up to 24 hours a day, can help to explain why some people reported sharing “just with my pad mate” and “just because we were doubled up together”. This resonates with other groups of drug injectors who report, “just using old works” inside prison (Turnbull *et al.*, 1996). Similar findings have been noted in community studies of drug injecting risk behaviour, which suggest risk behaviour may be more likely amongst people who live together (Donoghoe *et al.*, 1992). Related to these findings, an important determinant on willingness to share injecting equipment inside prison would depend on the extent to which individuals know each other.

When others are considered to be known then risk behaviour would be more likely than if they were not known. Craig exemplifies some of these issues:

If you're close close mates with someone and if it's safe between each other they share all the time. Like me and my pad-mate, we felt like that, we had a close, you know what I mean. I knew him, he knew me and we were like good mates and I knew him on the outside so we felt like we were relatively all right with each other.

Craig's comments are particularly valuable as he goes on to develop these points by noting that for people to develop close relationships inside prison will usually imply a period of sharing with people who are less well known. In his words:

But that always comes later on in your sentence it doesn't really come straight away that. So you're gonna share with people you don't know beforehand, before you get to this sort of stage.

The influence of distant relationships on risk behaviour inside prison will be returned to later in this section. Some drug injectors became good friends with others, often when they were living together in the same cell or neighbouring cells. This highlights the processual characteristics of interpersonal relationships (Duck and Sants, 1983), including drug injectors' risk relationships (Rhodes, 1997). Through this progression actions that are performed repeatedly become routinised or habitual (Aarts *et al.*, 1998) and, with reference to the theoretical framework, may be located at the level of practical consciousness and ontological security. Here they may then be afforded less direct attention than they were in the past and may be continually reinforced and reproduced. Social closeness in prison was also related to knowing people and perceiving them to be free from infection. In these circumstances risk behaviour was more likely. Karen reports on her own experiences:

Me and Toni were sharing next door, but I knew Toni was clean.

As will be discussed in Chapter 10, drugs and injecting equipment can be difficult to obtain inside prison. Procuring drugs with others and injecting together helped to build friendships among drug injectors. Thus, whilst sharing injecting equipment was considered safer behaviour between the socially close sharing amongst the socially distant may help to bridge the transition between social distance and closeness.

The friendliness of others can be an important part of establishing good social relationships. Inside prison the culture demands that individuals primarily look after themselves. However, drug injectors also reported that friendships play a particularly important role inside prison. People may take risks on the strength of friendships. Tim remarked in response to the vignette:

Friendships are a big part of it, you know, it depends how friendly they are. ... You're not just going to lend something to anybody are you, you know what I mean, but I think if they're friends she would lend her the works.

It was found that injecting equipment would be lent or drugs supplied when individuals were considered friends as Kieran's vignette-based comments illustrate:

If it was down to me, if it was my friend who wanted a hit I'd lend them, I would have done anyway.

Outside prison the reciprocal nature of drug injecting friendships can be an important influence on risk taking (Zule, 1992). Similarly, prison drug and injecting equipment markets often operate upon the principles of reciprocity (Chapter 10). Decisions to share injecting equipment can also be based on these principles. As Jane reported:

He would give Jim the works, yes, because they all stick together in prison. ... He would lend him the works definitely because if he's helped him out with drugs and Jim needs a hit, then he would lend him the works.

Drug injectors do not like to see others in need of drugs, and thus can inform decisions to share injecting equipment. These emotional influences can interact with the effects of friendship. Natasha made the point:

He's a mate isn't he? I think they do [share] because like you look after number one but if they've been friendly and a good pal to you, you would help him out. You wouldn't want to see him rattling.

Outside prison it has been noted that the socially close may find it more difficult to negotiate drug injecting safer behaviour (Barnard, 1993). Inside prison drug injectors described emotional obligations towards helping other drug injectors, especially friends who have assisted in the past. These obligations can be strongly felt and prison life may become more difficult if these obligations are not fulfilled. Jane comments:

Lend them because they are both close friends and things might get a bit difficult if she didn't lend them.

Close drug injecting relationships in prison may, therefore, perpetuate risk behaviour because of the expectations that are engendered. Put simply, if an individual has helped another then this may be reciprocated. In addition, injecting equipment lending may occur in the anticipation that help will be returned in the future. Craig illustrates this finding in response to the vignette:

You're real close, you know what I mean, you'd be like brothers, you know. You stick together and help each other. So she's going to lend it to sort that out so one day she gets, you know what I mean, she gets in that situation that person might lend her them.

Socially close relationships inside prison, including living within close physical proximity, the formation of friendship, and reciprocal obligations exert a strong influence on perceptions of drug injecting risk behaviour. As discussed earlier, distant sexual relationships had some distinctive influences on risk behaviour. Similarly, risk behaviour in distant drug injecting relationships inside prison may be different from close drug injecting relationships.

Drug injectors identified a number of risks associated with sharing injecting equipment inside prison. Words, including “safe”, were used to describe risk behaviour with the socially close. In contrast words, such as “dangerous”, were used to describe risk behaviour with the distant. Robert explains:

It is very dangerous injecting in prison. I mean at least if you've shared before and you sort of know the guy, you know the background and you've grown up with him kind of thing it's different to going into prison and someone who's maybe from Liverpool or Birmingham or wherever you don't know, you know, you're sharing with them it's dangerous.

When relationships inside prison were deemed distant it was considered less likely that risks should be taken. Typically comments include, “simply because she doesn't know her” and “cos she has only just met her and that and she doesn't have much on her background”. A distinction between social closeness and distance can help people to manage risky decisions.

Sexual relations in distant relationships was sometimes considered a game, as discussed earlier. With regard to drug injecting, risk behaviour was considered more serious amongst the socially distant than the close. If more risks are taken with the socially distant inside prison, as a result of the random mixing of individuals and groups (Dolan, 1997), then this

can help to explain why drug injectors may consider prison to be a greater risk environment than outside (Power, K.G. *et al.*, 1996).

One important risk identified from sharing injecting equipment with the socially close was the transmission of infection. A vignette-based discussion with Karen illustrates some of these points:

Karen: Well if she didn't know her there is always the risk of like she is carrying something so she'd have that to worry about as well. And she probably wouldn't know who she's been sharing with in prison. So that would be a great concern.

Rhidian: So do you think she would lend it out to that person she doesn't know, at the end of the day?

Karen: To be honest I don't think she would because she doesn't know her.

The sharing of injecting equipment should not only be considered in relation to the transmission of infection. In prison injecting equipment is scarce, it is bargained for and its use often has a cost attached to it. Lending injecting equipment to strangers may result in it not being returned (Chapter 10). Lending injecting equipment to others also needs to be located within these wider concerns that drug injectors also raised. The loan of injecting equipment needs to be equated to the loan of any item to strangers in prison. "You don't get anything for free", was a remark common to discussions centring upon the socially distant. As a result lending injecting equipment and its associated risks may not be taken because individuals were not known and "because she don't know her". In these cases, some drug injectors would not consider the risks associated with sharing injecting equipment as worthwhile. Consequently some people considered outright refusals necessary. Other people considered that these risks would be negotiated differently. This could include talking to others to learn more about an individual. Another strategy, illustrated by Jane in response to the vignette was:

She'd turn round and say, 'there is already two people on my works anyway', and like Vicky is using them and Sarah is using them and she is going to think to herself you know 'this is there is two of us on one set' she can't really afford just for herself to lend them to someone else because she might not get them back if she hardly knows her so I don't think she would.

These findings highlight some of the other influences that impact upon the operation of social distance. To link these ideas with those presented in the previous chapter, an important consideration for people dependent on drugs is the need for drugs, especially when individuals are experiencing drug withdrawal. In close relationships drug injectors would not want to see others in need of drugs and this can influence decisions to share injecting equipment. Similarly, the need for an injection of drugs can be an important influence on whether people will take risks with strangers. In prison injecting equipment can be exchanged for drugs and these exchanges can be seen as more attractive when people are in need of an injection. In response to the vignette, Keith suggests that the need and desire for drugs will take first place over and above the nature of the relationship with whom the person is sharing:

She don't know her. She's looking out for herself. She's not looking out for no-one else. Do you know what I mean, she don't know that other person. When it comes down to it if she ain't got no gear and she's ill she's gonna lend it. ... Now, I mean, there's if she's got plenty of gear herself and she doesn't know this other person you know what I mean she's gonna say no.

Patterns of drug injecting perceptions of risk in less close relationships can also inform the theoretical framework. If sharing amongst the socially close occurs at the level of practical consciousness and ontological security, a situation in which sharing injecting equipment could occur with those less close, may be understood as different from usual routines and can no longer be taken for granted and performed at this level. A break to discursive consciousness enables people to think more directly about the risky situation and leads

people to question potential behaviour. Such an explanation can help to understand why the problems raised by drug injectors about sharing injecting equipment amongst the less close inside prison – including lack of knowledge, risk of losing injecting equipment and problems with trade relations – were raised. However, there are many conflicting influences on behaviour. As Keith highlights above, sharing will also be influenced by the immediate need and desire for drugs.

This section of the chapter has demonstrated how some of the constituent influences of social closeness and distance influence drug injectors' perceptions of risk behaviour. Whilst recognising that social closeness and social distance are part of the same continuum, findings suggest that some influences on risk behaviour are emphasised in particular types of relationships. Within close sexual relationships, factors including the extent of trust, love and length of relationship, can influence risk behaviour. In distant relationships the need and desire for sexual relations and considering risks as a gamble can influence risk behaviour. Inside prison physical proximity, knowledge of others, reciprocal lending, sticking together and expectations that are engendered within close drug injecting relationships may lead to risk behaviour. Whereas in distant relationships the issues surrounding trade relations of injecting equipment, including losing injecting equipment, and knowledge of others, can influence behaviour.

The complex influence of these factors are well illustrated by the inherent contradictions between some of the findings. Social closeness may be used to reject risk reduction, as contrary to the premise of such relationships. Whereas social closeness may also justify the need for risk reduction so as not to put friends and loved ones at risk of infection. Similarly, whilst distant relationships may necessitate risk reduction because they are

unknown and moral character has not been established, the same factors were also used to justify risk behaviour with the socially distant. These findings can help to explain studies using more structured data collection. Table 3, presented earlier, shows that considerable numbers of drug injectors report never using condoms in close and distant relationships. The complexity of these issues resonates with the analysis of health risks by Burton-Jeangros (1998) who suggests that risk perceptions may be characterised by a circuitous and constant formation and where the relationship between perceptions and behaviour evolves over time as each person adjusts to the other. Thus, the processual relationship between social closeness and social distance together with their anchoring to risk taking and risk reduction remain critical unresolved issues for further research.

Whilst increased selectivity of sharing partners could reflect harm reduction strategies encouraging behavioural change (Judd *et al.*, 1999), such selectivity, however, does not necessarily reduce risk. As shown in the present study, the constituent factors of social distance may be incomplete or mistaken and that these do not necessarily imply absence of infection exposes the fragility of social distance as a real obstacle to HIV risk reduction. The next section of this chapter explores a practical method that drug injectors employ to reduce and manage HIV risks, namely the cleaning of needles and syringes when shared inside and outside prison.

“CLEAN THEM OUT”: THE CLEANING OF NEEDLES AND SYRINGES AND HIV RISK

There are a number of risk reduction strategies that drug injectors may employ to minimise the transmission of HIV. With regard to sharing needles and syringes, one important

strategy is to clean them. Cleaning needles and syringes can help to reduce, although never eliminate, the chance of infection transmission (ACMD, 1993).

As discussed in Chapter 7, the need and desire for drugs has been identified as an important influence on risk behaviour. This present section builds upon these findings presented earlier by reporting that such responses would often be qualified by the need to clean needles and syringes. Furthermore, the effectiveness of cleaning is important to the understanding of the nature and extent of risk drug injectors face. Examined here are the criteria used to assess cleanliness, the availability of cleaning materials, and, the thoroughness of cleaning practices.

Perceptions of Cleaning Strategies

In situations where sterile needles and syringes are unavailable, sharing was often considered inevitable both inside and outside prison. For example, “they would share because there’s no clean works”. These feelings were reported within the context of needing and desiring drugs (Chapter 7). However, this section can build upon these findings by reporting that such qualified responses would also be justified by the need to clean needles and syringes. Some people reported this is what they would always do when sharing and similarly, in response to the vignette that cleaning was something that should always be undertaken. Cleaning was considered important in both the wider community and prison setting, which suggest how cleaning can play an established and integral part of the process of sharing needles and syringes. Mark reports a preparedness to share needles and syringes in response to the vignette but only after they had been cleaned:

Personally myself in that situation I'd share but I'd thoroughly clean I'd let him use the needles first and then thoroughly clean it then I'd boil it and clean it all out.

Similarly, drug injectors reported sharing needles and syringes both inside and outside prison but cleaning them before use. As noted in Chapter 7, risk reduction strategies may be used to enable people to go on taking risks. As Terry said:

I've never used a needle directly that has not been cleaned afterwards. I've used works after people, yeah, but they've always been flushed as good as they can.

Health risks can be understood quantitatively (Heyman *et al.*, 1998). In the present study some drug injectors offered quantitative estimates on their perceived risks from using unsterile, but cleaned, needles and syringes. Some people saw the risk of HIV as remote.

As Karen said:

There is not a very high risk if you wash it out and do it properly. I'd say like 30 out of a 100 per cent risk. It's not very much. It's only if you don't know what you are doing and you don't know how to clean everything.

In contrast, other people felt the risks to be more real and recognised that cleaning was not a completely safe method in eliminating the risks of HIV. Keith illustrates this point:

They could boil it in water, they could put some bleach through it whatever, do you know what I mean, but whatever they do it is never going to be 100 per cent sure are you? The only sure way is never to do it.

For Jane, the recognition that cleaned needles and syringes can remain infectious came from her own experiences:

Even though the barrel looks clean and what have you, there is always a chance in the pin itself, in the head, there is a bit of dried blood stuck up there and you can't get that out. Which is probably what happened to me, which is why I picked up hepatitis C.

It has been argued that sharing may have become unacceptable among some communities of drug injectors and may be exceptional rather than usual behaviour (Burt and Stimson, 1993). However, findings from the present study tend to suggest high levels of injecting equipment sharing, which is also supported by normative perceptions on needle and syringe cleaning. Other vignette-based studies have also found a high levels of willingness of share needles and syringes (McKeganey *et al.*, 1995; 1996). The present study findings on qualified sharing also supports other studies on the generally high level of needle and syringe cleaning (Tables 1 and 7). Whilst sharing may be qualified by cleaning it is also important to consider the criteria used to assess cleanliness, the availability of cleaning materials and the thoroughness of cleaning practices. These factors will determine the effectiveness of cleaning that can, in turn, impact upon the transmission of HIV.

Effectiveness of Cleaning

Criteria Used to Assess Cleanliness

Outside prison, drug injectors were not prepared to use needles and syringes that looked well used and dirty, especially those containing visible traces of blood. For example, drug injectors “don't use it when there is blood already in it”. However, it was reported that drug injectors had seen or heard of others using well used and visibly dirty needles and syringes. An early consideration during the cleaning process is to look for needles and syringes that look clean and unused. On the basis of her own experience Jane said:

We went into the cin bin and got dirty works out of the cin bin. ... We looked for the cleanest ones sort of thing, 'cos some people wash them then put them in the bin. So we looked for the ones that looked pretty clean and had only been used once.

At the level of discursive consciousness and systems of relevances, sharing is motivationally relevant in this extract. However, also topically relevant is the need to clean needles and syringes to enable the continuation of sharing, which is recognised as a risk behaviour.

Thus, drug injectors' responses to cleaning injecting equipment outside prison identified the visual cleanliness of needles and syringes as an important part in the early stages of using shared needles and syringes. In marked contrast this was not reported by drug injectors' within the prison context. There are limited supplies of needles and syringes inside prison, which were often described as old and well-used. To facilitate smuggling, syringes can also be cut down and made up with substitute materials when needle and syringe sets were incomplete. Furthermore, when sharing inside prison, drug injectors are less likely to have a range of needles and syringes to choose from, such as those obtained from incineration bins. Drug injectors are likely to share injecting equipment inside prison (Table 5) and sometimes with considerable numbers of people. The practice of looking for visibly clean and less used needles and syringes is redundant inside prison because of less choice of needles and syringes. Closely allied to the criteria used to assess cleanliness is the availability of cleaning materials.

Availability of Cleaning Materials

Water and chemicals are essential for cleaning needles and syringes. Water is used on its own or with chemicals and is used hot or cold. Lorna reports:

All you can do is take it and flush it with really hot water boiling water which gets all the germs up but with hot water they can still be breeding in there so then you flush it with really cold water and that kills anything left hopefully. Then one of you would have a hit then you'd flush it and give it to the other one and share it like that.

Supplies of fresh hot and cold water may be more limited inside prison (Turnbull *et al.*, 1994; Turnbull *et al.*, 1996). Outside prison drug injectors use water and a number of chemicals and detergents to clean needles and syringes. Chemicals include bleach, toilet disinfectant, washing up liquid, soap, salt, and colour agents. As noted in other work both outside (Nyamathi *et al.*, 1995) and inside (Turnbull *et al.*, 1994) prison the unavailability of cleaning materials is one obvious impediment to preventing its use. In prison the more effective cleaning materials, notably bleach, were not always readily available. As a consequence, soap and water were commonly used and were relatively easy to obtain. In addition, drug injectors recognised that the prison service promotes the use of cold soapy water, which may influence these reported practices. Robert said:

I cleaned the barrel out thoroughly, not with bleach, but I cleaned it out with soap and cold water and that. In prisons it tells you to do that, there's leaflets all over the place telling you if your going to share clean and I did it that way and the guy who wanted me wash-out he just wasn't really bothered. I mean, he used that same pin.

Cleaning practices promoted by the Prison Service (1995b; 1995c) tend to be the most effective methods. However, these may be more relevant to cleaning practices outside prison where disinfecting solutions can be obtained. Cleaning guidelines should take into account the availability of materials inside prison and, as Dolan (1997) suggests, may also need to be modified to account for the poor quality needles and syringes that are used.

Many people felt that their chosen methods of cleaning – with chemicals, detergents and water – were adequate in preventing the transmission of infections. Perceptions on the fragility of viruses outside the human body, such as, “AIDS dies after about five seconds outside your body” were used to justify less effective cleaning practices. Drug injectors also discriminated between the types of infection inactivated by particular cleaning practices. Dan illustrates this finding:

Cold water and washing up liquid kills HIV. It doesn't kill hepatitis C which is the real bad one now isn't it? Cold water and washing up liquid kills AIDS.

Similar remarks were made by people who considered that water alone would be effective.

As Colin reports:

If he's careful cleaning it out he shouldn't catch anything. He should clean it out with warm water first, you know what I mean, and then cold water. He shouldn't really get much.

Both inside and outside prison problems were identified with using chemicals and detergents. It was reported that the use of strong detergents, notably bleach, would destroy the rubber on the syringe plunger affecting its quality and strength. This is a particularly important consideration for drug injectors inside prison where supplies of needles and syringes can be limited, where the needles and syringes are used for extended periods, and have to be carefully maintained.

Concern was raised about traces of chemicals being left in the needle and syringe, which might contaminate the body if injected. Some people would use chemicals but ensure that they have been thoroughly rinsed out. In contrast, some people prefer not to use chemicals

at all. A discussion with Lorna illustrates this finding and also shows how safer injecting campaigns may not have reached all drug injectors:

Lorna: I've never known anyone to clean their works out with bleach. I'd imagine that to be dangerous 'cos if there was a bit of bleach left in the works and you inject that into yourself then surely you'd die. But whether that is right or not I don't know. I've been using a while but I've never heard of bleach being used. It would just be hot water and cold water. But several times hot hot hot and then cold.

Rhidian: What about soap? Do people use soap at all?

Lorna: I never have. I think I might have heard about it but I wouldn't risk maybe injecting something like that into my vein. It could be very dangerous. No I wouldn't.

That drug injectors were concerned about chemical residues inside needles and syringes after cleaning has also been noted elsewhere (Crisp and Barber, 1997; Klee and Morris, 1997). It also resonates with other work on the fears surrounding the adulteration of drugs (Coomber, 1997a; 1997b; 1997c). These findings show how and why some drug injectors may not have responded fully to safer drug injecting advice. They may also help to explain why some drug injectors only use water to clean needles and syringes. This needs to be further investigated to examine fully drug injectors' concerns with the problems from safer injecting practices.

Thoroughness of Cleaning Practices

The rigour with which needles and syringes are cleaned varies. Some people reported using water and chemicals to simply rinse needles and syringes. Other people made more effort by taking apart the syringe barrel, plunger and needle, and cleaning each part separately.

Tim said:

I flushed them right through with bleach. So I rubbed the needle end in the bleach and the rubber, pulled that out and put it in as well. Then give it a real good flush with water.

There are a number of factors that influence how thoroughly needles and syringes are cleaned outside prison. These factors were often interconnected with the criteria used to assess needle and syringe cleanliness and the availability of cleaning materials. Terry illustrates how the thoroughness of cleaning was also influenced by the visual cleanliness of needles and syringes:

You squirt it with clean water and there is not a drop of blood. You can't see it and you'd think that works is clean. That's all right. ... As long as it is clean and it looks clean.

In prison, however, needles and syringes were cleaned less thoroughly than outside prison.

Keith remarks:

Obviously they wouldn't be as washed out as well they would be washed out in water and used. ... When you're in prison it's a couple of flushes of cold water and bang you're at it. That's, do you know what I mean, that's just unblocking that ain't cleaning them.

Some drug injectors expressed concerns that people in prison were not cleaning needles and syringes thoroughly when shared. Robert said:

I've seen them in the same pad all waiting to use the same works and they've hardly ever cleaned them out properly. The blood in the works is still going to be warm, you know. It's disgusting.

As noted earlier, the criteria used to assess cleanliness together with the availability of cleaning materials are some reasons why drug injectors may not thoroughly clean needles and syringes inside prison. Other explanations stem from the wider prison environment.

For example, drug injecting in prison is a fast-moving and clandestine activity. These activities being conducted in a closely observed environment, and with the risk of being caught and punished, were sometimes considered greater risks inside than outside prison. Consequently, less emphasis may be placed on cleaning practices. Craig illustrates some of these features of the prison environment, which restricted his ability to clean needles and syringes thoroughly:

It was coming up to just before eight o'clock and there was about three of us and we'd only just scored and the screws were already shouting, you know, "five minutes lights out five minutes bang up", and that. We were in the pad rushing. Really badly rushing and like the first lad whacked it in, and the second lad, and it come to me, because we were rushing that much no-one really cleaned it out. You know, they didn't flush it several times 'cos we didn't have time for that it was just like get it together and it was in and that and I just didn't think about that because I was thinking if I get banged up I'm going to be poorly all night. I've got to get this I've got to get me hit in so I can sleep and sit in my pad all right. If I hadn't have done I would have been badly. But that's how you think. You know, with it being that close to bang up we were all rushing and no-body cleaned it out throughout the three of us.

As this extract illustrates there are conflicting topical relevances, which include the intrinsic need to inject drugs quickly, cleaning needles and syringes, the imposed relevance of being caught, and the consequences of drug withdrawal. On this occasion, the need to inject drugs quickly to avoid drug withdrawal was interpreted as the most pressing and resulted in motivational relevances informing this direction of behaviour.

The findings presented in this section have shown that drug injectors qualified sharing by the need to clean needles and syringes, which was important both outside and inside prison. By cleaning needles and syringes some drug injectors understood that the risk of infection was significantly reduced to such an extent that they would be unlikely to become

infected. Others, however, recognised that the cleaning of shared needles and syringes can never eliminate HIV risk.

The effectiveness of cleaning depends on the criteria used to assess cleanliness, the availability of cleaning materials and the thoroughness of cleaning practices. Drug injectors understood that visible dirty and blood stained needles and syringes, and those showing signs of use would not be used outside prison. However, inside prison the shortages of injecting equipment meant that such discretion was unrealistic and people would, when in need of drugs, often be prepared to use whatever was available.

Findings on the availability of cleaning materials show how water and chemicals were part of cleaning strategies. However, inside prison less effective chemicals were likely to be used, reflecting the limited cleaning materials available to drug injectors inside prison. Belief about the virology of viruses outside the body could be used to justify less effective methods, as would concerns about the effect of residue cleaning chemicals in needles and syringes being injected into the body.

The thoroughness of cleaning practices varied from simply rinsing needles and syringes to careful cleaning. The thoroughness of cleaning could depend on other aspects of cleaning strategies. For example, cleaning may be performed until needles and syringes look visibly clean. This illustrates the interconnectivity of these findings together with the influence the wider prison environment can play on less effective cleaning strategies. Some of these features of the wider prison environment, for example hurried and clandestine drug injecting practices, are less easily remedied than others, such as limited supplies of cleaning materials. On this last point, the Prison Service (1995a) has recognised the need to

provide decontaminants to drug injectors. However, this policy has been subject to great delay and has yet to be implemented (Prison Service Directorate of Health Care, 1998). The findings presented here reinforce the need for freely available decontaminants to be provided in prison without further delay and, in line with CoE (1995) recommendations, this should be supported with information on how best to clean shared needles and syringes. Policy development can, however, go further. The findings reported here reinforce the arguments rehearsed earlier for the need for sterile needles and syringes to be provided freely to drug injectors inside prison. It is unlikely that the provision of sterile needles and syringes in prison will completely prevent sharing and the associated risk of infection transmission. However, the provision of sterile needles and syringes in prison could impact upon the spread of infections in prison far more than the cleaning of needles and syringes alone.

SUMMARY

This chapter has explored two very different risk management strategies that drug injectors employ in attempts to reduce the risk of HIV. These were chosen to capture a range of influences and mechanisms on drug injectors' risk reduction strategies.

First, the perception of social distance as a subjective form of risk management found greater risk taking amongst the socially close than the socially distant. However, there were contradictions in these accounts and the reverse was also found. In the second part of this chapter the focus shifted to explore a practical risk management strategy: the cleaning of needles and syringes. There were high normative beliefs surrounding the cleaning of needles and syringes both inside and outside prison. Differences in perceptions between these two environments may, in part, be attributed to contextual differences. Because of the

limited materials inside prison with which to inject drugs and to clean equipment, prison can be considered a riskier environment than outside and can help to explain the greater inadequacy of cleaning needles and syringes inside prison. In the following chapter on perceptions of risk, the focus shifts to understanding a response to risk behaviour by examining drug injectors' perceptions of HIV testing.

– CHAPTER 9 –

**DRUG INJECTORS' RESPONSES TO RISK BEHAVIOUR:
PERCEPTIONS OF HIV TESTING**

INTRODUCTION

In Chapter 7 risky situations were examined with a focus on the need and desire for drugs, and on the ways in which drug injectors think about risk behaviour. In Chapter 8 two aspects of risk reduction were explored: the influence of social closeness and distance on risk behaviour; and the cleaning of needles and syringes as mechanisms for risk reduction. Together these chapters have contributed to understanding more about the spectrum of drug injectors' perceptions of HIV risk. The present chapter examines HIV testing, which can be broadly understood as, at least partially, a response to acknowledged risk behaviour. It aims to help clarify the interconnectivity between different kinds of risk perceptions. Individuals' perceptions of HIV testing are influenced by the situations in which risks are taken, the ways people think about risk and the nature of the risk relationship involved.

HIV testing is a policy initiative that has been central in aiming to prevent the spread of HIV and AIDS (Berridge, 1996). As a public health measure, testing will work when people take the test and make appropriate changes to their behaviour as a result. In this way, testing is founded upon an individualised understanding of behavioural change rather than upon an attempt to alter social and cultural norms (Scott and Freeman, 1995).

The process usually involves pre- and post-test counselling to ensure that individuals have considered the implications of their behaviour and the potential consequences of a positive or negative test result. Typically a test is carried out on a small blood sample with results

available a few days later, although some establishments offer a 'same day' testing service (Green, 1997).

There is a small body of research on the social aspects of testing (Lupton *et al.*, 1995). However, there is not a great deal of qualitative research and even less is known about these issues from drug injectors' perspectives (McKeganey, 1990). This chapter sets out to explore drug injectors' perceptions of HIV testing looking at first, reasons for not taking a test, second, reasons for taking a test, and third, the impact of testing upon subsequent behaviour.

“IT IS NOT THE FIRST THING ON MY MIND”: REASONS FOR NOT TAKING HIV TESTS

Understanding why people do not take HIV tests when they have been at risk of infection is important, not least because higher rates of HIV have been found among those who refuse to take a test than those who agree (Jones *et al.*, 1993). Absence of testing could be due to inconsistent testing policies and practices (Beardsell and Coyle, 1996; Meyrick *et al.*, 1997); individuals not seeing testing as necessary or a priority; and some people not considering themselves to be at risk (Hart, 1991; Simon *et al.*, 1996; Rothman *et al.*, 1999). The need to understand more about HIV testing is important when, for example, some people will be infected with HIV despite not considering themselves to be at risk (Jackson *et al.*, 1997).

An HIV test result, positive or negative, may require some adjustment to people's lives. Drug injectors have found it difficult adjusting to the possibility of an HIV positive diagnosis (McKeganey, 1990; Warburton *et al.*, 1997). In the present study, some people

found certain scenarios contained within the vignette difficult to interpret (Hughes, 1998). A notable example of this was when one of the vignette characters is suspected of testing positive to HIV. One particular vignette scenario based inside prison saw the character Pete informing his friend Ben that he is being tested for HIV. Shortly after, Pete is moved off the prison wing and Ben assumes that Pete is HIV positive. A comment such as, “I don’t know what to say there”, reflects some of the difficulties people had in interpreting vignette scenarios. Difficulties in interpretation may reflect wider problems in adjusting to the possibility of a HIV positive diagnosis. It may also reflect these sorts of scenarios being less familiar to drug injectors than others concerning, for example, the dilemmas faced when people need and desire drugs but sterile injecting equipment is unavailable (Chapter 7).

Drug injectors’ experiences of testing are likely to differ from those of other groups of people (McKeganey, 1990) and an appreciation of drug injectors’ lifestyles may help to explain why considerable numbers of drug injectors do not return for test results (Valdiserri *et al.*, 1993; Molitor, *et al.*, 1999). In the present study the lifestyles some drug injectors identified with were often, although not always, chaotic and troublesome (Hughes, 1997a). With regard to HIV testing this can mean that drug injectors’ lifestyles do not fit easily with formally established testing procedures, such as meeting a series of pre-arranged appointments. Similarly, Lear (1995) found that lifestyle factors influenced undergraduate students’ ambivalence towards testing. This finding was manifest in the ways in which they procrastinated about taking a test, notably they “didn’t get round to it” or were “too lazy” (Lear, 1995, p.1319). Although it is important to note that what may be reported as procrastination may reflect people’s concerns with testing procedures.

In the present study, the pursuit of drugs has been shown to be a central priority in drug injectors' lives. When drug injecting becomes less important people think more about their previous behaviour and the risks taken (Chapter 7). In a vignette-based discussion when the character Ben leaves prison and sees his sexual partner Jo, Natasha considers that their sexual behaviour would not change unless Ben's drug injecting behaviour reduced. Natasha said:

No [change in sexual behaviour]. ... But if he's off the gear right then probably they would really try, go and get tested for her sake.

Closely allied to the influence of drugs on behaviour, the temporal dimension of being in a state of mind to consider risk behaviour and its consequences is important. As discussed in Chapter 7, the re-emergence of thoughts about HIV could take anything from a few minutes, to days, months or even years. Thus, for some people, HIV testing is not considered important or useful at particular points in time. Furthermore, when thoughts of HIV and AIDS are pushed to the back of the mind, the consequences of risk behaviour and the need to be tested is unlikely to be fully considered. Craig has shared injecting equipment and reflects on his own feelings about the HIV test with regard to the potential spread of infection to his sexual partner and unborn child:

If it [HIV and AIDS] was a main worry in my life I'd have been to the doctor's before today for a test especially with her [partner] becoming pregnant. I'd have been like worried for the kid, you know what I mean. I want to get checked out to see if we can have a kid sort of thing. But to me, I don't know, it doesn't seem a problem and it is not the first thing on my mind. But I think, in a way, I would rather not know. Because I wouldn't like to know that I was going to die. You know, I'd rather it just happened sort of thing.

As this extract shows, HIV testing is not currently a priority but closely allied to this are Craig's concerns with HIV and not wanting to know whether he is infected. This resonates

with findings presented in Chapter 7 on the disjunction between long term concerns and short term concerns with regard to risk behaviour. Other studies also show how HIV testing can be a lower priority compared with other, more immediate, concerns. For example, Boyd *et al.* (1999) found that pregnant women favoured HIV testing, although they were more concerned with the general health of their baby than the possibility of being infected with HIV themselves.

However, as discussed in Chapter 7, people do become concerned with their previous behaviour and its potential consequences. When they considered HIV testing many drug injectors reported feeling worried, scared and paranoid about the test and the implications of a positive result. These emotional feelings influenced the desire not to know their HIV-status. Robert had shared injecting equipment in the past and his personal experiences illustrate some of the concerns drug injectors voiced with regard to taking a test:

I've been asked to have AIDS tests and that in the past when I've been in the rehabs, you know, coming off the detox and that, but I never have. I think I'm too scared. I don't want to find out it is "yes", but it would be great to find out it is "no". But I'm one of them that I don't know whether I have got anything. I don't think I have. ... I've tried to get it together so I really am just hoping. The thing that would make it better is to have a test. To find out I'm all right and my life would be complete. But there's still that part. ... How would it change me? 'Cos I'd know that I was all right I'd feel like I could cope better. But at the moment I don't work, on this and that, there's the methadone and everything and my injecting and that. ... I wish I could pluck up the courage and the guts to have one.

People's reasons for not taking a test are diverse. In the present study some drug injectors did not want to take a test at particular points in their lives. Not wanting to take a test may, at least partially, be attributed to the chaotic nature of some people's lives. That HIV tests were not a priority may reflect any desire to be tested being subsumed by anxieties

surrounding the possibility of a positive test result. These findings may conflict with influences on the need to be tested for HIV.

“PUT IN FOR A TEST”: REASONS FOR HIV TESTS

Drug injectors did identify a range of reasons for taking HIV tests. This section examines two constituent themes, which include testing after engaging in risk behaviour and testing because of concerns about other people. It is important to recognise that these two themes are closely allied but are examined separately for the purposes of analysis and discussion.

Studies have found that when people take an HIV test it is usually presumed that the result will be negative (McKeganey, 1990; Lupton *et al.*, 1995). It is, however, important to recognise that taking a test could be a signal, albeit implicitly, that some people accept that they may be, to varying degrees, at risk of HIV. Individuals seek testing after engaging in risk behaviour (Klee *et al.*, 1991a; Wortley *et al.*, 1995; Grunseit *et al.*, 1996; Miller *et al.*, 1996; Norton *et al.*, 1997; Schwarcz *et al.*, 1997) and different motivations for testing have been identified. Event-related motivations to test, such as after having engaged in risk behaviour, may suggest that tests are used as a substitute for safer behaviour. Conversely, time-related motivations to test, such as seeking testing at regular time intervals unrelated to particular events, may suggest that tests are part of a regular health check (Grunseit *et al.*, 1996; Norton *et al.*, 1997).

