

A guide to assessing 'route transitions' and developing interventions that promote safer drug use

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Introduction

Background and aims

This guide has been written following the authors' input into a 'route transitions' project being run by the Eastern Europe, Central Asia and Thailand regional offices of Population Services International (PSI) – a US-based, international social marketing organisation that works to prevent HIV infection.

In preparation for this project Garry Stillwell visited Croatia and interviewed key informants to gather background data on drug use and transitions in the region and to begin to develop a Route Transitions Assessment Tool (RTAT). Neil Hunt and Andrew Preston then went to Zagreb in November 2004 to run a 3 day workshop for PSI and local NGO staff. This guide was written following the workshop.

The process was developed to help ensure that route transition interventions are designed in a way that is as appropriate to the local settings, drug using patterns and drug users as possible. This is likely to yield the best possible results: intervention without understanding may be counterproductive.

The aim of this guide is to give policy makers, funding organisations and drug service providers and drug users an introduction to:

- the 'route transitions' literature;
- 'route transition interventions' (RTIs) that have been developed;
- the framework we developed with PSI for conducting formative research to understand local patterns of drug transitions; and
- some guidance on how to produce effective and appropriate interventions to promote healthy route transitions.

Health needs and priorities

The scale of mortality, morbidity and human suffering caused by HIV related to injecting drug use is enormous and growing. Responding to this epidemic with practical measures to reduce the transmission of the virus is essential.

Increasing the supply of needles and syringes to injecting drug users and, for heroin users, ensuring access to high quality methadone treatment (and other opioid pharmacotherapies) have been proven to be cost-effective methods of preventing the transmission of HIV many times, and in many settings. A substantial body of evidence suggests that these should form a universal foundation within global responses to injecting drug use and HIV/AIDS (see Hunt et al. 2003 for a review of the evidence).

Transition interventions have the potential to add considerable health benefits at low cost, especially where they can reinforce existing norms and drug using patterns. Although they can be explored and implemented in situations where needle exchange and substitute prescribing are not currently permitted, **in no way should transition interventions be seen as an alternative to these measures.**

Route transitions theory

Definitions

There have been a number of definitions used in this field of work, for the purposes of this guide we have adopted the following definitions:

Route transition: a temporary or permanent transition in the way that a drug is administered

Route transition interventions: an intervention that either:

- a) attempts to prevent the transition to a more harmful route of drug administration such as injecting (usually prevention of initiation to injecting); or
- b) promotes a change in the route of drug administration from a more dangerous form (usually injecting) to a less dangerous route (also known as a reverse transition).

Break the cycle: an intervention to prevent the transition to injecting (developed in the UK by the authors).

Limitations to the evidence base

There are three major limitations to the evidence that we have on route transitions.

Firstly, the evidence in the literature is largely derived from samples drawn from treatment populations. This means that the subjects of studies may be older, have used drugs for longer and have experienced more problems as a result of their drug use than the general drug using population.

Secondly it should be borne in mind that the learning from the published studies in the literature cannot be assumed to be entirely transferable to other cities, countries or regions.

Finally, we know that patterns of heroin use/injecting can be subject to rapid change due to changes in:

- drug markets for example due to changes in policing policy;
- drug production (e.g. bumper crops or droughts);
- trafficking routes; and
- economic conditions.

Factors associated with using heroin and injecting

Age

Heroin use and injecting are predominantly a youth phenomenon. In Albania, Bosnia and Herzegovina, Croatia, the Federal Republic of Yugoslavia and the Former Yugoslav Republic of Macedonia – Mean age of first injection 17.3 – 19.1yrs (Wong 2002). In Serbia/Montenegro – Mean age of first injection is 18.2yrs (Cucic 2002).

Gender

Injectors are predominantly male. Epidemiological reviews consistently find ratios of between 3:1 and 4:1 (male to female).

Socio-economic status

Both heroin use and injecting are strongly associated with poverty and urbanisation in many parts of the world.

Ethnicity

Exposure to heroin use and injecting are often at higher levels than in the general population in minority populations for instance Russians in Estonia, and Roma populations in many areas of Eastern Europe (Grund 2001).

Key issues associated with the 'first hit'

A number of themes have developed from the international work on the issue of route transitions. The route transitions assessment tool we have developed is designed to try and capture and prioritise the drug transitions that occur in a given area, but are based on the understanding that in many settings the following factors are usually found to be significant.

