Technical Report No. 36

ILLICIT DRUG REPORTING SYSTEM (IDRS) TRIAL: ETHNOGRAPHIC MONITORING COMPONENT

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ISBN 0 947 229 58 2

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ACKNOWLEDGEMENTS

This research was funded by the Drugs of Dependence Branch, Commonwealth Department of Human Services and Health. I wish to thank the staff at the Southwest Alternative Program (SWAP) in Cabramatta and in particular, Stella Patete. Thanks also to Margaret Eagers and Josie Newton for timely transcription of the tape-recorded interviews and to Professor Wayne Hall and Ms. Julie Hando for comments on an earlier draft. Finally, I am grateful to the heroin users - both "old" and "new" - who participated in this study.

EXECUTIVE SUMMARY

In-depth ethnographic interviews and observational fieldwork designed to elicit information in relation to drug use patterns, local drug market conditions and emerging trends were undertaken in Cabramatta, Sydney, over a three month period between September and December 1995. A total of forty subjects participated in a tape-recorded interview and observational data in the form of fieldnotes were collected on each subject and on the nature, type and level of interactions between subjects in the study. In addition, subjects were required to complete a short structured questionnaire on local drug market conditions.

The principal findings concern a relatively "hidden" group of young, recent initiates to heroin use, the emergence of a street-based injecting culture in the study area and the apparent resilience of the local drug market to pressures from law enforcement. Specifically, the results of this preliminary study suggest that heroin users in Cabramatta may be significantly younger, have lower levels of education and higher levels of unemployment, be more likely to be female, less likely to be Anglo-Australian, more likely to have initiated heroin use by smoking rather than parenteral use, more likely to be involved in crime (including drug distribution and sales activity), more likely to engage in high risk injecting episodes and to have little or no experience of treatment, than those encountered in the literature.

The young people described in this study are worthy of further study from both a public health and a criminological perspective. The prevalence and incidence of heroin use among young people in the area is probably such as to indicate a new cohort of heroin users, many of whom have initiated use through smoking. Cabramatta itself is also worthy of further study. Many of the factors identified here, including drug acquisition routines, collective injecting episodes, use settings and law enforcement practices, represent components of a neighbourhood risk environment which is highly conducive to the transmission of HIV and other blood-borne viruses. The development of a large open air drug market has led to the emergence of a street-based injecting culture which draws heavily on young people from the local area. The density of these networks and their convergence in collective injecting episodes may have important implications for public health.

However, it is important to note that access to this group of young, relatively "new" heroin users was only possible because of ongoing fieldwork based in Cabramatta. The usual problems involved in gaining access and establishing relations of trust with subjects were avoided by "piggy backing" on existing research actively engaged in recruiting, interviewing and observing street-level drug users in the area. It is also important to note that the costs associated with this component of the research do not reflect actual costs involved in conducting ethnographic research. These issues are not insignificant in assessing the feasibility of an ethnographic monitoring component to the proposed Illicit Drug Reporting System.

1.0 INTRODUCTION

In a 1994 report, Wardlaw identified the need for an early warning system designed to equip policy makers with knowledge of significant changes in patterns of illicit drug use and to assist in the planning and development of appropriate responses. Wardlaw proposed that such a system be organised to "provide warning of trends in the illicit drug environment which require national policy attention" (1994:27) and recommended that data collection be capable of monitoring changes in the following areas:

- drugs of choice
- routes of administration
- populations using the drugs [i.e. types of users]
- problems emerging from new patterns of use
  [changes in demand for services, overdoses, changes in drug-related crime]
- the manufacture and distribution of illicit drugs
- price and purity
- market and illicit drug reactions to government strategies
  [especially law enforcement]
  (1994:21; see also Sutton and James 1995).

The National Drug and Alcohol Research Centre was subsequently asked by the Commonwealth Department of Human Services and Health to conduct a pilot study to evaluate the utility of key informant groups as a data collection strategy for a national Illicit Drug Reporting System. The results of this trial, which utilised key informant data, quantitative survey data and ethnographic data, will be published separately as a National Drug Strategy monograph. The present report presents the findings of the ethnographic component of the Illicit Drug Reporting System (IDRS) trial.

Ethnography is the use of direct observation and extended fieldwork to provide a "thick description" of groups or cultures. Ethnographic methods include a variety of research techniques including fieldwork, participant observation, observation, formal interviews, informal conversations and the use of visual images (e.g. video and still photography). All of these techniques are aimed at promoting discussion and eliciting information. Ethnographic research methods have demonstrated utility in situations where little is known about the phenomena under investigation, where populations are "hidden" or hard to access, where contexts and phenomena are not durably instituted, where trends and processes are emergent, and where populations display wide variation in roles and performances.

These features suggest that ethnography may be particularly well-suited to the task of monitoring trends in illicit drug use and drug-related problems. Indeed, in the United States, a significant application of this methodology has been the use of experienced urban ethnographers as "key informants" for the Office of National Drug Control Policy's (ONDCP) "Pulse Check" - a multi-source quarterly overview of national trends in drug abuse. Another important development in both the United States and Britain has been the use of ethnography as a forerunner to street-based intervention

and outreach to drug users at risk for HIV and other infectious diseases (Wiebel 1988; Power et al. 1995).

While the present study was primarily undertaken to provide convergent validity for the key informant reports and the survey data, it also seeks to explore the potential contribution of an ethnographic monitoring component to the proposed IDRS. With this in mind, data collection was undertaken in the spirit of bringing qualitative and quantitative research methods a little closer together. However, as McKeganey has recently argued, "If a closer link between quantitative and qualitative research in addictions research is to be forged, there needs to be a shift away from the belief held by some that qualitative methods represent a soft option, producing anecdotal information of uncertain relevance to the serious business of science" (1995:750). In Australia, where quantitative researchers are prone to eschew issues of meaning and cultural context in relation to drug use, there is a tendency to relegate qualitative research to the status of a poor relation incapable of addressing complex issues (Darke 1995). Such a view suggests that qualitative research provides a mere building block or stepping stone for more serious scientific endeavours. However, a growing body of evidence points to the increased sophistication, as well as the indispensability and centrality of qualitative methods, in conducting drug research (e.g. see Lambert et al. 1995).

While the present study provides convergent validity for many of the findings of the key informant and survey data components (to be published in a future NDARC Technical Report), it also identifies and elucidates a number of issues and themes that were not detected by the other research methodologies. The ethnographic capacity to observe and record *actual* behaviours, combined with the rich and detailed explanations provided by subjects, also permits a more nuanced exploration of particular phenomena, the meanings they hold for participants, and their implications for policy makers. As the following sections indicate, this small exploratory ethnographic study provides both depth and contrast and as such is a useful complement to the other components of the IDRS trial. Together, they highlight the benefits of collaborative research endeavours which combine multiple methods in developing a more balanced and comprehensive approach to detecting, understanding and preventing drug-related problems.

2.0 RESEARCH METHODS

In-depth ethnographic interviews and observational fieldwork designed to elicit information in relation to drug use patterns, local drug market conditions and emerging trends were undertaken in Cabramatta, Sydney, over a three month period between September and December 1995.

Informants were selected from subjects recruited for an ongoing ethnographic study[i] in the area which did not rely on a predetermined sampling frame.[ii] Initial ethnographic mapping conducted for the principal research project sought to identify geographic and social locations in which drug use and distribution occurred within the neighbourhood and to identify dominant drug use patterns, drug acquisition and drug consumption sites, social networks and demographic characteristics of the target population (Bluthenthal and Watters 1995). Mapping data were collected through direct observation, informal conversations, systematic "walk throughs" and the coding of locations. This process provided the ethnographer with a map of the street-level drug using population which was subsequently used to develop a targeted sampling plan using the time-by-location method (Clatts et al. 1995). This distribution, which involves the differentiation of potential subjects by geography (street location) and time (of day and day of week) was designed to achieve representation of all of the major segments of the street-level drug using population. Within this "frame", efforts were made to secure appropriate age, gender and racial/ethnic representation.

It is also important to note that while the parameters of this population remain unknown and the recruitment of subjects is not necessarily proportional to their distribution in the population, the sample selected for this study provides some representation of all the major segments of the street-level population identified. In this respect, careful ethnographic research and the use of ethnographic mapping techniques to inform targeted sampling can ensure more accurate representation at the local level than survey research which relies on self-selected or opportunity samples (i.e. recruitment through snowballing, advertising in newspapers, notices in treatment centres).

As noted by Stimson, two of the principal strengths of ethnography for drug research are the ability to "describe the social settings in which behaviour occurs" and the opportunities afforded by fieldwork to "actually watch people doing things (rather than just talking about doing them)" (1995:758). The combination of different data sources (observations recorded as fieldnotes, tape-recorded interviews, structured questionnaires and photographic images) permits information to be cross-validated (triangulated) and where necessary, targeted for follow up and clarification. As an additional measure, data collected for the IDRS study were triangulated against data collected for the principal research project.