Other studies have found quite opposite reasons for taking a test. For some people the test is used as an anxiety reduction technique amongst those who have persistent fears of HIV and AIDS, despite not engaging in high-risk activities and testing negative. These people

have been described as the 'worried well' (Miller *et al.*, 1988), as having an 'AIDS phobia' (Ross, 1988) and 'morbid fear' of HIV and AIDS (Scragg, 1995).

When people take a test it is important that results are received together with associated counselling and support to encourage appropriate behavioural changes (Hicks and Rundell, 1996). However, some people do not return for test results (Slutsker *et al.*, 1992; Valdiserri *et al.*, 1993; Bell *et al.*, 1997; Molitor *et al.*, 1999). Nevertheless some individuals vulnerable to infection do return for test results (Miller *et al.*, 1996), return for associated counselling and support (Valdiserri *et al.*, 1993), and express dissatisfaction when one or more of these are absent, including when testing is carried out inside prison (Turnbull *et al.*, 1991, 1993, 1994).

In the present study, drug injectors recognised HIV risk and its implications for health. The need to take a test was voluntarily identified after sexual and drug injecting risk behaviour. For example, in response to various vignette scenarios where risk behaviour had occurred responses centred on the need to take a test, and some people's personal experiences concur with this pattern. HIV testing was necessary to find out whether infection had been transmitted. Some drug injectors considered it important to take a test immediately after putting themselves at risk of infection. However, most neglected one of the basic uncertainties of the test, whilst a positive result is clearly that a negative result does not necessarily mean absence of infection because of the 'window period' of the virus where transmission may have occurred but cannot be detected.

In response to a vignette scenario inside prison, Mark suggests that if a friend was suspected to be infected with HIV, his behaviour would change and, in particular, Mark said:

If I really thought that someone was HIV and I'd been sharing those works I wouldn't be using them works again and I'd be straight down for a test, straight away.

Sharing injecting equipment is more likely when individuals need and desire drugs (Chapter 7). Just as some people would qualify risk behaviour by the need to clean injecting equipment before sharing (Chapter 8), risks would also be taken but qualified by the need to be tested afterwards. As Lorna said:

If I wanted that hit, I suppose I probably would do it. And then afterwards I'd probably, maybe, go to the nurse and say I want a test.

Just as there may be a series of risks for drug injectors (Rhodes, 1995), there may also be a hierarchy of risk reduction strategies or responses to risk behaviour (Connors, 1992). In the present study, the need to be tested was sometimes framed within a series of strategies. In response to a vignette scenario where drugs are needed but sterile injecting equipment is unavailable, Colin identified the need to use the injecting equipment after it had been cleaned followed by a test:

He's used to doing it [drugs] and he needs it, probably steam out the fucking, and bleach out the works probably like. It depends on himself like, but he'll probably go in for a test himself like won't he.

The need for HIV testing is particularly apparent when drug injecting risks have been taken with people who were less well known compared with when risks had been taken with

close friends and close sexual partners. Insights gleaned from the theoretical framework suggest how the routine of risk behaviour, occurring at the level of practical consciousness and ontological security, is broken when individuals share with the socially distant. The issue may be discursively considered and individuals may think about their behaviour for considerable periods, especially upon release from prison (Chapter 7). Topical relevances are formed and the interpretation of the problem may require a response, through motivational relevances, which can include the need to take a test.

Taking a test after engaging in sexual risk behaviour was less apparent. This could reflect the interplay between different topical relevances and their interpretation. Drug injecting risk behaviour may be considered more real in the spread of HIV than sexual risk behaviour (Rhodes and Quirk, 1996; Rhodes, 1997), resulting in lower motivations to test after engaging in sexual risk behaviour. However, as will be shown in the following section, a test may be taken in sexual relationships for other reasons, depending on the nature of the relationship.

Overall, testing was considered important after drug injectors had engaged in risk behaviour, such as sharing injecting equipment, and was also used to qualify and justify risk behaviour prior to the event. This suggests that drug injectors can attach considerable importance to testing after putting themselves at risk of HIV. The need to test was also apparent when drug injectors identified the need to take a test because of concerns about others.

In general, the literature on testing focuses on the voluntary nature of the tests that, as demonstrated in the previous section, can be a response to having engaged in risk

behaviour. However, it is important to note that not all individuals voluntarily elect to be tested (McKeganey, 1990; Jackson *et al.*, 1997). Similarly, other groups have been 'urged' to take a test by parents and sexual partners (Lupton *et al.*, 1995). In these cases testing may be a response to other people imposing perceptions of risk upon individuals. In the present study, it was suggested that non-drug injectors in sexual relationships with drug injectors should insist and exert pressure on their drug injecting sexual partners to take a test. This was important to help reduce the chance of infection transmission from drug injectors to non-drug injectors. In response to a vignette scenario when the character Ben is in a sexual relationship with Jo who does not inject drugs, Lorna reports:

He should go for his tests to make sure he hasn't got anything at all. And she should really insist on that, never mind that she is on the pill.

Similarly Craig comments:

She'd want to know for her own safety, you know what I mean. So she'd be pressuring him into getting, either wearing protection and at least getting a test as soon as possible.

These findings demonstrate awareness of the routes of infection from drug injecting and the chance of secondary infection spread through sexual relations (Moss, 1987; Newmeyer, 1988; Donoghoe, 1992; Friedman *et al.*, 1993; Ronald *et al.*, 1993). However, drug injectors placed less emphasis on the transmission of other sexually transmitted infections. These findings also resonate with others that show how drug injectors consider non-drug injectors to be cleaner from infection than other drug injectors (Chapter 8).

Thus, importance was attached to urging others to take a test because of concerns about someone else, usually a sexual partner. But drug injectors also identified voluntary reasons

for HIV testing because of their own concerns about others. When reporting the need to be tested because of concerns about others it was usually after drug injecting risk behaviour. If a drug injector perceives him or herself to be at risk, then he or she may go for a test in order to put at rest their own mind or the mind of a injecting equipment sharer or sexual partner. In particular, when drug injectors had engaged in risk behaviour, typically having shared injecting equipment, testing was a means to allay concerns about transmission to close sexual partners. Tim's observations exemplify this finding and also demonstrate how worrying about risk behaviour (Chapter 7) can lead to testing:

I know a guy who was sharing with somebody and was locked up with him for five month. They were cell mates, they were sharing a cell together, they were injecting, as soon as he came out he went and got all the tests. ... He said, you know, he really was worried about it so he had the test before he went back with his lass.

Within these types of situations individuals take a test because of concerns about others and to reassure themselves or others that they are not infected and will not spread infection. Taking a test because of concerns about others was also influenced by particular features of sexual relationships, including caring and loving sexual partners and sometimes as part of making a commitment to the relationship. These features of sexual relationships can be understood as part of social closeness (Chapter 8) and further demonstrate how emotional influences on risk behaviour can, in turn, affect behaviour. In response to the vignette when the character Ben had shared injecting equipment Karen said:

There is always a risk 'cos he's injecting. There's always a risk he could be carrying something so they've got to be careful of that so their best bet is to take precautions. Maybe get checked before they do go to bed.

Sharon took a test because of risks taken with her sexual partner. Sharon's sexual partner was found to be infected with viruses and taking a test was to find out whether infection had spread to her. Sharon gives her partner's risk behaviour, rather than her own risk behaviour with her partner, as the impetus for being tested. As Sharon said:

I've shared with my boyfriend. ... But I ain't got AIDS or owt 'cos I had to have an AIDS test 'cos of him. He found out he had hepatitis C, well one of them that goes, but I hadn't slept with him for ages and I hadn't shared for ages but I thought I'd get it done over there so I had a test [for HIV and hepatitis] and that and I was all right.

Relationships operate processually (Duck and Sants, 1983), including risk behaviour relationships (Rhodes, 1997). Studies have found that condoms are discarded in favour of other, non-prophylactic, methods of contraception when sexual relationships become long-term (McKeganey and Barnard, 1992; Lear, 1995). HIV testing has been noted to play a part in this process in that upon receiving a negative result condom use may be discontinued (Lear, 1995; Lupton *et al.*, 1995; Grunseit *et al.*, 1996; Hillier *et al.*, 1998). Similar patterns of behaviour were identified from drug injectors' perceptions of risk in the present study. Reflecting on his own experiences, Mark's sharing of injecting equipment was the prompt for testing in a sexual relationship.

I've always [used condoms]. ... With my girlfriend until we, before we, had the blood tests with me using and, you know, sharing before in the gaols. ... I loved her, so I had to for her.

Being tested for HIV because of concerns about others was generally discussed within the context of close sexual relationships. Social closeness may influence reasons to take a test because people care and love sexual partners and do not want to put partners at risk from infection. Conversely, social closeness may also influence risk behaviour because the

thought of a partner carrying infection may be contrary to the premise of the relationship (Chapter 8).

Although drug injectors qualified risk behaviour with the need for a test, as discussed earlier, testing is not in itself a risk reduction strategy. It serves to discover whether an individual is infected with HIV and a negative test result may not necessarily mean absence of infection. Testing can only serve to reduce risk if it results in safer types of behaviour. However, drug injectors sometimes considered the test as a form, or as part of a process, of risk reduction, such as testing before condom use cessation. But being tested can only be effective if people change risk behaviour and adopted safer behaviour that is, crucially, maintained over time.

“GOT TO BE CAREFUL NOW”: THE INFLUENCE OF HIV TESTS ON BEHAVIOUR

It is generally assumed that the decision to take an HIV test reflects a voluntary realisation on the part of individuals that their behaviour may have put them at risk of infection. However, HIV testing may lead to either safer or continued types of behaviour. This section considers the influence of going for a test in itself on behaviour, and the impact of a positive or negative result on behaviour .

The act of going for a test can, in itself, lead to behavioural change. In the present study, testing itself was identified as a marker from which to change risk behaviour and adopt safer behaviour. In response to the vignette Jane reports:

I think he [vignette character] would be more careful about who he is sharing with and what the consequences are of sharing needles and I think he'd probably just stick to using his own needle.

Drug injectors reported similar sentiments in what they believed they would do. As Kieran said:

I think I'd stop, yeah, and at the end of the day I don't think I'd be bothered how much I wanted a hit if I knew someone had AIDS I wouldn't touch anything.

However, testing itself may not necessarily led to behavioural change. Some drug injectors implied that risk behaviour would continue until HIV test results were known. This was often expressed within the context of previous behaviour. Repeated actions may become habitual (Aarts *et al.*, 1998) and it was understood that once a risk had been taken it would be taken a number of times until HIV infection could be determined. This also resonates with risk behaviour being discussed as a gamble (Chapter 8). In response to a vignette scenario when the vignette character Pete is being tested for HIV, Lorna reports his behaviour would be unlikely to change:

I suppose nothing until he's got his results. I mean it depends on each other. They're sharing works, they've already been sharing the works, so at the end of the day if you've got it now it's too late we might as well carry on. That is what would realistically happen isn't it because they've already done it and shared. ... They've already done it, so it's too late isn't it?

This application of the vignette technique was valuable in generating data on what drug injectors perceive should happen and what would really happen (Hughes, 1998). Findings centre on the realisation that when people are in need of drugs, and there are shortages of injecting equipment, then situations can arise when further risks would be taken before the test results. This can be in contrast to what should happen. A vignette-based discussion with Craig illustrates some of these issues:

Rhidian: Pete goes to the medical wing a couple of times, and returns one day saying that they are testing him for HIV/AIDS. Would anything change when Ben and Pete shoot up together?

Craig: Yeah it should do. Ben's thoughts on sharing with him would change. They should be a lot more careful now and really he should wait for the test to come back to see if he does have anything.

Rhidian: But what do you think they would do?

Craig: Oh, they'd carry on 'cos at the end of the day he can't wait a week or however long it takes for the test to come back. You know, he's going to need a hit that day. So they are still going to.

These findings can be located within the context of others. For example, as noted in Chapter 7, some drug injectors reported that they would not think about infection until it could be confirmed by being tested. As Karen said:

I don't think that you think about that risk until you find out that you've actually caught it because you think, 'it's never going to happen to me. I won't catch it'.

However, the very process of not thinking about HIV risk may inhibit the seeking of a test in the first place. Some people perceived drug injectors not to care about HIV risk. Mark exemplifies this in response to the vignette:

A lot of people would think the gaol is full of that many scum bags they just don't care they just carry on as they have been. They think about [HIV/AIDS] when it happens.

These data only refer to perceptions derived from vignette-based discussions. Given this caveat these findings remain important and can easily be located within other supporting findings within this thesis on, for example, the ways in which people think about risks (Chapter 7).

With regard to the theoretical framework, these findings illustrate how a test result, whether positive or negative, can break the routine of risk behaviour that can be understood at the level of practical consciousness and ontological security. When these routines are broken, at the level of discursive consciousness, motivational relevances influence particular directions of action that could lead people to continue risk behaviour after a HIV test. Considered hitherto has been the perceived effect of testing, regardless of the outcome, on behaviour. A positive or negative test result can also lead to safer or continued types of behaviour.

Studies have found that positive HIV test results among drug injectors lead to reductions in reported risk behaviour (McKeganey, 1990; MacGowan *et al.*, 1997). There are a number of strategies that drug injectors employ to reduce the risk of infection through drug injecting (Power, R., *et al.*, 1996). If infected with HIV, drug injectors may use similar techniques to reduce the risk of passing on HIV, which suggests they do not wish knowingly to spread the virus (McKeganey, 1990). However, drug use can increase as people try to come to terms with their HIV positive status (McKeganey, 1990; MacGowan *et al.*, 1997). This may lead to more situations where drug injectors might be called upon to share injecting equipment resulting in the spread of HIV.

Pre-test and post-test counselling is important to assist individuals to make necessary changes to their lives (Hicks and Rundell, 1996). The extent to which they change behaviour and adopt safer practices is influenced by the length and extent of counselling and support (MacGowan *et al.*, 1997; De Rosa and Marks, 1998). However, some people are not offered post-test counselling (Turnbull *et al.*, 1991, 1993, 1994; Jackson, 1997) and

some people fail to return for post-test counselling even when it is available (Ladner *et al.*, 1992).

Since Jane found out that she was infected with HCV she took steps to prevent others from sharing the same injecting equipment as her. Sexual behaviour was also negotiated in a similar way:

When me and Jake met, the first day we went to score together. This is how we met, and he didn't have a needle and wanted to use mine. So straight away, we weren't going out with each other, I turned round and said I've got hep C so you can't use mine. So we toddled off to [needle and syringe exchange scheme] and he got his own. So before I even got off with him he knew I had it. It obviously didn't put him off. Then when it came down to sex, you know, for the first couple of days or whatever we used protected sex and he talked to [drug worker] and he said, the only time you've got to be careful is when I'm on periods or whatever, so that's the only time we've got to be careful.

As the extract above illustrates, risk reduction was to protect another from HCV with little attention given to the two-way transmission of other infections including HIV. As Hart (1991) notes, people may not associate the risk of HIV with other infection spread by the same route.

Testing positive may also result in a fatalistic response. Disclosing results was not a certainty and risks may continue to be taken. In response to the vignette Keith reports:

He wouldn't say anything until he'd had a test and got the results. Still that scenario, nothing would be said till he gets the results and if he is negative he doesn't say nothing, if he's positive then he'll maybe have to think about telling her.

Testing negative does not always lead to a reduction in risk behaviour (Wilson *et al.*, 1996). In the present study, perceptions of social closeness and cleanliness exert an

influence on perceptions of risk (Chapter 8). A negative HIV test result can also be seen as a marker of cleanliness from infection. Sometimes people took risks with those considered clean from infection and individuals also saw themselves in this way. A negative test result can assist these processes, as Dan's personal experiences illustrate:

[I don't use a condom because] I've had a few tests for HIV, hepatitis B and hepatitis C, 'cos like I've got a girlfriend and she's never taken a drug in her life she doesn't even smoke a cig. ... She doesn't know about it. 'Cos I'm clean so what is the point in telling her about it?

Whilst testing negative may provide a symbolic starting point to adopt safer behaviour, it can be difficult to maintain this over time (Lupton *et al.*, 1995). This may reflect inadequate counselling and support (MacGowan *et al.*, 1997; De Rosa and Marks, 1998).

Some people felt that once a test had been taken, they were clear of infection despite the uncertainties surrounding an HIV negative result. Nevertheless, a negative result could then be used as a substitute for condom use. However, this was mainly within the confines of established sexual relationships. Jane exemplifies this finding in response to the vignette:

Well bearing in mind if he'd had blood tests and what have you and he was clean I think well possibly the pill. If he hasn't had blood tests and what have you, condoms would be a realistic thing to use.

"I haven't shared since then" represents some people's personal experiences of adopting safer drug injecting practices after a test. Similar sentiments apply to sexual behaviour as Sharon remarks:

Since I had a test and that lot since I got paranoid me 'cos like I was only like 15 when I had one, do you know what I mean, and I only slept with about three people after that and I've used condoms with them.

SUMMARY

The analysis of data on drug injectors' perceptions of HIV testing presented in this chapter centred around three main areas that explored reasons for taking a test, reasons for not taking a test, and the influence of tests on behaviour. These findings are clearly exploratory but have important implications for understanding drug injectors' perceptions of the test, which impact upon the direction of future research and the development of policy interventions.

Influences on not taking an HIV test were examined. The influence of drug injectors' lifestyles and, in particular, the need and desire for drugs in these lifestyles, are important factors on drug injectors' willingness to consider HIV testing. When drug injecting is less important, individuals may be more open to the idea of testing compared to when drugs are their main priority. It is important, therefore, for interventions to tackle the impact of drug dependency and the development of appropriate harm reduction measures as much as in responding to its consequences, which in this case refer to HIV testing. When drug injectors' thoughts about risk behaviour are sublimated they are less likely to seek testing. The sublimation of thoughts on testing may be enhanced by anxieties about testing procedures and the potential consequences of a positive result on people's lives. Continued effort is needed to reduce the potential uncertainties surrounding being tested for HIV.

Following the influences on why drug injectors may seek to be tested for HIV, the influences on not being tested were explored. These findings demonstrate drug injectors' awareness of risk and how HIV testing can be an appropriate response after engaging in risk behaviour. This was particularly important when risk had been taken with people who were less well known. Just as cleaning needles and syringes was used to qualify the risks

taken (Chapter 8), being tested would be used to justify risks to enable some people to pursue their usual intended courses of action. In these cases being tested helps to sublimate and defer the thought of HIV and AIDS to later points in time. This can be important when drug injecting risk behaviour occurs in drug oriented situations when issues secondary to the pursuit of drugs including HIV can be less important (Chapter 7). Sometimes being tested was considered necessary immediately after individuals had engaged in risk behaviour. This neglects the uncertainty of a negative test result, which should continue to be highlighted and discussed in pre and post-test counselling. Moreover, it is important that interventions emphasise that HIV testing is only effective if people make appropriate changes to their behaviour as a result.

Some drug injectors considered it necessary to take a test before engaging in unprotected sex after having shared injecting equipment. These findings resonate with 'negotiated safety' arrangements described by Kippax *et al.* (1993; 1997). In the present study, responses generally centred around people's accounts on taking a test because of concerns about others. Whilst these findings are clearly related to testing after risk behaviour they are, nevertheless, distinct. These findings were located within the confines of established sexual relationships. Sometimes testing was considered necessary in sexual relationships to justify the cessation of condom use. Interventions should focus on HIV testing as a prompt for safer behaviour rather than as a excuse for or response to taking risks. As discussed in Chapter 8, in some cases the closer relationships become, the less likely it is that condoms will be used. As shown in the present chapter, testing plays an important part in these processes. In sexual relationships it was also found that non-drug injectors sometimes urge drug injectors to be tested. This was to put at rest their own mind or the mind of another that the drug injector was not infected and was particularly apparent within the context of

closer sexual relationships. However, the importance attached to testing in these ways assumes that decisions will be successfully negotiated (Hillier *et al.*, 1998). It is also important to recognise that a negative test result does not imply absence of risk or guard against future infection (Lupton *et al.*, 1995; Simon *et al.*, 1996). Interventions should, therefore, encourage safer behaviour following a test and encourage the maintenance of this safer behaviour.

The influence of HIV tests on behaviour is important, not least because testing will only be effective if risk behaviour is reduced or stopped as a result. Tests can provide a break from the routines of risk behaviour, which can influence a shift from risk to safer behaviour. Against this, however, risk behaviour may continue after a test. A distinctive finding was that people perceived that individuals would not change their behaviour until a test result was known. Given the small size of the sample and that these findings were generated solely from vignette-based responses little can be said about how this applies to perceptions in the 'real world'. However, it is important to recognise that in many cases people's vignette-based responses reflected their own experiences or the experiences of their peers in this study (Hughes, 1998) and other vignette-based work (Rahman, 1996). Furthermore, it supports findings presented in Chapter 7 that people would only change behaviour when actually known to be infected. That people would not change behaviour until test result were known throws a new light on the importance attached to arguments for the fast turnaround of HIV test results from the test to the results being received by the individual (ACMD, 1993). These findings offer an important focus for future research, which should assess the extent to which other groups also consider making no behavioural change until a test result is known. These findings may indicate, for example, the need to

speed up the process of returning test results, or that counselling undertaken before a test should directly tackle these issues.

An HIV positive result may result in safer behaviour to prevent others becoming infected. Conversely, however, the result may lead to a fatalistic response that disclosure of a positive result is not a certainty and here continued risk behaviour may be likely. Similarly, an HIV negative result may give rise to continued risk behaviour. These findings may be attributed to other influences on perceptions of risk. For example, testing HIV negative may bond close relationships and known absence of infection will contribute to perceptions of cleanliness and, therefore, a greater willingness to take risks (Chapter 8). Continued risk behaviour in these situations may be better understood when considered within the wide-ranging influences on perceptions of risk and their impact upon behaviour. For example, despite testing negative drug injectors may still be faced with situations when they might be called upon to share injecting equipment when in need of drugs and experiencing drug withdrawal. These needs can be more immediate and pressing than testing. In contrast, an HIV negative result may prove to be a symbolic starting point from which individuals can change risk behaviour and adopt safer behaviour. For interventions encouraging safer behaviour for drug injectors and the wider population, this must be the ultimate aim for HIV testing policies.

As shown in this chapter, the social aspects of HIV testing should remain an important concern for future research and policy development. The end of this chapter marks a shift in emphasis for this thesis. The following two empirically-based chapters takes a wider perspective to drug injectors' lives inside prison to illuminate some important prison policy concerns.

**PRISON POLICY AND PRACTICE 1: THE ROLE AND OPERATION
OF PRISON DRUG AND INJECTING EQUIPMENT MARKETS**

INTRODUCTION

In recent years there have been a number of developments to prison policies that impact upon drug injectors. Existing literature points to the need for improvements to be made to prison health care, especially with regard to policies aimed at tackling risk behaviour (Chapter 4). Gore and Bird (1998) argue that prison drug policies are rarely subject to independent examination, which perhaps reflects long held secrecy within the prison service (Cohen and Taylor, 1978; Cavadino and Dignan, 1997). Every prison is different and the prison environment is continually changing as staff and residents move in and out of prison (Worrall, 1996). Drug injectors' experiences and their perceptions of HIV risk behaviour in prison are influenced by the supply and availability of drugs and injecting equipment, which also vary from place to place and from time to time. The CoE (1995, p. 9) recommend that prisons should employ "measures to prevent the illicit introduction of drugs and injection material into prisons", and current policy continues to place considerable emphasis on this (Prison Service, 1998b; Hellawell, 1999). To explore further the impact which recent policies on drug use in prison have had on drug injectors' lives, this chapter investigates the role and operation of prison drug and injecting equipment markets. The first section of this chapter begins by examining why and how drugs and injecting equipment enter prison from outside and how these activities take place. It then examines the ways in which supplies are maintained inside prison. This is followed by examination of the availability of drugs and injecting equipment inside prison.

“GETTING THEM IN”: DRUGS AND INJECTING EQUIPMENT ENTERING PRISON

Drugs and injecting equipment are brought into prison to maintain drug dependency and because of a lack of supply networks inside prison. There are two main methods by which drugs and injecting equipment enter prison. First, they are brought in when people enter prison. Second, visitors bring them in.

“Plugging” and “Crutching”: Drugs and Injecting Equipment Brought In When Entering Prison

Drugs play an important role in the lives of the drug injectors contacted in this study and this role continues when individuals spend time in prison. The use of drugs can help people to settle in to prison during the early stages and drug use can also help to break the monotony of mundane prison life. It is important for drug injectors to remain inconspicuous in order to prevent, as will be shown later, the theft of drugs and injecting equipment. Taking drugs into prison when entering can be useful in that individuals need not ask others for help to procure supplies. Lorna illustrates this finding:

I'm going to prison, and it could be for a while and I don't want to get mixed up with the wrong people. ... I take my own drugs in.

Upon entering prison individuals may not have established the necessary social networks that enable drugs and injecting equipment to be procured. Not having a visitor to bring in supplies through visits was one important reason for bringing drugs and injecting equipment into prison when entering. As Jane reports:

I'd finished with the boyfriend who was a dealer so I didn't have anyone to bring anything up for me and I knew I was going down. ... When I went to court that morning I got a tenth and a half and plugged it and I got a pin, I took a pin in with me.

Drugs and injecting equipment can be brought in when people enter prison from outside either at the onset of imprisonment or upon return from a temporary release period. People resident in lower security establishments may also work outside the prison and in these cases deposits at strategic locations placed there by friends and family enable people to obtain drugs and injecting equipment. People are searched on entering prison so it is difficult to conceal supplies on the person within clothing. Instead items can be concealed in the anus or vagina. As Lewis said:

I've known somebody whose got all his gear, citric, needles, even a little spoon, bent it round, put it in a Smarty tube in a Durex and up his bum.

The CoE (1995) emphasises the need for drug injectors to observe the rules of hygiene. From the outset, however, drugs and injecting equipment enter prison through unhygienic activities. As Terry recognised:

People are using it, that's all got brought in up somebody's arse piece be piece, you know, so there's that as well, you know, it is generally unclean. Never mind the blood disorders going through it.

Drug injectors explained that injecting equipment is more difficult to conceal than drugs inside the body. Smuggling personal sets of injecting equipment into prison may help to prevent individuals sharing injecting equipment, subsequently reducing their risk of infection through this route. However, bringing complete sets of injecting equipment into prison is not easy and sometimes only a needle may be brought in; other injecting equipment will need to be obtained inside prison, usually involving sharing. Any injecting equipment brought into prison from outside usually needs to be adapted. Typically, the sizes of syringes were reduced. As Dan said:

You get two-ml works, yeah, you chop it in half and put it up your bum.

A less commonly cited method for drug smuggling was to swallow drugs and wait for them to pass through the body. All these practices require planning and organisation. People awaiting a court appearance and expecting a custodial sentence would plan the concealment of drugs and injecting equipment. Some reported taking steps to save up drugs for these occasions. As Tim said:

When I go to prison I am going to make sure I am filled with a bit of dope and a bit of smack or whatever it might be I'm into in a few months time. Whenever I go into prison I am going to take something in with me.

“Taking a visit”: Drugs and Injecting Equipment Brought In During Visits

Unless people spend only a short period of time in prison supplies need to be maintained in order to avoid drug withdrawal. Visits play an important role in the maintenance of drug supplies. Contacts from outside prison, including family, partners and friends, assist by passing drugs and injecting equipment to people during visits. This section reports first on the planning and preparation and second on the visit and the exchange of drugs and injecting equipment.

“Getting ready”: Planning and Preparation

Making contact with people outside prison, typically by letter or telephone, allows drug injectors to ask for drugs and injecting equipment, albeit subtly. Keith describes the way he went about this:

I got a letter saying he was coming up on a visit. ... I said ... “are you going to bring me a present and a prick”. And he’s thinking “a parcel of smack and a works”, and that’s what he brought up for me.

Drug injectors identified a number of informal rules in prison, many of which reflect the need to remain inconspicuous. When expecting a visit it was important to maintain secrecy. Martin illustrates this on the basis of other people’s experiences:

That’s a rule you don’t tell a single soul when you’re getting a visit. Sometimes I’ve heard people getting caught on their visits because their pad-mate’s talking to his girlfriend on the phone “it’s all right love, my pad-mate is getting a visit and he will be coming up with this that and the other”. It’s recorded on the phone and then they come and nick you.

When information such as this is obtained by prison officers it should be documented in a security report that, if deemed reliable, is acted upon. Some individuals suspected of bringing in drugs and injecting equipment might be placed under increased observation. When individuals believe they are under observation, strategies to avoid detection may be employed, which can include cancelling the supply. Jane illustrates this:

If I thought that I was going to get searched and it was on top for me. Say like the night before I got a visit, yeah, something happened that was a bit on top. Our wing was getting searched or whatever or they had suspicion that I was using I’d phone my visitor and tell them not to bring any works up or any scag up.

In situations such as these people may try to find someone else to take a visit for them. As

Martin said:

You get someone else to take a visit for ya at the same time. Your missis meets them outside the gaol at the same time, gives them the parcel and then they pass it through on their visit.

Thus, considerable planning and preparation is necessary for a visit. The outcome of a visit is, however, dependent on the actual exchange.

“Pass them on”: The Prison Visit

Visitors to prison need to conceal drugs and injecting equipment to ensure they are not discovered during routine security searches and may conceal drugs inside the body as Sharon reports:

When I used to take them to my boyfriend I used to plug them, put them in my fanny, you know what I mean, and I used to get through security and then I'd just take it out and then pass them on.

Visitors may also use other techniques to conceal drugs and injecting equipment. Jane describes her experiences:

Well I had someone bring my daughter up and they put them in my daughter's nappy. Not while my daughter was wearing it, but in a spare nappy. So I undid the lining and put them in and they don't show up on the scanner you see 'cos they're blocked in with cotton wool inside the nappy, you see, so I had a supply of clean works. ... I was asking them to bring five in a week.

Other methods include storage in the mouth and passing drugs when kissing. As Karen said:

You can smuggle them in by kissing and stuff and just pass them on. And you can just hide them at the back of your filling. So it's really easy to get them in.

Concealed drugs may also be transferred in items available in prison visiting rooms, including food and drink. As Terry reports:

I had some dope and some gear brought into me and that was put into a bar of chocolate. The geezer had a beard and he put the packet [of heroin] inside it so when he came through it didn't look like a lump in his gob 'cos he had this big bushy beard and that and they didn't think nothing of it. He went to get the bar of chocolate stuffed it all in the bar of chocolate from the machine and the security think, "oh it's a machine chocolate there's nowt wrong with that". He comes up to me and says, "here's a bar of chocolate".

Once drugs have been exchanged the recipient conceals them. Drugs may also be swallowed although, as noted earlier, this can be the least favoured method because of the time taken for drugs to pass through the body. As discussed in Chapter 7, people often want drugs immediately. Dave comments:

Smackheads will never swallow their gear on a visit because it takes days to get through.

If drugs are swallowed, people may induce vomiting when back on the prison wing rather than wait for the drugs to pass through the body. In this way, Terry goes on to report:

It would go in swallowed and I know I had two minutes, to my cell, straight into my cell, warm salty water, and fingers down throat.

Drugs may be concealed in the anus, vagina, mouth and throat. These methods are considered more favourable when larger amounts of drugs, which are difficult to swallow, are being brought in. As Natasha reports:

He [visitor] used to put it in his mouth and spit it in a cup and I used to either swallow it and puke it back up or crutch it depending on. So I'd have it in my mouth, I'd take a drink, spit it out and five minutes later, I'd get the drink and put it in my mouth. ... Sometimes you can keep it in the side of your mouth but it is quite a big lump so you have to crutch it.

Concealing drug in the anus or vagina is a difficult task but can be made easier having made certain preparations. Injecting equipment was recognised as more difficult to conceal

than drugs. Consequently needles without a syringe barrel would be brought in during visits. As Robert said:

She [partner] brought a couple of needles up with her but she couldn't exactly bring the works, you know, to smuggle them in would be hard.

Drug injectors are reliant on other people for the provision of sterile injecting equipment. This reliance can mean that there is little choice over the equipment received and there is no guarantee that it is sterile.

Throughout activities that surround the exchange of drugs and injecting equipment, speed and discretion are essential. Keith exemplifies this:

The thing is that they've got to get you before you get it up there. If they don't get to you before you get it up there you don't have a chance; they have to catch you.

Prison visits take place in a very closely observed environment, which is increasingly assisted with close-circuit television. If prison visitors and residents are caught there are a number of punishments that may be imposed. Prison visitors face arrest. Prison residents face serving additional days on a sentence, being segregated, and having no-contact visits. The threat of being caught can make exchanging drugs an unnerving experience as Karen explains:

They've got cameras on each side of the room. There's about four cameras and beside officers watching you. You are allowed to kiss and that but they are going to be watching you. You don't want to make the mistake of dropping it out of your mouth. And so basically you had to be careful how you did it. It was nerve racking.

Some people are caught attempting to supply drugs and injecting equipment into prison. This may be when planning and preparation ahead of the visit has been inadequate and when individuals are placed under observation. Lorna attempted an exchange whilst under observation but was caught and punished

I got a visit I was put on the obs table and put on top and they got it off me. So I went down the block for seven days.

Despite the problems, some people reported regularly receiving drugs and injecting equipment through visits. Natasha said:

I had good visits, you know what I mean, I was getting every two weeks, you know what I mean, so I was always sorted.

For other people supplies were more sporadic, often depending on visitors' contacts with drug suppliers in the community. Friends, family and sexual partners would procure supplies, but not everyone could succeed. Some people could obtain drugs more readily than others. Karen's sister was able to supply her with drugs:

Me sister ... she knows one of the dealers. She just gets it in for me if I ask her to.

Thus, the exchange of drugs and injecting equipment occurs despite the threat of being caught and punished.

“YOU GET NOTHING FOR NOTHING INSIDE”: MAINTAINING SUPPLIES OF DRUGS AND INJECTING EQUIPMENT INSIDE PRISON

A number of factors influence the exchange of drugs and injecting equipment inside prison. The following were identified as particularly important in the present study: trading and giving of drugs and injecting equipment, credit and debt, and theft.

“You just do a deal”: Trading and Giving of Drugs and Injecting Equipment

Ownership of drugs and injecting equipment can confer a privileged position inside prison. It enables owners to levy a charge to others for the use of injecting equipment and, similarly, the trade of drugs for the loan of injecting equipment. These findings were located within a wider prison culture that asserts, “you get nothing for nothing inside”.

Lorna illustrates this:

There’s no point in lending it for nothing is there. If she could end up with something. ... She wouldn’t just give her them for nothing. What’s the point?