Modelling/social exposure

Seeing people using heroin, and injecting, makes the behaviour seem more normal, less frightening and can make it more inviting. Observing its use also enables people to learn how an injection is prepared or how the drug can be chased: skills and knowledge that people usually lack.

First use of a drug almost always follows exposure to its use amongst peers or family. Exposure to images of drug use, and perceptions of drug use as 'normal,' in the media may also be associated with the decision to try taking drugs or inject.

Peer influence and the desire to try 'just once'

Very few people decide to become drug dependent and experience all the problems that can bring. At the point of initiation, most people who inject are resolved that this will be no more than an occasional experience.

Type of drug

To be injectable a drug has to be converted to a liquid form, this is easier to achieve with some drugs than it is for others. For instance white heroin (diamorphine hydrochloride – the commonest *salt* form of the drug) is not smokable and is readily injectable, and this has an impact on how it is used. By contrast, brown heroin – the *base* form – requires an acidifier to become suitable for injection and is, in this respect, more complicated to inject.

In the workshop plan there is a blank version of the table below to be completed by participants covering the possible routes of ingestion of drugs by people in their region. This will vary from area to area, and not all drugs are commonly used by all the routes that are theoretically possible.

For instance, **the table for the UK** would read as follows:

Drug	Possible route of administration							
	Oral		Sniffing		Smoking		Injecting	
	POSSIBLE?	NOTES	POSSIBLE?	NOTES	POSSIBLE?	NOTES	POSSIBLE?	NOTES
Brown heroin	No	Perhaps only 30% efficacy therefore not cost effective	Yes	Not commonly known about/used in this way	Yes	Volatilises at a low temperature	Yes	Requires the addition of an acid
White heroin (currently not available in any quantity or used regularly)	No	Rarely documented	Yes		No	Burns before volatilisation	Yes	
Cocaine	No	Rarely documented	Yes		No	Not efficiently	Yes	
Crack	No	Rarely documented	No	Rarely documented	Yes		Yes	Requires the addition of an acid
Amphetamine sulphate	Yes		Yes		No		Yes	

Just because it is possible to take a drug by a particular route does not mean that it is commonly used in that way. For instance, it seems that relatively few heroin users in Australia sniff the white heroin that is available there. Gathering evidence about the routes by which drugs are used in a particular area is therefore an essential part of planning route transition interventions.

Drug buying arrangements

Examples of drug buying arrangements that increase the likelihood of the drugs being injected (or make it inevitable) include:

- drugs being sold in 'pre-loaded' syringes; and
- situations where an injector is buying drugs with/for other heroin users and wants to divide liquid because it is more accurate than trying to measure out small amounts of powder.

Reasons people use or avoid heroin/injecting

There are a number of factors that predispose people towards using heroin/injecting, and also factors that protect people from choosing the drug/route.

Awareness of the former can help target interventions more effectively. Furthermore, reinforcing protective factors where they exist, has the potential to prevent or delay transition to injecting.

Factors associated with wanting to try heroin/injecting:

- curiosity about the effects
- wanting to experience the 'rush'
- economics – injecting is generally a more efficient way of administering the drug, and the dose delivered is therefore greater
- managing post-stimulant 'come down'
- peer/partner influence
- anomie/self medication
- associations of injecting with modernity/potency
- glamour and heroin 'chic'
- cultural norms
- availability
- diffusion of innovation

NB: there is no evidence that increased availability of needles and syringes increases prevalence of injecting

Conversely, prominent factors that prevent people from choosing heroin/injecting include:

- fear of addiction
- fear of HIV/AIDS
- lack of knowledge/technical proficiency
- fear of needles
- stigma of heroin use/injecting.

The development of route transitions theory: history and evidence

In the early 1990s there were significant developments in the systematic study of transitions. Two of the most notable studies were:

- Griffiths et al 1994; and
- Darke et al 1994.

Griffiths et al

Studied a community sample of 408 heroin users. 54% preferred injecting, 44% preferred chasing.

Interestingly, more than a third had changed their preferred route or made a drug transition as defined within the study, which was:

'a change in the exclusive or predominant route of administration lasting one month or more'

They found that the transitions that had taken place were usually from chasing to injecting, and that multiple transitions were uncommon.

However, 16% of chasers had previously been regular injectors, and many chasers had not adopted injecting despite using at high doses for many years.