Once selected, potential subjects were approached and the purpose of the study was explained to them. Five potential subjects declined or were unable to participate in the research.[iii] Subjects were required to read and sign an informed consent outlining the possible risks and benefits of participating in the study. A total of forty subjects participated in an in-depth tape-recorded interview which covered a range of topics including demographics, childhood and family background, education and work history,

drug use experience (including routes of administration, transitions and overdose), current drug use, social networks, knowledge of distribution and sales activities, income generation and criminal activity, impact of law enforcement, injecting practices, knowledge of HIV and other blood-borne viruses, and experiences of treatment and/or quitting. Observational data in the form of fieldnotes were collected on each subject and on the nature, type and level of interactions between subjects in the study. In addition, each subject was also administered a short questionnaire on local drug market conditions, including specific information relating to the last occasion on which they purchased heroin (see Appendix One)[iv]. Subjects were paid $20 for each interview.[v]

Tape-recorded interviews were transcribed and, along with typed fieldnotes, were analyzed using Folio Views, an American hypertext software package. One of the strengths of this package is that while it appends all interviews and fieldnotes to a comprehensive infobase, text fields can be broken down into "idea-size" or paragraph size "folios" (Manwar et al. 1994). For example, an interview transcript consisting of forty typed pages and containing 120 paragraphs, can be converted into one or any number of folios and the program automatically indexes (in alphabetical order) all words and numbers. Both emic and etic concepts, words, phrases, ideas and descriptions were searched and analyzed. However, it is important to note that meanings of these words, phrases and concepts remain anchored in a social world. Decontextualizing or detaching textual data from its social contexts may lead to spurious analysis grounded in semantics. As Manwar et al have noted, drug users "talk in a metaphoric language and coin words that do not mean anything to people who do not belong to their culture" (1994:291). In this sense, the analysis and interpretation of ethnographic data rely heavily on the researcher's understanding of the study site and the target population.

3.0 RESULTS

3.1 Sample Characteristics

Table One presents the demographic characteristics of the forty subjects who participated in this research. Slightly more than half the sample (55%) were male. The majority of the sample were aged less than 25 years (85%). With the exception of Indo-Chinese respondents,[vi] the range of ethnic backgrounds represented by the sample approximates the major segments of the street-level population. While the sample is dominated by Anglo-Australians and Indo-Chinese, it is important to note the representation of Aboriginal Australians. The representation of other ethnic groups, most notably young Serbian-Australians and Latin-Americans, reflects the population demographics of the Fairfield Local Government Area.

On the whole, the sample had received little formal education with 68% having completed less than ten years of schooling. A full third of the sample (33%) had less than eight years of formal education and only two subjects reported completing high school. The majority of the sample (93%) were unemployed at the time of the study. Approximately 70% of subjects came from the South West Sydney area and 38% described themselves as residents of Cabramatta.

Table One: Demographic Characteristics

	Male	**Female**	**Persons**
N	22	18	40
Age in years (mean)	20.6	19.3	20.0
(SD)	4.3	5.9	5.1
Ethnicity(%)			
Anglo-Australian	32	44	38
Indo-Chinese	27	22	25
Serbian	14	11	12
Koori	9	17	12
Pacific Islander	9	6	8
Latin-American	9	0	5
School Education (mean years)	8.7	8.2	8.7
Unemployed (%)	96	89	93
Current Residence			
Cabramatta	27	50	38
Other SWS	37	28	33
Inner City	18	5	12
Other Sydney	9	17	12
Outside Sydney Metro	9	0	5

3.2 Drug Use Patterns

Patterns of drug use can be differentiated or classified along a number of different dimensions. The *type* of drug used can be used to describe users and to assess the level of harm associated with an individual's drug use. The *frequency* of drug use is another important dimension used to classify individuals as different types of users (i.e. occasional, experimental and regular) or to identify different stages of drug using careers. The *quantity* of drugs consumed on a single use occasion is a further dimension which is sometimes used to describe users. However, the absence of standardisation with respect to purity and unit sizes means that quantity is difficult to measure where illegal drugs are concerned. *Route of administration* is an important element in seeking to identify and isolate patterns of drug use and in particular, the health risks associated with particular methods of administration.

Subjects reported having used a wide range of drugs, including opiates other than heroin, cocaine, amphetamines, benzodiazepines, hallucinogens, cannabis, inhalants, tobacco and alcohol. The most frequently reported current drugs were heroin, benzodiazepines, cannabis and tobacco. Several subjects reported experience of injecting drug use prior to heroin use. These subjects tended to be ex-amphetamine users from the South West area, notably Fairfield, Liverpool and Canley Vale. While not the focus of this report, subjects familiar with Kings Cross reported that heroin was increasingly difficult to purchase in that area and several noted the increased availability of cocaine in the inner-city.

Table Two: Patterns of Heroin Use

	Male	**Female**	**Persons**
N	22	18	40
Heroin Use (mean years)	3.4	2.9	3.2
SD	43.8	4.1	3.9
Current Mode of Administration (%)			
IDU	91	83	88
Smoke	9	17	12
Transition from Smoking to IDU (%)	60	50	55

All of the subjects currently used heroin. The mean number of years of heroin use was 3.2 years with a range of two months to 17 years. The majority of subjects were current injectors (88%). While those who currently "smoked" or, more correctly, inhaled vapourized heroin only accounted for 12 percent of the sample, a majority of subjects (55%) reported having made a transition from smoking heroin to intravenous use (Maher 1996b). Insofar as most of the heroin users interviewed for this study were relatively new to injecting drug use and many of them had smoked heroin prior to

intravenous use, these findings suggests the existence of a cohort of young people whose experience and patterns of heroin use may be significantly different to that documented by previous research.

There may also be significant differences among those who initiate heroin use by smoking. This study identified two principal methods by which young people reported "smoking" heroin: either by inhaling the vapours or fumes of heroin heated on foil or by smoking it with cannabis (known as a "snow cone" or "harry cone"). The first method was the dominant means of administration among Indo-Chinese whilst Anglo-Australians were more likely to report their initial experience of smokeable heroin being combined with cannabis. In contrast, most Serbian-Australians, all of whom were from the surrounding area, reported initiating heroin smoking by the foil method, suggesting a process of "micro-diffusion" may be underway (Grund and Blanken 1993; Pearson and Gilman 1994)[vii]. It is also significant that none of the young people who reported smoking heroin were familiar with the terms "chasing the dragon" or "chasing". Where subjects described the process involved in inhaling heroin fumes they referred to this as "smoking" or " spotting" heroin and, less frequently, "foiling".

While it may be that the prevalence of heroin smoking has historically been under-reported because researchers have generally neglected to ask subjects whether they have ever smoked the drug, a number of factors suggest that heroin smoking may be a relatively recent phenomenon. Firstly, there has been both an increase in the purity of heroin available at the street-level in recent years and a relative decrease in price (BCI 1994; Weatherburn and Lind 1995). Secondly, those who reported having smoked heroin came from a range of cultural backgrounds including Indo-Chinese (45%), Serbian-Australian (23%), Anglo-Australian (18%), Latin-American (9%) and Pacific Islander (5%). Interestingly, no Kooris reported having smoked heroin. With the exception of one 28 year old Indo-Chinese male, those who reported having smoked heroin were aged under 25 years and a majority came from South West Sydney. Like most young drug users, heroin smokers were introduced to the drug by friends.

> I live here and I hang around here. I've got a lot of Asian friends around here, you know back from school days and that and I started smoking with them, like just smoking the heroin. (Alex, 23 year old Serbian-Australian male)

> Its the way the Asians do it you know. I didn't know any Aussie junkies so my first use of heroin I didn't shoot it up like an Australian junkie. The Chinese, the Asians, they don't even think they're junkies cause they're smoking it. (Josua, 20 year old Latin American male)

> Asians, I've known em since school and we smoked from foil, straight just poop poop, straight from the foil using a straw and you just light underneath. Once we take that in we have a cigarette on the side and just smoke the cigarette as a chaser sort of thing. (Suzie, 17 year old Serbian-Australian female)

> Asians like they smoke it. Like some of them are shooting but I think it came from the Asians the way of smoking like through the foil - the way I was smoking it I learnt it from them. (Sock, 19 year old Serbian-Australian male)

> First time with a friend. This girl she came up to the house and she asked me "Do you want to try white?" I said I didn't know what white was at the beginning and she opened it up and she took the foil out and the straw and everything and that and then I just tried first puff and then vomit. That's how I started. (Lyn, 15 year old Indo-Chinese female)

However the term "diffusion" implies a diffusing out from a particular group to a wider population which may not be an accurate characterisation of how young people's drug use patterns actually evolve. Rather, the simultaneous cross-fertilization of social networks through, for example, multi-ethnic friendship groups and drug acquisition and consumption routines (i.e. sharing cannabis dealers, doing rorts together, being locked up together, street-based injecting) is suggestive of an interactive dissemination involving shared values and reciprocal relations.[viii]

> The beginning of last year me and my friend started smoking snow cones. We always used to go to a friend's house to buy pot and we started hanging out there. And this Asian bloke started coming there. He used to sell heroin but he would come there to buy pot. He brang some caps and I bought one off him one day and had snow cones. (Peter, 19 year old Serbian-Australian male).

> My cousin used to deal as I was saying to you before. She knew all the Asians, she went to school with them. She used to hang out with them and stuff. When I was going to school and stuff I used to come down and say hello and we'd have a smoke of pot and shit. I helped her sell sometimes you know but never really touched it full on until like I left school. (Teddy, 20 year old Pacific Islander male)

Similarly, while there may well be Indo-Chinese influences at work in the "diffusion" of smoking to broader populations, some young Indo-Chinese are clearly influenced by non-Indo-Chinese in initiating injecting drug use.