Drugs are usually traded for a loan of injecting equipment. The form drugs are traded in varies. A small bag of drugs may be obtained for the receiver to prepare for injection themselves. During the process of preparing drugs for injection, drugs are liquefied and measures of this liquid may be traded. When more than one set of injecting equipment is available this process may occur through syringe-mediated syringe-sharing (Jose *et al.*, 1993; Grund *et al.*, 1996). The filter used during the process of drug injecting contains drugs, which may also be passed on. With the exception of trading a bag of drugs, these trading practices constitute risk behaviour that can result in the spread of infection (Koester *et al.*, 1990).

The trading of drugs for injecting equipment varies depending on a range of factors, such as whether the owner of the injecting equipment needs drugs themselves. Injecting equipment would be loaned for a limited time period or for a small number of drug injections. If a suitable trade was not offered, or was considered unsatisfactory, then injecting equipment might not be lent out. Colin explains:

He'd charge him to use the works. Unless he comes up with a price he wouldn't use the works. No one used our works without 'cos like they weren't coming up with a price. Well a couple of people did, well, come up with a price but a lot of people wouldn't come up with a price.

Trading led to the sharing of resources, including the sharing of injecting equipment. As Keith reports:

You've got the gear, I've got the works. I've got no gear right. I'll lend you my works if you give me a wash-out of your gear. Like both ways. You need what I've got, I need what you've got. You just do a deal.

Drugs and injecting equipment were the main currency but other items included tobacco, telephone cards and, less commonly reported, money. Women reported trading other personal items, as Jane illustrates:

It is what you get brought in is what you do your swaps with. Tobacco, razors are another thing. Personal things like shampoo, soap and all that in women's prison.

In addition to the trading of tangible assets, services may also be traded for drugs and injecting equipment. As Lorna notes:

They might want you to work for them listening to what goes on and who brings things in. And then getting someone to take the drugs off them. Running about for them.

Thus, people usually trade drugs and injecting equipment in order that both parties benefit from the trade to some extent. However, a distinction can be made here with giving based more on the principles of reciprocity (Gouldner 1960; Sahlins, 1965). People who are undergoing drug withdrawal or have recently entered prison may be freely provided with drugs as Karen illustrates:

Karen: Sometimes when you first come in people, you know, to sort you out they just give you some for nothing and you don't have to pay them back. But after the first time you've got to start fending for yourself. So it's not too bad.

Rhidian: Why do you think they give you stuff for the first time?

Karen: I don't know. Maybe it's because when they came in they were rattling the same as anyone else. Maybe they knew somebody who maybe gave them a fix for the first time. Because like everyone goes through it. So it's just helping people out until you're on your feet really.

This extract shows how drug injectors' do not like to see others experiencing drug withdrawal and in need of drug injection (Chapter 7). In these situations, people may be helped, especially during the early period of settling into prison and this may be influenced by the extent of social closeness and distance between individuals (Chapter 8). They also engender future obligations should the giver ever be in need of drugs so that communal giving in this way may be understood as a form of social insurance. It is in drug injectors' interests, individually and collectively, that communal distribution activities continue to take place in order that future supplies of drugs and injecting equipment are secured. Martin illustrates an example of communal distribution of injecting equipment:

I'd go on the phone but hide it [injecting equipment] where the telephone is. Then the next lad goes to the phone booth and that how we used to.

Karen illustrates another example of communal distribution:

When we used to get locked up at night we used to like swing it through the windows. Window to window passing, like sort of, needles over. ... After we'd finished with them I used to sling them out down this pipe at the side of the window.

Thus, drugs and injecting equipment may be directly traded for tangible assets and services. Giving may occur with fewer obligations being met at the time of the exchange. However, trading and giving may engender, implicitly or explicitly, future obligations. This may constitute credit and associated with this is the problem of debt.

“Lay ons” and “Debtheads”: Credit and Debt

Drugs can be provided on credit. Generally most people reported that drugs were not provided in this way. Others suggest, however, that credit was more likely to occur amongst the socially close. Jake explains:

They won't do lay ons unless you're fairly good mates with the person selling the drugs and they'll know that you'll actually pay for it.

Prisons are heterogeneous and credit strategies differ between prisons. Don suggests that credit is more common in prisons holding people on a long-term basis, where there has been more time for social closeness to develop. As Don said:

You've got people doing life, like no less than five years basically and the people in there are like big dealers. And they can get hold of a lot of drugs. They will lay it on. You can go to hundreds of pounds of debt. They know you are not going no-where because you're doing that many years.

Credit can lead to debt inside prison with far reaching consequences. Jane reports:

He is going to get himself into worse shit by taking scag because he is going to owe them and they'll always remember that and keep on his case for it.

There can be violent sanctions directed towards debtors, which may, ultimately, result in debtors being placed on a protected prison regime. The threat of violence inside prison also permeates the theft of drugs and injecting equipment.

“Taxing”: Theft

Inside prison drugs, like anything else, are at risk of being stolen. The likelihood of drugs and injecting equipment being stolen depends on their availability and desirability. In an attempt to reduce the risk of theft, drugs and injecting equipment may be concealed inside the body. However, if it is known that an individual possesses drugs, these drugs may be physically removed. Dan said:

Say you got a visit and someone knew you had scored, well, you know, the whole gaol will know. They would ask you for a sorter and if you didn't give it I've heard of people getting a toothbrush and taking it up someone's arse and scraping the gear out.

Assaults of this kind have also been reported elsewhere inside women's prisons (Devlin, 1998). In the present study, Amy said:

They sneak it [drugs] in ... put it inside themselves and lasses get it out of them.

It is important, therefore, for knowledge of possession of drugs and injecting equipment to be kept to a minimum. As few people as possible should know about the possession of drugs and injecting equipment as Lorna reflects:

I had a girl come up to me and say I can get you some works. [I said], “let me talk to my pad-mate about it”. She [pad-mate]says, “well I don’t think there are any works in prison so obviously what she’d do is tell you she can get you some works in prison and when you ask for them she is going to know that you’ve got something and she’ll tax ya”.

Remaining inconspicuous inside prison is important to avoid drawing attention, which risks violence. The theft of drugs and injecting equipment from individuals represents a real threat to drug injectors when they spend time inside prison. It is also important to recognise that the theft of drugs and injecting equipment is closely related to their availability.

“THEY’RE AROUND”: AVAILABILITY OF DRUGS AND INJECTING EQUIPMENT INSIDE PRISONS

The availability of drugs and injecting equipment varies and depends on, for example, the reliability of security information and associated enforcement activities together with the degree of drug injectors’ success in bringing drugs into prison when entering and making exchanges during visits. The following sub-sections report first on the availability of drugs and second on the availability of injecting equipment, including a special focus on the quality of the latter.

“Keeping a habit in gaol”: Availability of Drugs

Some people were able to procure drugs in prison with few problems. Terry attributed his ability to procure drugs to his relationship with a number of suppliers:

There was like four of my dealers in there. They were on remand so they got visits every day so the supply was really brilliant, better than waiting on the street corner. You know, just walking up one landing and sorted, you were off.

The relational dynamic that underpins drug availability is important. Drugs may be easier to procure amongst the socially close. Furthermore, social closeness may, in turn, foster drug injecting risk behaviour (Chapter 8). Lower drug availability was reported when people did not know others and when drug using activities were particularly clandestine. As Lorna said:

You don't get much drugs in there and if you do no-one will declare.

The variable and limited drug supplies can make drug dependency difficult to maintain. Colin notes:

There's no keeping a habit in gaol because you don't know when it's going to come and when it's not going to come.

The quantities of drug sold were generally smaller, sometimes by half, inside prison compared to what would be received outside prison for the same price. Inhaling these smaller quantities of drugs inside prison can be insufficient to sustain drug dependency. Consequently, drug injection is preferred, providing a much stronger drug administration. The limited availability of drugs inside prison may contribute to a shift in drug taking

behaviour towards drug injecting. Individuals may, therefore, be confronted with situations where they may be called upon to share injecting equipment. Craig reported only injecting drugs inside prison, when outside prison he switched back to inhaling drugs:

The bags in there were nothing like out here so you couldn't smoke it on foil, you had to inject to get enough off a tenner, you know. Five phone cards otherwise if you were putting it on foil you were spending like 100 pound a day at least.

Thus, for some people prisons may alter drug using behaviour. The findings presented here can help to understand why some people inject for the first time inside prisons (Bird *et al.*, 1995; Gore *et al.*, 1995a; Gore *et al.*, 1995b; Taylor *et al.*, 1995) and why prisons may contribute to sustained risk behaviour (Table 5). Furthermore, these findings can illustrate why some drug injectors may perceive prison to be a greater risk environment than outside (Power, K.G. *et al.*, 1994; 1996). When an individual's desire for drugs is reduced as a result of, for example, limited availability and having undergone drug withdrawal, then the use and injection of drugs may be reduced so that prisons can also help to hinder drug injecting behaviour. Tim said:

I did enquire to see if there was anything on the wing and someone like filled me in on [what] the size of the bags were like in prison. Thought about it then thought, 'it is not worth bothering with'.

“There's only a few works on the landing”: Availability of Injecting Equipment

Some people reported not being able to locate injecting equipment. This could reflect a lack of supplies or that individuals were outside these social networks where drug injecting equipment was available. This can reinforce the need to bring injecting equipment when entering prison as discussed earlier. Sharon said:

I couldn't get hold of one [set of injecting equipment]. It was too hard, really hard, to get hold of one.

Other people reported some limited availability of injecting equipment. As a consequence injecting equipment would be shared. Kieran reports:

There's only a few works on the landing you normally have to share because it is hard getting them in.

However, other people may not need to share when regular visits ensure a steady supply.

Mark reports:

I was on remand for a few months and I had a friend visiting me and was fetching me works when I wanted them so I was OK and I had my own works all the time I was in so I didn't need to share.

Outside prison the unsafe disposal of used injecting equipment represents a serious public health risk (Neale, 1998a) and reducing this risk remains a future challenge for policy (Hellawell, 1999). Outside prison needles and syringes are disposed of in a number of ways and are not often used for more than a small number of drug injections. Inside prison the reverse can apply. Injecting equipment may represent capital and it is less likely to be disposed of voluntarily. There are situations, however, when injecting equipment may be disposed of inside prison. For people who received a regular supply of injecting equipment, used injecting equipment would sometimes be passed on to others. Surplus injecting equipment may also be traded. Some individuals reported keeping one set of injecting equipment for personal use and another for communal exchange. Other individuals reported freely passing on used injecting equipment. The disposal of injecting

equipment may also occur in ways that result in individuals having no need to share other injecting equipment that has been set aside specifically for personal use. Mark said:

On my first visit I got another one so the one I already had I passed that on, "you can have that".

In contrast, injecting equipment may be lent to others on the condition that it is returned, which may be part of trade relations and reciprocal exchanges discussed earlier. Some people also reported injecting equipment being bought and sold. However, there can be little guarantee of its sterility. A discussion with Kieran illustrates these issues:

Kieran: I got one clean needle but I bought that off someone.

Rhidian: Was it sterile, in a pack then?

Kieran: No, but he said it was clean. I'm sure it was clean.

The quality of injecting equipment varied from the new to the old. Injecting equipment inside prison would be used for an extended period because of limited and variable supplies. To maintain injecting equipment, needles are sharpened on walls and, as Jane illustrates:

You sharpen them on a matchbox, you know, what you strike the matches on. ... Or a bit of glass, you sharpen them on and then, you see, it can last a very long time.

After continual use injecting equipment was described as, "old and scabby" and "bodged up". Drug injectors described very poor quality needles. Terry explains:

When they've been used that many times the actual fine point seems to go like a hook. If you run it across your finger you can feel it pulling your skin or if you rub it on your nail you'll see it score your nail.

In this instance, Terry goes on to explain the problems of using these poor quality needles:

in other studies (Seaman and Gaughwin, 1994; Turnbull et al., 1994; Rutter et al., 1995;

Tim: You could do some damage once it's inside because again when you're drug
withdrawing it you feel it pull, you know, like catching a fish sort of thing.

Injectors are at more risk of health complications, including scarring and breakage.

When needle and syringe sets are incomplete, missing items would be substituted from other needle and syringe sets or from materials available inside prison. Drug injectors described these items as including a "screw as a plunger", "bits of bed thread", "a bit of wire", a "bookie's pen", "Blu Tack", "elastic bands", and "a melted plastic bag". These would all be used in the production of makeshift injecting equipment. Two examples of makeshift injecting equipment are illustrated in Photograph 14. As Tim describes:

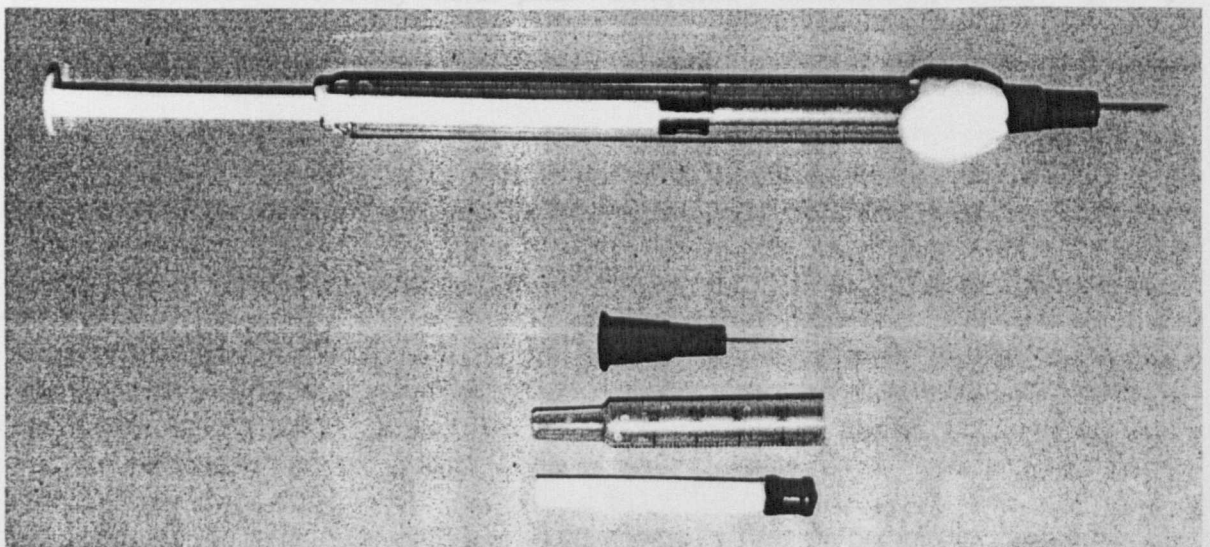
the prison drug injecting environment. Findings on drug injectors' perceptions of risk are

Tim: People using, you know, the inside of a pen, you know, what the actual ink is easy
in. Cleaning it out, sharpening it up and using that to inject.

people's minds and over the course of the study. Even drug injectors considered

Photograph 14. An example of makeshift injecting equipment with a sharing. This was generally perceived as

Photograph 14.
Two Examples of Makeshift Drug Injecting Equipment



groups. Drug injecting activities inside prisons are secretive, and involve considerable

planning and discretion.

Poor quality injecting equipment has also been noted earlier in this thesis (Chapter 8) and in other studies (Seamark and Gaughwin, 1994; Turnbull *et al.*, 1994; Rutter *et al.*, 1995; Taylor, 1996; Goldberg, 1997). Notwithstanding the serious risk of infection, drug injectors are at more risk of health complications, including scarring and bruising, abscesses and thrombosis from using extremely poor quality injecting equipment (Haverkos and Lange, 1990; Spikerman *et al.*, 1996; Morrison *et al.*, 1997).

The lack of sterile injecting equipment inside prison creates a need for drug injectors to repeatedly use injecting equipment, which raises serious concerns regarding the spread of infection. Drug injectors recognise the risk of HIV but still put themselves at risk despite the grim drug injecting environment. Findings on drug injectors' perceptions of risk are important here. The need and desire for drugs and the thought of drugs can preoccupy people's minds and over-ride considerations of risk. Even though drug injectors considered it necessary to clean injecting equipment prior to sharing, this was generally perceived to be undertaken less effectively inside prison compared with outside prison (Chapter 8). People may also perceive risk to be taken but compensate for their behaviour by taking an HIV test (Chapter 9).

SUMMARY

The research presented in this chapter has demonstrated how prison drug and injecting equipment markets play an important role in drug injectors' lives when they spend time inside prison. These markets operate with determined efforts on the part of individuals and groups. Drug injecting activities inside prison are clandestine, and involve considerable planning and organisation.

Current prison drug policy attempts to disrupt drug and injecting equipment supply networks and provide drug treatment (Prison Service, 1998b). However, successive prison drug strategies (Prison Service 1995; 1998b) have been introduced partially. There is an overemphasis on disrupting supply networks with much less attention being given to drug treatment. For example, MDT was quickly introduced in all 137 prisons following piloting, although there are far fewer prisons offering drug treatment (Travis, 1997). In one London prison during 1998 where 655 people declared drug problems, only 132 received treatment (House of Commons Hansard Debates for 2nd July 1999, Part 3). This discrepancy may be due, in part, to prison drug budgets being provided at the same time as a cut in overall prison spending. Consequently, the drug budget subsidises the overall prison budget cut resulting in fewer drug treatment places (Cohen, 1999).

Drug use and drug dependency does not occur in a vacuum inside prison. Drug use is, at least partly, the product of a oppressive prison regime where drugs are used in a desperate attempt to combat boredom and isolation. Cuts in prison welfare expenditure (Cohen, 1999) will disproportionately impact upon drug taking activities. As Ramsbotham (1998) argues, drug treatment is currently the financial responsibility of prison health care, which is inappropriate given that the consequences of drug use are manifest throughout prisons.

Drug injectors' responses to limited availability of drugs and injecting equipment mean that drugs and injecting equipment enter prisons usually concealed inside the body to minimise discovery by prison staff. Whilst swallowing drugs and waiting for them to pass through the body could be regarded as one method less likely to result in being caught, it was not preferred because drug injectors often require drugs immediately (Chapter 7). The methods used to bring drugs and injecting equipment into prison are contrary to CoE

(1995) recommendations that encourage drug injectors to observe basic rules of hygiene with regards to drug injecting inside prison. Furthermore, injecting equipment is introduced by methods which encourage the shared use of injecting equipment, in whole or in part.

Once drugs are brought into prison, strategies to maintain drug injecting activities usually centre on the exchange of drugs for injecting equipment or vice versa. A distinction is apparent between drugs and injecting equipment that are directly traded and where giving takes place with less emphasis on immediate returns. Direct trading and giving, however, involve the shared use of resources. With regard to drug sharing, there are infection risks when sharing drug solutions and using other people's drug filters. Similarly, outside prison drug injectors are more likely to share via syringe-mediated drug-sharing (Hunter *et al.*, 1995), and to share secondary drug injecting paraphernalia than needles and syringes directly (Gossop *et al.*, 1997). It is important, therefore, that safer injecting guidelines outside prison emphasising not sharing drug solutions and secondary drug injecting paraphernalia (Preston and Derricott, 1997; Hit, 1998) also reach drug injectors inside prison. Safer injecting guidelines also emphasise the safe disposal of used injecting equipment (Preston and Derricott, 1997; Hit, 1998). However, inside prison injecting equipment may also be disposed of unsafely. Individuals' efforts to protect themselves from infection by keeping one set of injecting equipment for personal use and using another set for communal distribution and through the more general trading and giving of injecting equipment also compounds the need for safer injecting guidelines inside prison.

Reciprocal giving of drugs and injecting equipment may be associated with perceptions of risk surrounding the relational aspects of risk behaviour. Drug injectors inside prison were

more prepared to share with the socially close, including people with whom a prison cell is shared, than others known more distantly. Furthermore, giving drugs and injecting equipment in these situations may, in turn, foster greater social closeness and, therefore, a greater propensity to take risks within closer relationships. When drug injecting relationships are more distant it is still within drug injectors' interests (as part of the maintenance of future drugs and injecting equipment supplies within the prison as a whole) for drugs and injecting equipment to be procured and distributed.

Drugs and injecting equipment may be provided on credit, which may be more common amongst close friends than distant acquaintances, especially when individuals are serving long sentences. Debt in prison is underpinned by the threat of violence and, similarly, violence underpins the theft of drugs and injecting equipment. The theft of drugs and injecting equipment is a response, at least in part, to the limited availability of drugs and injecting equipment.

Prison drug and injecting equipment markets prosper on limited resources and cause a great deal of harm. Lower availability of drugs in prison can lead to higher costs and smaller supplies compared with what is received outside prison. Whilst some drug injectors may respond to such situations by ceasing or reducing drug use, others may continue to inject and some people start to inject inside. This takes place in an environment when there is a lack of clean supplies of injecting equipment and the injecting equipment used is of very poor quality and maintained by equally poor techniques. It highlights the need for policies to take serious steps to reduce drug-related harm inside prison.

Throughout this chapter, various forms of injecting equipment sharing have been identified. For example, when injecting equipment is incomplete missing parts may be

shared. Typically a syringe is shared when only a needle has been brought in. Injecting equipment may be traded or given to others and may also be disposed of unsafely, sometimes to protect individuals from sharing. Infectious drug solutions and drug filters may also be shared. These and other issues identified in this section raise serious public health concerns regarding the transmission of infection. To reduce infection risk it is essential that drug injectors inside prison are provided with sterile injecting equipment on an exchange basis (Chapter 4).

Infection risk and the wider harms stemming from the role and operation of prison drug and injecting equipment markets could be further alleviated by the development of a prison drug policy seriously committed to minimising the problems associated with drug injection inside prison. An increased emphasis on drug treatment coupled with a reduction in punitive drug control measures could reduce the harm associated with prison drug and injecting equipment markets. However, as the next chapter demonstrates, these opportunities are lost in current drug policy.

PRISON POLICY AND PRACTICE 2: MANDATORY DRUG TESTING AND SUBSTITUTE DRUG PRESCRIBING

INTRODUCTION

The value and importance of evidence-based policies for tackling drug problems is recognised (Polkinghorne, 1996). These include policies to reduce drug-related harm (Strang, 1998). Inside prison, however, little attention is directed towards examining drug policies (Gore and Bird, 1998). As discussed in the previous chapter, considerable harm is caused when prisons attempt to restrict the supply and availability of drugs and injecting equipment when individuals continue to need and desire drugs. MDT and substitute drug prescribing policies attempt to reduce the demand for drugs. This chapter explores drug injectors' views and experiences of MDT first, and substitute drug prescribing second. The effectiveness of these policies in reducing the demand for drugs is brought into question.

“YOU TAKE THE SAMPLE AND YOU TAKE THE GAMBLE”: MANDATORY DRUG TESTING

MDT policy requires, by law, people resident in prison to provide a urine sample, or other types of specimen for testing for the presence of illicit drugs (Prison Service, 1995a). It is undertaken to provide data on prison drug use and, as part of demand reduction, to identify drug users for treatment and to punish people who have used drugs. Testing may occur randomly or may be targeted, such as when there is suspicion that people have brought drugs into prison (Chapter 4). During 1998 there were 88,304 MDT cases of which 20,152 were positive for the presence of drugs (House of Commons Hansard Written Answers for 28th June 1999, Part 18). Less than ten per cent of people refused to be tested during the

piloting of MDT (Gore *et al.*, 1996) and since then refusals are noted at two per cent (Farrell *et al.*, 1998). However, MDT is a costly exercise. Between 1997 and 1998, £1.5 million was spent on processing tests and £4.5 million spent on staffing costs, reflecting an average cost per prison resident of approximately £96 per year (House of Commons Written Answers for 27th July 1998, Part 9).

This chapter considers MDT in relation to the lives of drug injectors in prison. It examines drug injectors' experiences of the test, and views on the punishment associated with using drugs. The strategies employed to evade detection are also examined. Finally, some of the problems with MDT are considered.

“I couldn't go, it was awful”: Experiences of the Test

People's experiences of MDT varied. Although people recognised that testing was usually carried out randomly, others knew that they were being tested on suspicion of drug use because of drug-related activities, including activities surrounding drug and injecting equipment markets. Martin comments:

They say it is automatically random picked on a computer, say in the gaol. This is bollocks. They watch you on the wing, they know you have been jibbing and jiving earning your crust over and bang they get you.

Most considered MDT to be embarrassing. Amy was searched after a visit, nothing was found but a day later she was tested:

They took me in a room and took all my clothes off me, every stitch like, make you turn round and everything. You've got to put like a gown over you, wash your hands, and there is like a toilet. ... They watched me all the time on the

toilet which I couldn't go. ... She says, "look you have to sit in here for five hours until you go". So they were going to make me sit in there for five hours. I kept drinking loads and loads of water and eventually I went but they were watching me, you know.

Embarrassment and difficulties in urinating on demand have also been noted in community samples of drug users (Taylor *et al.*, 1998). Prison officers dislike observing and supervising the process (Bond *et al.*, 1995). Drug injectors also felt MDT to be unfair.

"It was totally unfair": Punishment for a Positive Result

The punishments for using drugs can make a real difference to the quality of people's lives in prison. The withdrawal of privileges, the imposition of closed visits and being placed on a basic regime or being segregated can contribute to resentment of the system in which people feel powerless and unfairly treated. As Lorna reflects:

There's a girl in there, she was offered some [drugs] by her pad-mate and she had some. She got given a test and, therefore, she got closed visits and all. All that could come and see her was her mother and her little boy. It's terrible, a big thick bit of glass and you can hardly see or hear. It was horrific for her. I mean her mother and her little boy ain't gonna get drugs in for her. So it was totally unfair.

People testing positive lose remission depending on the type and number of drugs detected. This means that poly-drug users can receive extra days for the use of each drug. Punishment for positive tests can be different depending on the type of MDT. For example, people who have entered drug treatment and drug-free wings may be punished more severely because they are seen to have misused their privileges. As Jake said:

You've got more visits on the drug free wing. There's also like, you've got more, different, privileges but if you actually [are] caught with drugs there's

like different rates of punishment. If you got caught in your system with cannabis you could lose up to 21 days which is like 21 days added onto the end of your sentence, so you had to do an extra 21 days. If you got caught with opiates in your system it is anything up to 49 days so you're like talking over an extra month added on. An extra month might not sound much but it is when you're sitting there waiting for the end of your sentence.

It is important to recognise that the penalties for drug detection, such as the imposition of additional days, refer to the maximum penalty allowed. It is noteworthy that many of the participants experienced these punishments to their maximum. Recently, this was recognised by the Prison Service (1998a) and there has been a reduction in the recommended number of additional days that can be served for cannabis (Prison Service, 1998b). Nevertheless, many individuals employ strategies to evade detection.

“I never got caught”: Strategies to Evade Detection

MDT encourages evasion of drug detection rather than the self-identification of drug problems (Bird, Gore and Co-signatories, 1995; Edgar and O'Donnell, 1998). A study by Edgar and O'Donnell (1998) with 148 prison residents found that one-third believed that it easy to 'get round' MDT procedures. However, it is not always in an individual's best interests to refuse to provide a sample. The penalty of up to 28 day loss of remission for not providing a sample is more severe than the punishment for testing positive to one Class A drug.

In the present study, MDT procedures would be evaded by deciding whether or not provide a sample. Refusing to provide a sample can be preferable when a number of drugs have been used, since additional days may be served for each drug detected. Nick describes his experiences:

They came in and they says this is mandatory drug testing Nick. Well I'd just had a fucking wash out right, and I'd been smoking pot the week before. So I thought fuck this, I'll get 28 days for the gear and 14 days for the cannabis and whatever downers. So what I'll do here right is, I thought, I can't piss, I can't piss, I can't piss until the full five hours right, like that [acting]. I went on my adjudication, right, and I says "I've got a problem me, that I can't piss in front of fellows. I'm not a homosexual". He buyed it, he buyed it.

When about to be tested, drug injectors will decide whether or not to provide a sample. In addition, strategies to avoid testing positive focus on choosing drugs and timing their use. Drugs remain detectable in the body for different time periods. Cannabis remains detectable from three to 27 days depending on how frequently it is used. In contrast, heroin cannot be detected after about three days (Wish and Gropper, 1990). Some drug injectors noted that drug users were switching from cannabis to heroin to reduce the risks of detection. As Dan reports:

It's mad in gaol because ... this drug policy where they say they take days off ya if you take drugs. Smack stays in your system three days, cannabis stays in your system 28 days, you know, everyone is on smack 'cos they don't want to lose their 28 days. ... It's real bad now.

Concerns about this phenomenon have been raised elsewhere (Gore and Bird, 1995; Campbell, 1996; Gore *et al.*, 1996; Hewitt, 1996). During the piloting of MDT Gore *et al.* (1996) noted that between February and May 1995, 33.2 per cent of inmates tested positive for cannabis and 4.1 per cent positive for opiates or benzodiazapines. However, later figures relating to the period between June and December report a reduction of positive test results for cannabis to 29.1 per cent. Positive test results for opiates or benzodiazapines increased to 7.4 per cent. Although there are a number of caveats to these data, it remains cause for concern to find a reduction in the detection of cannabis without a similar reduction in the detection of Class A drugs (Gore *et al.*, 1996).

Farrell *et al.* (1998) report on random MDT from the introduction of MDT in each prison. They found that there was a reduction in the number of cannabis detections from over 30 per cent to 20 per cent after 18 months of random MDT implementation. They also found that opiate positive tests remained relatively constant at around 5 per cent over the same period. However, they remark that these data do not show 'substantial' numbers of people switching from cannabis to opiate use under random MDT.

Edgar and O'Donnell's (1998) study with 146 prison residents found that 57 per cent believed that MDT would encourage people to switch from using cannabis to heroin. It also found that 46 per cent of cannabis users stopped their drug use whilst only 13 per cent of heroin users reported stopping in response to MDT. Thus MDT may not impact upon more problematic heroin use. In addition, four people reported taking heroin in response to MDT although no-one reported making a permanent switch.

People recognised that timing is a crucial factor in the effectiveness of MDT. Avoiding testing positive may also be determined by the timing of the sample provision in relation to the use of drugs. Some people tested negative after using drugs because of the sensitivity of the tests and the length of time drugs remained detectable in the body. Karen said:

I had one [MDT] twice but they always showed up clear. Because by the time they'd done mine it was out of me system. I had it like one night and two days later they came for my random piss test. And it was like well out of me system by then. So I never got caught [for taking heroin].

A study by Bird *et al.* (1997) assessed the efficiency of MDT in detecting the injection of Class A drugs at two prisons in Scotland using anonymous risk factor questionnaires. Combined data from both establishments found 51 per cent of drug injectors reported

injecting in prison. However, they suggest that between one and two thirds of drug injectors will actually test positive during MDT. This discrepancy could be due to the effectiveness of MDT being reliant on time. It is, for example, skewed toward the detection of 'soft' drugs that remain detectable in the body longer than 'harder' drugs. In addition, Bird *et al.* (1997) remark that in England MDT does not operate on weekends and as a result individuals can organise injecting to reduce the risks of testing positive. For example, injecting on a Friday evening would enable someone to test negative on Monday. Thus, random MDT can underestimate the extent of drug use in prison. In addition, MDT provides little information on the nature of drug problems. Incomplete information has the real potential to misguide policies that aim to tackle drug problems and address the healthcare needs of people in prison.

Outside prison urine tests have been sabotaged to avoid drug detection (Kintz, 1996). In the present study, men in particular reported other methods of evading detection, including adding soap or other contaminants to the sample. These contaminants are concealed on the body such as behind fingernails and on genitals. As Tim explains:

Get a bit of soap behind their fingernail and when you turn your back to pee ... just flicking the soap in or pissing on ... [their] thumb ... that contaminated the tests and they had to take another one but maybe by that time they was clean.

Contaminating the sample was important because the delay in returning the result of a contaminated sample, which may result in a second test, can mean that by this later point in time drugs are not be detectable. This can be an effective strategy as it has been reported that samples take between four and seven days to be analysed and communicated to the prison authorities and, in addition, samples may be held for up to seven days to justify the

cost of courier charges (House of Commons Hansard Written Answers for 28th February 1997, Part 34).

“It’s a head hunter”: The problems with MDT

MDT was formulated to provide data on prison drug use, to identify drug users in need of treatment, and to punish people for using drugs. The Prison Service (1995; 1998a) use MDT as an important data generating device. The data collected from MDT includes each donor’s ethnic group and sex. To inform central and local policies on the use of drugs further information is required. To be able to monitor drug use and the public health implications of infection transmission, information gathering should also indicate whether drugs are injected and whether injecting equipment is shared. This is not possible from the simple MDT sample. Gore *et al.* (1996) note that the number of people tested is too small to monitor trends within prison establishments and the information too unreliable in the short term to form a basis for future policy directions. There is little information available on the operation and effectiveness of the policy and there have been calls for the wider availability of MDT data (Gore *et al.*, 1996). What is known about MDT has been based on local studies permitted by the Prison Service (Williams, 1997), secondary analysis of information disclosed by the Prison Service (Gore *et al.*, 1996), and the use of existing studies to inform assumptions as to what the effectiveness of MDT could be (Bird *et al.*, 1997). More recently, independent studies (MacDonald, 1997) and commissioned studies have been made available (Edgar and O’Donnell, 1998; Farrell *et al.*, 1998).

Furthermore, MDT obtains information by coercion and as a result the quality of data obtained is limited. Drug users employ strategies to ‘get round the system’ by trying to

evade detection. Engendering such attitudes towards data collection jeopardises the success of future research strategies in prisons that rely on more voluntary participation and proceed on the basis of informed consent. Inmates may be wary of participating in, for example, studies of drug use in prison for fear of being identified by the prison staff and being targeted by MDT. Bird, Gore and their Co-signatories (1995, p.1) argue that MDT leads to a “betrayal of prisoners’ trust in previous researchers, their methods and that appropriate public health actions would follow scientific data”. This argument was, however, refuted by the Scottish Prison Service who state that support is offered to drug users who test positive (Stewart, 1995). The statement reflects Prison Service policy (1995a; 1998b) that states that positive test results will enable interventions to be targeted towards individuals in assisting the management of drug use.

Another of the stated aims of MDT is identifying drug users for treatment. In the present study, drug injectors did not report receiving treatment in connection with positive test results. This has also been found in other studies (Edgar and O’Donnell 1998). Rather, people described the punishments received for taking drugs and these were usually the maximum penalties permitted. As noted earlier there is a discrepancy between all prisons employing MDT, but far fewer prisons providing drug treatment (Travis, 1997). These problems have been compounded by financial cutbacks within prisons (Cohen, 1999).

Another intention of MDT is to identify people who use drugs in order to punish them. In doing so, there are some highly undesirable effects. Prison sanctions, controls and the exertion of power over people in prison, manifest in MDT, would be expected “to induce a profound sense of powerlessness among the prisoners” (Cohen and Taylor, 1972, p.122).

At one level people's reports of the effects of MDT on their lives supports this. As Mark comments:

They don't like it, but what can they do? There is nothing they can do about it.
... They're really stuck with it.