Darke et al

Shane Darke and colleagues in Australia studied a community sample of 301 regular amphetamine users. They defined a transition as:

'a change in the usual route of administration lasting four or more occasions of amphetamine use'

They found that the first route of use was as follows:

- inject 23%
- snort 58%
- swallow 19%
- smoke 1%

40% had made a transition to injecting from another route of use with reasons being given of:

- a better rush;
- more economical / cost efficient; and
- it's a cleaner way to take the drug.

9% had made a transition from injecting, with the main reason given for this being concern about vascular damage.

The development of route transition interventions

These studies were important in developing thinking about delivering route transition interventions.

Griffiths concluded that we should *'take account of current administration and the potential for future transitions,'* and Darke noted that we should *'address the misconceptions that injecting is more economical and more healthy, and... emphasise the vascular problems associated with injecting.'*

These observations, coupled with renewed interest in the circumstances surrounding initiation into injecting – notably 'the first hit' (Crofts et al, 1996) and, growing levels of concern at the extent and implications of the hepatitis C epidemic led Alex Wodak to suggest in 1997 that harm reductionists should promote Non-Injecting Routes of Administration – NIROA.

The two main targets for intervention that have been identified are:

- **preventing** people from beginning to inject drugs they are using; and
- encouraging people to **switch** from injecting to a safer route.

Preventing commencement of injecting

Information on transitions for heroin sniffers

In 1990, Casriel et al. published an initial paper describing their project working with 'at risk' users (heroin sniffers), and in 1992 Des Jarlais et al. published the full results of their study.

They used a controlled trial to evaluate a four part 'psycho-educational programme' targeting heroin sniffers that focused on transition to injecting and the risks associated with it; comparing this with more general psycho-social support and information to a control group.

The intervention group was significantly less likely to begin injecting. Fourteen out of 43 controls switched to injecting, while 6 out of 40 in the experimental group switched to injecting.

However, the authors reported that it was hard to contact and recruit heroin sniffers to the study, largely because at the time many did not see themselves as having any sort of drug problem.

Prevention of initiation to injecting

A study carried out in Kent, London and Surrey by Hunt et al. (1997) suggests that it is possible to work with existing injectors to reduce the initiation of new injectors. The intervention aims to reinforce current injectors' reluctance to give non-injectors their first injection and, to reduce their inadvertent modelling of injecting: a programme that is now known as the 'Break the Cycle' intervention.

The design used was a three-month follow-up study in which 73 out of 86 injectors who received the transition intervention were recontacted. It found that:

- it was possible to train drug workers to deliver an effective intervention, which was acceptable both to them and to drug users;
- less than 1 in 10 of the injecting drug users interviewed felt that pressure from injectors had been an important influence on their own decision to try injecting: many more had been active in seeking initiation;
- about 7 out of 10 considered that seeing someone inject had been an important factor in their decision to inject for the first time;
- more than half thought talking about injecting with an injecting drug user was an important part of their decision to start injecting;
- more than 8 out of 10 had injected in front of a non-injecting drug user at some time and well over half had done so in the three months before the first interview; and
- only about 2 out of 10 of those who had used treatment services had ever discussed initiation with a drug worker before.

After receiving the intervention:

- injecting in front of non-injectors was halved;
- people's disapproval of initiating others was higher;
- people taking part were receiving fewer than half as many requests to initiate others; and
- the number of people initiated by those taking part fell.

Although this was an uncontrolled trial, there were statistically significant reductions in 'modelling' injecting, willingness to initiate others, initiation requests and initiations (before and after intervention).

Substitute prescribing to prevent initiation to injecting

Opioid substitution treatment is often regarded as an intervention to move people from injecting towards oral administration (see below). However, given that natural transitions from heroin chasing/sniffing towards injecting occur so readily, there is also a clear case for viewing substitute prescribing to non-injecting heroin users as an intervention that is likely to prevent initiation into injecting: an argument that has been made by Southwell et al. (1997).

There appear to be few studies that have systematically studied prevention of injecting as a primary outcome of opioid substitute prescribing targeted at non-injecting heroin users. Nevertheless, enough is known about methadone treatment for us to be able to assume that the main questions are about how programmes should be designed so that this outcome can be optimised, rather than asking whether it occurs at all.

In particular, it is clear that programmes that have injecting as a criterion for treatment entry may increase harm in some instances by providing a reason to begin injecting for non-injecting heroin users who want treatment.

Encouraging people to switch from injecting to a safer route**Substitute prescribing**

Substitute prescribing remains the most widely used and, almost certainly, the most effective transition intervention. Reduced injecting is not necessarily the primary stated outcome within evaluations of methadone treatment but where this has been examined it is clear that treatment enables some people to stop injecting entirely and reduces the frequency of injecting for others (Strang et al. 1997).