> He was Aussie. I introduce him to heroin. When he came over to visit and I smoked it, he started smoking it. Three days he smoking it with me and he told me we should try shoot up and I said yeah we should try it and we try together. He know how to do it - did it before with other drug. I was very scared of needle, of becoming a junkie. I was seeing all my customers you know. (Thai, 18 year old Indo-Chinese male)

> Us whites, we tell em you're fuckin idiots smoking it mate you know, its a waste you know and it is a waste. They try it once and they think well fuck, they were right those Aussies, they're not that dumb after all. We can make a $1,000 profit now instead of $200 and we're still getting the same amount of stuff. (John, 27 year old Anglo-Australian male)

There is also clearly a very strong anti-injecting sentiment amongst the Indo-Chinese community and especially amongst Vietnamese in Cabramatta. Many young Vietnamese people strive to keep their injecting drug use secret and some feel considerable confusion and guilt about their injecting behaviour (Maher 1996b).

> Before we hated people who injected. We didn't like it. We thought it was gross. Looking very bad, very dirty. (Linda, 15 year old Indo-Chinese female)

> I want to go back to just smoking it. I know the needle is very bad. You can catch all diseases and stuff. Look at the junkies around here. I don't want to be like that. (Kim, 16 year old Indo-Chinese female)

> A lot of Vietnamese people are scared to shoot up because they see the junkies, a lot of Aussies, the customers that are shooting up and they look at them and they have got no life at all you know, just like zombies walking around the streets and the Vietnamese people are really scared to be like that. They like to look respectable and they like to get respect. They don't want no-one looking down on them you know so thats a lot of reason why they will never shoot up. (Tien, 19 year old Indo-Chinese male)

While the patterns and correlates of heroin smoking remain to be explored[ix], fieldwork and interviews suggest that many young people experience a fairly rapid transition from smoking heroin to intravenous use. While not an inevitable progression, the transition from smoking to intravenous use holds significant implications for health, including the potential for overdose and the transmission of blood-borne viruses (Griffiths et al. 1994; Gossop 1995). An important determinant of this transition may be the pharmacological properties of the heroin itself [x]. While in theory all heroin mixtures can be smoked, base heroin is more suited to smoking than heroin hcl or salt which is more likely to decompose upon heating. Given that the heroin currently available in Cabramatta does not need to be alkalized prior to intravenous use, it would appear to be a salt. Smoking heroin salt is inefficient and yields a considerably lower recovery rate than heroin base (Huizer 1987; Griffiths, Gossop and Strang 1994).

I changed to shootin up because first of all my dose started getting high and I couldn't smoke that much like. I couldn't sit there and keep smoking and smoking you know. And plus injecting, I like it more than smoking because when you inject it hits you straight away. And like its not as much of a fuss like smoking and putting it on the foil you know, needing cigarettes to smoke. And like smoking you vomit a lot. (Kim, 16 year old Indo-Chinese female)

When I shot it first time I seen it as a waste of gear smoking it cause you've got to smoke so much to get you stoned and it was just a waste. You have a shot and you get this instant hit to your head and to your body and it feels mad. So I just kept doing it from there. (Alex, 23 year old Serbian-Australian male)

3.3 Local Drug Market Conditions

In addition to in-depth tape-recorded interviews, a brief questionnaire on local drug market conditions was administered. All data refer to the most recent occasion on which heroin was purchased in Cabramatta. Most purchases (70%) were made in small units packaged for individual sale known as "caps". Caps are typically wrapped in a small piece of foil, often taken from the inside lining of a cigarette packet, and then sealed in small plastic water balloons. Only 30% of purchases involved half-weights. The mean purchase price for a cap of heroin was $30.42 with a range of $20 to $40. The mean purchase price for a half-weight was $169.28 with a range of $150 to $200. Women appear to pay significantly less than men for both caps and half-weights.

Buyers purchased an average of 2.0 caps on the last occasion on which they scored and an average of 1.14 half-weights. In an apparent contradiction of fieldwork observations and interviews conducted for the principal research project, most subjects paid for their heroin in cash (87%), with only 13% reporting that they had traded or swapped an item in return for heroin on the last purchase occasion. However, just under half the subjects (43%) reported that they did not contribute all the money or goods themselves on the last occasion on which they purchased heroin, with women significantly more likely to be involved in collective drug purchasing than men.

Subjects' responses also suggest that the quality or purity of heroin available at the street-level was reasonably stable or consistent. While we are unable to comment on objective purity or whether consumers got what they paid for when they purchased heroin in Cabramatta, many at least got what they were used to. Slightly less than half the subjects (43%) described the purity of the heroin purchased on this occasion as "normal". One third (35%) described the purity of their purchase(s) as "more than normal" and the remaining 22% described their most recent purchase as being of "less than normal" purity.

Table Three: Most Recent Heroin Purchases

	Male	**Female**	**Persons**
N	22	18	40
Type of Transaction (%)			
Cash	91	83	87
Trade/Swap	9	17	13
Collective Drug Purchase* (%)	27	61	43
Unit of Purchase (%)			
Caps	64	78	70
Half Weights	36	22	30
Mean Purchase Price ($)			
Caps	31.00	29.79	30.42
Range	20-40	22-34	20-40
SD	4.8	2.6	4.1
Half Weights ($)	173.00	160.00	169.28
Range	150-200	150-180	150-200
SD	20	14.1	18.2
Mean # Units Purchased			
Caps	2.4	1.7	2.0
Range	1-6	1-3	1-6
SD	1.5	.91	1.3
Mean # Units Purchased			
Half Weights	1.25	1	1.14
Range	1-2	N/A	1-2
SD	.46	1	.36
Relative Purity (%)			
Normal	45	39	43
Less than Normal	9	39	22
More than Normal	45	22	35
Police Activity Affected Access to Heroin (%)	27	33	30

* Individuals did not contribute all the cash/goods themselves

While the academic literature on heroin markets is dominated by the twin referents of "price" and "purity", the discourse of street-level heroin users in Cabramatta is overwhelmingly one of "size". In a marketplace with relatively stable prices and reasonably consistent levels of purity (at least according to consumer perceptions), the size of the deal may be the variable that matters most. Size is clearly a strong determinant of value for money, with interview transcripts literally littered with references to cap size: e.g. "small", "puny", "tiny", "pinhead", "massive", "mad sizes" "huge" and "mega".

> I have a dealer I always go to that always got *good sizes* ... he's got *good sizes* and I can count on him. (Kate, 31 year old Anglo-Australian female)

> I know this dealer. He started dealing only about three or four months ago, you can see the changes. When he first started dealing he had *massive* caps so everybody started going to him. So when he knows he has about 100 customers or something he makes the caps *real small* and people still go to see him because they think he still has got *big caps*. (Bon, 22 year old Anglo-Australian male)

> If there's two people standing there and one's got a certain size and the next bloke's got *double the size*, who you going to score off? You're gonna score double so you're gonna get twice as much for your money. Its the same dope. (John, 27 year old Anglo-Australian male)

> Some of them look so *scummy* ... Now man, it is just unbelievable, some of the caps are getting so *small*. I know this old bloke that me and me mate got ripped off by the other day ... It looks like now he is trouble and he hasn't got much money and he has been selling real *small* caps and we got rorted the other day. We got *puny little caps* with nuthing, we didn't even taste it, we didn't even feel it. (Peter, 19 year old Serbian-Australian male)

The term "rock" appears to be something of a misnomer when applied to most of the heroin available for purchase at street-level in Cabramatta. Some older user have suggested that heroin is cut (diluted) and recompressed or, alternatively, baked in a microwave to make it look like "rock" before it hits the streets (most likely at the ounce or half-ounce level). Certainly most of the heroin observed during fieldwork appeared to be rather soft and powdery in texture. These issues should be clarified by pharmacologists or others with appropriate expertise.

> When you smoke it you can tell it sugar or no sugar. See because when the heroin is like 70% its easy to know because the rock, if it good rock - number one quality pure, you put it on the foil, it run up and down, up and down four or five time ok. That's the pure gear. The one mixed up, it not run very good - still run but maybe just one time. They got a little bit bubble go up that mean it mix in a bit of sugar. If they pure, OK, when you smoke it, the rock run up and down three or four times. (Snoop, 17 year old Indo-Chinese male)

> Like some heroin you've gotta use the back of the syringe to crush it and its got that strong smell. But like the gear you buy now, you mix it up with water and it mulls up just like that and its only got a small bit of smell and it isn't even that bitter (Peter, 19 year old Serbian-Australian male)

> Sometimes when they get the white gear now, it's like wet or something - like mushy, not like the other white or the beige - that was mad gear. (Taylor, 16 year old Anglo-Australian female)

> Yesterday, I picked up something that was very wet and putty. It was white but it was moist, it was like putty - like it had been like steamed or something. (Fatman, 20 year old Anglo-Australian male)

> Like some dealers they keep the rock for themselves and just use the powder for the junkies. Like give them a tiny little bit of the rock but mainly give them the powder bits. (Lyn, 15 year old Indo-Chinese female)