Risk taking is a feature of life outside prison as much as it is inside prison. But the social context of risk is, of course, very different. As discussed in Chapter 3, HIV risk behaviour can be enhanced inside prison. Cohen and Taylor (1972) argue that controls within prison have unintended consequences, which can lead to various forms of risk behaviour. When discussing the behavioural aspects of people's lives it is important to recognise the social context in which behaviour occurs. There are a number of risks drug injectors face inside prison. These risks include, for example, experiencing drug withdrawal, procuring supplies of drugs and injecting equipment and, when using drugs, the risk of being caught. Drug use continues against these risks, including the risk of being caught and punished for using drugs found through MDT. Tim explains:

For the likes of people who just have a smoke once on a weekend, you know, you take the sample and you take the gamble don't you. They say it's just a gamble. ... You can't stop it [drugs]. I've never come across anyone who said, "No, I'm not doing that now 'cos of the piss tests", you know. Bollocks to that, it's just one of those things.

When individuals have been involved in procuring supplies of drugs and injecting equipment (Chapter 10), it is not difficult to see how the threat of MDT can make little difference to the pursuit and use of drugs. These findings are pertinent to the ways drug injectors think about drugs with regards to HIV risk (Chapter 7). Just as the long term consequences of HIV risk behaviour may be put to the back of the mind when drug

injecting activities are being pursued, the same processes may operate with regard to the sanctions imposed by the prison service. Drawing on the theoretical framework (Chapter 5), MDT is an imposed relevance. Whilst topically relevant, manifest through drug injectors' views and experiences of MDT, it is unlikely to bring about reductions in drug use. The need and desire for drugs remain motivationally relevant. Drug injectors identified a range of risks associated with prison life and prison drug and injecting equipment markets. Being caught for possession of drugs or injecting equipment or having traces of drugs detected in urine samples is just one of the risks drug injectors face inside prison. The immediate need to take drugs (Chapter 7) can outweigh the risk of being tested and drugs being detected. As Karen said:

There's always the possibility of getting caught. They do random piss tests. ... If that shows up you get an extra 28 days on your sentence. So there is always that risk. But like I say, if he [character in the vignette] has been on drugs that long he won't really be bothered about the risk. Just as long as he can get knocked out for the night and get some sleep and that.

MDT can also discourage drug users from approaching prison staff with drug problems for fear of being tested, found positive, and punished. It does not encourage individuals' safer management of drug use.

In summary, this section of the research found that drug injectors understood what MDT is, its aims and objectives, but experiences of the test were embarrassing. Being punished for using drugs contributes further to resentment of being imprisoned. The punishments resulting from using drugs detected through MDT were recognised to reduce further people's quality of life inside prison. People's embarrassing experiences and feelings of the unfairness of MDT may contribute to strategies that try and evade detection. These

methods of evasion may reflect the power struggles between prison residents and the prison structure imposed upon them. Individuals may decide whether or not to provide a test sample. Not providing a sample may be preferable when a number of drugs have been used. If these drugs are detected individuals may receive harsher punishments. The timing constraints in detecting drugs means that some drug injectors are able to evade detection through their choice of drugs and timing their use. Considerable attention has been directed to the potential for MDT to encourage people to switch from using cannabis to heroin. Whilst recognised by the participants in this study, this consideration may be less likely given that most were dependent drug users. Nevertheless, such a shift in perceived drug taking behaviour raises important concerns with regard to drug injecting HIV risk behaviour.

There are a number of problems with MDT when set against its objectives. MDT aims to provide information. However, sabotaging samples hinders this. Poor MDT sampling is unable to seriously monitor and inform policy, especially with regard to drug injecting risk behaviour. However, MDT results can provide a crude indication of patterns over time, and this continues to be emphasised in government debates surrounding MDT (House of Commons Hansard Debates for 16th July 1997, Part 48).

MDT does aim to identify drug users for treatment. However, this does not happen. There are few treatment places available (Travis, 1997), and the treatment that has been made available has sometimes been subsumed by other prison service concerns, including security and control (Cohen, 1999).

MDT can also induce powerlessness among drug injectors as the threat of MDT together with its punishments pose a real threat. However, MDT is only one of a number of risks that drug injectors face inside prison. Prior to the threat of punishment associated with MDT, considerable risk will have been taken in procuring and maintaining supplies of drugs and injecting equipment inside prison (Chapter 10). As discussed in Chapter 7, when the pursuit of drugs are the main priority, people are unlikely to think about the consequences that may or may not occur some time in the future. Or if they do, this is unlikely to be when drugs are being pursued. MDT, as a punitive strategy aiming to deter people from using drugs, will not work for the people contacted in this study who were mainly dependent drug users. The need and desire for drugs continues despite the risk of being tested for drugs and the chance of being caught.

In short, what is clear from the evidence presented in this section of the chapter is that the methods used to test people for drugs, the types of results MDT obtains and its effectiveness in tackling drug use in prison brings the policy into question. These findings are compounded when, as will be shown in the following section with the example of substitute prescribing, drug treatment strategies are inconsistent inside prison and outside prison.

“THEY’VE GOT THE POWER ON A PIECE OF PAPER”: SUBSTITUTE DRUG PRESCRIBING

Substitute drug prescribing is one of a range of social policy interventions that aims to reduce drug-related harm (O’Hare *et al.*, 1992; Riley, 1994; Riley *et al.*, 1999). Reducing the desire for illicit drugs, such as heroin, with the provision of substitutes can help some people to reduce their dependence on illicit drugs and consequently reduce some of the

problems that the use of these illicit drugs bring (Strang *et al.*, 1997; Marsch, 1998). Substitute drug prescribing has been identified as a priority for the development of harm reduction strategies inside prison (Riley *et al.*, 1999). Substitute drug prescribing procedures inside prison, and some of the problems with these, were discussed in Chapter 4. Current policy has been summarised as:

The Prison Service health care standard for the management of opiate misusers calls for abstinence to be achieved wherever possible. The standard does, however, allow for the provision of methadone maintenance for those remand prisoners who are already on maintenance treatment and require its continuation (House of Commons Hansard Written Answers for 13th July 1998, Part 17).

There is a genuine concern to prevent prescribed drugs from entering the informal prison drug and injecting equipment market (Prison Service, 1995; 1998a; 1998b; Hellowell, 1999) and to prevent substitute drugs being offered to individuals not already dependent on drugs. The provision of substitute prescribed drugs to people not dependent on drugs has had tragic consequences in the past (Dyer, 1999).

Ultimately, the success of substitute drug prescribing can only be assessed in the light of its goal but it depends on wide ranging factors. Analysis of drug injectors' views and experiences on substitute drug prescribing inside prison identified past drug using patterns, including prescribing, and current needs and priorities as being important in achieving success.

“They shouldn’t have just stopped it”: Drug Using Patterns

The success of substitute drug prescribing depends on individuals' previous drug use and whether substitute drugs have been prescribed. However, the duration of drug prescribing

in prison was reported as brief and the medication reduced quickly. Some treatment would end abruptly and without notice as Kieran exemplifies:

One day I went down to get my medication and they just stopped it just like that, they didn't tell me or anything. That weren't right, they should have let me know before or they should have reduced what I was taking. They shouldn't have just stopped it.

Others expressed concerns about the differences in drug prescribing between prisons and differences in the same prisons over time. Tim reported:

I got the impression this time when I went in that [lofexidine] wasn't on offer.

Terry had received detoxification courses inside prison on some previous occasions. When entering prison Terry had come to expect the same treatment, but on the last occasion he spent time in prison the courses had been stopped. He said:

When I was going to prison I thought, methadone all right, I'll do a ten-day detox. But when I got there it had been stopped a week because of money. I think that is wrong.

Drug injectors held strong views about prison health care and methadone maintenance was one topic that evoked particularly strong responses. A common source of dissatisfaction was the lack of consistency in methadone maintenance prescription inside prison compared to what drug injectors received outside. Drug injectors were resolute that when prescriptions had been established outside prison, prescriptions should not be disrupted when people spend time in prison. This is not the case at present. Robert develops this point by suggesting that the costs of methadone maintenance would be incurred outside prison and treatment should continue when people enter the prison environment:

You can't just go into prison and get taken away from your medication. ... I think if you're a methadone user and have been for a long time, I think there should be a clinic where you go every morning in prison and get your medication. ... I know it costs money maybe but it cost money on the outside.

Inconsistencies in substitute prescribing could also reflect funding arrangements for drug treatment within the Prison Service. As noted earlier, the Prison Service Directorate of Health Care currently has responsibility for funding drug treatment, which is inappropriate given that the consequences of drug use in prison stem far beyond health issues to much wider social problems (Ramsbotham, 1998). Over the next five years health care in prisons is to be subject to reorganisation and these funding issues need to be addressed (Prison Service and National Health Service Executive, 1999).

The consequences of inconsistent prescribing could lead to increases in illicit drug use.

Jane reports:

They don't hand out methadone even if you're getting it prescribed before you go in. They stop it straight away. Which is stupid I think because then you're going to get more heroin users.

Adequate and consistent prescribing inside prison was also discussed to reduce drug injecting risk behaviour and the spread of infection. Dan said:

Dan: I think they should give them their methadone pills when they go in to cut out the risks of sharing.

Rhidian: Do you think the Prison Service will do that?

Dan: Na. 'Cos they can't be seen to give in can they? We will clean you up [knocking on table].

Robert makes a similar point based upon his own experiences of sharing injecting equipment inside prison:

I had to get myself right and I had to do. And that's why I injected on that first day of being there to get myself, I wouldn't have done that if they'd said here you are there's some methadone take that.

Drug injectors recognised that restrictive prescribing practices can lead to increases in illicit drug use and injecting equipment sharing. Health care interventions inside prison are far from systematic and current policies do little to reduce drug injectors' risk behaviour and the potential spread of infection.

“It's like having half a sugar when you were used to three”: Drug Injectors Needs and Priorities

The needs and priorities of drug injectors can determine the success of substitute prescribing. The extent of people's drug using needs and, in particular, their withdrawal symptoms was considered to influence treatment. As Karen said:

It depends how bad you rattle when you come off the drug. If you're really bad, like vomiting and you can't eat anything, the doctor puts you on methadone for about a week, which basically makes you sleep all the time and calms you down.

However, the provision of substitute drugs varies and may not always meet individuals' needs in alleviating the desire for drugs and experiences of drug withdrawal. Drug injectors discussed the provision of substitute drugs in three main ways. First, not receiving substitute drugs, second, the provision of sedatives, painkillers and anti-depressants, and third, detoxification with methadone and lofexidine.

“I wasn’t prescribed”: Not Receiving Substitute Drugs

Some drug injectors reported not being offered substitute drug treatment in connection with their drug use. A typical comment was, “when you go in gaol you get nothing”. These reports may reflect individuals not being prescribed. However, drug injectors also used this term to reflect the inadequacy of the treatment they received. Drug injectors identified problems with not receiving treatment, notably describing the effects of their drug withdrawal that could influence risk behaviour. However, advantages to not being treated with prescribed drugs were also identified. Not taking substitute drugs enabled people to withdraw from illicit drugs quicker and easier than if methadone had been prescribed. Lorna was not offered methadone inside prison and remarks on its value in not delaying the inevitable drug withdrawal:

I wasn’t prescribed and it was all over quick instead of prolonging it and having to go through it anyway.

Whilst Lorna was not offered treatment, other people were offered methadone but refused it. This can be because individuals had undergone drug withdrawal before entering prison, such as when held in police cells or because they understood that they would undergo drug withdrawal and wished the process to occur as quickly as possible. Karen refused methadone:

At end of t’day, what I’d rather do is just do my rattle and get on with it. ‘Cos I was rattling for a week when I went in and I refused the methadone ‘cos it would have made me worse.

“Zimmers, DFs, Moggies and Temaze” : Sedatives, Painkillers and Anti-Depressants

Drug injectors’ experiences of drug treatment, with regard to meeting the need to alleviate the need for drugs and drug withdrawal, also focused on the provision of sedatives, painkillers and anti-depressants. These drugs include, for example, temazepam, Mogadon, DF118, zimmervane and diazepam. However, these were commonly reported to be inadequate in alleviating the effects of drug withdrawal. As Terry said:

When I went in the first time I was like on a 2½ gram a day habit. They started me off on one zimmervane and it was just like useless. It’s like having half a sugar when you were used to three. I was going off the wall and eventually he put me on three and then I was getting my head down.

Terry’s experiences illustrate that when sedatives and painkillers are provided on their own they can be inadequate in meeting people’s needs. As shown in the previous section drugs may not be prescribed at all, or may be prescribed of a type or at a level inadequate to meet individuals’ needs, which has also been recently reported by others (Brooke *et al.*, 1998). The shortfall in treatment departs from sound clinical judgement (Ward *et al.*, 1996) and from prison ‘Health Care Standards’ (Prison Service Directorate of Health Care, 1996). Such problems reflect more general problems with these standards not always being met (Reed and Lyne, 1997).

“Do a detox” : Detoxification with Methadone and Lofexidine

As noted earlier, one of the goals of drug treatment is detoxification. In some cases detoxification programmes were adequate in meeting people’s needs. Adequate drug prescribing in prison was reported when people were detoxified with lofexidine. Although

not successful for some people, others said it helped. Terry spoke very positively about these particular experiences:

When you first go on the hospital ward you get them [lofexidine] three times a day for the first two days. For the first night they give you like benzo's to get you to sleep. The second night you've ... stopped rattling. There is no rattle mate. These little BritLofex work there is no doubt about it.

Drug injectors recognised that few people are maintained on methadone during time in prison. However, on one occasion, the drugs Jane was prescribed were adequate for her needs when she spent a night in custody and she attributes these experiences to her exceptional circumstances and to her short prison stay:

This time I was getting 30ml and 30ml of temazepam and 20ml of valium because of what happened [death of a family member]. They didn't dare take me off my prescription.

Drug injectors often reported receiving short detoxification courses with methadone and lofexidine but the methadone detoxification course was often insufficient to relieve the effects of drug withdrawal because of the amount of drug prescribed and the short length of the course. The detoxification would not last long and common concerns centred upon its fast reduction. Amy said:

I was really bad and they gave me 40ml and they cut me down every three days. But it was just like prolonging it I was so ill.

Ross *et al.* (1995) consider accelerated detoxification as unethical because it does not replicate the body's natural rate of drug withdrawal. As reported earlier, some people wish to undergo drug withdrawal quickly, and see it as an inevitable part of the prison

experience. Others found rapid detoxification, in this case assisted with methadone and lofexidine, to be inadequate.

“Every prison is different”: The Diverse Experiences of Substitute Prescribing

Experiences of substitute drug prescribing varied considerably and ranged from reporting no treatment, to being provided with painkillers and sedatives, to being prescribed methadone and lofexidine. These differing experiences are captured in a small group discussion:

Martin: You see the doctor and you can blag him the first time. You can usually get eight to ten DF's out of him for the first three or four days you're in gaol, do you know what I mean, a day like. Then he'll start bringing you down. You'll only get drugs out of him for a week. The first week he will then after that you won't get jack shit.

Dave: And that if you're talking about [prison name] gaol you're talking two zimmers a day. In [prison name] gaol they don't give you fuck all. ...

Terry: Go down the hospital wing and do a fucking detox on fucking BritLofex it's fucking brilliant. Knocks the spots of methadone mate. If I had the chance to go on a BritLofex course I'd take it tomorrow. It's better than any methadone.

Drug injectors' experiences of drug prescribing in prison varied against set standards (Prison Service Directorate of Health Care, 1996). As Martin illustrates in the extract presented, some people believed that prescribing would be dependent on the extent to which drug injectors could convince medical officers of their needs. Negative attitudes held by staff could influence treatment. Phil reported:

You tell them you're coming down off heroin and they say, "see you later, you're a junkie, you do your rattle".

Negative attitudes held by some staff towards drug injectors shape their prison experiences and may reflect some more widely held beliefs about drug addiction among staff who work with drug users (Ross and Darke, 1992; Caplehorn *et al.*, 1997). As in the wider community, prescribing practices influence who is treated (Bell *et al.*, 1992; Daunno and Vaughn, 1992). For example, Bell *et al.* (1992) retrospectively analysed decisions by staff not to provide methadone maintenance. They found that exclusions were based on the perceived need to keep non-addicted people from obtaining methadone. However, by doing so staff prolong dependent drug users' entry into treatment. On the basis of the present study, similar factors may also be at work inside some prisons. These concerns have also been raised by the ACMD (1996).

Substitute drug prescribing inside prison needs to be flexible, responding to individuals' needs. This flexibility should help to determine such factors as whether to prescribe, what to prescribe, how much to prescribe, and the length of the prescription course. However, drug injectors' experiences of substitute drug provision suggest that current procedures are instead characterised by vast inconsistency. The absence of flexibility directed at individual needs result in current practice appearing to be neither adequate, useful nor successful.

Drug injectors expressed views on the need for equal drug treatment inside and outside prison. Equitable drug treatment inside prison should be the focus for future policy development. At a minimum, policies and practices inside prison should be aligned to those outside. This would ensure that, on the basis of sound clinical judgement, people are maintained on drugs inside prison rather than rapidly detoxified. At present, short-term policy goals directed towards abstinence are unlikely to help people dependent on drugs in

the long-term. Drug injectors' perceptions of failure of the current strategy are likely to compound these problems by reducing their willingness to participate in drug treatment and hence will lead to further failure.

Drug injectors in the present study recognised that restrictive prescribing practices can lead to increases in illicit drug use and injecting equipment sharing. Developing adequate prescribing policies to help reduce risk behaviour remains an important consideration for policy development in this area. Health care interventions inside prison do little to reduce drug injectors' risk behaviour as shown throughout this chapter. As discussed in Chapter 7, people in need of drugs are likely to engage in risk behaviour. These findings are important as they demonstrate how adequate substitute prescribing can reduce the need and desire for illicit drugs that can be injected.

Being prescribed sedatives, painkillers and anti-depressants could have some benefit. However, these were inadequate in reducing the need for drugs. Similarly, methadone was sometimes prescribed at a lower level and for too short a period to enable drug injectors to experience any great gain. Consequently, drug injectors continue to need drugs which can lead to risk behaviour.

Prisons could offer a valuable treatment opportunity to drug injectors by assisting the break from drugs, crime and imprisonment. On the basis of the present research, and other examples of supporting work (Polkinghorne, 1996; Brooke *et al.*, 1998), it is unfortunate that these treatment opportunities are largely missed. As substitute drug prescribing plays some role in alleviating the need and desire for drugs, policies should strive to achieve a

reduction in the physical and psychological need for drugs. Until this is achieved, prisons will continue to put their drug injecting residents at risk of transmitting infection.

SUMMARY

This chapter has provided analyses of drug injectors' views and experiences of MDT policy and substitute prescribing. MDT is a weak attempt to provide data on prison drug use and to identify drug users in need of treatment, and also has an over-reliance on punishing people for using drugs. For drug injectors in this study MDT does not achieve these aims. Drug injectors' experiences of MDT were embarrassing and most considered the policy including the punishments associated with it to be unfair. Embarrassment and feelings of unfairness may contribute to the evasion of MDT procedures. Important to drug injectors was the decision whether to provide a sample. Not providing a sample may be preferable when a number of drugs have been used, as punishments can increase for each drug taken. When a sample is provided people may choose drugs and time their drug use carefully, which can help to explain concerns that some people may choose heroin over cannabis to avoid being caught. In addition, urine tests may be sabotaged by adding contaminants to the sample to further disrupt procedures. Other problems with MDT include its poor sampling and limited data collection that makes it difficult to inform serious research and policy development. When MDT penalties from using drugs are set against the role and operation of prison drug and injecting equipment markets, described in Chapter 10, it is not difficult to see how drug using activities continue. Individuals will have taken considerable risk in bringing drugs and injecting equipment into prison and it is unlikely that the risk associated with MDT will impact, significantly, on drug taking at such late a stage.

The success of substitute prescribing depends on past patterns of drug use and whether individuals were prescribed substitute drugs. Drug injectors suggest that substitute prescribing is inconsistent between prisons, inconsistent within prisons, and inconsistent inside prison compared with what individuals receive outside prison. These inconsistencies could lead to increases in drug taking, drug injection, and consequently drug injecting risk behaviour inside prison.

The success of substitute prescribing is also determined by drug injectors' current needs and priorities. However, these needs were sometimes inadequate when drug injectors had not received substitute drugs, when sedatives, painkillers and anti-depressants were prescribed, and when methadone was prescribed at a low dosage and the course of treatment pursued rapidly. Drug injectors' experiences of substitute drug prescribing were, therefore, diverse. Some drug injectors attributed these diverse experiences to negative attitudes held by some prison staff.

Substitute prescribing directed towards drug injectors should be flexible in order that prescribers can respond to, and fully meet, individual need. However, currently substitute prescribing is characterised by inconsistency, rather than flexibility, which does not meet individual needs. Substitute prescribing could help to reduce risk by reducing drug injectors' need and desire for drugs. However, at present substitute prescribing is likely to continue to put drug injectors at risk of infection rather than helping to reduce it because the need for drugs is sustained.

Overall, prison drug policies do little to reduce drug injectors' risk behaviour and, sometimes exacerbate the likelihood of risk taking. Ultimately, these policies put drug injectors and the wider population at risk of HIV and other infection.

CONCLUDING DISCUSSION

INTRODUCTION

Since the emergence of HIV infection, research on risk behaviour has burgeoned. Attention directed towards drug injectors' HIV risk behaviour has helped to expose the influencing factors, and the type and extent of risk behaviour. However, patterns of drug injecting behaviour are ever changing and differ depending on geographical, social and physical environments.

The empirical focus of this thesis aimed to explore and understand more about the influences on drug injectors' HIV risk behaviour and how these influences might operate inside and outside prison. A second aim was to explore the impact recent policies had on tackling drug injection inside prison and how this affected drug injectors' lives. These are important considerations as the transmission of HIV and other infections inside prison raise serious public health issues for policy. As already explained the Glenochil outbreak of HBV and HIV demonstrates how drug injectors' risk behaviour led to HBV and HIV transmission. These infections, originating from a single source, had been transmitted amongst drug injectors inside the prison within a short period of time. As drug injectors move between prisons and into the wider community the potential consequences for further infection spread are far reaching. Thus, infection risk of this kind is not restricted to individual groups, such as drug injectors, but is an important public health issue for the well being of the population as a whole.

This concluding chapter will discuss four main issues arising from this thesis. The first part will discuss the empirical evidence to explore why drug injectors put themselves at risk of infection despite knowledge of the transmission of HIV. At a more abstract level, the second part will address some of the theoretical implications arising from the study of drug injectors' perceptions of risk. The third part uses the principles of harm reduction to suggest some future directions for prison drug policies. The fourth and final part of the chapter considers harm reduction and social policy at a much wider level of abstraction.

DRUG INJECTORS' PERCEPTIONS OF HIV RISK: SOME EMPIRICAL EVIDENCE

Drug injectors know how HIV is transmitted and are generally aware of the risk of infection resulting from engaging in certain risk behaviour. This knowledge of risk was manifest in the ways in which drug injectors recognised risky situations, how they considered the use of strategies to reduce risk, and their responses to risks that had already occurred. Nevertheless, drug injectors go on taking risks. Why risk behaviour continues in the face of known risk is an important question that arises from the evidence presented in this thesis.

The evidence has highlighted two risk management strategies that are particularly salient in explaining why drug injectors engage in risk behaviour, despite knowledge of its consequences. First, risk behaviour decisions made on the basis of judgements about the social closeness and social distance with others are perceived to represent a subjective form of risk management. Second, the strategies drug injectors use to clean shared needles and syringes represent a practical form of risk management.

Socially close relationships, including those between sexual partners and friends, and socially distant relationships, between casual acquaintances, influence decisions about risk behaviour. The findings in this thesis demonstrate how close relationships can influence risk reduction when drug injectors do not want to put others, for whom they care about, at risk of infection. Conversely, close relationships can also increase the level of risk because infection transmission is not considered a real possibility amongst friends and sexual partners. Similarly, distant relationships can increase the likelihood of risk behaviour. HIV risk is one of a range of problems identified from engaging in activities with others not well known. Risks may be perceived in ways tantamount to a game of Russian roulette. However, sometimes in distant relationships drug injectors were more cautious when faced with risk and in some instances risk reduction strategies might be adopted.

Although drug injectors made distinctions between close and distant relationships in risk reduction strategies, many individuals still reported a willingness to share injecting equipment. These actions would be qualified by the need to clean needles and syringes. Cleaning was a risk reduction strategy that enabled individuals to continue injecting drugs when there was no sterile injecting equipment and when other options, such as not injecting, were unrealistic. Some people would be reassured that cleaning was effective in reducing infection risk, although others rightly recognised that cleaning is not totally effective. However, by cleaning some drug injectors perceived, to varying degrees, that they could reduce risk and some people believed they could eliminate the risk of HIV.

Making decisions about risk behaviour on the basis of particular types of relationships and the cleaning of needles and syringes are, however, tenuous risk management strategies. Decision making on the basis of social relationships neglects the fact that perceptions of

risk may be mistaken, personal knowledge of others may be incomplete, and in any case subjective assessment of risk does not mean there is absence of infection. Thus, people may take risks without realising it when they base judgements of risk on the quality of their social relationships with others.

The cleaning of shared needles and syringes is an equally tenuous risk management strategy, not least because cleaning can never eliminate the risk of infection. Some drug injectors are misguided as to the extent to which cleaning can eliminate infection risk. For example, some people did not recognise that cleaning was not wholly effective in eliminating infection. Furthermore, some drug injectors raised concerns about particular cleaning strategies resulting in less effective techniques being employed. For example, sometimes bleach would not be used because of the perceived harm of injecting any residue bleach into the body. Even so the cleaning of needles and syringes was an important risk reduction strategy that enabled people to carry on sharing injecting equipment. Whether cleaning does or does not take place, people still subject themselves to HIV risk by using shared injecting equipment.

Attempting to reduce risk by making judgements about the quality of social relationship and by cleaning shared needles and syringes are even more tenuous strategies when employed inside prison. Inside prison decisions about risk behaviour are constrained by the environment in which risks are considered and taken. With regard to social relationships it is important to recognise that when individuals are brought together within a physically, socially, and culturally close environment such as a prison, they experience falsely imposed social closeness. Relationships formed inside prison may actually be characterised by people having little real knowledge about one another. Thus, if risk behaviour decisions

based on the quality of social relationships are flawed outside prison, they are even more likely to be flawed inside prison.

The cleaning of needles and syringes outside prison is problematic, not least because of the criteria drug injectors use to assess cleanliness. Inside prison the situation is worsened. Visibly dirty needles and syringes are not used outside prison but may be used inside prison because of the limited availability of sterile injecting equipment. Furthermore, a lack of availability of cleaning materials, such as bleach, can also mean that needles and syringes are not cleaned as effectively as they might be outside prison. Drug injecting in the prison environment is a particularly clandestine activity. Prison cells can be entered by prison officers at any time so that drug injection often takes place in a hurried fashion, with less attention being given to cleaning, to avoid being caught and punished for using drugs.

Thus, drug injectors' risk management strategies are tenuous, especially inside prison. But there are more important factors that can influence risk behaviour. This research has demonstrated how the need and desire for drugs can preoccupy people's minds, especially when drugs are used to alleviate drug withdrawal. Preoccupation with drugs can totally overshadow concerns about HIV, such that thoughts about the consequences of risk behaviour may be deferred. A disjunction between short term concerns and long term concerns help to explain these deferment processes. Short term concerns are generally focused on drugs, whereas long term concerns are generally focused on the consequences of actions. The long term consequences of risk behaviour, notably HIV infection, are less likely to be fully considered when short term concerns for drugs are being pursued. The potential consequences are, therefore, deferred and re-emerge later when the need for drugs has become less overwhelming.

The disjunction between short term concerns for drugs and long concerns about health is an important explanation as to why drug injectors may continue to put themselves at risk of infection despite knowledge of HIV risk. Moreover, inside prison the absence of drugs magnifies the disjunction between short-term concerns and long-term concerns. The need and desire for drugs are heightened inside prison, sometimes through enforced drug withdrawal that is compounded by the provision of inadequate substitute prescribed drugs. Whilst outside prison individuals will raise concerns and question their risk behaviour, albeit after the event, inside prison the 'pressures' of prison life, including wide ranging problems faced during imprisonment, can hinder individuals' readiness to question risk behaviour. Furthermore, that these thought processes raise concerns about risks only after they have been taken can make drug injecting risk behaviour a real possibility when people need and desire drugs and sterile injecting equipment is unavailable within the prison environment.

These deferment processes can also be related to the findings on drug injectors' perceptions of HIV testing. Drug injectors are usually aware of HIV risk and in this study identified the need to take a test, notably after engaging in risk behaviour and because of concerns raised by others. However, drug injectors may sublimate the need to be tested for HIV because of other concerns and priorities. Concerns focus on anxieties surrounding a potentially positive test result and the impact of the result on people's lives. Drug injecting lifestyles may prioritise the use of drugs over and above concerns with HIV and the need to be tested. Equally though, HIV testing may be considered important when anxieties surrounding the test result are alleviated and drug injecting lifestyles become less important than the risk of HIV.

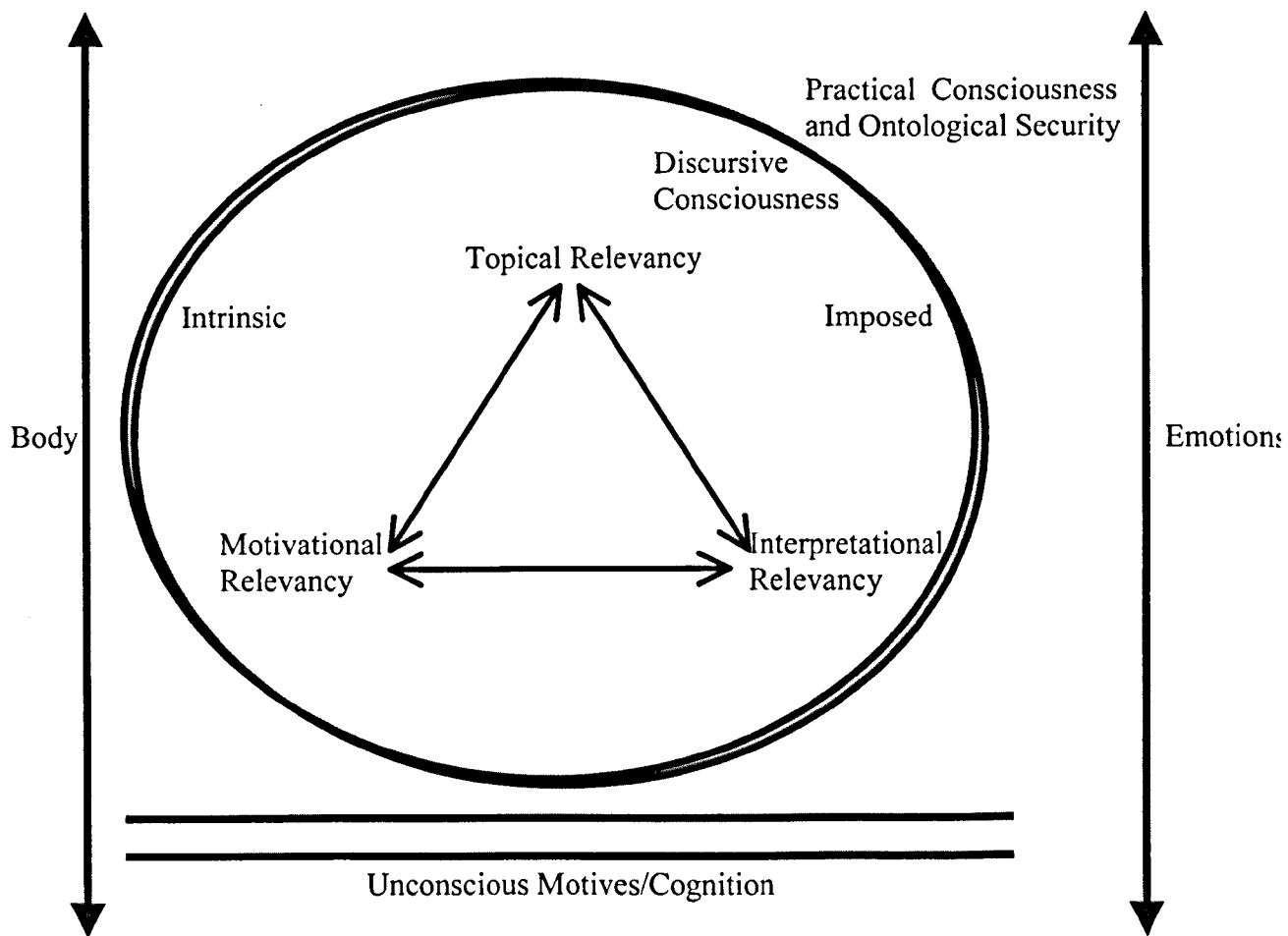
Short term and long term concerns with HIV also manifest themselves in drug injectors' perceptions of HIV testing. In the short term HIV testing could encourage people to take risks as concerns with HIV are deferred. In particular, some people defer HIV risk by thinking about the need to be tested at a later point in time. Deferring thoughts about HIV cannot, of course, prevent infection transmission. Furthermore, there is no guarantee that HIV testing, as a future long term consideration, will actually take place. Given the process of deferring thoughts about HIV to long term considerations means that it is likely that undertaking a HIV test is perceived as something that must be undertaken some time in the future, but not now. When a test is taken and the result is negative, risk behaviour deferment processes may be used to justify continued risk behaviour. Since past risk behaviour has not yet resulted in infection, a long term perspective to HIV may encourage continued risk behaviour. Encouraging individuals to think about HIV in the short term, where behavioural change is more likely, is an important challenge for future research and policy development.

DRUG INJECTORS' PERCEPTIONS OF HIV RISK: SOME THEORETICAL DEVELOPMENTS

The empirical evidence goes some way to explaining why drug injectors engage in risk behaviour despite knowledge of the risk of infection. A deeper explanation can be gleaned using the theoretical framework developed in Chapter 5 of this thesis and reproduced here, as shown in Figure 9. The outer portion of Figure 9 represents the non-discursive and unthinking influences on risk behaviour, while the empirical results presented in Chapter 7 to 9 reflect the importance of these components in the theoretical model. Practical consciousness and ontological security can be understood conceptually as referring to long

term concerns with HIV. When risks are being taken such concerns may be deferred and pushed to the back of the mind to enable people to go on with risk behaviour.

Figure 9.
Conceptualising HIV Risk Behaviour: A Theoretical Framework



The new sociologies recognise the influence of the body and emotions on risk behaviour. These are useful in identifying the physical need and desire for drugs, and emotions such as trust and love as influences on risk behaviour within particular social relationships. Generally, the components of risk behaviour represented in the outer portion of the theoretical framework contribute to understanding why risk behaviour is often sustained and is engaged in routinely and unthinkingly.