Buprenorphine treatment is used increasingly and with similar outcomes to methadone and seems especially well-suited for people on lower doses of heroin.

For amphetamine injectors, oral dexamphetamine prescribing may also have prospects for reducing injecting; however, most research in this area comprises small scale pilot projects.

The prescription of inhalable heroin has also been undertaken in England and the Netherlands and warrants consideration among the options that may help reduce injecting. Within a prescribing programme in north west England, diamorphine was added to tobacco-based reefers prepared in accordance with a protocol developed with the Royal Pharmaceutical Society (Marks and Palombella 1991). In the Netherlands, an evaluation of heroin prescribing tested a system in which the heroin is administered using a heating device (van den Brink et al 2003).

Promoting heroin smoking to current injectors

Drawing on social marketing principles, the Healthy Options Team in London developed a set of materials to promote heroin smoking to current injectors – known as the 'chasing campaign.' Lifeline – a major UK drug information charity – has since developed an illustrated booklet entitled 'How to chase' that has the same objectives. See www.lifeline.org.uk. Neither of these campaigns has yet been evaluated.

Rectal administration

A booklet entitled 'Up Your Bum' (UYB) has been produced by Southwell/HIT in the UK as an intervention to promote rectal administration of liquid drugs to people with seriously impaired venous health who still persist in trying to inject. See www.hit.org.uk. To deliver drugs using this method a syringe (without a needle) is inserted a short distance into the rectum and the liquid introduced. The rectum has a highly vascular lining that exists to draw water out of the faeces, so drugs administered in this way are usually absorbed quickly. Some injectors report that absorption is as quick as injecting, although others find it far less satisfactory.

UYB has not been formally evaluated, but clinical experience suggests that only a minority of people who inject regard this as an acceptable route of administration. Nevertheless, there are anecdotal accounts that it may be useful as an intervention targeted at injectors with poor venous access in situations when the drug within a syringe is clouded with blood and, it is no longer possible to determine when the needle is successfully introduced into a vein.

Promoting sniffing

Both white (salt) and brown (base) heroin are absorbed into the bloodstream when the drug is used intranasally (sniffing/snorting) so it is logical to consider promoting heroin sniffing as an alternative route of administration to current injectors. Some drug information materials in Bulgaria have included this information in a targeted way. Such messages may be particularly relevant in situations where heroin sniffing is not common practice. However, targeting would be important to avoid exposing heroin-naïve people to the drug.

Mass media campaigns

Drug prevention campaigns tend to target specific drugs rather than a particular route of administration e.g. *Speed Kills* in the USA or the *Heroin Screws You Up* campaign in the UK. However, it may be feasible to develop campaigns drawing on social marketing principles and selectively focusing on injecting as a high-risk form of drug-taking, rather than a particular drug. Such campaigns would need to emphasise the relative risks of injecting over other routes of administration.

Drug market interventions

As discussed above, certain formulations of drugs have greater 'injectability' than others, (notably, brown heroin is more suited to 'chasing' and less readily injected than white heroin). Although, historically, the impact of drug interdiction efforts has been questionable, Strang and King (1997) have asked whether, in certain circumstances, it would be feasible to target enforcement efforts in a way that favours formulations that are less likely to be injected. This proposal has not yet been tried and would have little or no relevance in those areas where brown heroin is already the norm. However, it may have application in situations where white and brown heroin are each available or where white heroin is entering a market dominated by brown heroin.

Other studies exploring route transitions

This guide does not attempt to provide an exhaustive review of the international literature. Nevertheless, other people with a research interest in route transitions and the associated opportunities for intervention include John Howard (Australia), Elise Roy (Canada) and Sue Sherman (USA); consequently their work may also be of interest. Additionally, evidence regarding young and occasional injectors in central and eastern Europe has been reviewed for a UNICEF/CEEHRN meeting by Howard, Hunt and Arcuri (2003) and, at the time of writing, work to better understand and intervene within route transitions is being developed in Ukraine by Olga Balakireva, Cas Berendregt, Jean-Paul Grund and others.

Finally, as part of the project to which this guide contributes, Population Services International are planning to undertake interviews with a number of samples of injectors in south eastern Europe in 2005 using the Route Transitions Assessment Tool that is available at: exchangesupplies.org » [briefings](#) » [route transitions](#)

Two day workshop programme

Route transition interventions have to be developed in response to local drug using patterns, and where possible, reinforce existing social norms amongst drug users.