There appears to be at least two types of half-weights available for purchase at the street-level in Cabramatta. "Asian halves", which are reserved for Asian customers (usually dealers) consist of a weighed half gram - i.e. 0.5gms - or very close to. Many Asian customers take their own scales to the dealer when picking up half-weights. During fieldwork I was party to a long and animated discussion between two Indo-Chinese women dealers concerning a recent transaction where one of them felt she had been ripped off by an Indo-Chinese weight dealer. Indeed this woman was quite insulted that she had not gotten the "Asian weight" she was entitled to and felt she had been treated like an "Aussie junkie". "Aussie halves" are closer to what is known as a "streetie" and typically weigh between 0.3 and 0.4gms. The higher price and lower weight of "Aussie halves" no doubt reflect the risks (as perceived by Asian weight dealers) involved in selling to "Aussies". There is also a version of the half-weight in Cabramatta which is reserved for rank outsiders (i.e. non-Asian, non-regulars and non-locals). These "tripper's halves" are the most expensive and may weigh less than 0.2gms. [xi]

> The outsiders they get charged $200, $220 you know. They know I grew up around here so I get you could say Asian price ($150-$160). They got Asian price and Aussie price and all this shit. They know you know. (Stan, 23 year old Serbian-Australian male)

> Here junkies are paying $200, in the City they're payin something like $360 you know and they start coming to Cabra and they're freaking out ... They find out fuck $200, they're saving $160 know what I mean ... But God do they get ripped off. Half of them get sick of it and say fuck I'm just gonna pay an extra hundred sixty. They get ripped off heaps ... Just say if you're from the Cross right, usually we'll tax [deduct a portion] it right but we tax extra from your one and charge

you extra too so they're getting ripped off hard core (Suzie, 17 year old Serbian Australian female)

Finally, despite the increased police presence in Cabramatta during the study period, only a minority of subjects (30%) reported that police activity had affected their access to heroin. While some subjects mentioned delays and difficulties in accessing their "regular" dealers, these delays were typically measured in minutes or hours. For individuals who did not patronise specific dealers, there appeared to little or no interruption to supply as a result of the increased police presence. As subjects commented:

> It is so easy to score. Unbelievable. When I walked through Cabramatta this morning about ten people asked me to get on. (Peter, 19 year old Serbian-Australian male)

> As soon as you get off the train you've got ten people asking you before you even get to the ramp to go over to the other side. If you want to score thats how easy it is here. Straight up - "Do you want to score?" "Hey sis, you right sis?" They'll show you the size. "Big rock mate, I show you, I open". (John, 27 year old Anglo-Australian male)

3.4 Drug Distribution and Sales Activities

Contrary to media reports and popular images, street-level heroin distribution in Cabramatta takes the form of a freelance market [statistically] dominated by Indo-Chinese user-sellers. Fieldwork in progress suggests that this particular marketplace is not "controlled" or monopolized by them, the 5T, or anyone else.[xii] Heroin is primarily distributed under a freelance model by individuals and multiple units of small entrepreneurs (mostly user-dealers) rather than mega-organizations or businesses. Entrepreneurial participation is relatively easy to accomplish but often short-lived and sporadic. It is also important to note that heroin has been bought and sold in Cabramatta since the 1960s.[xiii] According to Curtis and Sviridoff:

> Freelance markets are defined by a lack of formal hierarchy among street-level distributors. Alliances are made on a strictly ad hoc basis and are typically short-lived. Relationships between street-level distributors are 'egalitarian' - no-one owes anything to anyone else and every man (sic) is his own boss. Reciprocity guides daily interactions between distributors; they generally acknowledge that their peers should reciprocate in kind when done favors. Leadership positions among freelance distributors, though often fleeting, are determined by longevity, skill and generosity (1994:157-8).

This description from the literature provides a reasonably accurate assessment of the social organization of most street-level heroin distribution in Cabramatta. It is also

concordant with most user's perceptions and personal experiences of the marketplace as dominated by freelance dealers, as evidenced by the following selection of quotations:

> There's heaps of people just working for themselves mate, you know what I mean. Like they're using and um the only way they can support, the only way they can support themselves is they sell and they pick up and have a bit of gear for themselves and sell the rest to make their money back. And it just keeps on going on and on.(Alex, 23 year old Serbian-Australian male)

> My friend just gave us the idea of selling. Cause like I said how you going to look for money and keep getting the white, you know. Cause I don't have my [youth] homeless [allowance], my unemployment [benefit] or anything. So my friend said why don't you try hocking your necklace, my sister's necklace and then we sell and we earn profit and get it back. So my sister went to hock it yesterday and the man said $190. We said $180 will do, just enough to get the white to sell. We got it for $160 off my friend, usually it cost $180. We put them all into caps and made a lot of money. (Linda, 15 year old Indo-Chinese female)

> I think out here its a bit of a free for all you know. If you're there, you might be talking to somebody and saying oh yeh I'll have one and someone else'll motion to you they've got big caps. I mean they're trying to cut each others throat. The competition is there in that regard and there's a lot of people selling. There's too many sellers for buyers. (Rob, 20 year old Anglo-Australian male)

> At first when I started dealing that was heaven because the junkies, they're so pissed off with the Asians cause' they give em tiny little caps and they get ripped off and everything and they'd look at me and think, a chick, its easy to come back and tell her off - and white too. Believe me they'd rather score off a white person than an Asian and it was magic right, sometimes we could do four halves a day. (Suzie, 17 year old Serbian-Australian female)

> Asians? They're just selling for themselves, sell cause they're on the gear too. They sell to support their own habit, you know. (Harry, 34 year old Koori male)

> I got a guy who comes down and buys half an ounce once a week you know and I make four or five hundred on that alone you know. He's Australian and I'm a white man and he's white and he's wanting big quantity and he comes and sees me.
> He sees the Asian here the other night and the Asian tried to sell it to him you know and I've got it off him for him too and he's just walked up and seen me and come straight to me and just pretended he didn't even know that Asian guy you know what I mean? Cause he knows I look after him (Stan, 23 year old Serbian-Australian male)

> Its like if you have the good sizes, the good gear, you will sell easy. Like if I buy have an ounce of hammer and I have the best sizes in Cabramatta everyone will score off me and the Asians can't say anything because I have got the good sizes. Simple as that. (Bon, 22 year old Anglo-Australian male)

While the market is dominated by a freelance system of distribution, the reality is slightly more complex than that suggested by the last quotation. In a marketplace dominated by Asians, issues of risk and respect structure the participation of non-Asian sellers.

> Sometimes it happen that some Asian boy see some Aussie boy, if they know you its all right but if they don't know you, they get smart with you. (Tien, 19 year old Indo-Chinese male)

> I think basically its what you call a freelance situation but if you start taking too much business then I think the Asians will come down on you. But as far as a little bit of say personal use money you're pretty right to sell. But if you're gonna be making big dollars, well, you're taking it off those Asians and you take money off the Asians, that's what talks and they'll end up snuffing you out you know ... They'd be jumpin' down your throat. They wouldn't let it go on too long. (John, 27 year old Anglo-Australian male)

> I don't think they've ever suspected me of selling it. Like I can recognise who they are. If they come around I won't do nothin so if someone says they see me dealing or anything like that I'll just wait until they go by and just, you know, carry on my business again.(Harry, 34 year old Koori male)

> You could think that he [a rather flamboyant Anglo-Australian dealer] is like he's trying to cut the throats of the Asians by taking business and stuff. But you see because he is an Aussie, sort of like a bikie type and the people I see scoring off him are his type, you know what I mean - bikies and sort of Aussie blokes you know what I mean. You don't see like um other people scoring off him. Like he has his own customers, his own group of people that always score off him. You don't see many people from our side come to score off him. (Bon, 22 year old Anglo-Australian male)

> There is a couple of Aussies and that that sell out here. I don't know if they're selling for the Nips or for themselves but if they get too busy or get too much to sell, they'll soon be stopped. They don't care the Nips out here mate. They'll just shoot ya, stab ya, whatever. They don't care about the police or nothin. (Jack, 21 year old Anglo-Australian male)

Finally, interviews and observations to date suggest that involvement in drug distribution and sales activity may serve to protect some Indo-Chinese young people,

and young Indo-Chinese women in particular, from involvement in income generating crime such as robberies and burglaries.

> Vietnamese people, they got skill for dealing. They don't like to do this - to do stealing and go in people houses. They like to deal heroin. A lot of young people, most of them you know, white people, they break in and armed robbery, you know, to get money to buy heroin. Most Asian they deal heroin than armed robbery ... That's why all the Vietnamese they always deal, they didn't do break and enter a lot and armed robbery. (Tran, 22 year old Indo-Chinese male)

Table Four presents characteristics relating to the last occasion on which subjects purchased heroin in Cabramatta. While 77% of subjects described the person from whom they bought the heroin as "Asian", 20% reported making their most recent heroin purchase from an "Aussie". Contrary to media reports (e.g. Daily Telegraph Mirror, 29 May 1995), almost half the subjects (48%) reported the person from whom they most recently bought heroin as being aged between 20 and 30 years of age. A majority of subjects (85%) also reported either selling heroin or helping others to sell it in the week prior to interview. Coupled with fieldwork observations and interviews, these data support the hypothesis of Cabramatta as a market dominated by freelance user-dealers and characterised by extremely high entrance and exit rates.

Table Four: Drug Distribution and Sales Characteristics

	Male	**Female**	**Persons**
N	22	18	40
Culture of Dealer (%)			
Asian	86	67	77
Anglo-Australian	14	28	20
Other	0	5	3
Age of Dealer (%)			
Under 20	23	72	45
20-30	68	22	48
Over 30	9	6	7
Dealer Loyalty*			
Always	23	28	25
Usually	23	22	22
Occasionally	31	22	28
Never Before	23	28	25
Location of Drugs			
Mouth	55	61	58
Pocket	23	11	17

Nose	9	11	10
Other**	13	17	15
Buyer Involvement in DDS During Week Prior to Interview (%)	86	83	85

* Subjects were asked how often they bought drugs from this person

** At the point of purchase drugs were also retrieved from inside buildings, underneath tables, packages or wrappers on the ground, underclothes, tracksuit linings and mobile phones.