Within the spectrum of daily routines and unthinking behaviour, the inner portion of Figure 9 represents discursive and reasoned thinking about risk behaviour and, in particular, Schutz's systems of relevances. Here routines are broken and issues are discursively considered as a result of imposed or intrinsic systems of relevances. The unfamiliarity prompted by broken routines represents topical relevances referring to issues arising from unfamiliarity and difference from daily routines. For drug injectors, concerns may be raised about previous risk behaviour when the routines surrounding drug dependency are broken. Interpretational relevances referring to informed thought processes and the potential direction of behaviour may, for example, consider the need to be tested to find out whether infection has occurred. Motivational relevances refer to a particular course of action, as informed through interpretational relevances, which can help to conceptualise why, for example, people take a test for HIV. Schutz recognises that systems of relevances are constantly forming and may come into conflict. With regard to HIV testing, examples of conflicting systems of relevances include the interpretation of awareness of HIV risk as requiring action, but other topical relevances, such as worry and fear, inhibiting interpretations and subsequent motivations to be tested. Similarly, an HIV test may be taken and a commitment made to adopt safer behaviour. However, new topical relevances such as the need and desire for drugs may override such a commitment.

The theoretical interpretation highlights some important implications for understanding risk behaviour and the ways in which risk behaviour can be reduced. At a conceptual level, it highlights the challenges for policy and practice to encourage the adoption of safer behaviour. At the point in which risk behaviour occurs there is a need to shift risk behaviour from the non-discursive to the discursive, thereby breaking the routines of risk behaviour and its unthinking components. The shift towards discursive consciousness

prompts systems of relevances that should make HIV risk behaviour topically relevant. However, risk behaviour, as a topical relevance, also needs to be interpreted in ways which motivate the decision to adopt safer behaviour. Continuing education and prevention interventions must inform and encourage the correct interpretation of relevances. Engaging in safer behaviour at the level of practical consciousness and ontological security could potentially encourage sustained safer behaviour among drug injectors.

OPERATIONALISING THE PRINCIPLES OF HARM REDUCTION INSIDE PRISON

Throughout this thesis, concerns have been raised about the impact which prison drug policies have on drug injectors' lives and, in particular, the ways in which policies can shape individuals' behaviour. These relate to prison health care, absence of PNSES and the provision of needle and syringe decontaminants, the role and operation of drug and injecting equipment markets, MDT policy and substitute drug prescribing. Whilst the thesis does not intend to provide a review of the prison service drug strategy, it does illustrate a range of problems with current prison drug policies and highlights the need for urgent reform. Following an ideological commitment to harm reduction, this analysis explores the potential for harm reduction inside prison within the context of current prison drug and health care policies.

Saunders and Marsh (1999) describe how policy can try to reduce drug use and how, as a consequence, some drug related harm may be minimised. Conversely, harm reduction strategies can aim to reduce the negative consequences arising from drug use without necessarily reducing drug use itself. As shown in this thesis, attempts to reduce drug use alone may have unintended consequences. There are a number of dilemmas surrounding harm reduction including, for example, ideological and political conflicts (Saunders and

Marsh, 1999). Furthermore, the concept of harm reduction is noted to be ambiguous and weak (Shelley 1999; Riley *et al.* 1999). Riley *et al.* (1999) discuss a number of components to harm reduction: pragmatism; humanistic values; focus on harm; balancing costs and benefits; and the priority of immediate goals, that all provide a sound foundation for the development of practical harm reduction interventions. These components of harm reduction are, however, misrepresented or underrepresented within prison drug policies. To redress this, Riley *et al.*'s (1999) components of harm reduction are operationalised within the context of the current prison service drug strategy. This analysis highlights future advances in the social policy arena together with some suggestions for further research.

Pragmatism

Harm reduction is characterised by pragmatism that acknowledges the use of drugs and the benefits they bring to individuals. To reduce the harms associated with drug use inside prison, research and policy making should be directed towards understanding why drug use exists within prison. It is important to recognise that the role of drugs in people's lives provides a meaningful social and self-identity inside prison, to alleviate boredom, and to fill the void that the absence of constructive regimes leaves (Tumin, 1993; Hughes and Huby, forthcoming).

Harm reduction recognises that the elimination of drugs inside prison is neither attainable nor is it necessarily desirable. The elimination of drug use inside prison would be at the expense of the wider functions of imprisonment, including rehabilitation (Shewan, 1996), and could lead to further harm being caused. For example, with regard to reducing the supply of drugs inside prison, it has been argued:

We could cut the supply of drugs into prisons to an irreducible minimum, but to do so we would have to compel closed visits and intimate searches. By such compulsion, we could stop drugs being concealed – internally or in nappies – by the person visiting, stop drugs being transferred to the prisoner and stop them being secreted internally by the prisoner immediately afterwards. The difficulty with that approach, however, is threefold. First, it would lead to hideous problems of management in prison. Secondly, it would breach fundamental human rights, not only of the prisoners but of the visitors who have committed no crime at all. Thirdly, and most important, it would threaten the family relationships of the person in custody, whereas we know that preserving those family relationships is the single best way of trying to prevent that person from going back to crime once he [sic] has left custody. (House of Commons Hansard Debates for 2nd July 1999, Part 8.)

This extract demonstrates the tensions between policies that respond to drug use through attempts to reduce demand and those that aim to reduce harm. The findings presented in Chapter 10 suggest that prison visitors are the main source of drugs. However, Draconian searches to prevent drugs entering prison have the real potential to compromise the liberties of unconvicted prison visitors. Moreover, such reduction strategies compromise the principles of harm reduction, not least in the potential to disrupt family and social relationships. Despite such considerations current prison drug policy responds to drug use mainly as a security and control issue, and neglects harm reduction. By attempting to prohibit the import of drugs and injecting equipment into prison (Prison Service, 1995; 1998), drug related harm is substantial. Injecting equipment brought into prison by drug users and their visitors is usually incomplete and altered to facilitate smuggling and, over a short period of time, becomes of very poor quality. Injecting equipment and drugs are usually in short supply within prisons and considerable benefit can accrue to residents through trading injecting equipment, drug solutions and drug filters. This can all, however, result in the increased risk of infection transmission. A pragmatic and straightforward solution to undermine the harm caused by the role and operation of drug and injecting equipment markets is PNSES. If PNSES were accessible to all, it could eliminate the use of incomplete and altered injecting equipment; it could make a significant impact upon the

number of people with whom injecting equipment is shared; and would enable people who really want to inject to do so safely. PNSES should be piloted and evaluated with a view to full introduction without delay.

Humanistic Values

The acceptance of drug use, without moral judgement for or against the use of drugs, underpins the humanistic values that underlie harm reduction. Inside prison, the humanity with which prison residents are treated is questionable (Scruton *et al.*, 1990; Stern, 1993). To reduce harm the prison service must alleviate the series of crises that pervade prisons, including the crises caused by prison conditions (Cavadino and Dignan, 1997). Of course, problems related to poor prison conditions and prison regimes are faced by everyone within the prison environment. However, drug injectors are more likely to find themselves subject to poorer prison conditions and prison regimes through the punishments imposed for using drugs. The introduction of MDT, for example, illustrates the emphasis placed on punishment for using drugs with little attention directed towards effective harm reduction. MDT aims to provide data on drug use, but since MDT is compulsory it offers only a questionable data source with which to inform future research and policy development. Furthermore, drug injectors' feelings of embarrassment, unfairness and powerlessness contribute to their evasion of MDT procedures thereby undermining the whole policy. MDT does nothing to reduce the harm associated with drug use inside prison. It should therefore be abandoned and enable the freed resources from such a reform being better focused on harm reduction. Punishment of drug use will always fail because it does not accept drug use "as fact" (Riley *et al.*, 1999, p. 12). Punishing people for using drugs neglects the fact that drug use has become a ubiquitous feature of all communities (Gossop, 1994), including prison communities. The irony is that punishments excluding

people from constructive educational, employment or leisure programmes leave many drug injectors with little to occupy their time. Small wonder then that they seek relief from the dreary prison regime in efforts to acquire more drugs to fill the void.

Focus on Harm

A focus on harm aims to alleviate the problems associated with drug use to individuals, communities and societies. It is less concerned with the reduction and cessation of drug use and more concerned with the reduction of the negative consequences arising from the use of drugs. In this respect, substitute drug prescribing inside prison is inadequate. Prison health care standards, for example, state that rapid detoxification should occur assisted by drugs including methadone (Prison Service Directorate of Health Care, 1996). These are problematic standards in the first instance. Moreover, adequate substitute drug prescribing is not reaching the drug injectors who need it, raising serious questions about the value of the current approach. Substitute prescribing should be flexible but vast inconsistencies in people's experience prevail. The absence of adequate substitute prescribing, as based on individual need, makes the current approach ineffective. A focus on harm would ensure that people who are prescribed outside prison are prescribed at the same level when they spend time inside prison when this is beneficial. Similarly, even if dependent drug injectors have not been prescribed outside prison, if harm can be reduced then substitute prescribing should be made available. At present, however, restrictive prescribing practices contribute to the persistence of drug related harm inside prison, including HIV risk behaviour.

Balancing Costs and Benefits

Harm reduction involves assessing the costs and benefits arising from drug use to enable priorities to be identified. In order to assess fully the costs and benefits of prison policies

there needs to be far less secrecy within the prison service (Cohen and Taylor, 1978; Fitzgerald and Sim, 1982; Cavadino and Dignan, 1997) and prison drug policies should be subject to independent examination (Gore and Bird, 1998). A costs and benefits analysis would, for example, seriously question the worth of sending drug users to prison when greater benefits can be gained from punishment in the community (Worrall, 1997). Given the wider problems of imprisoning people, if any real and significant change to drug related harm inside prison is to be achieved the use of imprisonment must be reduced as part of a wider harm reduction approach. Sim (1994, p. 36) argues:

Prison should therefore become places of last resort, not the first stop on what often proves to be a grim institutional journey...

A classic example of the usefulness of analysis of costs and benefits is given by CNSES, which have been described as the “epitome” of harm reduction (Riley *et al.*, 1999, p. 12). Outside prison the benefits gained from reducing the spread of infection are set against potential costs, such as the potential to increase the prevalence of drug injection. However, inside prison the potential costs from introducing PNCSES are considered too high when set against potential benefits. For example:

The arguments in favour [of PNCSES] are counter-balanced by the risk of increasing the number of needles in circulation and undermining the need to deter and prevent drug misuse. (House of Commons Hansard Written Answers for 17th December 1998, Part 56).

This extract demonstrates the current government position on PNCSES. It also shows, however, that currently decision making with regard to harm reduction is based on much more than the assessment of costs and benefits. In particular, the balance of costs and benefits may be tipped by ideological considerations. In this case, PNCSES are not

introduced because the prevention of drug use is considered more important than the reduction of harm. The components of harm reduction, however, demand that drug prevention is less important, in the first instance, than reducing the negative consequences of drug use. An ideological shift is necessary, as was witnessed with regards to the introduction of CNSES, to provide drug injectors with the means and the knowledge to inject drugs safely when drug abstinence is not an attainable or a realistic goal.

Priority of Immediate Goals

Balancing the costs and benefits of drug use to individuals, communities and societies should enable priorities to be set and a hierarchy of harm reduction interventions developed. First, the most pressing and immediate needs are addressed. These include the need to reduce rates of infection transmission amongst drug injectors. Interventions should therefore include the introduction of PNSES, injecting equipment decontaminants, and HBV vaccinations. Second, the continuing reduction of risk will demand, where appropriate and beneficial to the goals of harm reduction, strategies to encourage changes in drug taking including a reduction in drug use, and a shift from drug injection to oral administration. Together these may sometimes, although not necessarily, enable individuals to pursue the goal of eventual abstinence. Interventions should include the adequate provision of substitute drugs, education initiatives, and personal and social support.

Riley *et al.*'s (1999) components of harm reduction have a real value in helping to clarify, both at a conceptual and practical level, some of the changes that are urgently needed with regard to adopting the principles of harm reduction inside prison. It is unfortunate that current policy orthodoxy contrasts with these. Instead current prison drug policy has the real

potential to devastate drug injectors' lives. The development of effective prison drug policies in the future must be underpinned by the components of harm reduction. Such a shift in policy direction is likely to impact upon reducing HIV risk behaviour inside prison much more than the punitive policies currently employed. It is also important to recognise that these components of harm reduction do not only refer to specific types of drug policies, such as the provision of PNSES and adequate substitute prescribing inside prisons. Moreover, harm reduction also encompasses the much wider changes needed to effectively deliver health care to drug users, both inside and outside prison, within the wider context of social policy.

BEYOND HARM REDUCTION AND SOCIAL POLICY

Successive governments have spent considerable time and resources attempting to prevent the use of drugs in society. As drug use continues and prevention efforts pursue, within social policy drug users are one group that have been marginalised from government priorities. Consequently, drug users' health and social welfare needs are rarely addressed. As noted earlier in this thesis, drug users' views and experiences have remained peripheral to policy making during a period when, for other groups, views and experiences have become an important resource for developing and improving policies (Forbes and Sashidharan, 1997).

Drug users' activities are sometimes illicit, sometimes disruptive and sometimes the problems arising from drug use may be considered self-inflicted. As Polkinghorne (1996) points out, these factors should not be used as a means to disregard identifying and meeting drug users' individual and collective needs. Within social policy, two dominant discourses have repeatedly surrounded the treatment of vulnerable groups. As Carlen (1996) argues,

these discourses are characterised by citizen risk and less eligibility, which date back to the historical roots of social policy and administration. Put simply, these discourses suggest that those who pose a risk to society are less eligible for social welfare. With regards to the provision of health and social care, these discourses clearly situate drug users as citizens who place themselves at risk. Consequently, drug users should not rely on the state for health and social welfare. Through the social policy purview, it is not difficult to understand why attention directed towards drug users' health and social welfare needs has remained so peripheral to current policy making agendas. This is particularly apparent when set against the dominant anti-social discourses of citizen risk and less eligibility that continue to impact upon and shape drug users' lives.

Discourses on citizen risk and less eligibility are ubiquitous concerns for social policy. Of particular importance for this thesis is health care within prisons. As noted previously, health care in prison is set and delivered at a lower standard inside prison than outside – both historically and to the present day (Sim 1990; 1994). In Sim's (1994, p.33) words, health care is characterised:

[B]y a culture of power still based on the principles of less eligibility which undermines any move towards a more humane or benevolent delivery of health provisions.

Clearly, as health care for drugs users, and other vulnerable groups, operates along the discourses of citizen risk and less eligibility within the community, then such problems are magnified when examining drug users' health care needs within prisons. Presented throughout this thesis are a number of practical means through which policies can be developed to improve the delivery of health care to drug users within prisons. These are all urgently required. Underpinning these practical changes, however, is the need for the

absolution of the discourses of citizen risk and less eligibility that have shaped health and social care provision for drug users both inside and outside prison. The discourses that have shaped past provision do not need to be replicated and to achieve this necessary change would be a remarkable forward step for social policy.

IN-DEPTH INTERVIEW TOPIC GUIDE

INTRODUCTION

Outline of the study.
Confidentiality and usage of data.
Tape recorder.

VIGNETTE, INCLUDING FEEDBACK

REASONS FOR INJECTING DRUGS, OUTSIDE AND INSIDE OF PRISON

IDENTIFICATION OF RISKS

IDENTIFICATION OF DRUG INJECTING RISKS AND EXPERIENCES OF OTHERS AND THEMSELVES, OUTSIDE AND INSIDE OF PRISON

IDENTIFICATION OF SEXUAL RISKS AND EXPERIENCES OF OTHERS AND THEMSELVES, OUTSIDE AND INSIDE OF PRISON

GENERAL DISCUSSION ON RISKS

IDENTIFICATION OF SOCIAL POLICY IMPLICATIONS GENERALLY, ALSO FOCUSED ON MANDATORY DRUG TESTING, SUBSTITUTE DRUG PRESCRIBING AND PRISON NEEDLE AND SYRINGE EXCHANGE SCHEMES

LIFE IN PRISON

PRISON DRUG MARKETS

DESCRIPTIVE DATA

Collect notes on participant's sex, age, ethnicity, first drug of choice and whether it is injected, drugs mainly used, length of injecting career, experiences of treatment, how many times spent in prison, how long was last prison sentence, reason for previous sentence, length of time since release, employment status, living arrangements, services in contact with through drug use.

REASONS FOR PARTICIPATING

THOUGHTS ON INCENTIVE

CONCLUDING DISCUSSION

Summary of main points.
Recruitment of other drug injectors.
Feedback of results.

‘INJECTORS AND THE INSIDE’ VIGNETTE

Page Text

- 1 Injectors and the Inside.
- 2 Ben has been injecting scag (heroin) for three years. His girlfriend Jo hates the thought of Ben injecting and he is now on a methadone script. They are serious about each other and making plans to move in together. Ben has shared works in the past.
- 3 Ben and Jo don't want children. When they go to bed together and have sex, what protection, if any, do you think they will use?
- 4 Jo and Ben used condoms when they first started to sleep together but now Jo takes the contraceptive pill.
- 5 One day Ben bumps into his good friend Paul. They go for a drink and Paul suggests that they get money together to score some scag. Later they break into a house and sell the stolen stuff to one of Paul's friends. By the time they find a dealer and get back to Paul's flat it is past midnight. After all their efforts they are both dying for a hit. Paul tells Ben that he doesn't have any clean works left and they don't know of anyone nearby who might have some spare works.
What do you think would realistically happen in this situation?
- 6 Paul lent Ben his works that time after they had been cleaned with bleach and water.
- 7 The next time Ben and Paul get together they go into a department store and steal some clothes to sell on but just as they are leaving Ben gets caught by the security guard. Paul manages to run free.
- 8 Ben gets prosecuted for this and other offences and the judge puts him away for two years. Inside prison he's off his methadone and isn't feeling too good for lack of it. He tells this to one of the men on his floor who introduces him to a group of men. That night before lights out they offer Ben some scag and a loan of the works that are being shared in the toilets.
What do you think will realistically happen in this situation?
- 9 Ben actually borrows the works and gives them a rinse with cold water in the sink before injecting.
- 10 Things get pretty desperate for Ben in prison and he starts to inject whenever he can. He has sorted out a supply of scag. A new lad on the wing called Pete offers him a loan of his works in exchange for a wash out.
What do you think will happen?

Page Text (Continued)

- 11 Ben accepts the offer and Pete has a wash out.
- 12 Ben and Pete become close friends. They inject whenever they can.
- 13 Pete goes to the medical wing a couple of times, and returns one day saying that they are testing him for HIV/AIDS.
Would anything change when Ben and Pete shoot up together?
- 14 Pete is moved off the wing shortly after this and Ben hasn't seen him since. Ben guesses that Pete is HIV positive. Pete left behind his set of works.
Would anything change with Ben's injection of drugs?
- 15 Ben uses the works Pete left behind.
- 16 Ben is asked for a loan of the works by Jim. He knows Jim well as he has helped Ben get his scag.
What do you think would realistically happen?
- 17 Ben lent Jim the works.
- 18 Ben's solicitor manages to get him off early and Ben leaves prison.
- 19 When Ben gets out he starts to see Jo again.
Would anything change when they have sex?
- 20 Ben told Jo about his time in prison and who he had shared with. Jo went mad, she left, and they haven't seen each other since.
- 21 One night Ben is invited to a party and is introduced to Sarah. They both get on really well and share a common interest - banging up heroin! Later they leave the party and go back to Sarah's flat.
- 22 At the flat they smoke dope together and crash out that night. The next morning Sarah and Ben stay in bed and have sex.
How do you think they will act when they inject drugs and have sex together?
- 22 Ben and Sarah spend a lot of time together. They stopped using condoms when their relationship began to get serious. They inject together but have not shared works.
- 23 One day Sarah is called to court and gets put away for four months for defaulting on fines and other offences.
- 24 Now Sarah is inside what do you think will happen to her drug use?

Page Text (Continued)

- 25 Sarah managed to get a set of works in prison. She is in need of a hit and asks Vicky who injects drugs if she can sort her out for scag. That night she meets in a cell where there are six women shooting up. One of them turns to Sarah and offers gear for Sarah's phone card.
What do you think Sarah will do in this situation?
- 26 Sarah takes the drugs and uses her own set of works.
- 27 Sarah stays friends with these women but injects regularly with Lisa who also has her own set of works.
- 28 One day Vicky comes up to Sarah telling her that her works have been stolen. She is desperate for a fix and asks for a loan of her works.
What do you think Sarah would do in this situation?
- 29 Sarah lends the works to Vicky.
- 30 Since lending Vicky the works Sarah is asked for a loan by someone she hardly knows.
What would Sarah do here?
- 31 Sarah lends out the works.
- 32 Sarah decides to try and stop injecting inside. She starts smoking instead.
- 33 Sarah is out from prison now. While she was inside Sarah lost her bed-sit so she is staying with Ben until she can find herself somewhere to live.

SMALL GROUP DISCUSSION TOPIC GUIDE

INTRODUCTION

Outline of the study.

Confidentiality and usage of data.

Tape recorder.

Invite participants to say a little about themselves.

REASONS FOR INJECTING DRUGS

LIFE IN PRISON

PRISON DRUG MARKETS

LIFE AFTER PRISON

IDENTIFICATION OF SOCIAL POLICY IMPLICATIONS - INCLUDING MANDATORY DRUG TESTING, SUBSTITUTE PRESCRIBING AND NEEDLE AND SYRINGE EXCHANGE

DESCRIPTIVE DATA

Collect notes on participant's sex, age, ethnicity, first drug of choice and whether it is injected, drugs mainly used, length of injecting career, experiences of treatment, how many times spent in prison, how long was last prison sentence, reason for previous sentence, length of time since release, whether they injected in prison, employment status, living arrangements, services in contact with through drug use.

REASONS FOR PARTICIPATING

THOUGHTS ON INCENTIVE

CONCLUDING DISCUSSION

Summary of main points.

Recruitment of other drug injectors.

Feedback of results.

– APPENDIX 4 –

SUMMARY PROFILES OF PARTICIPANTS

<i>Name</i>	<i>Summary Profile</i>
Adam	22 years old and has been injecting amphetamine for 4 years. The drug Adam mainly uses is amphetamine. He has been in prison on 1 occasion. Adam was contacted on the street and participated in a small group discussion (with Mike and Phil) in a café. He is unemployed and lives in a hostel.
Amy	30 years old and has been injecting heroin for heroin for 8 years. The drugs Amy mainly uses are heroin and methadone. She has been in prison on 18 occasions. Amy was contacted in a drop-in centre and participated in a small group discussion (with Nick) in their home. She is unemployed and lives in a house with her partner Nick.
Colin	36 years old and has been injecting heroin for 19 years. The drugs Colin mainly uses are heroin and cannabis. He has been in prison on 11 occasions. Colin was contacted on the street and interviewed in a restaurant. He sells a magazine for homeless people and lives in a flat on his own.
Craig	24 years old and has been injecting heroin for 2 years. The drugs Craig mainly uses are heroin, cannabis, methadone and diazepam. He has been in prison on 4 occasions. Craig was contacted through a probation service and interviewed in a restaurant. He sells cars and lives in a flat with his partner.
Dan	23 years old and has been injecting heroin for 1 year. The drugs Dan mainly uses are methadone and cannabis. He has been in prison on 5 occasions. Dan was contacted on the street and interviewed in a restaurant. He sells a magazine for homeless people and lives in a trailer on his own.
Dave	22 years old and has been injecting for 9 months. The drugs Dave mainly uses are heroin and methadone. He has been in prison on 4 occasions. Dave was contacted in a probation service hostel and participated in a small group discussion (with Keith, Martin and Terry) in the hostel. He is unemployed and lives in the hostel.
Don	32 years old and has been injecting for heroin for 10 years. The drugs Don mainly uses are heroin and physseptone. He has been in prison on 5 occasions. Don was contacted in a drop-in centre and interviewed in a café. He is unemployed and stays in a friends' home intermittently.
Jake	22 years old and has been injecting for 3 years. The drugs Jake mainly uses are heroin and cannabis. He has been in prison on 2 occasions. Jake was contacted through a mutual friend of the researcher and interviewed in a restaurant. He is unemployed and lives in a shared house.

Name Summary Profile (Continued)

- Jane 23 years old and has been injecting heroin for 8 years. The drugs Jane mainly uses are heroin and benzodiazapines. She has been in prison on 3 occasions. Jane was contacted and interviewed in a probation service hostel. She is unemployed and lives in the hostel.
- Karen 18 years old and has been injecting heroin for 4 years. The drugs Karen mainly uses are heroin and benzodiazapines. She has been in prison on 2 occasions. Karen was contacted and interviewed in a probation service hostel. She is unemployed and lives in the hostel.
- Keith 33 years old and has been injecting heroin for 15 years. The drugs he mainly uses are heroin, cannabis and methadone. He has been in prison on 4 occasions. Keith was contacted and interviewed in a probation service hostel and later participated in a small group discussion (with Dave, Martin and Terry) in the hostel. He is unemployed and lives in the hostel.
- Kieran 22 years old and has been injecting heroin for 4 years. The drugs he mainly uses are heroin and methadone. He has been in prison on 3 occasions. Kieran was contacted and interviewed in a probation service hostel. He is unemployed and lives in the hostel.
- Lewis 23 years old and has been injecting heroin for 3 years. The drug he mainly uses is methadone. He has been in prison on 1 occasion. Lewis was contacted through a drugs counselling service and interviewed in a pub. He is unemployed and lives in a house with his parents.
- Lorna 23 years old and has been injecting heroin for 4 years. The drugs she mainly uses are heroin and methadone. She has been in prison on 1 occasion. Lorna was contacted and interviewed in a probation service hostel. She is unemployed and lives in the hostel.
- Mark 31 years old and has been injecting heroin for 11 years. The drugs he mainly uses are heroin, methadone and cannabis. He has been in prison on 9 occasions. Mark was contacted on the street and interviewed in his home. He is unemployed and lives in a flat on his own.
- Martin 29 years old and has been injecting heroin for 15 years. The drugs he mainly uses are methadone and cannabis. He has been in prison on 2 occasions. Martin was contacted in a probation service hostel and participated in a small group discussion (with Dave, Keith and Terry) in the hostel. He is unemployed and lives in the hostel.
- Mike 32 years old and has been injecting heroin for 10 years. The drugs he mainly uses are heroin and cannabis. He has been in prison on 10 occasions. Mike was contacted on the street and participated in a small group discussion (with Adam and Phil) in a café. He is unemployed and lives in a hostel.

Name Summary Profile (Continued)

- Natasha 24 years old and has been injecting heroin for 1 year. The drugs she mainly uses are heroin and methadone. She has been in prison on 2 occasions. Natasha was contacted and interview in a probation service hostel. She is unemployed and lives in the hostel.
- Nick 32 years old and has been injecting heroin for 8 years. The drugs Nick mainly uses are heroin and methadone. He has been in prison on 17 occasions. Nick was contacted in a drop-in centre and participated in a small group discussion (with Amy) in his home. He is unemployed and lives in a house with his partner Amy.
- Phil 27 years old and has been injecting heroin for 6 years. He has been in prison on 15 occasions. Phil was contacted on the street and participated in a small group discussion (with Adam and Mike) in a café. He is unemployed and lives in a house with his parents.
- Robert 27 years old and has been injecting heroin for 8 years. The drugs he mainly uses are heroin and methadone. He has been in prison on 12 occasions. Robert was contacted and interviewed in a needle and syringe exchange scheme. He is a window cleaner and lives in a house with his partner.
- Sharon 17 years old and has been injecting heroin for 3 years. The drugs she mainly uses are heroin and methadone. She has been in prison on 1 occasion. Sharon was contacted and interviewed in a probation service hostel. She is unemployed and lives in the hostel.
- Terry 28 years old and has been injecting for 5 years. The drug he mainly uses methadone. He has been in prison on 3 occasions. Terry was contacted and interviewed in a probation service hostel and later he participated in a small group discussion (with Dave, Keith and Martin) in the hostel. He is unemployed and lives in the hostel.
- Tim 26 years old and has been injecting heroin for 4 years. The drug he mainly uses is methadone. He has been in prison on 3 occasions. Tim was contacted and interviewed in a probation service hostel. He is unemployed and lives in the hostel.

– LIST OF ACRONYMS AND ABBREVIATIONS –

ACMD	Advisory Council on the Misuse of Drugs
AIDS	Acquired Immune Deficiency Syndrome
CoE	Council of Europe
CNSES	Community Needle and Syringe Exchange Schemes
HBV	Hepatitis B Virus
HCSP	Health Care Service for Prisoners
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MDT	Mandatory Drug Testing
NHS	National Health Service
PMS	Prison Medical Service
PNSES	Prison Needle and Syringe Exchange Schemes
UK	United Kingdom
WHO	World Health Organization

– GLOSSARY –

DRUG INJECTORS' VOCABULARY

Backloading: Drug solution shared via the front of one syringe to the back of another.

Bag: Parcel of drugs.

Bairn: Child.

Bang, crank, dig, fix, hit, shoot: Drug injecting.

Barrel: Syringe.

Bird, lass: Woman.

Block: Segregation cell.

Brown, gear, scag, smack: Heroin.

Cat A: Category A prison.

Cell-mate, pad-mate: Other occupant(s) of a prison cell or dormitory.

Cin bin: Incineration container for the safer storage of used injecting equipment.

Citric: Citric acid.

Cluck, rattle, turkey: Drug withdrawal.

Crutch: Concealment in vagina.

Debtheads: Debtors.

DFs: DF118.

Dope: Cannabis.

Drunk, gouch, smashed, stoned: Intoxicated.

Durex: Condom.

E: Ecstasy.

Fanny: Vagina.

Frontloading: Syringes are used to mix and share drug solution via the front of one syringe to the front of another.

Geezer, lad: Man.

Graft: Generating income to purchase drugs.

Habit: Drug dependence.

Hep: Hepatitis.

Lay on: Advance.

Mls: Liquefied drugs.

Numbers: Prison protection, removal from the main prison wings.

Obs: Observation.

Pad: Prison cell or dormitory.

Pad-mate: Other occupant(s) of prison cell or dormitory.

Pad-thief: Person who steals from prison cell or dormitory.

Pin: Needle.

Plug: Concealment in anus.

Protection: Prison protection, removal from the main prison wing.

Scoring, sorting: Obtaining drugs.

Screws: Prison officers.

Script: Prescription.

Smackheads: Heroin users.

Teenth: Sixteenth of an ounce, a quantity drugs are sold in.

Wash out: Residue drugs in a 'filter' (such as cotton wool) can be rehydrated and reheated to produce a further weaker injection.

Whistle and flute: Suit

Works: Needle and syringe.

BIBLIOGRAPHIC REFERENCES

- Aarts, H., Verplanken, B. and van Knippenberg, A. (1998) 'Predicting behavior from actions in the past: repeated decision making or a matter of habit?', *Journal of Applied Social Psychology*, 28(15): 1355-1374.
- Abdala, N., Stephens, P.C., Griffith, B.P. and Heimer, R. (1999) 'Survival of HIV-1 in syringes', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 20(1): 73-80.
- Abrams, F. (1998) 'Needle exchange system for jails', *The Independent*, 24th February: 8.
- Adams, J. (1995) *Risk*. London: University College London.
- Adler, M.W. (Ed) (1997) *ABC of AIDS*. London: British Medical Journal.
- Advisory Council on the Misuse of Drugs, ACMD (1988) *AIDS and Drug Misuse Part 1*. London: Her Majesty's Stationery Office.
- Advisory Council on the Misuse of Drugs, ACMD (1989) *AIDS and Drug Misuse Part 2*. London: Her Majesty's Stationery Office.
- Advisory Council on the Misuse of Drugs, ACMD (1993) *AIDS and Drug Misuse Update*. London: Department of Health.
- Advisory Council on the Misuse of Drugs, ACMD (1996) *Drug Misusers and the Criminal Justice System, Part III: Drug Misusers and the Prison System – An Integrated Approach*. London: Her Majesty's Stationery Office.
- Advisory Council on the Misuse of Drugs, ACMD (1998) *Drug Misuse and the Environment*. London: Stationery Office.
- Aggleton, P., Davies, P. and Hart, G. (Eds) (1993) *AIDS: Facing the Second Decade*. London: Falmer.

- Agostinelli, G. and Seal, D.W. (1998) 'Social comparisons of one's own with others' attitudes toward casual and responsible sex', *Journal of Applied Social Psychology*, 28(10): 845-860.
- AIDS Advisory Committee (1995) *The Review of HIV and AIDS in Prison*. London: Prison Service.
- Albarracin, D., Fishbein, M. and Middlestadt, S. (1998) 'Generalizing behavioral findings across times, samples, and measures: a study of condom use', *Journal of Applied Social Psychology*, 28(8): 657-674.
- Aldridge, J. (1993) 'The textual disembodiment of knowledge in research account writing', *Sociology*, 27(1): 53-66.
- Alexander, N.J. (1996) 'Sexual spread of HIV infection', *Human Reproduction*, 11(7): 111-120.
- Anderson, H.H. and Anderson, G.L. (Eds) (1951) *An Introduction to Projective Techniques and Other Devices for Understanding the Dynamics of Human Behavior*. Englewood Cliffs: Prentice-Hall.
- Balshem, M., Oxman, G., Van Rooyen, D. and Girod, K. (1992) 'Syphilis, sex and crack cocaine: images of risk and morality', *Social Science and Medicine*, 35(2): 147-160.
- Barnard, M.A. (1993) 'Needle sharing in context: patterns of sharing among men and women injectors and HIV risks', *Addiction*, 88(6): 805-812.
- Barnard, M. and Frischer, M. (1995) 'Combining quantitative and qualitative approaches: researching HIV-related risk behaviours among drug injectors', *Addiction Research*, 2(4): 351-362.
- Baxter, L.A. and Wilmot, W.W. (1985) 'Taboo topics in close relationships', *Journal of Social and Personal Relationships*, 2(3): 253-269.

- Bean, P. (1994) 'The drug takers: 1920–1970', in R. Coomber (Ed) *Drugs and Drug Use in Society: A Critical Reader*. Kent: Greenwich University Press.
- Beardsell, S. and Coyle, A. (1996) 'A review of research on the nature and quality of HIV testing services: a proposal for process-based studies', *Social Science and Medicine*, 42(5): 733-743.
- Bearn, J., Gossop, M. and Strang, J. (1996) 'Randomised double-blind comparison of lofexidine and methadone in the in-patient treatment of opiate withdrawal', *Drug and Alcohol Dependence*, 43(1-2): 87-91.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*. London: Sage.
- Beckerleg, S.E., Lewando-Hunt, G.A., Borkan, J.M., Abu Saad, K.J. and Belmaker, I. (1997) 'Eliciting local voices using natural group interviews', *Anthropology and Medicine*, 4(3): 273-288.
- Bell, J., Digiusto, E. and Byth, K. (1992) 'Who should receive methadone maintenance?', *British Journal of Addiction*, 87(5): 689-694.
- Bell, R.A., Molitor, F. and Flynn, N. (1997) 'On returning for one's HIV test result: demographic, behavioral and psychological predictors', *AIDS*, 11(2): 263-264.
- Bellaby, P. (1990) 'To risk or not to risk? Uses and limitations of Mary Douglas on risk-acceptability for understanding health and safety at work and road accidents', *Sociological Review*, 38(3): 465-483.
- Bellis, M.A., Weild, A.R., Beeching, N.J., Mutton, K.J. and Syed, Q. (1997) 'Prevalence of HIV and injecting drug use in men entering Liverpool prison', *British Medical Journal*, 315(7099): 30-31.
- Bendelow, G. and Williams, S.J. (Eds) (1997) *Emotions in social life: critical themes and contemporary issues*. London: Routledge.