We have developed the following outline programme for a two day workshop that would enable local policy makers, funders, drug workers and drug users to begin to identify where opportunities might exist for route transition interventions, and develop the route transitions assessment tool given here for local use.

The workshop would need to be run by experienced trainers with a good understanding of drug use, drug treatment and the papers described in this guide. Process notes are included (in orange) as it is important that all parties, especially drug users who are likely to receive them and those likely to deliver them are engaged in the development of the interventions.

The workshop can be delivered with the PowerPoint slides that are available at: exchangesupplies.org » [briefings](#) » [route transitions](#)

To maximise discussion and productivity, we would recommend a maximum of 16 participants and two trainers.

If all participants do not speak the same language, or many have little knowledge about drug use, the course may need to be extended by an evening session or an extra day.

Day One AM

Session	Content & process
AM1	Use introduction exercise(s) to get all participants and trainers to introduce themselves, where they work and their experience. The group will be working closely together for some time so it is important that everyone gets the opportunity to speak, and that at the end of the session they all know each other and have a basis for working together.
	Describe the course ethos [show 'ethos' PowerPoint slide]
	Outline the course structure [show 'structure' PowerPoint slide]
COFFEE	
AM2	Give definitions [show 'definitions' PowerPoint slide] Clarify this key issue so everyone knows what the course will cover
	Set out your learning objectives [show 'learning objectives' PowerPoint slide]
	Split into pairs, ask to discuss for 10 minutes: 1. their learning objectives 2. any misgivings they have about transition interventions Engage participants in adapting the course appropriately for their needs
	Add additional objectives to flip chart
	Facilitate discussion on the issue of misgivings This is a crucial exercise, and everyone should have the opportunity to speak because transition interventions may not be everyone's priority and some may feel that they are in some way 'anti-drug user.' If these feelings are not aired and discussed at the beginning they could hinder discussion at every stage of the course.
LUNCH	

Day One PM

Session	Content & process
PM1	<p>Local services, gaps and priorities</p> <p>[Show 'health needs and priorities' PowerPoint slide] Ask the group to split themselves into groups of 4–5 with people they don't know well (if possible) and ask them to describe:</p> <ul style="list-style-type: none"> ■ injecting drug use in their area; ■ health needs of injectors; ■ services available – type coverage etc.; and ■ how they see priorities for interventions/services that are needed. <p>This exercise will further help the group to work together and will develop understanding where everyone is coming from in terms of services and priorities with everyone in group to understand what people have got, what they haven't got, and what their sense of priorities is.</p>
	<p>Allow 30 minutes for group discussion. 45 mins for feedback/discussion Facilitate debate/dissent in line with the course ethos, so as to set up norms for managing disagreement in the group.</p>
COFFEE	
PM2	<p>Different drugs, different routes, different risks Group should be working together and comfortable with each other. Finish day with some solid content to give everyone a foundation for the discussion of transitions tomorrow.</p>
	<p>The chemistry, physiology, psychology of routes of administration: explain the psychopharmacology; half-life and differences between smoked, sniffed and injected heroin and oral methadone</p>
	<p>Flip chart – work with the group to develop the matrix of drugs (including methadone)/possible routes table as shown in the guide on page 8.</p>
	<p>Heroin use, injecting and the 'first hit' go through the following PowerPoint slides:</p> <ul style="list-style-type: none"> ■ 'heroin use injecting/first hit' ■ 'limitations to the evidence base' ■ 'factors associated with heroin/injecting' ■ 'key issues associated with first hit' ■ 'reasons people use'
	<p>Split into small groups (2–3 people) for 5 minutes to identify key factors (including factors not listed on the slide) in their areas. Sets up day two by bringing the group back together in an interactive way to focus on the issue of transition to injecting.</p>
	<p>Bring back together for 15 minutes feedback.</p>
<p>Quickly run through tomorrow's programme and handout RTAT. Ask people to read through it by tomorrow</p>	