Table Four also presents information in relation to dealer loyalty - i.e. how often subjects reported buying heroin from the dealer they used on the most recent purchase occasion. Just under half of the sample (47%) reported that they either "always" or "usually" bought heroin from this person. John was one of these people but, as he explained, it wasn't so much quality he sought in a regular dealer but rather, consistency.

> There's a couple of blokes I see there regular. Like if they're there I'll see em you know what I mean. Of course if I can't spot em straight away I don't like hanging around too much. Their dope isn't as good as the stuff I had this morning but its consistent, you know, it does the job. Rather than if you go to someone else it might be great today and its shit tomorrow whereas theirs is not the best but its consistent. (John, 27 year old Anglo-Australian male)

Slightly more than half (53%) indicated that they had either "never" before or only "occasionally" purchased heroin from this person. These data suggest that while most individuals attempt to establish relationships with regular dealers, the dynamic nature of the marketplace, the contingent nature of the heroin lifestyle, and the fluctuating economic fortunes of individuals, mean that most users are reluctant to place all their eggs in one basket.

> [How many different dealers do you reckon you've scored off in the last week?] About ten, ten dealers because usually I score off Tam but he comes out late at night but during the day he is not there so I will score off someone else. It just depends who is there and what time. (Peter, 19 year old Serbian-Australian male)

The questionnaire also asked subjects where the dealer had retrieved the heroin from on the last purchase occasion. The majority of subjects (58%) indicated that the dealer had retrieved the heroin from his or her mouth, with a further ten percent reporting that the dealer had retrieved heroin from his or her nose. More than two thirds of the dealers then, were storing heroin in body cavities and risking potential exposure to blood and other bodily fluids. This may have implications for the transmission of

tuberculosis as well as blood-borne viruses if the buyer then places the purchase in his or her own mouth.

> Out of their mouth or out of their nose. I knew one bloke, fair dinkum, I've seen him pull ten caps, ten caps out of his nose. Mate, I don't know where the hell he puts em. He's gotta have a huge cavern at the back of his nose. Ten deals, no sweat mate, wrapped in foil and then in them little water bomb balloons tied up at the end. (Jack, 20 year old Anglo-Australian male)
>
> I have seen a guy down at the railway station and he had two halves up each nostril. I seen this girl go over to him and he put one finger over the nostril and these two big balls come flying out of his nostril and then he did the same to the other nostril and two big balls came out of the other nostril like. They just jam it right up you know. There was a bit of gooey stuff hanging off but I didn't get a really good look at it. He just had em in his hand and then I seen the chick hand him the money. He sat there and counted all the money and then handed them other. (Zell, 19 year old Anglo-Australian male)

> I remember one dealer he used to have a big nose, a massive nose. I reckon he used to fit three or four caps in there at least. Yuk, I couldn't imagine putting it my mouth. (Bon, 22 year old Anglo-Australian male)

The remaining 32% of subjects reported that dealers retrieved heroin from a range of external locations including pockets (17%) and inside buildings, underneath tables, packages or wrappers on the ground, underclothes, tracksuit linings and mobile phones (15%).

> You know the garbage bins they have got on the side of the street, they have got those metal lift off lids. I have seen a lot of them hide their caps under those lift off lids you know. I have gone up to a guy "Have you got any caps mate?" I seen him walk up to the bin, lift off the lid, reach in and just pull out a cap. Like you got a garbage bin sitting in the metal bin holder, you have got a plastic garbage bin then there is a metal ring that sort of sits on top of it and they lift up the metal ring and they have got all the caps stashed underneath. There is a sort of little ledge. (Zell, 19 year old Anglo-Australian male)

> I have seen guys wrap it up in an old MacDonalds cheeseburger wrapper and they have just got in lying on the side of the ground you know, like no-one would even think of looking out and they just walk over, pick it up, undo it and it is full of caps and pull out a cap ... Maybe the cops think who is going to leave 20 caps lying on the ground, you know. (David, 15 year old Indo-Chinese male)

> Mouth mostly but there are a few dealers that put it near them. Like if they are sitting near trees they put it in the bark, underneath a piece of bark or I have seen dealers at the front of the pub and they get a packet of empty cigarettes, put the caps at the bottom, squash the packet a bit and throw it on the ground. Or tissue

or whatever and you just throw it on the ground. (Peter, 19 year old Serbian-Australian male)

3.5 The Emergence of Street-based Injecting

As a neighbourhood, Cabramatta is a high risk environment for the potential transmission of blood-borne viruses. Four factors represent this risk at the neighbourhood level: 1) drug acquisition routines (collective drug purchasing), 2) injecting practices (especially collective injecting episodes), 3) use settings and 4) law enforcement practices. This environment routinely influences individual risk behaviours and may hold significant implications for public health (Maher 1996a; see also Bluthenthal and Watters 1995).

In Cabramatta, the emergence of a street-based injecting culture is evidenced by streets, alley-ways and stairwells littered with discarded syringes, spoons and other injection paraphernalia. This culture has emerged for a number of reasons including homelessness, the need to conceal drug use from other household members, individual need or craving for drugs and the fear of arrest (Ouellet et al. 1991; Koester 1994; Klee and Morris 1995). In Cabramatta, the relatively young age of new injectors means that many are attempting to conceal their drug use from parents and caretakers. Perhaps more significantly however, the large open air drug market and associated street scene provides a focal point for the convergence of young people. Few of these young people have enough income (either legal or illegal) to purchase desired quantities of heroin. Collaborative criminal activity frequently results in collective drug purchasing and collective injecting episodes. Fear of overdose and the inability to self administer have also contributed to the development of a street-based injecting culture.

Elsewhere, street-based injecting has been associated with a number of adverse public health consequences. The street-based injectors studied by Klee and Morris were more likely to be homeless, to inject frequently, and in the company of others, to dose themselves more heavily, share injecting equipment and report more sexual partners and casual sex (Klee and Morris 1995). Links have also been established between street-based injecting and overdose and vascular problems (see also Ouellet et al. 1991).

Table Five indicates that 83% of subjects in this study consumed their most recent heroin purchase within 15 minutes of buying the drug. A majority (78%) used the drug in public or semi-public settings, with 43% using in outdoor locations. Slightly more than half (55%) consumed their purchase in the company of at least one other person.

Table Five: Contexts of Use Following Most Recent Purchase

	Males	**Females**	**Persons**
N	22	18	40
Used Within15 Minutes of Purchase (%)	86	78	83
Use Location (%)			

Flats	54	28	43
Toilets	14	17	15
Abandoned House	14	28	20
Other*	18	27	22
Others Present (%)	55	56	55

*Includes locations outside Cabramatta

3.6 High Risk Practices

Related research (Maher 1996a) has identified four factors which undergird the level of risk associated with street-based injecting in the study site. These factors are 1) drug acquisition routines; 2) collective injecting episodes (sharing of drug solutions and injecting equipment; 3) use settings; and 4) law enforcement practices.

3.6.1 Drug Acquisition Routines

Among the subjects recruited for this study, crime was the most common means of acquiring funds or goods with which to purchase heroin. A majority of subjects were engaged in income generating crime, principally high-frequency low-volume shoplifting, other commercial thefts (e.g. "run-outs" and "searches"), domestic burglaries and drug distribution and sales activities. The high level of demand for stolen goods in Cabramatta has diminished the role of cash transactions, making it possible for many participants in the street-level drug economy to support their heroin use through direct exchanges. In particular, the demand for name-brand sportswear (Adidas at the time of writing), gold, mobile phones, linen and illicit pharmaceuticals (methadone and benzodiazepines) supports a thriving trade economy.

Young people were more likely than older users to commit income generating crime in the company of age-based peers. Collaborative criminal activity by young people typically translated to collective drug purchasing as indicated in the following quotation where Peter describes a successful "rort". Peter and his friends used the proceeds of this rort to purchase a half weight of heroin which they subsequently used together.

> Well um Les had a half made up. It was a fake half and I walked into this bloke, this Australian bloke from Newcastle. He come down here and we just started talking. Actually it was just me and him alone at the station sort of late at night and we just started talking and stuff and he said he did a rort ... and wanted to get on to a half. I go "I know a bloke who has a half if you want to get on" and he says yeah. So I found Les and he gave him the half. We went three ways in the money and bought a real half. Then we got into a bit of an argument about who is going to get what, this and that so then we cut it, the half, three ways and then everyone threw in like equal amounts like about two caps each. We put 70 [lines

of] water. I had 20 [lines], Alex had 20, Les had twenty and we gave the little Asian 10 to stop him hanging out. (Peter, 19 year old Serbian-Australian male)

However, drug acquisition routines are not motivated by collaborative criminal activity alone. For many young people, the interactions involved in drug acquisition and consumption episodes are largely social in nature. Kylie, a 17 year old Anglo-Australian woman, was a successful marijuana dealer in the area prior to becoming immersed in heroin use. In the early stages of her heroin using career, Kylie would use her marijuana profits to purchase heroin for herself and her friends.