- Bendtsen, P., Hensing, G., Ebeling, C. and Schedin, A. (1999) 'What are the qualities of dilemmas experienced when prescribing opioids in general practice?', *Pain*, 82(1): 89-96.
- Berridge, V. (1996) *AIDS in the UK: The Making of Policy, 1981-1994*. Oxford: Oxford University Press.
- Biernacki, P. and Waldorf, D. (1981) 'Snowball sampling: problems and techniques of chain referral sampling', *Sociological Methods and Research*, 10(2): 141-163.
- Bird, A.G., Gore, S.M., Jolliffe, D.W. and Burns, S.M. (1992) 'Anonymous HIV surveillance in Saughton Prison, Edinburgh', *AIDS*, 6(7): 725-733.
- Bird, A.G., Gore, S.M., Jolliffe, D.W. and Burns, S.M. (1993a) 'Second anonymous HIV surveillance in Saughton Prison, Edinburgh: prisoners give a lead to other heterosexuals on being HIV tested', *AIDS*, 7(9): 1277-1279
- Bird, A.G., Gore, S.M., Burns, S.M. and Duggie, J.G. (1993b) 'Study of infection with HIV and related risk factors in young offenders' institution', *British Medical Journal*, 301(6809): 228-231.
- Bird, A.G., Gore, S.M. and Co-signatories (1995) 'Mandatory drug tests (MDT) in Scottish Prisons', letter to M. Forsyth, Secretary of State for Scotland. 14 September.
- Bird, A.G., Gore, S.M., Cameron, S., Ross, A.J. and Goldberg, D.J. (1995) 'Anonymous HIV surveillance with risk factor elicitation at Scotland's largest prison, Barlinnie', *AIDS*, 9(7): 801-808.
- Bird, A.G., Gore, S.M., Hutchinson, S.J., Lewis, S.C., Cameron, S. and Burns, S. (1997) 'Harm reduction measures and injecting inside prison versus mandatory drugs testing: results of a cross sectional anonymous questionnaire survey', *British Medical Journal*, 315(7099): 21-24.

- Birmingham, L., Mason, D. and Grubin, D. (1996) 'Prevalence of mental disorder in remand prisoners: consecutive case-study', *British Medical Journal*, 313(7099): 1521-1524.
- Blaxter, M. (1990) *Health and Lifestyles*. London: Routledge.
- Blaxter, M. (1999) 'Risk, health and social research: lessons from the ESRC programme on Risk and Human Behaviour', *Health, Risk and Society*, 1(1): 11-24.
- Bloor, M. (1995a) *The Sociology of HIV Transmission*. London: Sage.
- Bloor, M. (1995b) 'A user's guide to contrasting theories of HIV-related risk behaviour', in J. Gabe (Ed) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.
- Bloor, M., Frischer, M., Taylor, A., Covell, R., Goldberg, D., Green, S., McKeganey, N. and Platt, S. (1994) 'Tideline and turn: possible reasons for the continuing low HIV prevalence among Glasgow's injecting drug users', *Sociological Review*, 42(4): 738-757.
- Bloor, M., Goldberg, D. and Emslie, J. (1991) 'Ethnostatistics and the AIDS epidemic', *British Journal of Sociology*, 42(1): 131-138.
- Bloor, M.J., McKeganey, N.P., Finlay, A. and Barnard, M.A. (1992) 'The inappropriateness of psycho-social models of risk behaviour for understanding HIV-related risk practices among Glasgow male prostitutes', *AIDS Care*, 4(2): 131-137.
- Bond, P., Roger, I. and McGowan, P. (1995) 'Drugs in prison – the Downview perspective', *Prison Service Journal*, 99(May): 32-35.
- Boulton, M. (Ed) (1994) *Challenge and Innovation: Methodological Advances in Social Research on HIV/AIDS*. London: Taylor and Francis.
- Boulton, S. (Ed) (1997) *World in Action*. Granada Television: Broadcast 17th March.

- Bowser, B.P. and Sieber, J.E. (1993) 'AIDS prevention research: old problems and new solutions', in C.M. Renzetti and R.M. Lee (Eds) *Researching Sensitive Topics*. London: Sage.
- Boyd, F.M., Simpson, W.M., Hart, G.J., Johnstone, F.D. and Goldberg, D.J. (1999) 'What do pregnant women think about the HIV test? A qualitative study', *AIDS Care*, 11(1): 21-29.
- Brewer, T.F. and Derrickson, J. (1992) 'AIDS in prison: a review of epidemiology and preventive policy', *AIDS*, 6(7): 623-628.
- Bridgwood, A. and Malbon, G. (1995) *Survey of the Physical Health of Prisoners 1994*. London: Her Majesty's Stationery Office.
- British Liver Trust in association with LifeLine Manchester (1997) *Injecting Drug Use and Hepatitis C*. Ipswich: British Liver Trust.
- British Medical Association (1997) *The Misuse of Drugs*. Amsterdam: Harwood Academic Publishers.
- Brooke, D., Taylor, C., Gunn, J. and Maden, A. (1998) 'Substance misusers remanded to prison – a treatment opportunity?', *Addiction*, 93(12): 1851-1856.
- Bryman, A. (1988) *Quantity and Quality in Social Research*. London: Unwin Hyman.
- Buchanan, J. and Young, L. (1998) 'Examining the relationship between material conditions, long term problematic drug misuse and social exclusion: a strategy for social inclusion', paper presented to the *Conference to Mark the Centenary of Seebohm Rowntree's First Study of Poverty in York*. York: University of York.
- Buchbinder, S.P., Katz, M.H., Hessel, N.A., O'Malley, P.M. and Holmberg, S.D. (1994) 'Long term HIV-1 infection without immunologic progression', *AIDS*, 8(8): 1123-1128.

- Bunton, R. and Burrows, R. (1995) 'Consumption and health in the 'epidemiological' clinic of late modern medicine', in R. Bunton, S. Nettleton and R. Burrows (1995) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Bunton, R., Nettleton, S. and Burrows, R. (1995) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Burt, J. and Stimson, G.V. (1993) *Drug Injectors and HIV Risk Reduction: Strategies for Protection*. London: Health Education Authority.
- Burton-Jeangros, C. (1998) 'The social construction of health risks', paper presented to the *European Society of Health and Medical Sociology 7th Biennial Conference* on 'The Making of Health Policies in Europe'. Rennes: Ecole Nationale de la Santé Publique.
- Buysse, A. (1998) 'Safer sexual decision making in stable and casual relationships: a prototype approach', *Psychology and Health*, 13(1): 55-66.
- Buysse, A. and Van Oost, P. (1997) 'Conflicting male and female perceptions of safer sexual behaviours', *International Journal of Adolescent Medicine and Health*, 9(2): 71-83.
- Cabinet Office (1999) *Tackling Drugs to Build a Better Britain: The Government's 10-Year Strategy for Tackling Drug Misuse*. London: Stationery Office.
- Caceres, C.F. and van Griensren, G.J.P. (1994) 'Male homosexual transmission of HIV-1', *AIDS*, 8(8): 1051-1061.
- Calvez, M. (1995) 'Perception of risks, definition of interest and commitment to a community: a cultural approach', in D. Friedrich and W. Heckmann (Eds) *Aids in Europe – The Behavioural Aspects* (Volume 4, Determinants of Behaviour Change). Berlin: Sigma.

- Calvez, M. (1998) 'Biographical transition and exposure to Aids risks. The value pertinence of grid-group analysis', paper presented to the *European Society of Health and Medicial Sociology 7th Biennal Conference* on 'The Making of Health Policies in Europe'. Rennes: Ecole Nationale de la Santé Publique.
- Cameron, D. and Jones, I.G. (1985) 'An epidemiological and sociological analysis of the use of alcohol, tobacco and other drugs of solace', *Community Medicine*, 7(1): 18-29.
- Campbell, D. (1996) 'Prisoners switch to hard drugs', *The Guardian*, 1 June: 6.
- Campbell, N.A. (1993) *Biology*. California: Benjamin Cummings.
- Caplehorn, J.R.M., Hartel, D.M. and Irwig, L. (1997) 'Measuring and comparing the attitudes and beliefs of staff working in New York methadone maintenance clinics', *Substance Use and Misuse*, 32(4): 399-413.
- Carlen, P. (1996) *Jigsaw – A Political Criminology of Youth Homelessness*. Buckingham: Open University Press.
- Carlisle, J. (1996) *The Housing Needs of Ex-Prisoners*. York: Centre for Housing Policy.
- Carre, N., Meyer, L., Boufassa, F., Deveau, C., Persoz, A., Rouzioux, C., Vilde, J.L., Bary, M., Burgard, M., Dellamonica, P., Durant, J., Gallais, H., Mars, M.E., Gallais, J., Dormont, J., Delfraissy, J.F, Levy, A., Boue, F., Beclere, A., Lefrere, J.J., Lerable, J., Joubert, L., Cassuto, J.P., Reboulot, B., Quaranta, M., Dupont, B., Beuzelin, C., Fournier, S., Vittecoq, D., Bolliot, C., Pechalat, M.T., Herson, S., Coutellier, A., Gastaut, J.A., Dhiver, C., Drogoul, M.P., Sereni, D., Gomez, V., Bachmeyer, C., Leport, C., Colassante, U., Katlama, C., Brucker, G., Sobel, A., Duval, J., Majerholc, C., Deforges, L., Kazatchkine, M., Vellay, A., Buisson, M., Lebras, P., Goujard, C., Quertainmont, Y., Andrieu, J.M., Even, P., Guillevin, L., Jarousse, J., Trogoff, B.

(1996) 'High risk of HIV disease progression after infection through a sexual partner with AIDS', *AIDS*, 10(1): 77-80.

Carretero, M.D., Chicwick, A. and Catalan, J. (1998) 'Whose health is it? The views of injecting drug users with HIV infection and their professional carers', *AIDS Care*, 10(3): 323-328.

Carter, S. (1995) 'Boundaries of danger and uncertainty: an analysis of the technological culture of risk assessment', in J. Gabe (Ed) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.

Carvel, A.L.M. and Hart, G.J. (1990) 'Risk behaviours for HIV infection among drug users in prison', *British Medical Journal*, 300(6736): 1383-1384.

Cattaneo, C., Nuttall, P.A. and Sokol, R.J. (1996) 'Detection of HIV, hepatitis B and hepatitis C markers in discarded syringes and bloodstains', *Science and Justice*, 36(4): 271-274.

Cavadino, M. and Dignan, J. (1997) *The Penal System: An Introduction*. London: Sage.

Chitwood, D.D., McCoy, C.B., Inciardi, J.A., McBride, D.C., Comerford, M., Trapido, E., Mccoy, V., Page, J.B., Griffin, J., Fletcher, M.A. and Ashman, M.A. (1990) 'HIV Seropositivity of needles from shooting galleries in South Florida', *American Journal of Public Health*, 80(2): 150-152.

Clemmer, D. (1940) *The Prison Community*. London: Holt, Rinehart and Winston.

Cline, T.R. (1979) 'A markov analysis of strangers' roommates', and married couples' conversational focus on their relationships', *Southern Speech Communication Journal*, 45(Fall): 55-68.

- Cohen, J. and Metzger, M. (1998) 'Social affiliation and the achievement of ontological security through interpersonal and mass communication', *Critical Studies in Mass Communication*, 15(1): 41-60.
- Cohen, N. (1999) 'The drugs tsar and the vital prison fix', *The Observer*, 15 August: 27.
- Cohen, S. and Taylor, L. (1972). *Psychological Survival: The Experience of Long-Term Imprisonment*. London: Penguin.
- Cohen, S. and Taylor, L. (1978) *Prison Secrets*. London: National Council for Civil Liberties/Radical Alternatives to Prison.
- Cohen, S. and Taylor, L. (1992) *Escape Attempts: The Theory and Practice of Resistance to Everyday Life*. London: Routledge.
- Collison, M. (1995) *Police, Drugs and Community*. London: Free Association.
- Conner, M. and Norman, P. (Eds) (1996a) *Predicting Health Behaviour: Research and Practice with Social Cognition Models*. Buckingham: Open University Press.
- Conner, M. and Norman, P. (1996b) 'The role of social cognition in health behaviours', in M. Conner and P. Norman (Eds) *Predicting Health Behaviour: Research and Practice with Social Cognition Models*. Buckingham: Open University Press.
- Connor, S. 'Thousands of prisoners face HIV screening', *The Independent on Sunday*, 29th January: 6.
- Connors, M.M. (1992) 'Risk perception, risk taking and risk management among intravenous drug users: implications for AIDS prevention', *Social Science and Medicine*, 34(6): 591-601.
- Connors, M.M. (1994) 'Stories of pain and the problem of AIDS prevention: injection drug withdrawal and its effect on risk behavior', *Medical Anthropology Quarterly*, 8(1): 47-68.

- Coomber, R. (1997a) 'Vim in the veins – fantasy or fact: the adulteration of illicit drugs', *Addiction Research*, 5(3): 195-212.
- Coomber, R. (1997b) 'The adulteration of drugs: what dealers do to illicit drugs and what they think is done to them', *Addiction Research*, 5(4): 297-306.
- Coomber, R. (1997c) 'The adulteration of illicit drugs with dangerous substances – the discovery of a “myth”', *Contemporary Drug Problems*, 24(Summer): 239-271.
- Corkery, J.M. (1998) *Statistics of Drug Seizures and Offenders Dealt With, United Kingdom, 1996* (Home Office Statistical Bulletin, Issue 10/98). London: Government Statistical Service.
- Cornwell, J. (1984) *Hard-Earned Lives: Accounts of Health and Illness from East London*. London: Tavistock.
- Cottler, L.B., Compton, W.M. and Keating, S. (1995) 'What incentives are effective rewards for 'hidden populations' interviewed as part of research projects?', *Public Health Reports*, 110(2): 178.
- Cottler, L.B., Compton, W.M., Ben-Abdallah, A., Horne, M. and Claverie, D. (1996) 'Achieving a 96.6 percent follow-up rate in a longitudinal study of drug abusers', *Drug and Alcohol Dependence*, 41(3): 209-217.
- Council of Europe, CoE (1973) *Council of Europe Standard Minimum Rules for the Treatment of Prisoners*. Strasbourg: CoE Press.
- Council of Europe, CoE (1995) *Prison and Criminological Aspects of the Control of Transmissible Diseases Including Aids and Related Health Problems in Prisons: Recommendation No. R (93) 6 and Explanatory Report*. Strasbourg: CoE Press.

- Covell, R.G., Frischer, M., Taylor, A., Goldberg, D., Green, S., McKeganey, N. and Bloor, M. (1993) 'Prison experience of injecting drug users in Glasgow', *Drug and Alcohol Dependence*, 32(1): 9-14.
- Cregan, J., Kippax, S. and Crawford, J. (1996) 'Sex, contagion, control: prison officers vs condoms in New South Wales gaols', *Australian and New Zealand Journal of Criminology*, 29(3): 227-246.
- Crisp, B.R. and Barber, J.G. (1997) 'The prevention of AIDS among injecting drug users', *British Journal of Social Work*, 27(2): 255-274.
- Crisp, B.R., Barber, J.G. and Gilbertson, R. (1998) 'The relative importance of factors which influence order of injecting with a shared needle and syringe', *AIDS Care*, 10(6): 713-721.
- Crofts, N. (1997) 'A cruel and unusual punishment', *Medical Journal of Australia*, 166(3): 116.
- Crofts, N., Stewart, T., Hearne, P., Yi Ping, X., Breschkin, A.M. and Locarnini, S.A. (1995) 'Spread of bloodborne viruses among Australian prison entrants', *British Medical Journal*, 310(6975): 285-288.
- Crofts, N., Thompson, S., Wale, E. and Hernberger, F. (1996) 'Risk behaviours for blood-borne viruses in a Victorian prison', *Australian and New Zealand Journal of Criminology*, 29(1):20-28.
- Crossley, N. (1996) *Intersubjectivity: The Fabric of Social Becoming*. London: Sage.
- Curran, H.V., Bolton, J., Wanigaratne, S. and Smyth, C. (1999) 'Additional methadone increases craving for heroin: a double-blind, placebo-controlled study of chronic opiate users receiving methadone substitution treatment', *Addiction*, 95(5): 665-674.

- Darke, S., Kaye, S. and Finlay-Jones, R. (1998) 'Drug use and injection risk-taking among prison methadone maintenance patients', *Addiction*, 93(8): 1169-1175.
- Daunno, T. and Vaughn, T.E. (1992) 'Variations in methadone treatment practices: results from a national study', *Journal of the American Medical Association*, 267(2): 253-258.
- Davies, A.G., Dominy, N.J., Peters, A.D. and Richardson, A.M. (1996) 'Gender differences in HIV risk behaviour of injecting drug users in Edinburgh', *AIDS Care*, 8(5): 517-527.
- Davies, M., Croal, H. and Tyrer, J. (1998) *Criminal Justice: An Introduction to the Criminal Justice System in England and Wales*. Harlow: Longman.
- De Rosa, C.J. and Marks, G. (1998) 'Preventive counseling of HIV-positive men and self-disclosure of serostatus to sex partners: new opportunities for prevention', *Health Psychology*, 17(3): 224-231.
- Dennis, M.L., Fetterman, D.M. and Sechrest, L. (1994) 'Integrating qualitative and quantitative evaluation methods in substance abuse research', *Evaluation and Program Planning*, 17(4): 419-427.
- Denzin, N.K. (1978) *The Research Act: A Theoretical Introduction to Sociological Methods*. London: McGraw-Hill.
- Department of Health (1992) *The Health of the Nation: A Strategy for Health in England*. London: Her Majesty's Stationery Office.
- Department of Health, Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland (1999) *Drug Misuse and Dependence – Guidelines on Clinical Management*. London: Her Majesty's Stationery Office.
- Devlin, A. (1998) *What's Wrong with Women's Prisons*. Winchester: Waterside Press.

- Dingwall, R. (1976) *Aspects of Illness*. London: Martin Robertson.
- Djamba, Y.K. (1995) 'Premarital sexual experience of married-women in Kinshasa, Zaire', *Journal of Biosocial Science*, 27(4): 457-466.
- Dolan, K. (1994) 'Sex in the slammer', *National AIDS Bulletin*, July: 12-13.
- Dolan, K. (1997) 'AIDS, drugs and risk behaviour in prison: state of the art', *International Journal of Drug Policy*, 8(1): 5-17.
- Dolan, K. and Wodak, A. (1996) 'An international review of methadone provision in prisons', *Addiction Research*, 4(1): 85-97.
- Dolan, K.A. and Wodak, A. (1999) 'HIV transmission in a prison system in an Australian state', *Medical Journal of Australia*, 171(1): 14-17.
- Dolan, K.A., Donoghoe, M.C. and Stimson, G.V. (1990) 'Drug injecting and syringe sharing in custody and in the community: an exploratory survey of HIV risk behaviour', *Howard Journal of Criminal Justice*, 29(3): 177-186.
- Dolan, K., Wodak, A. and Penny, R. (1995) 'AIDS behind bars: preventing HIV spread among incarcerated drug injectors', *AIDS*, 9(8): 825-832.
- Dolan, K., Hall, W. and Wodak, A. (1996a) 'Methadone maintenance reduces injecting in prison', *British Medical Journal*, 312(7039): 1162.
- Dolan, K.A., Wodak, A.D. and Rutter, S.A. (1996b) 'Is a syringe exchange feasible in a prison setting? Reply', *Medical Journal of Australia*, 165(1): 59.
- Dolan, K.A., Rutter, S.A., Wodak, A.D., Hall, W.D., Maher, L.S. and Dixon, D.C. (1996c) 'Is a syringe exchange feasible in a prison setting?', *Medical Journal of Australia*, 164(8): 508.

- Dolan, K., Wodak, A., Hall, W., Gaughwin, M. and Rae, F. (1996d) 'HIV risk behaviour of IDUs before, during and after imprisonment in New South Wales', *Addiction Research*, 4(2): 151-160.
- Dolan, K.A., Wodak, A.D. and Hall, W.D. (1998) 'Methadone maintenance treatment reduces heroin injection in New South Wales prisons', *Drug and Alcohol Review*, 17(2): 153-158.
- Dolan, K., Wodak, A. and Hall, W. (1999) 'HIV risk behaviour and prevention in prison: a bleach programme for inmates in NSW', *Drug and Alcohol Review*, 18(2): 139-143.
- Donoghoe, M.C. (1992) 'Sex, HIV and the injecting drug user', *British Journal of Addiction*, 87(3): 405-416.
- Donoghoe, M.C., Dolan, K.A and Stimson, G.V. (1992) 'Life-style and social circumstances of syringe sharing in injecting drug users', *British Journal of Addiction*, 87(7): 993-1003.
- Dorn, N., Baker, O. and Seddon, T. (1994) *Paying for Heroin: Estimating the Financial Cost of Acquisitive Crime Committed by Dependent Heroin Users in England and Wales*. London: Institute for the Study of Drug Dependence.
- Douglas, M. (1986) *Risk Acceptability According to the Social Sciences*. London: Routledge.
- Douglas, M. and Wildavsky, A. (1982) *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers*. Berkley: University of California Press.
- Douglas, M. and Calvez, M. (1990) 'The self as risk taker: a cultural theory of contagion in relation to AIDS', *Sociological Review*, 38(3): 445-464.
- Dowie, J. (1999a) 'Communication for better decisions: not about 'risk'', *Health, Risk and Society*, 1(1): 41-53.

- Dowie, J. (1999b) 'Against risk', *Risk Decision and Policy*, 4(1): 57-73.
- Duanno, T. and Vaughn, T.E. (1992) 'Variations in methadone treatment practices: results from a national study', *Journal of the American Medical Association*, 267(2): 253-258.
- Duck, S. and Sants, H. (1983) 'On the origin of the specious: are personal relationships really interpersonal states?', *Journal of Social and Clinical Psychology*, 1(1): 27-41.
- Dufour, A., Alary, M., Poulin, C., Allard, F., Noël, L., Trottier, G., Lépine, D. and Hankins, C. (1996) 'Prevalence and risk behaviours for HIV infection among inmates of a provincial prison in Quebec City', *AIDS*, 10(9): 1009-1015.
- Dupuis, A. and Thorns, D.C. (1998) 'Home, home ownership and the search for ontological security', *Sociological Review*, 46(1): 24-47.
- Dye, S. and Isaacs, C. (1991) 'Intravenous drug misuse among prison inmates: implications for spread of HIV', *British Medical Journal*, 302(6791): 1506.
- Dyer, C. (1999) 'English prison doctor struck off', *British Medical Journal*, 318(7182): 485.
- Edgar, K. and O'Donnell, I. (1998) *Mandatory Drug Testing in Prisons: The Relationship Between MDT and the Level and Nature of Drug Misuse*. (Home Office Research Study Number 189). London: Home Office.
- Edwards, A., Curtis, S. and Sherrard, J. (1999) 'Survey of risk behaviour and HIV prevalence in an English prison', *International Journal of STD and AIDS*, 10(7): 464-466.
- Eklund, C., Hiltunen, A.J., Melin, L. and Borg, S. (1997) 'Abstinence fear in methadone maintenance withdrawal: a possible obstacle for getting off methadone' *Substance Use and Misuse*, 32(6): 779-792.

- Esser, H. (1993) 'The rationality of everyday behaviour: a rational choice reconstruction of the theory of action by Alfred Schütz', *Rationality and Society*, 5(1): 7-31.
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1991) *Report to the United Kingdom Government on the Visit to the United Kingdom*. Strasbourg: CoE.
- Eyland, S.J. (1996) 'Is a syringe exchange feasible in a prison setting?', *Medical Journal of Australia*, 165(1): 59.
- Farrell, M., Macauley, R. and Taylor, C. (1998, unpublished) *An Analysis of the Mandatory Drug Testing Programme: Key Findings*. London: National Addiction Centre.
- Fielding, N.G. and Fielding, J.L. (1986) *Linking Data* (Sage University Paper Series on Qualitative Research Methods, Volume 4). Beverley Hills: Sage.
- Finch, J. (1987) 'The vignette technique in survey research', *Sociology*, 21(1): 105-114.
- Fitzgerald, M. and Sim, J. (1982) *British Prisons*. Oxford: Basil Blackwell.
- Flemen, K. (1997) *Smoke and Whispers: Drugs and Youth Homelessness in Central London*. London: Hungerford Drug Project.
- Flynn, N. (1998) *Introduction to Prisons and Imprisonment*. Winchester: Waterside Press.
- Flynn, N., Jain, S., Keddie, E.M., Carlson, J.R., Jennings, M.B., Haverkos, H.W., Nassar, N., Anderson, R., Cohen, S. and Goldberg, D. (1994) 'In vitro activity of readily available household materials against HIV-1: is bleach enough?', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 7(7): 747-753.
- Forbes, J. and Sashidharan, S.P. (1997) 'User involvement in services – incorporation or challenges?', *British Journal of Social Work*, 27(4): 481-498.

- Fox, N. (1998) 'Risks', 'hazards' and life choices: reflections on health at work', *Sociology*, 32(4): 665-687.
- Friedland, G.H. and Klien, K.S. (1987) 'Transmission of the human immunodeficiency virus', *New England Journal of Medicine*, 317: 1125-1135.
- Friedman, S.R., Des Jarlais, D.C., Ward, T.P., Jose, B., Neaigus, A. and Goldstein, M. (1993) 'Drug injectors and heterosexual AIDS', in L. Sherr (Ed) *AIDS and the Heterosexual Population*. Reading: Harwood Academic Publishers.
- Frommel, M. (1997) 'Ban on drugs or health care: the dilemma of a repressive drug policy', *International Journal of Drug Policy*, 8(1): 18-21.
- Fry, E. (1847) *Memoir of the Life of Elizabeth Fry: With Extracts from her Journal and Letters*. London: Charles Gibin.
- Gabe, J. (Ed) (1995a) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.
- Gabe, J. (1995b) 'Health, medicine and risk: the need for a sociological approach', in J. Gabe (Ed) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.
- Gage, N.L. (1993) 'The obviousness of social and educational research results', in M. Hammersley (Ed) *Social Research: Philosophy, Politics and Practice*. London: Sage in association with the Open University.
- Gahan, C. and Hannibal, M. (1998) *Doing Qualitative Research Using QSR NUD•IST*. London: Sage.
- García Coll, C., Miller, J.B., Fields, J.P. and Mathews, B. (1997) 'The experiences of women in prison: implications for services and prevention', *Women and Therapy*, 20(4): 11-28.

- Gaspar de Almeida, J.M. and Encarnação, R. (1998) 'Building a drug treatment system in postrevolutionary Portugal', in H. Klingemann and G. Hunt (Eds), *Drug Treatment Systems in an International Perspective: Drugs, Demons, and Delinquents*. London: Sage.
- Gerrard, M., Gibbons, F.X., Benthin, A.C. and Hessling, R.M. (1996) 'A longitudinal study of the reciprocal nature of risk behaviors and cognitions in adolescents: what you do shapes what you think, and vice versa', *Health Psychology*, 15(5): 344-354.
- Giddens, (1984) *The Constitution of Society: Outline of the Theory of Structuration*. Cambridge: Polity Press in association with Basil Blackwell.
- Giddens, A. (1991a) *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press in association with Blackwell Publishers.
- Giddens, A. (1991b) 'Structuration theory: past present and future', in C.G.A. Bryant and D. Jary (Eds) *Giddens' Theory of Structuration: A Critical Appreciation*. London: Routledge. Chapter 8, pp. 201-221.
- Giddens, A. (1993) *New Rules of Sociological Method: A Positive Critique of Interpretative Sociologies*. Cambridge: Polity Press in association with Blackwell Publishers.
- Giggs, J., Bean, P., Whynes, D. and Wilkinson, C. (1989) 'Class A drug users: prevalence and characteristics in Greater Nottingham', *British Journal of Addiction*, 84(12): 1473-1480.
- Gleghorn, A.A., Doherty, M.C., Vlahov, D., Celentano, D.D. and Jones, T.S. (1994) 'Inadequate bleach contact times during syringe cleaning among injection drug users', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 7(7): 767-772.

- Goffman, E. (1959) *The Presentation of Self in Everyday Life*. London: Anchor Books.
- Goldberg, D. (1997) 'The case against: it isn't time to provide prisoners with clean needles and syringes', *International Journal of Risk, Security and Crime Prevention*, 2(4): 223-228.
- Goldberg, D., Taylor, A., McGregor, J., Davis, B., Wrench, J. and Gruer, L. (1998) 'A lasting public health response to an outbreak of HIV infection in a Scottish prison?', *International Journal of STD and AIDS*, 9(1): 25-30.
- Goodstein, L. (1970) 'Prisonization and transition to community life', *Journal of Research in Crime and Delinquency*, 16: 265-266.
- Gore, S.M. and Bird, A.G. (1993) 'No escape: HIV transmission in jail', *British Medical Journal*, 307(6897): 147-148.
- Gore, S.M. and Bird, A.G. (1995) 'Mandatory drug tests in prisons', *British Medical Journal*, 310(6979) 595.
- Gore, S.M. and Bird, A.G. (1998) 'Drugs in British prisons', *British Medical Journal*, 316(7140): 1256-1257.
- Gore, S.M., Bird, A.G., Burns, S.M., Goldberg, D.J., Ross, A.J. and Macgregor, J. (1995a) 'Drug injection and HIV prevalence in inmates of Glenochil prison', *British Medical Journal*, 310(6975): 293-296.
- Gore, S.M., Bird, A.G. and Ross, A. (1995b) 'Prison rites: starting to inject inside', *British Medical Journal*, 311(7013): 1135-1136.
- Gore, S.M., Bird, A.G. and Ross, A.J. (1996) 'Prison rights: mandatory drug tests and performance indicators for prisons', *British Medical Journal*, 312(7043): 1411-1413.

- Gore, S.M., Bird, A.G., Burns, S., Ross, A.J. and Goldberg, D. (1997) 'Anonymous HIV surveillance with risk-factor elicitation: at Perth (for men) and Cornton Vale (for women) Prisons in Scotland', *International Journal of STD and AIDS*, 8(3) 166-175.
- Gore, S.M., Bird, A.G., Cameron, S.O., Hutchinson, S.J., Burns, S.M. and Goldberg, D.J. (1999) 'Prevalence of hepatitis C in prisons: WASH-C surveillance linked to self-reported risk behaviours', *QJM*, 92(1): 25-32.
- Gossop, M. (1996) *Living With Drugs*. Aldershot: Arena.
- Gossop, M., Griffiths, P., Powis, B., Williamson, S., Fountain, J. and Strang, J. (1997) 'Continuing drug risk behaviour: shared use of injecting paraphernalia among London heroin injectors', *AIDS Care*, 9(6): 651-660.
- Goto, S.G. (1996) 'To trust or not to trust: situational and dispositional determinants', *Social Behavior and Personality*, 24(2): 119-132.
- Gouldner, A.W. (1960) 'The norm of reciprocity: a preliminary statement', *American Sociological Review*, 25(2): 161-178.
- Green, J. (1997) *HIV Testing*. Horsham: Aids Education and Research Trust.
- Griffiths, P., Gossop, M., Powis, B. and Strang, J. (1993) 'Reaching hidden populations of drug users by privileged access interviewers: methodological and practical issues', *Addiction*, 88(12): 1617-1626.
- Grund, J-P.C., Friedman, S.R., Stern, L.S., Jose, B., Neaigus, A., Curtis, R. and Des Jarlais, D.C. (1996) 'Syringe-mediated drug sharing among injecting drug users: patterns, social context and implications for transmission of blood-borne pathogens', *Social Science and Medicine*, 42(5): 691-703.
- Grunseit, A., Rodden, P., Crawford, J. and Kippax, S. (1996) 'Patterns of serologic testing in HIV-1 seronegative men', *Venereology*, 9(2): 120.

- Hall, J.M. (1997) 'Promoting health in prison – NHS would provide an inferior service', *British Medical Journal*, 314(7076): 302.
- Hamid, A. (1992) 'Drugs and patterns of opportunity in the inner city: the case of middle-aged, middle-income cocaine smokers', in A.V. Harrell and G. E. Peterson (Eds) *Drugs, Crime and Social Isolation: Barriers to Urban Opportunity*. Washington: Urban Institute Press.
- Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in Practice*. London: Routledge.
- Hammersley, R., Forsyth, A., Morrison, V. and Davies, J.B. (1989) 'The relationship between crime and opioid use', *British Journal of Addiction*, 84(9): 1029-1043.
- Hammett, T.M., Gaiter, J.L. and Crawford, C.C. (1998) 'Reaching seriously at-risk populations: health interventions in criminal justice settings', *Health Education and Behavior*, 25(1): 99-120.
- Hando, J., Topp, L. and Hall, W. (1997) 'Amphetamine-related harms and treatment preferences of regular amphetamine users in Sydney, Australia', *Drug and Alcohol Dependence*, 46(1-2): 105-113.
- Hankins, C.A. (1998) 'Syringe exchange in Canada: good but not good enough to stem the HIV tide', *Substance Use and Misuse*, 33(5): 1129-1146.
- Hanrahan, A. and Reutter, L. (1997) 'A critical review of the literature on sharps injuries: epidemiology, management of exposures and prevention', *Journal of Advanced Nursing*, 25(1): 144-154.
- Hargreaves, D. (1997) 'The transfer of severely mentally ill prisoners from HMP Wakefield: a descriptive study', *Journal of Forensic Psychiatry*, 8(1): 62-73.

- Harling, R. (1998) 'Heroin use among young people is increasing in England and Wales', *British Medical Journal*, 317(7156): 431.
- Hart, G. (1990) 'Needle exchange in historical context: responses to the 'drugs problem'', in P. Aggleton, P. Davies and G. Hart (Eds) *AIDS: Individual, Cultural and Policy Dimensions*. Hampshire: Falmer.
- Hart, G. (1991) 'Factors associated with requesting and refusing human immunodeficiency virus antibody testing', *Medical Journal of Australia*, 155(9): 586-589.
- Hart, G. (1999) 'Risk and health: challenges and opportunity', *Health, Risk and Society*, 1(1): 7-10.
- Hartel, D.M., Schoenbaum, E.E., Selwyn, P.A., Kline, J., Davenny, K., Klien, R.S. and Friedland, G.H. (1995) 'Heroin use during methadone maintenance treatment: the importance of methadone dose and cocaine use', *American Journal of Public Health*, 85(1): 83-88.
- Hartnoll, R. and Hedrich, D. (1996) 'AIDS prevention and drug policy: dilemmas in the local environment', in T. Rhodes and R. Hartnoll (Eds) *AIDS, Drugs and Prevention: Perspectives on Individual and Community Action*. London: Routledge.
- Haverkos, H.W. and Lange, W.R. (1990) 'Serious infections other than human immunodeficiency virus among intravenous drug users', *Journal of Infectious Disease*, 161(5): 894-902.
- Heimer, R., Khoshnood, K., Jariwala-Freeman, B., Duncan, B. and Harima, Y. (1996) 'Hepatitis in used syringes: the limits of sensitivity of techniques to detect hepatitis b virus (HBV) DNA, hepatitis c virus (HCV) RNA, and antibodies to HBV core and HCV antigens', *Journal of Infectious Diseases*, 173(4): 997-1000.