Day Two AM

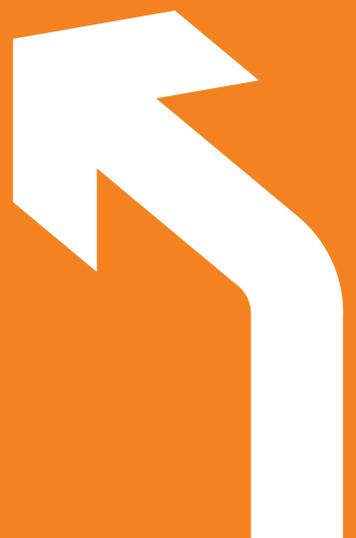
Session	Content & process
AM1	<p>[Show title PowerPoint slide] Introduce day Check for questions/feedback from yesterday.</p>
	<p>Move into content with 15 minutes each on:</p> <ol style="list-style-type: none"> 1. Route transitions theory, history and evidence [showing theory history evidence Griffiths et. al Darke et. al the road to interventions subsequent studies PowerPoint slides] 2. Describe the principles of Prochaska and DiClemente cycle of motivation and change, and explain how it can be applied to component behaviours of drug use as well as to the 'global' issue of whether to stop taking drugs or not. [Show 'motivation and change' PowerPoint slide] 3. Transition interventions: options (routes e.g. UYB & methods e.g. social marketing), evidence and limitations, showing the following PowerPoint slides: <ul style="list-style-type: none"> ■ 'route transitions interventions' ■ 'switching (prescribing)' ■ 'preventing commencement 1' ■ 'social marketing' ■ 'preventing commencement 2' ■ 'intervening in drug markets' ■ 'preventing commencement 3' ■ 'route transitions overview' <p>Group should be happy working together now this content heavy session gets participants fully informed and feeling as if the course is delivering solid information.</p>
COFFEE	
AM2	<p>Describe 'break the cycle' as both one-to-one intervention showing the following PowerPoint slides:</p> <ul style="list-style-type: none"> ■ 'break the cycle title slide' ■ 'the intervention' ■ 'three key points' ■ 'the research results' ■ 'injecting as risk laden...' ■ 'evaluation results' ■ 'the initiation process 1' ■ 'the break the cycle campaign' ■ 'the initiation process 2' ■ 'three key points' ■ 'the intervention aims' <p>Allows processing of information given earlier.</p> <p>and as a peer delivered model showing th following PowerPoint slides:</p> <ul style="list-style-type: none"> ■ 'can btc...' ■ 'disseminators' ■ 'aims' ■ 'recipients' ■ 'the main messages' ■ 'experience of initiation' ■ 'design 1' ■ 'risk behaviour audit' ■ 'design 2' ■ 'learning points' ■ 'results process' ■ 'residual questions and issues' ■ 'disseminators' <p>Allows processing of information given earlier.</p> <p>Which transition interventions seem directly applicable / most relevant?</p>
	<p>Break into small groups 2's, 3's or 4's (allow them to self select groups) [show transitions interventions exercise PowerPoint slide] and discuss for 20 minutes:</p> <ul style="list-style-type: none"> ■ which are most significant in your area; ■ other possible issues; ■ priorities; and ■ things that would work.
Take feedback for 20 minutes	
LUNCH	

Day Two PM

Session	Content & process
PM1	<p>[Show 'what do we know/need to know PowerPoint slide] [Show 'rtat sections' PowerPoint slide]</p> <p>Go through RTAT checking it will usefully assess route transitions in your area. Depending on the sense of how much work is needed, this may be at the content level, as a large group or nuance level in small groups (if there are lots of changes) or large group if the sense is that the tool is almost there.</p>
COFFEE	
PM2	<p>Practical issues in data collection.</p> <p>Allow people to form a group around the topic of their choice, so they end up in 3 groups looking at:</p> <p>interviewer training and supervision issues:</p> <ul style="list-style-type: none"> ■ quality control / consistency / supervision ■ personal safety (if collecting data in the field) ■ field notes <p>the interview process:</p> <ul style="list-style-type: none"> ■ leading questions ■ terminating the interview if subject is not appropriate or intoxicated ■ social desirability responding <p>sampling issues:</p> <ul style="list-style-type: none"> ■ ethnicity ■ gender ■ locality ■ length of injecting career <p>20 minutes, listing issues on the flip chart paper</p> <p>Take feedback: get one person from each group to come to the front and present/discuss. 10 mins per topic.</p> <p>Action plan in pairs 5 minutes</p> <p>Allow people to:</p> <ul style="list-style-type: none"> ■ process course ■ leave with a clear plan ■ give feedback <p>Take feedback from those who want to give it</p> <p>Evaluation forms</p> <p>Close and group photo Positive ending to the course.</p>
CLOSE	

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tools for harm reduction