> They used to talk me into buying a cap. The other night I bought 2 caps for all of them out there and me. I thought I'd have the littlest bit and I'd smoke it and they can shoot it up, whatever they want. They'd go in the bathroom and they'll do their thing and I would just sit out there and just smoke mine. And then I'd think I'm paying for this and they're getting more than me and they're getting it for free, you know. Why shouldn't I get more than them. And I'm only getting this little bit out of it and they would say to me "Oh, but we need more than you Kylie cause we're shooting it ... So I asked em to sharp me. (Kylie, 17 year old Anglo-Australian female)

The group situations in which many young people - for whatever reasons - find themselves in can also exert an influence on the route of administration. As in Kylie's case, the economic and social dynamics of drug acquisition and consumption can place young people under pressure to commence injecting drug use. The following quotations illustrate the ways in which social, cultural and economic factors influence both drug acquisition, preparation and administration routines.

> If I had the money I would smoke it like but I don't ever really have it on my own, the heroin, I always go with someone else. I don't really like having it on my own and um so there wouldn't really be enough to go halves with anyone if I smoked it. So if it was cheaper and there was more of it I would smoke it but ... (Dee, 17 year old Anglo-Australian female)

> [If you had already split the half into threes, why didn't you just all get your own spoons and mix up separately - why did you mix it together?] Because we think if you mix it together it will be stronger thats what we have always thought. Like I know it isn't true probably. Like it is probably the same. (Peter, 19 year old Serbian-Australian male)

3.6.2 Collective Injecting Episodes

Ethnographers have done much to elaborate the situational contexts of needle and syringe sharing (e.g. Koester 1989, 1992, 1994; Koester et al. 1990; Page et al. 1990; Grund et al. 1991; Zule 1992; Jose et al. 1993).[xiv] However, few qualitative studies have explored the effects of age on health beliefs as they relate to injecting drug use (but see Loxley et al. 1991). While almost all the injectors in this study reported having used a syringe after someone else had used it, the timing of these episodes suggest that extensive sharing may occur during the initial period of injecting drug use. During this period, user's perceptions of risk appear to be conditioned by perceptions of their own health and that of their peers.

> When we first started, we started with a whole group of us - none of us knew anything. We got into smoking and some of us got into injecting and I guess we all followed. We didn't know anything. We shared but we all knew each other

> and we were all young and healthy. Nobody had anything. (Rebecca, 17 year old Serbian-Australian female)

> I've shared heaps. I've shared with Dragon before. I've shared with Peter. I've shared with my best friend so many times. At first I wasn't that worried cause I thought our group of friends that like started using, like my best friend and her boyfriend, like we'd share but we knew we were clean. But the deeper we got we didn't realise how sick we were getting and all that ...We thought we were so healthy. (Suzie, 17 year old Serbian-Australian female)

Regardless of age, most subjects perceived that it was "OK" to share injecting equipment with their (regular) sexual partners. The following comments were typical of this group of respondents.

> Well, we sleep together so if I'm going to get something, I've already got it. (Kylie, 17 year old Anglo-Australian female)

> Cause we sleep together like I know I haven't got AIDS, he hasn't got AIDS but with friends you don't now. Like I smoke it mostly but everyone's a bit worried about my boyfriend. Like he injects it all the time cause he thinks its better, he gets a better head rush but I'm a bit scared if, cause I don't know sometimes I'm at home and if he's sort of up here and hasn't got a fit and that. (Smiley, 14 year old Anglo-Australian female)

Young people were more likely than older people to make decisions about whether or not to share injecting equipment (with other than sexual partners) on the basis of perceived health status. For many young people this was no more than a "feeling" that the person was "clean" or "didn't have anything". Sometimes young people's beliefs concerning the health risks presented by sharing with particular individuals were gleaned simply from witnessing them inject. Sock, a 19 year old Serbian-Australian male described a recent episode as follows:

> Yeah, I did use some girl's fit but umm, I trust her, I don't know if I should of but I did, so. She's not, y'know, she's clean and that y'know. I don't know I can't explain it. I've known her a while, I've seen how she hits up and does stuff, I don't know.

Some young people felt that a reluctance to lend or pass on a syringe was a "good" sign in that it was interpreted as indicating that the person with whom they were "sharing" did not normally share injecting equipment.

> I have shared a few times but only with some people. Some people I will share with and some people I won't. I make sure I clean it out and that. But the people I did share with were the people who didn't like sharing and things so I felt safe doing it. (Dee, 17 year old Anglo-Australian female)

However, these data also suggest that while most young people are aware of the health implications of contracting HIV/AIDS (known colloquially as "the dreaded"), many do not perceive HBC and HCV to present serious health risks.

> This friend of ours when he found out he was positive for Hepatitis he reckoned it was OK because he could just go out and get three shots and be cured. They think its not as bad as HIV - at least its not AIDS. Its not going to affect me for thirty years so they don't care. (Suzie, 17 year old Serbian-Australian female)

In addition to health beliefs, the likelihood of sharing a syringe is also strongly conditioned by more material concerns including the reluctance of many users to carry syringes on their person, availability of and access to clean syringes, and the individual's need or desire for heroin. While the possession of needles and syringes is not a crime in New South Wales[xv] , many users were unaware of the legal status of injecting equipment. More importantly however, the difference between "law in the books" and "law in practice" means that many users fear being harassed and brought to the attention of police because they are carrying a syringe (see also Koester 1994). While users are rarely arrested in this situation, the police usually run warrant checks which may result in them being taken into custody. For women, gender issues in relation to police treatment may also condition their reluctance to carry syringes:

> Once a cop found a fit in my bag and he smashed it and broke my water. OK, that's bad enough, but its the way they make you feel - made me feel like a real slut. They treat you like you are a prostitute or something just cause you've got a fit. (Rebecca, 17 year old Serbian-Australian female)

User's perceptions of the risks involved in carrying syringes on their person were clearly differentiated by age, gender and ethnicity. For many young injectors, the fear of detection was not limited to the police but extended to detection by parents. For some young Indo-Chinese injectors, the fear of detection as an intravenous drug user by their peers exacerbated a general reluctance to carry injecting equipment (Maher 1996a). As Koester has pointed out in the North American context, for many injecting drug users, "Breaking laws to buy and use illicit drugs, and committing crimes to obtain money to buy drugs are [seen as] unavoidable consequences of drug addiction, but carrying a syringe is not" (1994:290).

The availability of clean injecting equipment in Cabramatta is virtually restricted to business hours. During business hours, sterile injecting equipment can be obtained at varying cost[xvi] from one of four chemists, or free of charge from one of two local agencies which provide needle and syringe exchange. There is also an outreach bus service in Cabramatta on Friday and Saturday evenings. During the week, a single chemist remains open until 9.00pm. With the exception of Friday and Saturday evenings, after hours availability is restricted to this chemist. Between 9.00pm at night and 8.30 am in the morning (Sunday-Thursday) and 10.00pm at night and 9.00am in the morning (Friday and Saturday) sterile injecting equipment is simply not available in

Cabramatta. While there is a chemist in Fairfield that remains open until 12.00 midnight, the hours between 9.00pm and 9.00am constitute a distinct window period which places users at risk of sharing or re-using previously used injecting equipment. This is illustrated by the following section of quotations:

> There was about four of us, we scored, we got onto a half and we had no syringes. We looked around a few places where we used to stash syringes - new syringes - and we couldn't find no syringes. We had no syringes and the chemists were all closed. There was one chemist at Fairfield we knew was open till 12 and it was after 11.30 and we hopped on the train but by the time we got there it was closed. (Peter, 19 year old Serbian-Australian male)

> After nine o'clock it is so hard to get syringes. There is one chemist open in this whole area. That's in Fairfield and that is open till twelve. (Linda, 15 year old Indo-Chinese female)

> These days we stash fits at so many different places like in bushes where people wouldn't look and some people still find them. Cause where we go to have shots, other people go to have shots so they just find it. (Kylie, 17 year old Anglo-Australian female)

> I did find one eventually. It took me at least five flats worth. I went through a lot of flats like I know ... About half an hour. (Tran, 22 year old Indo-Chinese male)

> I always end up getting a fit, I don't know how ... I'll get them off someone or someone that's going for a shot or something like that. I'll ask them for one. I just keep an eye out for anyone going for a shot, go chase after them and see if they've got a spare one. (Bon, 22 year old Anglo-Australian male)

> Everything just closes and um, I remember before when I first started using I was using with two of me mates and sometimes they would come and pick us up late at night like at one or two o'clock in the morning and you couldn't get fits nowhere. We used to go to the hospital and try but sometimes they won't give it to you without exchange. [Which hospital?] Liverpool Hospital. And sometimes they just say no we can't give em out and then we have to go around and look for old fits. (Alex, 23 year old Serbian-Australian male)

> The latest time they close [in Cabramatta] is nine o'clock, And we had no way of getting syringes and we didn't want to use [other people's] old ones. So we were looking around everywhere for about an hour, we were even thinking about sharing cause one of my mates had one syringe and we were thinking about sharing. (John, 27 year old Anglo-Australian male)

Late at night and early in the morning, the scarcity of this particular commodity in Cabramatta markedly increases its value. In addition to interview data collected for

this project, fieldnotes recorded for the principal research project provide several accounts of instances involving the after-hours sale or exchange of sterile syringes.

> There was one Asian the other night when me and Alex had a shot. He gave me two caps cheap for $50 and Stan said he would help him out because he needed syringes and he couldn't get them anywhere. And we only had one to give him - one new one - because me and Stan only had one new one each. And we gave him one and he said he was going to share a fit with three other people - that one. (Sock, 19 year old Serbian-Australian male).