- Hellawell, K. (1999) *The United Kingdom Anti-Drugs Co-ordinator First Annual Report and National Plan*. London: Cabinet Office.
- Hendriks, J.C.M., Medley, G.F., Van Griensvein, G.J.P., Coutinho, R.A., Heisterkamp, S.H., Vandruuten, H.A.M. (1993) 'The treatment-free incubation period of AIDS in a cohort of homosexual men', *AIDS*, 7(2): 231-239.
- Hermida-Lazcano, P. (1996) 'The taken-for-granted world: a study of the relationship between A. Schutz and J. Ortega y Gasset', *Human Studies*, 19(1): 43-69.
- Hewitt, A. (1996) 'Drug testing in prisons', *Druglink*, 11(3): 16-18.
- Heyman, B. (Ed) (1998) *Risk, Health and Health Care: A Qualitative Approach*. London: Arnold.
- Heyman, B., Henriksen, M. and Maughan, K. (1998) 'Probabilities and health risks: a qualitative approach', *Social Science and Medicine*, 47(9): 1295-1306.
- Hicks, D. and Rundell, J. (1996) 'HIV testing and counseling', *International Review of Psychiatry*, 8(2-3): 177-184.
- Higate, P.R. (1998, unpublished) *Soldiering on? An Analysis of Homelessness Amongst Ex-servicemen*. University of York: D.Phil (Centre for Housing Policy and Department of Social Policy and Social Work) Thesis.
- Hillier, L., Harrison, L. and Warr, D. (1998) "'When you carry condoms all the boys think you want it": negotiating competing discourses about safe sex', *Journal of Adolescence*, 21(1): 15-29.
- Hit (1998) *[Not Just Syringes] Information for Drug Injectors*. Liverpool: Hit.
- Holden, G., Rosenberg, G., Barker, K., Tuhim, S. and Brenner, B. (1993) 'The recruitment of research participants: a review', *Social Work in Health Care*, 19(2): 1-44.

- Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. and Thomson, R. (1990) 'Sex, gender and power: young women's sexuality in the shadow of AIDS', *Sociology of Health and Illness*, 12(3): 336-350.
- Hollway, W. (1984) 'Women's power in heterosexual sex', *Women's Studies International Forum*, 7(1): 63-68.
- Home Office (1964) *The Organisation of the Prison Medical Service*. London: Her Majesty's Stationery Office.
- Home Office (1979) *Committee of Inquiry into the U.K. Prison Services Report*. London: Her Majesty's Stationery Office.
- Home Office (1990) *Report on an Efficiency Scrutiny of the Prison Medical Service*. London: Home Office.
- Home Office (1991) *Custody, Care and Justice: The Way Ahead for the Prison Service in England and Wales*. London: Her Majesty's Stationery Office.
- Home Office (1992) *Prison Health*. London: Home Office.
- Home Office and Department of Health and Social Security (1975) *The Report of the Committee on Mentally Abnormal Offenders*. London: Her Majesty's Stationery Office.
- Hough, M. (1996) *Drug Misuse and the Criminal Justice System*. London: Home Office, Drugs Prevention Initiative.
- Howard, J. (1777) *The State of Prisons*. London: J.M. Dent & Sons.
- Huby, M. and Hamer, S. (1994, unpublished) *HIV, Sexual Health and Drugs Misuse: Assessment of Need in HM Prison Everthorpe*. Report prepared for: United Health.
- Huby, M. and Hughes, R. (work in progress) 'On using incentives in social research'. Unpublished manuscript.

- Hughes, R. (1997a, unpublished) 'The Lives of Drug Injectors and Social Policy', paper presented to: *Social Policy Association 31st Annual Conference on New Politics, New Welfare*. Lincoln: University of Lincolnshire and Humberside.
- Hughes, R. (1997b, unpublished) *Poverty in York – A Drugs Perspective*. Report prepared for: Joseph Rowntree Foundation Study of Town Life in Britain at the End of the Millennium: A Review of Evidence on Poverty in York.
- Hughes, R. (1998) 'Considering the vignette technique and its application to a study of drug injecting and HIV risk and safer behaviour', *Sociology of Health and Illness*, 20(3): 381-400.
- Hughes, R. (1999) 'Why do people agree to participate in social research? The case of drug injectors', *International Journal of Social Research Methodology*, 1(4): 315-324.
- Hughes, R. (forthcoming a) 'Notes on contacting and recruiting injecting drug users', in J. Fountain (Ed) *Understanding and Responding to Drug Use: The Role of Qualitative Research*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction, in press.
- Hughes, R. (forthcoming b) 'Health, place and British prisons', *Health and Place*, in press.
- Hughes, R. (forthcoming c) 'Drug injectors and prison mandatory drug testing', *Howard Journal of Criminal Justice*, in press.
- Hughes, R. (forthcoming d) "'Clean" or "dirty"? Drug injectors' perceptions of cleanliness and dirtiness in relation to HIV risk behaviour', *Addiction Research*, in press.
- Hughes, R. (forthcoming e) "'Friendships are a big part of it": Social relationships, social distance and HIV risks', *Substance Use and Misuse*, in press.
- Hughes, R.A. (forthcoming f) 'Lost opportunities? Prison needle and syringe exchange schemes', *Drugs: Education, Prevention and Policy*, in press.

- Hughes, R.A. (forthcoming g) “‘It’s like having half a sugar when you were used to three” – Drug injectors’ views and experiences of substitute drug prescribing inside English prisons’, *International Journal of Drug Policy*, in press.
- Hughes, R.A. (forthcoming h) ‘Illicit drug injectors’ strategies for cleaning needles and syringes: findings from qualitative research’, *Scandinavian Journal of Public Health*, in press.
- Hughes, R.A. (forthcoming i) ‘Drug injectors and the cleaning of needles and syringes’, *European Addiction Research*, in press.
- Hughes, R.A. (forthcoming j) ‘Drug injectors in prison and HIV risk behaviour. A perspective from the United Kingdom’, *Justice Professional*, in press.
- Hughes, R. and Huby, M. (forthcoming) ‘Life in prison: perspectives of drug injectors’, *Deviant Behavior*, in press.
- Hunt, A. and Davies, P. (1991) ‘What is a sexual encounter?’, in P. Aggleton, G. Hart and P. Davies (Eds) *AIDS: Responses, Interventions and Care*. London: Falmer Press.
- Hunt, G., Riegel, S., Morales, T. and Waldorf, D. (1993) ‘Changes in prison culture: prison gangs and the case of the “pepsi generation”’, *Social Problems*, 40(3): 398-409.
- Hunt, N. (1997) ‘Incidence of needlestick injuries among people who inject’, *Addiction*, 92(2): 219-220.
- Hunt, N., Shelley, H. and Jones, K. (1994) ‘You say ‘sharing’, I say...’, *Druglink*, 9(4): 10-12.
- Hunter, G.M., Donoghoe, M.C., Stimson, G.V., Rhodes, T. and Chalmers, C.P. (1995) ‘Changes in the injecting risk behaviour of injecting drug users in London, 1990-1993’, *AIDS*, 9(5): 493-501.

- Hutchinson, S.J., Goldberg, D.J., Gore, S.M., Cameron, S., McGregor, J., McMenamin, J. and McGavigan, J. (1998) 'Hepatitis B outbreak at Glenochil prison during January to June 1993', *Epidemiology and Infection*, 121(1): 185-191.
- Ingham, R., Woodstock, A. and Stenner, K. (1992) 'The limitations of rational decision-making models as applied to young people's sexual behaviour', in P. Aggleton, P. Davies and G Hart (Eds) *AIDS: Rights, Risk and Reason*. London: Falmer Press.
- Irwin, J. and Cressey, D.R. (1962) 'Thieves, convicts and the inmate culture', *Social Problems*, 10(2): 142-155.
- Jackson, L.A., Millson, P., Calzavara, L., Rachlis, A., Rowe, C., Strathdee, S., Wagner, C. and Walmsley, S. (1997) 'HIV-positive women living in the metropolitan Toronto area: Their experiences and perceptions related to HIV testing', *Canadian Journal Of Public Health*, 88(1): 18-22.
- Jacobs, B.A. (1998) 'Drug dealing and negative reciprocity', *Deviant Behavior*, 19(1): 29-49.
- Jacobs, J.B. (1977) *Stateville: The Penitentiary in Mass Society*. London: University of Chicago Press.
- Jamner, M.S., Corby, N.H., Wolitski, R.J. (1996) 'Bleaching injection equipment: influencing factors among IDUs who share', *Substance Use and Misuse*, 31(14): 1973-1993.
- Jick, T.D. (1979) 'Mixing qualitative and quantitative methods: triangulation in action', *Administrative Science Quarterly*, 24: 602-611.
- Joint Prison Service and National Health Service Executive Working Group (1999) *The Future Organisation of Prison Health Care*. London: Department of Health.

- Jones, J.L., Hutto, P., Meyer, P., Dowda, H., Gamble, W.B. and Gunn, R.A. (1993) 'HIV seroprevalence and reasons for refusing and accepting HIV testing', *Sexually Transmitted Diseases*, 20(6): 334-337.
- Jones, P.D. (1991) 'HIV transmission by stabbing despite zidovudine prophylaxis', *The Lancet*, 338(8771): 884.
- Jose, B., Friedman, S.R., Neaigus, A., Curtis, R. and Grund, J-P.C. (1993) 'Syringe-mediated drug sharing (backloading) – a new risk factor for HIV among injecting drug users', *AIDS*, 7(12): 1653-1660.
- Judd, A., Hunter, G.M., Maconochie, N., Hickman, M., Parry, J.V., Renton, A.M. and Stimson, G.V. (1999) 'HIV prevalence and risk behaviour among female injecting drug users in London, 1990 to 1996', *AIDS*, 13(7): 833-837.
- Jürgens, R. (1996) *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society.
- Kassler, W.J., Zenilman, J.M. and Erickson, B. (1994) 'Seroconversion in patients attending sexually transmitted disease clinics', *AIDS*, 8: 351-355.
- Kennedy, D.H., Nair, G., Elliot, L. and Ditton, J. (1991) 'Drug misuse and sharing of needles in Scottish prisons', *British Medical Journal*, 302(6791): 1507.
- Kershaw, C. and Renshaw, G. (1997) *Reconvictions of Prisoners Discharged from Prison in 1993, England and Wales* (Home Office Statistical Bulletin Issue 5/97). London: Government Statistical Service.
- King, R.D. and McDermott, K. (1995) *The State of Our Prisons*. Oxford: Oxford University Press.
- Kintz, P. (1996) 'Drug testing in addicts: a comparison between urine, sweat, and hair', *Therapeutic Drug Monitoring*, 18(4):450-455.

- Kippax, S., Crawford, J., Davis, M., Rodden, P. and Dowsett, G. (1993) 'Sustaining safe sex: a longitudinal study of a sample of homosexual men', *AIDS*, 7(2): 257-263.
- Kippax, S., Noble, J., Prestage, G., Crawford, J.M., Campbell, D., Baxter, D. and Cooper, D. (1997) 'Sexual negotiation in the AIDS era: negotiated safety revisited', *AIDS*, 11(2): 191-197.
- Kirkman, M., Rosenthal, D. and Smith, M.A. (1998) 'Adolescent sex and the romantic narrative: why some young heterosexuals use condoms to prevent pregnancy but not disease', *Psychology, Health and Medicine*, 3(4): 355-370.
- Kitzinger, J. (1994) 'The methodology of focus groups: the importance of interaction between research participants', *Sociology of Health and Illness*, 16(1): 103-121.
- Klee, H. (1992) 'Sexual risk among amphetamine misusers: prospects for change', in P. Aggleton, P. Davies and G. Hart (Eds) *AIDS: Rights, Risk and Reason*. London: Falmer.
- Klee, H. and Morris, J. (1997) 'Amphetamine misuse: the effects of social context on injection related risk behaviour', *Addiction Research*, 4(4): 329-342.
- Klee, H., Faugier, J., Morris, J., Hayes, C., Boulton, T. and Morris, J. (1990) 'Sexual partners of injecting drug users: the risk of HIV infection', *British Journal of Addiction*, 85(3): 413-418.
- Klee, H., Faugier, J., Hayes, C. and Morris, J. (1991a) 'Risk reduction among injecting drug users: changes in the sharing of injecting equipment and in condom use', *AIDS Care*, 3(1): 63-73.
- Klee, H., Faugier, J., Hayes, C. and Morris, J. (1991b) 'The sharing of injecting equipment among drug users attending prescribing clinics and those using needle-exchanges', *British Journal of Addiction*, 86(2): 217-223.

- Koester, S., Booth, R. and Wiebel, W. (1990) 'The risk of HIV transmission from sharing water, drug mixing containers and cotton filters among intravenous drug users', *International Journal on Drug Policy*, 1(6): 28-30.
- Kosten, T.R., Rosen, M.I., Schottenfeld, R. and Ziedonis, D. (1992) 'Buprenorphine for cocaine and opiate dependence', *Psychopharmacology Bulletin*, 28(1): 15-19.
- La Pierre, R.T. (1934) 'Attitudes vs actions', *Social Forces*, 13(2): 230-237.
- Ladner, J., Leroy, V., Msellati, P., Nyiraziraje, M., DeClerq, A., Van de Perre, P., Dabis, F., Ntawuruhunga, J., Cyamana, A., Mudaheranwa, M., Munyangabe, C., Ntezayabo, B., Ukulikiyimfura, C., Zilimwagabo, C., Bogaerts, J., Karita, E., Simonon, A., Bazubagira, A., Hitimana, D.G., Murayire, E., Nsengumuremyi, F., Nyandwi, C., Van Goethem, C., Gazille, C. and Salamon, R. (1996) 'A cohort study of factors associated with failure to return for HIV post-test counselling in pregnant women: Kigali, Rwanda, 1992-1993', *AIDS*, 10(1): 69-75.
- Laing, R.D. (1959) *The Divided Self: An Existential Study in Sanity and Madness*. London: Penguin.
- Lambert, E.Y. (Ed) (1990) *The Collection and Interpretation of Data from Hidden Populations* (National Institute on Drug Abuse Research Monograph 98). Rockville: National Institute on Drug Abuse.
- Lambert, E.Y., Ashery, R.S. and Needle, R.H. (Eds) (1995) *Qualitative Methods in Drug Abuse and HIV Research* (National Institute on Drug Abuse Research Monograph 157). Rockville: National Institute on Drug Abuse.
- Lamden, K.H., Kennedy, N., Beeching, N.J., Lowe, D., Morrison, C.L., Mallinson, H., Mutton, K.J. and Syed, Q. (1998) 'Hepatitis B and hepatitis C virus infections: risk

factors among drug users in Northwest England', *Journal of Infection*, 37(3): 260-269.

Layder, D. (1998) *Sociological Practice: Linking Theory and Social Research*. London: Sage.

Lear, D. (1995) 'Sexual communication in the age of AIDS: the construction of risk and trust among young adults', *Social Science and Medicine*, 41(9): 1311-1323.

Leclerc-Madlala, S. (1997) 'Infect one, infect all: Zulu youth responses to the AIDS epidemic in South Africa', *Medical Anthropology*, 17(4): 363-380.

Lee, R.M. (1993) *Doing Research on Sensitive Topics*. London: Sage.

Lees, S. (1986) *Losing Out: Sexuality and Adolescent Girls*. London: Hutchinson.

Lees, S. (1993) *Sugar and Spice: Sexuality and Adolescent Girls*. London: Penguin.

Leigh, B.C. and Miller, P. (1995) 'The relationship of substance use with sex to the use of condoms among young adults in two urban areas of Scotland', *AIDS Education and Prevention*, 7(2): 278-284.

Leiker, J.J., Taub, D.E. and Gast, J. (1995) 'The stigma of AIDS: persons with AIDS and social distance', *Deviant Behavior*, 16(4): 333-351.

Lemaine, G. and Ben Brika, J. (1997) 'Rejection. From attitudes to intentions to exclude: social distance, phenotype, race and culture', *Social Science Information*, 36(1): 81-113.

Lengermann, P.M., Niebrugge, J. and The Women's Institute for Freedom of the Press (1995) 'Intersubjectivity and domination: a feminist investigation of the sociology of Alfred Schutz', *Sociological Theory*, 13(1): 25-36.

Levy, M. (1997) 'Prison health services should be as good as those for the general community', *British Medical Journal*, 315(7120): 1394-1395.

- Liebling, A. (1992) *Suicides in Prison*. London: Routledge.
- Lishner, D.M. and Look, M.S. (1990) 'Needle-sharing practices and risk for AIDS transmission among intravenous drug users in Seattle', *International Journal of the Addictions*, 25(12): 1475-1483.
- Lo, B. (1991) 'Ethical issues in drug testing', in R.H. Coombs and L.J. West (Eds) *Drug Testing: Issues and Options*. Oxford: Oxford University Press.
- Lord President of the Council and Leader of the House of Commons, the Secretary of State for the Home Department, the Secretary of State for Health, the Secretary of State for Education and the Paymaster General (1995) *Tackling Drugs Together: A Strategy for England 1995-98*. London: Her Majesty's Stationery Office.
- Loue, S., Lurie, P. and Lloyd, L.S. (1995) 'Ethical issues raised by needle exchange programs', *Journal of Law Medicine and Ethics*, 23(4): 382-388.
- Loxley, W. and Davidson, R. (1998) 'How rational is needle sharing to young injecting drug users?', *Addiction Research*, 6(6): 499-515.
- Lupton, D. (1993) 'Risk as moral danger: the social and political functions of risk discourse in public health', *International Journal of Health Services*, 23(3): 425-435.
- Lupton, D., McCarthy, S. and Chapman, S. (1995) "'Doing the right thing': the symbolic meanings and experiences of having an HIV antibody test", *Social Science and Medicine*, 41(2): 173-180.
- MacDonald, M. (1997) *Mandatory Drug Testing in Prisons*. Birmingham: Centre for Research into Quality and the Department of Sociology, University of Central England in Birmingham.
- MacFarlane, I.A. (1996) 'The development of health-care services for diabetic prisoners', *Postgraduate Medical Journal*, 72(845): 214-217.

- MacGowan, R.J., Brackbill, R.M., Rugg, D.L., Swanson, N.M., Weinstein, B., Couchon, A., Scibak, J., Molde, S., McLaughlin, P., Barker, T. and Voigt, R. (1997) 'Sex, drugs and HIV counseling and testing: a prospective study of behavior-change among methadone-maintenance clients in New England', *AIDS*, 11(2): 229-235.
- MacGregor, S. and Smith, L. (1998) 'The English drug treatment system: experimentation or pragmatism?', in H. Klingemann and G. Hunt (Eds) *Drug Treatment Systems in an International Perspective: Drugs, Demons, and Delinquents*. London: Sage.
- Macklin, R. (1981) "'Due' and 'undue' inducements: on paying money to research subjects', *IRB: A Review of Human Subjects Research*, 3(5): 1-6.
- Macintyre, S. and West, P. (1993) 'What does the phrase safer sex mean to you? Understanding among Glaswegian 18 year old in 1990', *AIDS*, 7(1): 121-125.
- Macintyre, S., Maciver, S. and Sooman, A. (1993) 'Area, class and health: should we be focusing on places or people?', *Journal of Social Policy*, 22(2): 213-234.
- Maden, A. Swinton, M. and Gunn, J. (1992) 'A survey of prearrest drug-use in sentenced prisoners', *British Journal of Addiction*, 87(1): 27-33.
- Mahon, N. (1997) 'Prisoners and the harm reduction movement', *International Journal of Drug Policy*, 8(1): 1-2.
- Malliori, M., Sypsa, V., Psychogiou, M., Touloumi, G., Skoutelsi, A., Tassopoulos, N., Hatzakis, A. and Stafanis, C. (1998) 'A survey of bloodborne viruses and associated risk behaviours in Greek prisons', *Addiction*, 93(2): 243-251.
- Marsch, L.A. (1998) 'The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis', *Addiction*, 93(4): 515-532.

- Marsden, J., Gossop, M., Farrell, M. and Strang, J. (1998) 'Opioid substitution: critical issues and future directions', *Journal of Drug Issues*, 28(2): 243-263.
- Mason, D., Birmingham, L. and Grubin, D. (1997) 'Substance use in remand prisoners: a consecutive case study', *British Medical Journal*, 315(7099): 18-21.
- Mason, J. (1994) 'Linking qualitative and quantitative data analysis', in A. Bryman and R.G. Burgess (Eds) *Analyzing Qualitative Data*. London: Routledge.
- Mason, J. (1996) *Qualitative Researching*. London: Sage.
- Mason, P. (1998, unpublished) *Evaluation of Prison Drug Treatment and Rehabilitation Services: Summary of Recommendations*. PDM Consulting.
- McCoy, C.B., Metsch, L.R., Chitwood, D.D., Shapshank, P. and Comerford, S.T. (1998) 'Parenteral transmission of HIV among injection drug users: assessing the frequency of multiperson use of needles, syringes, cookers, cotton, and water', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18(Supplement 1): S25-S29.
- McCoy, H.V., Chitwood, D.D., Page, J.B. and McCoy, C.B. (1997) 'Skills for HIV risk reduction: evaluation of recall and performance in injecting drug users', *Substance Use and Misuse*, 32(3): 229-247.
- McKee, K.J., Marková, I., and Power, K.G. (1995) 'Concern, perceived risk and attitudes towards HIV/AIDS in Scottish prisons', *AIDS Care*, 7(2): 159-170.
- McKeganey, N. (1990) 'Being positive: drug injectors' experiences of HIV infection', *British Journal of Addiction*, 85(9): 1113-1124.
- McKeganey, N. (1995) 'Quantitative and qualitative research in the addictions – an unhelpful divide', *Addiction*, 90(6): 749-51.

- McKeganey, N. (1996) 'The need for cautious congratulations', *Addiction*, 91(8): 1092-1093.
- McKeganey, N. and Barnard, M. (1992) *AIDS, Drugs and Sexual Risk: Lives in the Balance*. Buckingham: Open University Press.
- McKeganey, N. and Barnard, M. (1996) *Sex Work on the Streets: Prostitutes and their Clients*. Buckingham: Open University Press.
- McKeganey, N., Abel, M., Taylor, A., Frischer, M., Goldberg, D. and Green, S. (1995) 'The preparedness to share injecting equipment: an analysis using vignettes', *Addiction*, 90(9): 1253-1260.
- McKeganey, N., Abel, M. and Hay, G. (1996) 'Contrasting methods of collecting data on injectors' risk behaviour', *AIDS Care*, 8(5): 557-63.
- McKeganey, N., Barnard, M. and Watson, H. (1989) 'HIV-related risk behaviour among a non-clinic sample of injecting drug users', *British Journal of Addiction*, 84(12): 1481-1490.
- McLoone, P. (1996) 'Suicide and deprivation in Scotland', *British Medical Journal*, 312(7030): 543-544.
- McNeal, J.L. (1997) 'The association of idealization and intimacy factors with condom use in gay male couples', *Journal of Clinical Psychology in Medical Settings*, 4(4): 437-451.
- Melrose, M. (1996) 'Enticing subjects and disembodied objects', in H. Dean (Ed) *Ethics and Social Policy Research*. Luton: University of Luton Press in conjunction with the Social Policy Association.
- Merikle, E.P. (1999) 'The subjective experience of craving: an exploratory analysis', *Substance Use and Misuse*, 34(8): 1101-1115.

- Meyenberg, R., Stöver, H., Jacob, J., Pospeschill, M. (1997) *Infektionsprophylaxe im Niedersächsischen Justizvollzug*. Oldenburg: BIS-Verlag.
- Meyrick, J., Lawrence, A.G., Barton, S.E. and Boag, F.C. (1997) 'To test or not to test, could you repeat the question?', *International Journal of STD and AIDS*, 8(1): 36-39.
- Miles, M.B. and Huberman, A.M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook* (Second Edition). London: Sage.
- Millar, T. and Donmall, M. (1995) 'Actual and perceived sharing of injecting equipment by drug users', paper presented to *Sixth International Conference on the Reduction of Drug Related Harm*. Florence: Palazzo dei Congressi.
- Miller, D., Acton, T.M.G. and Hedge, B. (1988) 'The worried well: their identification and management', *Journal of the Royal College of Physicians of London*, 22(3): 158-165.
- Miller, K.S., Hennessy, M., Wendell, D.A., Webber, M.P. and Schoenbaum, E.E. (1996) 'Behavioral risks for HIV-infection associated with HIV-testing decisions', *AIDS Education and Prevention*, 8(5): 394-402.
- Mills, C.W. (1959) *The Sociological Imagination*. Oxford: Oxford University Press.
- Mills, H. (1995a) 'Prison cuts raise fears of return to riots', *The Independent*, 28th November: 8.
- Mills, H. (1995b) 'Prison turning shoplifters into drug addicts', *The Independent*, 8th February: 5.
- Mirin, S.M., Meyer, R.E., Mendelson, J.H. and Ellingboe, J. (1980) 'Opiate use and sexual function', *American Journal of Psychiatry*, 137(8): 909-915.
- Mishler, E.G. (1991) 'Representing discourse: the rhetoric of transcription', *Journal of Narrative and Life History*, 1(4): 255-280.

- Molitor, F., Bell, R.A., Truax, S.R., Ruiz, J.D. and Sun, R.K. (1999) 'Predictors of failure to return for HIV test result and counseling by test site type', *AIDS Education and Prevention*, 11(1): 1-13.
- Moore, S., Rosenthal, D. and Mitchell, A. (1996) *Youth, AIDS and Sexually Transmitted Diseases*. London: Routledge.
- Morgan, D.L. (1997). *Focus Groups as Qualitative Research* (Sage University Paper Series on Qualitative Research Methods, Volume 16). Beverley Hills: Sage.
- Morris, T. and Morris, P. (1963) *Pentonville: A Sociological Study of an English Prison*. London: Routledge and Kegan Paul.
- Morrison, A., Elliott, L. and Gruer, L. (1997) 'Injecting-related harm and treatment-seeking behaviour among injecting drug users', *Addiction*, 92(10): 1349-1352.
- Morse, J.M. (1999) 'Qualitative generalizability', *Qualitative Health Research*, 9(1): 5-6.
- Moss, A.R. (1987) 'AIDS and intravenous drug use: the real heterosexual epidemic', *British Medical Journal*, 294(6569): 389-390.
- Mulleady, G., White, D., Phillips, K. and Cupitt, C. (1990) 'Reducing sexual transmission of HIV for injecting drug users: the challenge for counselling', *Counselling Psychology Quarterly*, 3(4): 325-341.
- Murdoch, A. (1997) 'Prison gang hold warders hostage', *The Independent*, 6th January: 6.
- Murphy, D.A., Rotheram-Borus, M.J. and Reid, H.M. (1998) 'Adolescent gender differences in HIV-related sexual risk acts, social-cognitive factors and behavioral skills', *Journal of Adolescence*, 21(2): 197-208.
- Murphy, E., Dingwall, R., Greatbatch, D., Parker, S. and Watson, P. (1998) *Qualitative Research Methods in Health Technology Assessment: A Review of the Literature*

(Health Technology Assessment 2(16)). Southampton: Core Research on behalf of National Coordinating Centre for Health Technology Assessment.

Myers, S. S., Heimer, R., Liu, D. and Henrard, D. (1993) 'HIV DNA and antibodies in syringes from injecting drug users: a comparison of detection techniques', *AIDS*, 7(7): 925-931.

Neale, J. (1998a) 'Reducing risks: drug users' views of accessing and disposing of injecting equipment', *Addiction Research*, 6(2): 147-163.

Neale, J. (1998b) 'Drug users' views of prescribed methadone', *Drugs: Education, Prevention and Policy*, 5(1): 33-45.

Neale, J. (1998c) 'Drug users' views of drug service providers', *Health and Social Care in the Community*, 6(5): 308-317.

Nelles, J. (1997) 'The contradictory position of HIV prevention in prison: Swiss experiences', *International Journal of Drug Policy*, 8(1): 2-4.

Nelles, J. and Fuhrer, A. (1995) *Drugs and HIV Prevention at the Hindelbank Penitentiary: Abridged Report of the Evaluation Results of the Pilot Project*. Bern: Swiss Federal Office of Public Health.

Nelles, J. and Harding, T. (1995) 'Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism', *Lancet*, 346(8989): 1507-1508.

Nelles, J., Bernasconi, S., Dobler-Mikola, A. and Kaufman, B. (1997) 'Provision of syringes and prescription of heroin in prison: the Swiss experience in the prisons of Hindelbank and Oberschöngrün', *International Journal of Drug Policy*, 8(1): 40-52.

Nelles, J., Fuhrer, A., Hirsbrunner, H.P. and Harding, T.W. (1998) 'Provision of syringes: the cutting edge of harm reduction in prison?', *British Medical Journal*, 317(7153): 270-273.

- Nelles, J., Fuhrer, A. and Hirsbrunner, H.P. (1999) 'How does syringe distribution in prison affect consumption of illegal drugs by prisoners?', *Drug and Alcohol Review*, 18(2): 133-138.
- Nettleton, S. and Burrows, R. (1998) 'Mortgage debt, insecure home ownership and health: an exploratory analysis', *Sociology of Health and Illness*, 20(5): 731-753.
- Nettleton, S. and Watson, J. (Eds) (1998) *The Body in Everyday Life*. London: Routledge.
- Newburn, T. (1995) *Crime and Criminal Justice Policy*. Essex: Addison Wesley Longman.
- Newcombe, R. (1996) 'Live and let die: is methadone more likely to kill you than heroin?', *Druglink*, 11(1): 9-12.
- Newmeyer, J.A. (1988) 'The intravenous drug user and secondary spread of AIDS', *Journal of Psychoactive Drugs*, 20(2): 169-172.
- Newmeyer, J., Drew, L. and Miner, R. (1990) 'HIV transmission in simulated conditions of sharing of hypodermic equipment', *Journal of Acquired Immune Deficiency Syndromes*, 3(10): 1019-1021.
- Norton, J., Elford, J., Sherr, L., Miller, R. and Johnson, M.A. (1997) 'Repeat HIV testers at a London same-day testing clinic', *AIDS*, 11(6): 773-781.
- Nyamathi, A.M., Lewis, C., Leake, B., Flaskerud, J. and Bennet, C. (1995) 'Barriers to condom use and needle cleaning among impoverished minority female injection drug users and partners of injection drug users', *Public Health Reports*, 110(2): 166-172.
- O'Brien, M. (1989) 'Needle exchange programs: ethical and policy issues', *AIDS and Public Policy Journal*, 4(2): 75-82.
- O'Donnell, I. and Edgar, K. (1998) 'Routine victimisation in prisons', *Howard Journal of Criminal Justice*, 37(3): 266-279.

- O'Hare, P.A., Newcombe, R., Matthews, A., Buning, E.C. and Drucker, E. (Eds) (1992) *The Reduction of Drug-Related Harm*. London: Routledge.
- Ostrow, D.G. and Kessler, R.C. (Eds) (1993) *Methodological Issues in AIDS Behavioral Research*. London: Plenum Press.
- Padfield, A. and Procter, I. (1996) 'The effect of interviewer's gender on the interviewing process: a comparative enquiry', *Sociology*, 30(2): 355-366.
- Paget, D.Z. (1998, unpublished) *Needle distribution in the Swiss prison setting: a breakthrough?* Bern: Swiss Federal Office of Public Health.
- Parker, H., Bakx, K. and Newcombe, R. (1988) *Living with Heroin: The impact of a drugs 'epidemic' on an English Community*. Buckingham: Open University Press.
- Pearson, G. (1987) 'Social deprivation, unemployment and patterns of heroin use', in N. Dorn and N. South (Eds) *A Land Fit for Heroin? Drug Policies, Prevention and Practice*. London: Macmillan.
- Pearson, G. (1996) 'Drugs and deprivation', *Journal of the Royal Society of Health*, 116(2): 113-116.
- Peat, B.J. and Winfree, L.T. (1992) 'Reducing the intra-institutional effects of prisonization: a study of a therapeutic community for drug using inmates' *Criminal Justice and Behavior*, 19(2): 206-225.
- Peters, A., Davies, T. and Richardson, A. (1998) 'Multi-site samples of injecting drug users in Edinburgh: prevalence and correlates of risky injecting practices', *Addiction*, 93(2): 253-267.
- Pierzchniak, P., Purchase, N. and Kennedy, H. (1997) 'Liaison between prison, court and psychiatric services', *Health Trends*, 29: 26-29.

- Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review*. London: King's Fund.
- Poland, B.D. (1995) 'Transcription quality as an aspect of rigour in qualitative research', *Qualitative Inquiry*, 1(3): 290-310.
- Polkinghorne, J. (1996) *The Task Force to Review Services for Drug Misusers: Report of an Independent Review of Drug Treatment Services in England*. London: Department of Health.
- Pollack, S. (1985) 'Sex and the contraceptive act', in H. Homans (Ed) *The Sexual Politics of Reproduction*. Aldershot: Gower.
- Power, K.G., Marková, I., Rowlands, A., McKee, K.J., Anslow, P.J. and Kilfedder, C. (1991) 'Sexual behaviour in Scottish prisons', *British Medical Journal*, 302(6791): 1507-1508.
- Power, K.G., Marková, I., Rowlands, A., McKee, K.J. and Kilfedder, C. (1994) 'Inmates self-perceived risk of HIV infection inside and outside Scottish prisons', *Health Education Research*, 9(1): 47-55.
- Power, K.G., Marková, I., McKee, K.J. and Kilfedder, C. (1996) 'Correlates of HIV/AIDS knowledge in a Scottish prison sample', *Health Education Research*, 11(3): 287-297.
- Power, R. (1989) 'Participant observation and its place in the study of illicit drug abuse', *British Journal of Addiction*, 84(1): 43-52.
- Power, R. (1995) 'A model for qualitative action research amongst illicit drug users', *Addiction Research*, 3(3): 165-181.
- Power, R. (1998) 'The role of qualitative research in HIV/AIDS', *AIDS*, 12(7): 687-695.