> A few nights ago some bloke asked him, he goes have you got a few clean syringes, we will blow you out like, give you half a cap. (Joe, 23 year old Koori male)

One way of potentially overcoming problems in relation to the availability of sterile injecting equipment would appear to be the provision of vending machines in the area. These machines would provide a much needed service which may help reduce the transmission of blood-borne viruses. Ideally however, the installation of vending machines which operate on a non-cash (i.e. one-for-one exchange) basis may also - in addition to meeting the demand for after hours availability - reduce the incidence of discarded syringes in the surrounding area.

However, availability must also be distinguished from issues of access and equity. In the absence of access to and/or awareness of public NSEP's, access to sterile injecting equipment is mediated by financial constraints and subjects' perceptions of their economic choices. Many young people reported that they were simply unable to afford to purchase a clean syringe.

> A lot of people just have enough money to buy their gear and then they haven't got no money to buy fits and that and that's why a lot of people share their needles (Dee, 17 year old Anglo-Australian female)

> I was just talking to them, walking. They bought fits. I was there and they said to me this and that and then they go "Oh, we'll blow you out" and I said "Well, I've got no money for new fits" and then I said "Don't worry, I'll use hers". She said "If you wanna do it, do it".[Did you clean it out first?] Yeh, just water. Does that do anything? It doesn't ay? (Sock, 19 year old Serbian-Australian male).

This potent combination of economic dependency and drug dependency in influencing risk behaviours is perhaps most apparent than when users are "hanging out" or withdrawing from heroin. Users who are hanging out often see themselves as having little or no choice when confronted with an opportunity to alleviate their symptoms.

> I remember my mate, like I met him in Fairfield when I was *hanging out* and he goes do you want half a cap so I go yeah. This was when I was just kind of starting using like. I had 5mls and I would be off my face. He had 15mls and he

gave me 15 and I left 5mls in the fit. I felt good and I said I don't want to do it and so he had it - 5mls of my blood. (Josua, 20 year old Latin-American male)

There were a few people that I found out had something just lately and um I think maybe at least once I did share with them because I had no other choice. I was *hanging out* bad. But if I did have the choices, I wouldn't do it. I would go down to the chemist. (Joe, 23 year old Koori male)

I've had a fit with gear in it with blood in it, my blood, and a bloke that was *hanging out* said "Can I have that?". A bloke that I know hasn't got nothing, thats not a full on user but he's just gotten into it and he's hanging out and he wanted to use my fit thinking that I haven't got nothing. Cause I've just got out of jail
and I looked healthy. I was doing weights and that and he just wanted to use my fit with my blood in it. And I knew I had Hep C and I told him you can't have that and he made me feel this low [gestures with fingers]. (Jack, 21 year old Anglo-Australian male)

[What time was this?] About four in the afternoon. [So you could have gone and got a fit?] I could of, too lazy to go, didn't have money ... People will do it [share] cause they're *hanging out* ... (Sock, 19 year old Serbian-Australian male)

It is important to note however, that collective injecting episodes in the study site more often involved the sharing of filters, spoons and rinse water than the direct sharing or transfer of syringes (Koester 1989; Koester and Hoffer 1994; Needle et al. 1994). In terms of frequency, high risk practices took the form of equipment-mediated, and in some instances, syringe-mediated, drug sharing. Equipment-mediated drug sharing here refers to the use by two or more persons of any of the following: spoons or drug mixing containers, filters and rinsing/mixing water. Syringe-mediated drug sharing (or indirect sharing: Koester 1992) involves the sharing of drug solution that has been in direct contact with injecting equipment (i.e. frontloading and backloading).

We only had one spoon. We found it in the flats somewhere. Washed it with tap water and just wiped it really well. (Taylor, 16 year old Anglo-Australian female)

Like yesterday, these two Asian guys, I used my water to clean out my fit and a little bit of [my] blood went in and it was all pinky. He didn't care, he just used the water. (Suzie, 17 year old Serbian-Australian female)

A couple of lines is a big deal. I sucked up too much [into a previously used fit rinsed only with water] and they started spinning out so I had to squirt some back [into the spoon]. (Fatman, 20 year old Anglo-Australian male)

While the order of injecting is important to users, the reasons behind this are not always based on perceptions of health risks. Economic considerations are probably the most important element in determining "who goes first".

> [What is the main thing that determines who goes first?] Well, whoever puts in most would get the first kick I suppose. If he puts in more money, if he uses more money that me he goes first. If I use more money I go first ... But a lot of times we just do it the same time just to get it over and done with real quick. Just so the coppers won't bust us. (Rob, 21 year old Anglo-Australian male)

> He scored, he had all the money ... We went to the flats on this side up here and he goes I've only got one fit. And I said you can't be serious you must have another fit and he goes no and it was on o'clock in the morning and there was no fit. He goes I've already used it, I might as well use it first. He knew I had nothin cause I'd just got out of jail long before. I had all the tests in jail. I didn't have nuthin. This bloke knew he had Hep C but he never told me he had it and he lied to me then and there ... First he used it, then I used it and I caught Hepatitis C. Thats how I've got Hepatitis C because of that ... Cause I've been too weak-hearted to walk away from a good shot. (Bon, 22 year old Anglo-Australian male)

As noted in the previous quotation from Bon, collective injecting episodes in the study site also involved simultaneous administration. In this instance, the scenario whereby two or more individuals simultaneously draw heroin solution from a [plastic] spoon into their syringes resembles what one user described as "pigs in a trough" (Maher 1996a).

> It like if I go first my mate is hanging out too, he wants to have it first before me so he doesn't want to wait till I mix up and then he has it and then he has to wait and then my girlfriend has got to use the spoon so its rather we just do it all together and all have it all together. (Rob, 20 year old Anglo-Australian male)

The fear of being interrupted or "busted" by the police also exerts a significant influence on collective injecting practices (see 4 below).

> Going first is very important to people who use let me tell you. You can put away and the other blokes halfway through sucking up and the coppers turn up. Cause you know the coppers could turn up at any second. While he's sucking up, you've just had it, its too late for the coppers. (John, 27 year old Anglo-Australian male)

However, other factors influencing the preparation, distribution and administration of heroin solutions include a lack of injecting experience and the fear of overdose. The data suggest that these factors are highly gendered, with young women less likely to be willing or able to self administer and more reluctant to "go first".

> They were going to do me first but I said no, I don't want to be done first. I want to see the other person, see how they react on it. We had brand new needles and they had their old ones. But what's worrying me is that Lazzares went after her. He reckons I brought the wrong needles. He likes the thick ones. I don't know what it is. Gail had a thick one so he says I'll use after you Gail. He washed it out with tap water. (Kylie, 17 year old Anglo-Australian female)

> I wanted to smoke it cause if that guy isn't there I won't shoot up. I'd rather go and smoke it than shoot it up cause I don't trust any other person to do it for me. (Dee, 17 year old Anglo-Australian female)

Finally, it is important to note that young injectors who were aware that they had been infected with a blood-borne virus (typically HCV) were reluctant to disclose their health status to other users. As Bon, a 22 year Anglo-Australian man, told me:

> [Why don't you tell people?] I just don't want to tell all these young blokes around here cause they say [gossip] in the toilets, they're stupid and that. Blow it out of proportion and what not. If they were mature and decent and knew what it all meant ... Might start spinning or they might not even touch me or something. I don't know.

3.6.3 Use Settings

Injecting episodes in Cabramatta take place in a variety of locations that include private, semi-private and public settings. Private settings include residential addresses and motel rooms. Semi-private settings include motor vehicles and some abandoned houses. Public settings include the walkways, stairwells and gardens of local flats, abandoned houses, public toilets, trains, bus shelters and outdoor locations such as parks, underpasses and car parks.

> People go in toilets, alley ways, abandoned houses, anywhere you can get, even on the trains, under the train bridge, anywhere. Thats it, once they know the police aint there they will go there but they know the police always come around here. (Smiley, 14 year old Anglo-Australian female)

> You go in there and you can't even see the floor its just full of needles. You look anywhere, its just a normal house you look anywhere and there's needles everywhere. I reckon there'd be about a thousand [used] needles. (Kylie, 17 year old Anglo-Australian female)

> [We are looking at photographs I have taken and comparing people using in New York City to people using in Cabramatta] Looks the same to me. It is unbelievable. Its just I always used to think that like in New York and stuff like that it used to be real bad and it looks bad in all the photos. But then when you look at the photos in Cabramatta it looks basically the same. When you look at

> all these houses and that where people go to shoot up it's just unbelievable, unbelievable. There is all the flats around Cabramatta, there are galleries, syringes where people use and stuff it is unbelievable. I am just looking at a photo of myself shooting now and I'm freaking out. I can't believe how filthy it was where we went yesterday and all the garbage and all the syringes and needles. Unbelievable. (Peter, 17 year old Serbian-Australian male)

> That's where we all go [an abandoned house]. You got some dealers doing their caps up and you got us hanging around for a try to give it to us. (JJ, 15 year old Anglo-Australian female)

> A lot of people go there but the police know it now so they're always there and like we were there yesterday and they busted a friend. We were out of there, everyone for themselves once you're in trouble, you've gotta look after yourself, you know.(Teddy, 20 year old Pacific-Islander male)

Perhaps not suprisingly, collective injecting episodes are more likely to occur in public settings. Most of these locations are well known to IDUs, local residents and the police and provide little, if any, privacy. Conditions tend to be unsanitary and are typically poorly lit and poorly ventilated. With the exception of public toilets, few have access to running water and the majority are littered with injecting paraphernalia, including discarded syringes. Many of these settings can be characterized as "free" shooting galleries in the sense that they provide a "space where IDUs regularly gather to inject drugs but where there is no admission fee" (Ouellet et al. 1991). While the vigorous policing of such locations may reduce the number of users who utilise public settings, it may also promote the emergence of less desirable and possibly more "hidden" settings.