- Power, R., Jones, S., Kearns, G. and Ward, J. (1996) 'An ethnography of risk management amongst illicit drug injectors and its implications for the development of community-based interventions', *Sociology of Health and Illness*, 18(1): 86-106.
- Prendergast, C. (1993) 'Rationality, optimality, and choice: Esser's reconstruction of Alfred Schutz's theory of action', *Rationality and Society*, 5(1): 47-57.
- Preston, A. and Armsby, T. (1990) *What Works? Safer Injecting Guide*. Exeter: Exeter Drugs Project.
- Preston, A. and Derricott, J. (1997) *The Safer Injecting Handbook*. Dorchester: Andrew Preston.
- Prison Service (1995a) *Drug Misuse in Prison*. London: Prison Service.
- Prison Service (1995b) *AIDS Inside and Out: An education package on HIV infection and AIDS for the use of prisons and young offender institutions in England and Wales*. London: Prison Service.
- Prison Service (1995c) *Talking About AIDS: A teaching resource for use with inmates of prisons and young offender institutions in England, Wales and Scotland*. London: Prison Service.
- Prison Service (1998a) *The Review of the Prison Service Drug Strategy, "Drug Misuse in Prison"*. London: Prison Service.
- Prison Service (1998b) *Tackling Drugs in Prison: The Prison Service Drug Strategy*. London: Prison Service.
- Prison Service Directorate of Health Care (1996) *Health Care Standards for Prisons in England and Wales*. London: Prison Service.
- Prison Service Directorate of Health Care (1997) *Report of the Director of Health Care 1995-1996*. London: Prison Service.

- Prison Service Directorate of Health Care (1998) *Report of the Director of Health Care 1996-1997*. London: Prison Service.
- Public Health Laboratory Service and the Scottish Centre for Infection and Environmental Health (1999, unpublished) *AIDS/HIV Quarterly Surveillance Tables: UK Data to End March 1999* (No. 43: 99/1).
- Pym, M. (1998) 'Water, water everywhere, but not a drop to fix...the plight of homeless injecting drug users', *Mainliners*, December: 1.
- Qualitative Solutions and Research, QSR (1997) *QSR NUD•IST 4 User Guide*. Melbourne: QSR.
- Quirk, A., Rhodes, T. and Stimson, G.V. (1998) 'Unsafe protected sex': qualitative insights on measures of sexual risk', *AIDS Care*, 10(1): 105-114.
- Rahman, N. (1996) 'Caregivers' sensitivity to conflict: the use of the vignette methodology', *Journal of Elder Abuse and Neglect*, 8(1): 35-47.
- Ralli, R.A. (1994) 'Health care in prisons', in Player, E. and Jenkins, M. (Eds) *Prisons After Woolf: Reform through Riot*. London: Routledge.
- Ramsbotham, D. (1996) *Patient or Prisoner? A New Strategy for Health Care in Prisons*. London: Home Office.
- Ramsbotham, D. (1998) *Report of Her Majesty's Chief Inspector of Prisons*. London: Stationery Office.
- Reed, J. and Lyne, M. (1997) 'The quality of health care in prison: results of a year's programme of semistructured inspections', *British Medical Journal*, 315(7120): 1420-1424.
- Rhodes, T. (1994) *Risk, Intervention and Change: HIV Prevention and Drug Use*. London: Health Education Authority in association with the National AIDS Trust.

- Rhodes, T. (1995) 'Theorizing and researching 'risk': notes on the social relations of risk in heroin users' lifestyles', in P. Aggleton, P. Davies and G. Hart (Eds) *AIDS: Safety, Sexuality and Risk*. London: Taylor and Francis.
- Rhodes, T. (1997) 'Risk theory in epidemic times: sex, drugs and the social organisation of 'risk behaviour'', *Sociology of Health and Illness*, 19(2): 208-227.
- Rhodes, T. and Quirk, A. (1996) 'Heroin, risk and sexual safety: some problems for interventions encouraging community change', in T. Rhodes and R. Hartnoll (Eds) *AIDS, Drugs and Prevention: Perspectives on Individual and Community Action*. London: Routledge.
- Rhodes, T. and Stimson, G.V. (1994) 'What is the relationship between drug taking and sexual risk? Social relations and social research', *Sociology of Health and Illness*, 16(2): 210-228.
- Rhodes, T., Donoghoe, M., Hunter, G., Soteri, A. and Stimson, G.V. (1994) 'Sexual behaviour of drug injectors in London: implications for HIV transmission and HIV prevention', *Addiction*, 89(9): 1085-1096.
- Rhodes, T., Hunter, G.M., Stimson, G.V., Donoghoe, M.C., Noble, A., Parry, J. and Chalmers, C. (1996) 'Prevalence of markers for hepatitis B virus and HIV-1 among drug injectors in London: injecting careers, positivity and risk behaviour', *Addiction*, 91(10): 1457-1467.
- Rich, J.D., Dickinson, B.P., Carney, J.M., Fisher, A. and Heimer, R. (1998) 'Detection of HIV-1 nucleic acid and HIV-1 antibodies in needles and syringes used for non-intravenous injection', *AIDS*, 12(17): 2345-2350.

- Ricklin, F. (1996) 'Methadone maintenance: the Swiss experience', *Addictions 1996: An International Research Journal*:
 <http://www.vitanova.on.ca/Addictions_1996_Research_Communication_1.html>.
- Rietmeijer, C.A., Kane, M.S., Simons, P.Z., Corby, N.H., Wolitski, R.J., Higgins, D.L., Judson, F.N. and Cohn, D.L. (1996) 'Increasing the use of bleach and condoms among injecting drug users in Denver: outcomes of a targeted community-level HIV prevention program', *AIDS*, 10(3): 291-298.
- Riggs, A. and Turner, B.S. (1997) 'The sociology of the postmodern self: intimacy, identity and emotions in adult life', *Australian Journal on Ageing*, 16(4): 229-232.
- Riley, D. (1994) *The Harm Reduction Model*. Toronto: Harm Reduction Network.
- Riley, D., Sawka, E., Conley, P., Hewitt, D., Mitic, W., Poulin, C., Room, R., Single, E. and Topp, J. (1999) 'Harm reduction: Concepts and practice. A policy discussion paper', *Substance Use and Misuse*, 34(1):9-24.
- Roberts, J. (1994) 'The relationship between the community and the prison', in E. Player, and M. Jenkins (Eds) *Prisons After Woolf: Reform through Riot*. London: Routledge.
- Robertson, J. (1990) 'The Edinburgh epidemic: a case study', in J. Strang and G. Stimson (Eds) *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s*. London: Routledge.
- Robertson, J.R., Bucknall, A.B.V., Welsby, P.D., Roberts, J.J.K., Inglis, J.M., Peutherer, J.F. and Brettell, R.P. (1986) 'Epidemic of AIDS related virus (HTLV-III/LAV) infection among intravenous drug abusers' *British Medical Journal*, 292(6519): 527-529.

- Ronald, P.J.M., Robertson, J.R., Wyld, R. and Weightman, R. (1993) 'Heterosexual transmission of HIV in injecting drug users', *British Medical Journal*, 307(6913): 1184-1185.
- Rosenthal, S.L., Cohen, S.S. and Biro, F.M. (1996) 'Developmental sophistication among adolescents of negotiation strategies for condom use', *Journal of Developmental and Behavioral Pediatrics*, 17(2): 94-97.
- Ross, M., Grossman, A.B., Murdoch, S., Bundy, R., Golding, J., Purchase, S., Munyard, T., Scott, M. and Bridger, A. (1995) 'Prison: Shield from threat, or threat to survival?', *Prison Service Journal*, 99(May): 23-28.
- Ross, M.W. (1988) 'AIDS phobia – report of 4 cases', *Psychopathology*, 21(1): 26-30.
- Ross, M.W. and Darke, S. (1992) 'Mad, bad and dangerous to know: dimensions and measurement of attitudes towards injecting drug users', *Drug and Alcohol Dependence*, 30(1): 71-74.
- Rossi, P.H. and Alves, W.M. (1979) 'Rejoinder to Faia', *American Journal of Sociology*, 85(4): 954-955.
- Rothman, A.J., Klein, W.M. and Weinstein, N.D. (1996) 'Absolute and relative biases in estimations of personal risk', *Journal of Applied Social Psychology*, 26(14): 1213-1236.
- Rothman, A.J., Kelly, K.M., Weinstein, N.D. and O'Leary, A. (1999) 'Increasing the salience of risky sexual behavior: promoting interest in HIV-antibody testing among heterosexually active young adults', *Journal of Applied Social Psychology*, 29(3): 531-551.

- Rotily, M., Galinier-Pujol, A., Obadia, Y., Moatti, J-P., Toubiana, P., Vernay-Vaisse, C. and Gastaut, J-A. (1994) 'HIV testing, HIV infection and associated risk factors among inmates in south-eastern French prisons', *AIDS*, 8(9): 1341-1344.
- Rotily, M., Gore, S. and Weilandt, C. (1998) 'Heterosexual intercourse in a French prison', *Journal of the American Sexually Transmitted Diseases Association*, 25(4): 217.
- Royal Society (1983) *Risk Assessment: Report of a Royal Society Study Group*. London: Royal Society.
- Royal Society (1992) *Risk: Analysis, Perception and Management: Report of a Royal Society Study Group*. London: Royal Society.
- Rump, J-A., Peter, H.H. and Meyerhans, A. (1996) 'Long-term survivors with continuously high levels of HIV type-1', *AIDS Research and Human Retroviruses*, 12: 757.
- Rutter, S., Dolan, K., Wodak, A., Hall, W., Maher, L. and Dixon, D. (1995) *Is Syringe Exchange Feasible in a Prison Setting? An Exploratory Study of the Issues*. Technical Report Number 25. Sydney: National Drug and Alcohol Research Centre.
- Sahlins, M.D. (1965) 'On the sociology of primitive exchange', in M. Banton (Ed) *The Relevance of Models for Social Anthropology*. London: Tavistock.
- Saunders, P.R. (1990) *A Nation of Home Owners*. London: Unwin Hyman.
- Saunders, W. and Marsh, A. (1999) 'Harm reduction and the use of current illegal drugs: some assumptions and dilemmas', *Journal of Substance Use*, 4(1): 3-9.
- Schutz, A. (1962) *Collected Paper I The Problem of Social Reality* (Edited and introduced by M. Natanson with a preface by H.L. Van Breda). The Hague: Martinus Nijhoff.
- Schutz, A. (1964) *Collected Papers II Studies in Social Theory* (Edited and introduced by A. Brodersen). The Hague: Martinus Nijhoff.

- Schutz, A. (1966) *Collected Papers III Studies in Phenomenological Philosophy* (Edited by I. Schutz with an introduction by A. Gurwitsch). The Hague: Martinus Nijhoff.
- Schutz, A. (1970) *Reflections of the Problem of Relevance* (Edited, annotated and with an Introduction by R.M. Zaner). New Haven: Yale University Press.
- Schutz, A. (1972) *The Phenomenology of the Social World* (Translated by G. Walsh and F. Lehnert with an introduction by G. Walsh). London: Heinemann.
- Schutz, A. and Luckmann, T. (1974) *The Structures of the Life-World* (Translated by R.M. Zaner and H.T. Engelhardt). London: Heinemann.
- Schwarcz, S.K., Spitters, C., Ginsberg, M.M., Anderson, L., Kellogg, T. and Katz, M.H. (1997) 'Predictors of human immunodeficiency virus counseling and testing among sexually transmitted disease clinic patients', *Sexually Transmitted Diseases*, 24(6): 347-352.
- Schwing, R.C. and Albers, W.A. (Eds) (1980) *Societal Risk Assessment: How safe is safe enough?*. London: Plenum Press.
- Scott, S. and Freeman, R. (1995) 'Prevention as a problem of modernity: the example of HIV and AIDS', in J. Gabe (Ed) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.
- Scottish Home and Health Department (1996) *HIV infection in Scotland: Report of the Scottish Committee on HIV Infection and Intravenous Drug Misuse*. Scotland: Scottish Home and Health Department.
- Scragg, P. (1995) 'A critical analysis of morbid fear of HIV/AIDS', *Clinical Psychology and Psychotherapy*, 2(4): 278-284.
- Scruton, P., Sim, J. and Skidmore, P. (1991) *Prisons Under Protest*. Buckingham: Open University Press.

- Seale, C. (1996) 'Living alone towards the end of life', *Ageing and Society*, 16(1): 75-91.
- Seamark, R. and Gaughwin, M. (1994) 'Jabs in the dark: injecting equipment found in prisons, and the risks of viral transmission', *Australian Journal of Public Health*, 18(1): 113-116.
- Seddon, T. (1996) 'Drug control in prison', *Howard Journal of Criminal Justice*, 35(4): 327-335.
- Shah, S.M., Shapshak, P., Rivers, J.E., Stewart, R.V., Weatherby, N.L., Xin, K-Q., Page, J.B., Chitwood, D.D., Mash, D.C., Vlahov, D. and McCoy, C.B. (1996) 'Detection of HIV-1 DNA in needles/syringes, paraphernalia, and washes from shooting galleries in Miami: a preliminary laboratory report', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 11(3): 301-306.
- Shamir, B. (1995) 'Social science and charisma: theoretical notes and an exploratory study', *Leadership Quarterly*, 6(1): 19-47.
- Shapshak, P., McCoy, C.B., Rivers, J.E., Chitwood, D.D., Mash, D.C. and Weatherby, N.L. (1993) 'Inactivation of Human Immunodeficiency Virus-1 at short-time intervals using undiluted bleach', *Journal of Acquired Immune Deficiency Syndromes*, 6(2): 218-219.
- Shapshak, P., McCoy, C.B., Shah, S.M., Page, J.B., Rivers, J.E., Weatherby, N.L., Chitwood, D.D. and Mash, D.C. (1994) 'Preliminary laboratory studies of inactivation of HIV-1 in needles and syringes containing infected blood using undiluted household bleach', *Journal of Acquired Immune Deficiency Syndromes*, 7(7): 754-759.

- Shelley, H. (1999) 'Lost in medicine and morals: harm minimisation would benefit from further close scrutiny of the drug related risk discourse', *Addiction Research*, 7(1): 7-18.
- Shewan, D. (1996) 'The role of prisons in relation to harm reduction', *Addiction Research*, 4(3): i-iii.
- Shewan, D., Gemmel, M. and Davies, J.B. (1994a) 'Behavioral change amongst drug injectors in Scottish prisons', *Social Science and Medicine*, 39(11): 1585-1586.
- Shewan, D., Gemmel, M. and Davies, J.B. (1994b) 'Prisons as a modifier of drug using behavior', *Addiction Research*, 2(2): 203-215.
- Shewan, D., Reid, M., MacPherson, A. and Davies, J.B. (1995) 'HIV infection in prisons – most drug injectors stop injecting on entry to prison', *British Medical Journal*, 310(6989): 1264.
- Shilling, C. (1997) 'The undersocialised conception of the embodied agent in modern sociology', *Sociology*, 31(4): 737-754.
- Silverstone, R. (1993) 'Television, ontological security and the transitional object', *Media, Culture and Society*, 15(4): 573-598.
- Sim, J. (1990) *Medical Power in Prisons: The Prison Medical Service in England 1774-1989*. Buckingham: Open University Press.
- Sim, J. (1994a) 'Tougher than the rest? Men in prison', in T. Newburn and E.A. Stanko (Eds) *Just Boys Doing Business? Men, Masculinities and Crime*. London: Routledge.
- Sim, J. (1994b) 'Prison medicine and social justice', *Prison Service Journal*, 95(September): 30-38.

- Simon, P.A., Weber, M., Ford, W.L., Cheng, F. and Kerndt, P.R. (1996) 'Reasons for HIV antibody-test refusal in a heterosexual sexually-transmitted disease clinic population', *AIDS*, 10(13): 1549-1553.
- Simpson, S. (1999) 'Maintenance programmes are denied to addicted prisoners in Victoria', *British Medical Journal*, 318(7186): 811.
- Singer, L. (1993) *Erotic Welfare: Sexual Theory and Politics in the Age of Epidemic*. Routledge: London.
- Sjöberg, L. (1998) 'Worry and risk perception', *Risk Analysis*, 18(1): 85-93.
- Skolbekken, J.-A. (1995) 'The risk epidemic in medical journal', *Social Science and Medicine*, 40(3): 291-305.
- Slutsker, L., Klockner, R. and Fleming, D. (1992) 'Factors associated with failure to return for HIV post-test counseling', *AIDS*, 6(10): 1226-1227.
- Smith, R. (1984) *Prison Health Care*. London: British Medical Association.
- Smith, R. (1992) 'Prison medicine – beginning again', *British Medical Journal*, 304(6820): 134-135.
- Smith, R. (1999) 'Prisoners: an end to second class health care?', *British Medical Journal*, 318(7189): 954-955.
- Smoyer, K.E. (1998) 'Putting risk in its place: methodological considerations for investigating extreme event health risk', *Social Science and Medicine*, 47(11): 1809-1824.
- South, N. (1994) 'Drugs: use, crime, and control', in M. Maguire, R. Morgan and R. Reiner (Eds) *The Oxford Handbook of Criminology*. Oxford: Oxford University Press.
- Spicker, P. (1995) *Social Policy: Themes and Approaches*. London: Prentice Hall.

- Spiers, J.A. (1998) 'The use of face work and politeness theory', *Qualitative Health Research*, 8(1): 25-47.
- Spijkerman, I.J.B., van Ameijden, E.J.C., Mientjes, G.H.C., Coutinho, R.A. and van den Hoak, A. (1996) 'Human immunodeficiency virus infection and other risk factors for skin abscesses and endocarditis among injection drug users', *Journal of Clinical Epidemiology*, 49(10): 1149-1154.
- Spooner, C. and Flaherty, B. (1993) 'Comparison of three data collection methodologies for the study of young illicit drug users', *Australian Journal of Public Health*, 17(3): 195-202.
- Spooner, C., Bishop, J. and Parr, J. (1997) 'Research methods for studying injecting drug users in a rural centre', *Drug and Alcohol Review*, 16(4): 349-355.
- Squires, N. (1996) 'Promoting health in prisons – requires more than a change in who purchases health services for prisoners', *British Medical Journal*, 313(7066): 1161.
- Stanley, L. and Wise, S. (1993) *Breaking Out Again*. London: Routledge.
- Stein, M.D. (1990) 'Medical complications of intravenous drug use', *Journal of General Internal Medicine*, 5(6): 249-257.
- Stern, V. (1993) *Bricks of Shame: Britain's Prisons*. London: Penguin.
- Stevens, D.J. (1994) 'The depth of imprisonment and prisonization: levels of security and prisoners' anticipation of future violence', *Howard Journal of Criminal Justice*, 33(2): 137-157.
- Stewart, D.A. (Director, Strategy and Corporate Affairs) (1995, unpublished) 'Mandatory Drug Testing in Scottish Prisons', letter to A.G. Bird, S.M. Gore and co-signatories, 2 October.

- Stimson, G. (1992) 'Drug injecting and HIV infection: new directions for social science research', *International Journal of the Addictions*, 27(2): 147-163.
- Stimson, G.V. (1995) 'AIDS and injecting drug use in the United Kingdom, 1987-1993: the policy response and the prevention of the epidemic', *Social Science and Medicine*, 41(5): 699-716.
- Stimson, G.V. (1996a) 'Measuring the *Health of the Nation* target for injecting drug users: the injecting risk questionnaire', *The Centre for Research on Drugs and Health Behaviour Executive Summary*, 54(November/December). London: The Centre for Research on Drugs and Health Behaviour.
- Stimson, G.V. (1996b) 'Has the United Kingdom averted an epidemic of HIV-1 infection among drug injectors?', *Addiction*, 91(8): 1085-1088.
- Stimson, G.V., Alldritt, L.J., Dolan, K.A., Donoghoe, M.C. and Lart, R.C. (1988) *Injecting Equipment Exchange Schemes: Final Report*. London: Monitoring Research Group.
- Stimson, G., Lart, R., Dolan, K. and Donoghoe, M. (1991) 'The future of syringe exchange in the public health prevention of HIV infection', in P. Aggleton, G. Hart and P. Davies (Eds) *AIDS: Responses, Interventions and Care*. London: Falmer.
- Strang, J. (1998) 'AIDS and drug misuse in the UK – 10 years on: achievements, failings and new harm reduction opportunities', *Drugs: Education, Prevention and Policy*, 5(3): 293-304.
- Strang, J., Finch, E., Hankinson, L., Farrell, M., Taylor, C. and Gossop, M. (1997) 'Methadone treatment for opiate addiction: benefits in the first month', *Addiction Research*, 5(1): 71-76.

- Stuart, A.B., O'Rourke, S. and Power, K.G. (1997) 'Regional variations in pre-imprisonment drug use among female inmates of a Scottish prison', *Addiction Research*, 5(2): 83-94.
- Sturrock, J. (1993) 'The estate – a family secret', in S. Mayes and L. Stein (Eds) *Positive Lives: Responses to HIV – A Photodocumentary*. London: Cassell.
- Sykes, G.M. (1958) *The Society of Captives: A Study of a Maximum Security Prison*. New Jersey: Princeton University Press.
- Tansey, J. and O'Riordan, T. (1999) 'Cultural theory and risk: a review', *Health, Risk and Society*, 1(1): 71-90.
- Taylor, A. (1993) *Women Drug Users: An Ethnography of a Female Injecting Community*. Oxford: Oxford University Press.
- Taylor, A. (1996) 'Drug use and injecting behaviour in Glenochil prison', in N. Squires and J. Strobl (Eds) *Healthy Prisons A Vision for the Future. Report of the First International Conference on Healthy Prison*. Liverpool: University of Liverpool, Department of Public Health.
- Taylor, A., Goldberg, D.J, Emslie, J., Wrench, J., Gruer, L., Cameron, S., Black, J., Davis, B., McGregor, J., Follett, E., Harvey, J., Basson, J. and McGavigan, J. (1995) 'Outbreak of HIV infection in a Scottish prison', *British Medical Journal*, 310(6975): 289-292.
- Taylor, J.R., Watson, I.D., Tames, F.J. and Lowe, D. (1998) 'Detection of drug use in a methadone maintenance clinic: sweat patches versus urine testing', *Addiction*, 93(6): 847-853.
- Thomas, C.W. (1977) 'Prisonization and its consequences: an examination of socialization in a coercive setting', *Sociological Focus*, 10(1): 53-68.

- Thomas, C.W. and Cage, R. (1977) 'Correlates of prison drug use: an evaluation of two conceptual models', *Criminology*, 15: 193-210.
- Thomas, P.A. (1990) 'HIV/AIDS in prisons', *Howard Journal of Criminal Justice*, 29(1): 1-13.
- Thomas, P.A. and Costigan, R.S. (1992) 'Health care or punishment?: Prisoners with HIV/AIDS', *Howard Journal of Criminal Justice*, 31(4): 321-336.
- Tierney, K.J. (1999) 'Towards a critical sociology of risk', *Sociological Forum*, 14(2): 215-242.
- Timbury, M.C. (1994) *Notes On Medical Virology*. Edinburgh: Churchill Livingstone.
- Titus, S., Marmor, M., Des Jarlais, D., Kim, M., Wolfe, H. and Beatrice, S. (1994) 'Bleach use and HIV seroconversion among New York City injection drug users', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 7(7): 700-704.
- Travis, A. (1996) 'An injection of common sense', *The Guardian*, 19th June: 26.
- Travis, A. (1997) '1,300 held taking drugs into prisons', *The Guardian*, 19th June: 12.
- Travis, A. (1999) 'Jail ban for visitors who carry drugs', *The Guardian*, 26th January: 9.
- Tritter, J. (1997) 'Focusing on the inappropriate: focus groups, cancer patients, gender and ethnicity', paper presented to *British Sociological Association Medical Sociology Group 29th Annual Conference*. York: University of York.
- Tumin, S. (1993) *Doing Time or Using Time: Report of a Review by Her Majesty's Chief Inspector of Prisons for England and Wales of Regimes in Prison Service Establishments in England and Wales*. London: Her Majesty's Stationery Office.
- Turnbull, P.J. and Stimson, G.V. (1993) 'Prisons: heterosexuals in a risk environment', in L. Sherr (Ed) *AIDS and the Heterosexual Population*. Reading: Harwood Academic Publishers.

- Turnbull, P.J., Dolan, K.A. and Stimson, G.V. (1991) *Prison, HIV and AIDS: Risks and Experiences in Custodial Care*. Horsham: Aids Education and Research Trust.
- Turnbull, P.J., Dolan, K.A. and Stimson, G.V. (1993) 'HIV testing, and the care and treatment of HIV positive people in English prisons', *AIDS Care*, 5(2): 199-206.
- Turnbull, P.J., Stimson, G.V. and Stillwell, G. (1994) *Drug Use in Prison*. Horsham: Aids Education and Research Trust.
- Turnbull, P.J., Power, R. and Stimson, G.V. (1996) "'Just using old works": injecting risk behaviour in prison', *Drug and Alcohol Review*, 15(3): 251-260.
- Turner, D., Gordon, S. and Powar, I. (1997) *Projections of Long Term Trends in the Prison Population to 2005* (Home Office Statistical Bulletin, Issue 7/97). London: Government Statistical Service.
- Uchtenhagen, A. (1997) 'Drug prevention outside and inside prison walls', *International Journal of Drug Policy*, 8(1): 56-61.
- United Nations (1955) *United Nations General Assembly standard Minimum Rules for the Treatment of Prisoners*. New York: United Nations.
- Valdiserri, R.O., Moore, M., Gerber, A.R., Campbell, C.H., Dillon, B.A. and West, G.R. (1993) 'A study of clients returning for counseling after HIV testing: implications for improving rates of return', *Public Health Reports*, 108(1): 12-18.
- Van Haastrecht, H.J.A., Bax, J.S. and Van Den Hoek, A.(J).A.R. (1998) 'High rates of drug use, but low rates of HIV risk behaviours among injecting drug users during incarceration in Dutch prisons', *Addiction*, 93(9): 1417-1425.
- Vlahov, D., Astemborski, J., Solomon, L. and Nelson, K.E. (1994) 'Field effectiveness of needle disinfection among injecting drug users', *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 7(7): 760-766.

- Vogt, I. (1998) 'Gender and drug treatment systems', in H. Klingemann and G. Hunt (Eds) *Drug Treatment Systems in an International Perspective: Drugs, Demons and Delinquents*. London: Sage.
- Wadsworth, J., Hickman, M., Johnson, A.M., Wellings, K. and Field, J. (1996) 'Geographic variation in sexual behaviour in Britain: implications for sexually transmitted disease epidemiology and sexual health promotion', *AIDS*, 10(2): 193-199.
- Wagner, G.J., Remein, R.H. and Carballo-Diequez, A. (1998) "'Extramartial" sex: is there an increased risk for HIV transmission? A study of male couples of mixed HIV status', *AIDS Education and Prevention*, 10(3): 245-256.
- Wagner, H.R. (1983) *Alfred Schutz: An Intellectual Biography*. Chicago: University of Chicago Press.
- Wagner, H.R. (1984) 'Schutz's life story and the understanding of his work', *Human Studies*, 7(2): 107-116.
- Waldby, C., Kippax, S. and Crawford, J. (1993) 'Cordon Sanitaire: 'Clean' and 'Unclean' Women in the AIDS Discourse of Young Heterosexual Men', in P. Aggleton, P. Davies and G. Hart (Eds) (1993) *AIDS: Facing the Second Decade*. London: Falmer.
- Walklate, S. (1998) 'Crime and community: fear or trust?', *British Journal of Sociology*, 49(4): 550-569.
- Waller, T. and Holmes, R. (1995) 'The sleeping giant wakes', *Druglink*, 10(5): 8-11.
- Walsh, J.M. and Trumble, J.G. (1991) 'The politics of drug testing', in R.H. Coombs and L.J. West (Eds) *Drug Testing: Issues and Options*. Oxford: Oxford University Press.
- Walsh, M.B. and Calabrese, L.H. (1992) 'Rapid progression of HIV-1 infection to AIDS', *Cleveland Clinical Journal of Medicine*, 59(4): 637-639.

- Warburton, L.A., Fishman, B. and Perry, S.W. (1997) 'Coping with the possibility of testing HIV positive', *Personality and Individual Differences*, 22(4): 459-464.
- Ward, J., Bell, J., Mattick, R.P. and Hall, W. (1996) 'Methadone maintenance therapy for opioid dependence: a guide to appropriate use', *CNS Drugs*, 6(6): 440-449.
- Wasserfallen, F., Paget, D.Z. and Bauer, P.G. (1997) 'AIDS prevention strategies: an overview', *International Journal of Drug Policy*, 8(1): 62-66.
- Weild, A., Curran, L., Parry, J., Bennett, D., Newham, J. and Gill, O.N. (1998) 'The prevalence of HIV and associated risk factors in prisoners in England and Wales in 1997: Results of a national survey', poster presentation to 12th World AIDS Conference. Geneva.
- Weinstein, N.D. (1987) 'Unrealistic optimism about susceptibility to health problems: conclusions from a community wide sample', *Journal of Behavioral Medicine*, 10(5): 481-500.
- Weinstein, S.A. and Goebel, G. (1979) 'The relationship between contraceptive sex role stereotyping and attitudes toward male contraception among males', *Journal of Sex Research*, 15(3): 235-242.
- Weinstein, N.D. and Klein, W.M. (1995) 'Resistance of personal risk perceptions to debiasing interventions', *Health Psychology*, 14(2): 132-140.
- Weinstein, N.D. and Klein, W.M. (1996) 'Unrealistic optimism: present and future', *Journal of Social and Clinical Psychology*, 15(1): 1-8.
- Wellings, K., Field, J., Johnson, A.M. and Wadworth, J. with Bradshaw, S. (1994) *Sexual Behaviour in Britain: The National Survey of Sexual Attitudes and Lifestyles*. London: Penguin Books.

- Wibberley, C. (1997) 'Young people's feelings about drugs', *Drugs: Education, Prevention and Policy*, 4(1): 65-78.
- Wiebel, W.W. (1990) 'Identifying and gaining access to hidden populations', in E. Y. Lambert (Ed) *The Collection and Interpretation of Data from Hidden Populations*. National Institute on Drug Abuse (NIDA) Research Monograph 98. Rockville: National Institute on Drug Abuse.
- Wight, D. (1992) 'Impediments to safer heterosexual sex: a review of research with young people' *AIDS Care*, 4(1): 11-23.
- Wilkinson, R.G. (1996) *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge.
- Willette, R.E. (1991) 'Techniques of reliable drug testing', in R.H. Coombs and L.J. West (Eds) *Drug Testing: Issues and Options*. Oxford: Oxford University Press.
- Willman, J. (1998) *A Better State of Health: A Prescription for the NHS*. London: Profile.
- Williams, A.E. (1997, unpublished) *The Personality and Behaviour of Inmates at a Young Offender Institution Regarding Mandatory Drug Testing*. Nottingham Trent University: BA (Hons) Social Science (Psychology) Dissertation.
- Williams, S.J. (1998a) 'Modernity and the emotions: corporeal reflections on the (ir)rational', *Sociology*, 32(4): 747-769.
- Williams, S.J. (1998b) "'Capitalising' on emotions? Rethinking the inequalities in health debate", *Sociology*, 32(1): 121-139.
- Willis, J. (1991) 'Prescribing to addicts', in D.K. Whyne and P.T. Bean (Eds) *Policing and Prescribing: The British System of Drug Control*. London: Macmillan.

- Wilson, T.E., Levinson, R.A., Jaccard, J., Minkoff, H. and Endias, R. (1996) 'Testing for HIV and other sexually-transmitted diseases: implications for risk behavior in women', *Health Psychology*, 15(4): 252-260.
- Wineman, N.M. and Durand, E. (1992) 'Incentives and rewards for subjects in nursing research', *Western Journal of Nursing Research*, 14(4): 526-531.
- Winfree, L.T., Mays, G.L., Crowley, J.E. and Peat, B.J. (1994) 'Drug history and prisonization: toward understanding variations in inmate institutional adaptations', *International Journal of Offender Therapy and Comparative Criminology*, 38(4): 281-296.
- Wish, E.D. and Gropper, B.A. (1990) 'Drug testing by the criminal justice system: methods, research, and applications', in M. Tonry and J.Q. Wilson (Eds) *Drugs and Crime*. London: University of Chicago Press.
- Witt, M.B., Pantula, J., Folsom, R.E. and Cox, B.G. (1992) 'Item nonresponse in 1988', in C.F. Turner, J.T. Lessler and J.C. Gfroerer (Eds) *Survey Measurement of Drug Use: Methodological Studies*. Rockville: National Institute on Drug Abuse.
- Wodak, A., Dolan, K., Imrie, A.A., Gold, J., Wolk, J., Whyte, B.M. and Cooper, D.A. (1987) 'Antibodies to the human immunodeficiency virus in needles and syringes used by intravenous drug-abusers', *Medical Journal of Australia*, 147(6): 275-276.
- Wood, K., Maforah, F. and Jewkes, R. (1998) "'He forced me to love him": putting violence on adolescent sexual health agendas', *Social Science and Medicine*, 47(2): 233-242.
- Woodhead, P. (1999) *Prisons Ombudsman Annual Report 1998/99*. London: Prisons Ombudsman.

- Wool, R. J. (1994) 'Prison health care today', *Prison Service Journal*, 95(September): 25-30.
- Woolf, H. and Tumin, S. (1991) *Prison Disturbances April 1990: Report of an Inquiry by the Rt Hon Lord Justice Woolf (Parts I and II) and His Honour Judge Stephen Tumin (Part III)*. London: Her Majesty's Stationery Office.
- World Health Organisation, WHO (1987) 'Acquired immunodeficiency syndrome (AIDS), 1987 revision of CDC/WHO case definition for AIDS', *Weekly Epidemiology Record*, 63: 1-7.
- World Health Organization, WHO (1993) *World Health Organization Guidelines on HIV Infections and AIDS in Prison*. Geneva: WHO.
- Worrall, A. (1996) 'Of rats and real men? Prison as community', *Prison Service Journal*, 108(5): 27-31.
- Worrall, A. (1997) *Punishment in the Community: The Future of Criminal Justice*. Essex: Addison Welsey Longman.
- Wortley, P.M., Chu, S.Y., Diaz, T., Ward, J.W., Doyle, B., Davidson, A.J., Checko, P.J., Herr, M., Conti, L., Fann, S.A., Sorvillo, F., Mokotoff, E., Levy, A., Hermann, P. and Norris-Walczak, E. (1995) 'HIV testing patterns: where, why, and when were persons with AIDS tested for HIV?', *AIDS*, 9(5): 487-492.
- Wright, S., Klee, H. and Reid, P. (1998) 'Interviewing illicit drug users: observations from the field', *Addiction Research*, 6(6): 517-535.
- Yirrell, D.L., Robertson, P., Goldberg, D.J., McMenamain, J., Cameron, S. and Leigh Brown, A.J. (1997) 'Molecular investigation into outbreak of HIV in a Scottish prison', *British Medical Journal*, 314(7092): 1446-1450.

- Young, A. (1996) *Imagining Crime: Textual Outlaws and Criminal Conversations*. London: Sage.
- Young, A. and McHale, J.V. (1992) 'The dilemmas of the HIV positive prisoner', *Howard Journal of Criminal Justice*, 31(2): 89-100.
- Zule, W.A. (1992) 'Risk and reciprocity: HIV and the injection drug user', *The Journal of Psychoactive Drugs*, 24(3): 243-249.
- 6, P., Jupp, B., Perry, H. and Laskey, K. (1997) *The Substance of Youth: The Place of Drugs in Young People's Lives Today*. York: Joseph Rowntree Foundation.