> Where I usually have a shot now is this house up there cause I find it is really suss cause all the flats down here now I have seen coppers going in there during the day, they walk in and out of the flats and they busted a couple of guys down there yesterday in behind the bottom flats. Before I heard people saying "Lets just go to the flats its cool, no-one ever goes there" but now the coppers are starting to go to all these flats you know. (Joe, 23 year old Koori male)

There is also at least one "taste gallery" currently operating out of an abandoned house in Cabramatta. According to Ouellet et al., taste galleries have three things in common: "They offer some amount of privacy; someone is in charge; and drugs are the price of admission" (1991:71). Indeed, conditions in Cabramatta at the moment would appear conducive to the development of commercially-oriented galleries where people provide places for others to inject for a fee (either drugs or money). The presence of several vacant (abandoned/condemned) houses in the area indicates that there is no shortage of suitable premises. While in one sense, the establishment of more commercial galleries may be desirable (i.e. presence of gatekeepers, potential for safe using norms and safe disposal), this is highly contingent on the type or nature of

galleries that emerge. For example research in the United States indicates that in the North American context certain types of shooting galleries can serve as vectors for the transmission of HIV and other blood-borne viruses (Des Jarlais et al. 1986, Marmour et al. 1987; Des Jarlais and Friedman 1990; Ouellet et al. 1991).

3.6.4 Law Enforcement Practices

During the study period Cabramatta was the site of high profile, intensive and sustained policing intervention. While the complex and often contradictory effects of drug law enforcement on particular markets will not be addressed here,[xvii] it is important to note that some types of policing may have the potential to do more, rather than less, harm. While overt operations (e.g. presence of uniformed beat police, mobile patrols, officers on horseback and dog teams) appear to have had little impact on the market per se, these data suggest that they have had a negative impact on consumption practices and the risks associated with injecting drug use.

From a health perspective, the increased (overt) police presence in Cabramatta may have contributed to a number of undesirable outcomes. Firstly, the intensity of police activity in the area has encouraged both the oral and intranasal storage and transfer of heroin.

> Normally I take it in my hand and try and rub it on my clothes or something and clean it up a bit before I put it in my mouth. [You never put it straight into your mouth?] Sometimes if the police are really hot I do. Everyone does. I have even gone mouth to mouth, like kissing if things are really hot. (Rebecca, 17 year old Serbian-Australian female)

> When I get it, I put it in my mouth. I wipe it sort of, rub it on my jeans a bit and then put it in my mouth because I don't want to get busted with it. If cops come, I just swallow it. (Gavin, 17 year old Latin American male)

Until recently, the oral storage of caps has been perceived as a risk-reduction measure on the part of sellers. If the police approach and appear "serious", sellers can simply swallow the caps. While this may have a cost attached if the caps cannot be recovered, it is considerably less than that incurred by arrest.

> Before when I was dealing with ____, I think we had six caps each and a cop came up to me and I had to swallow all the caps and went around the corner and tried to vomit them up and I could only vomit three back up so I lost three caps you know. (Tien, 19 year old Indo-Chinese male)

However, most sellers and users are now aware that the police know that sellers store heroin inside their mouths and that the police usually take steps to prevent potential arrestees from swallowing the evidence.

> Most of the cops are pretty cluey so if they do you over and they search you they always ask to look in your mouth like you know, have you got anything in your mouth, open your mouth and you know, I have even had a cop stick his finger in my mouth. (Harry, 34 year old Koori male)

> Now when the cops grab you they try and put a hand around your throat so you can't swallow. They punch you in the back, try and make you cough it up because if you get punched in the back. I have seen a lot of people get hit actually. (Chantelle, 23 year old Anglo-Australian female)

However there is evidence to suggest that - possibly in response to the police "wising up" in relation to the oral storage of caps - some sellers have taken to storing heroin in their noses.

> He'll pull em out of his nose and say "Put in your mouth quick" Piss off. They say "Put in your mouth". I wouldn't put them in my mouth. I have done but only if the coppers are walking straight towards me and they're gonna question me and that then I'll put it in my mouth but other than that, there's no fuckin way in the world I'll put it in my mouth. Those cunts carry TB and everything mate. (John, 27 year old Anglo-Australian male)

> I have seen a guy down at the railway station and he had two halves up each nostril. I seen this girl go over to him and he put one finger over the nostril and these two big balls come flying out of his nostril and then he did the same to the other nostril and two big balls came out of the other nostril like. They just jam it right up you know. There was a bit of gooey stuff hanging off but I didn't get a really good look at it. He just had em in his hand and then I seen the chick hand him the money. He sat there and counted all the money and then handed them other. (Zell, 19 year old Anglo-Australian male)

More importantly however, the overt police presence may have exacerbated the incidence of high-risk injecting episodes in the area. Both observations and interviews suggest that street-based injectors who utilise public settings are increasingly at risk of being interrupted by police - either during preparation or actual administration.

> They could turn up at any moment. Its a worry cause there's nothing worse than them coming when you're halfway through sucking up and just losing things like that. (Josua, 20 year old Latin American male)

> I was in the toilets. I put the rock in the spoon just about to have a shot and the copper I think he stood up on the tray or something and looked over. He started yellin to me stop, stop and one of the police started to kick the door down so I grabbed the spoon and threw the rock in the water in the toilet bowl and they kicked the door in and started hassling me and stuff. They say were do you come from and that you're a junkie, they called me junkie and all this. They pushed

me against the wall. One of the coppers grabbed me by the throat and I said to em like "Why don't you bust the dealers like, why do you hassle us for?" and he goes "Mate, if you want to set up a buy for us we can bust a dealer" and I went there's no way I'm going to do that. No chance. (Peter, 19 year old Serbian-Australian male)

[How does the fact that you know the coppers could turn up any minute impact on what you're doing?] Obviously you do it a lot quicker. You are a lot more worried and rushed and looking around and you're sort of spinning out right through you know. (Zell, 19 year old Anglo-Australian male)

From the time when I'm just about to get it [buy heroin] til the time when I've just finished using, all that time is a major stress period. (Teddy, 20 year old Pacific Islander male)

There's so many police. They can watch you anywhere. Even after you get it, all you gotta do is go to the wrong place and they see you walk into somewhere and they'll come from behind ya and boom, you know, you're busted. (Taylor, 16 year old Anglo-Australian female)

The fear and uncertainty this induces often translates to high risk injection episodes with users anxious to "get on" and get away as soon as possible. Such situations are not conducive to safer injection practices or safe disposal of equipment. Related research suggests that street-based injectors may be less likely to carry injecting equipment on person, less likely to use tourniquets, less likely to swab before and after, more likely to engage in collective injecting episodes, unsafe drug preparation and division procedures (e.g. backloading) more likely to share needles, use discarded needles and to leave paraphernalia behind (Maher, 1996a).

Its like pigs in a trough. You gotta be quick, Hurry up, hurry up. Get me quick, put it away quick and then its too late [to get busted]. Once you've taken it out of your arm, too late now, throw the fit in the box and say well the coppers can go and get lucky. (Alex, 23 year old Serbian-Australian male)

You gotta be quick cause if you take your time and the coppers do see ya ... if you take your time, they're gonna come around and sneak up on ya and they'll bust ya but if you're quick about it by the time they come around and go the long way and sneak up behind ya, its already gone you know. (Rob, 20 year old Anglo-Australian Australian male)

I'm always looking over my shoulder everytime I'm down the south flats and I'm always watching me back and everything you know, always looking around. Trying to do it real quick and then everything is a bit rush ... If I'm sitting at home you know, its easy, no hassles no stress. (Bon, 22 year old Anglo-Australian male)

3.7 Heroin-related Fatalities

In 1995, more than 30 fatal heroin "overdoses" were recorded by police in Cabramatta. However, recent research conducted by NDARC suggests that the term "heroin overdose" may be misleading (Darke and Zador forthcoming). In particular, a study of fatal "overdoses" found that blood morphine levels alone could not account for most fatalities. In many cases, the deceased had been using alcohol and/or benzodiazepines (Zador et al. 1995). This research challenges the common assumption that heroin-related deaths are a product of either sudden increases in the purity of the drug or the use of chemical contaminants.

Three of the young people who participated in this study died during the study period. Two of them died from suspected "overdoses". One of these fatalities involved a 15 year old girl whose death attracted considerable media attention, and the other was a young man aged 19. These deaths occurred within a four week period and I spent considerable time, during both formal interviews and informal conversations, canvassing user's reactions to these deaths and, in particular, the reactions of those who had known either one or both of these young people.

The sudden increase in purity hypothesis was not widely subscribed to among young people although older, more experienced users tended to identify this as a possible explanation for heroin-related deaths.

> They're not sensible. They should know, should take a bit of gear, use a bit, then see how it is y'know. (Harry, 34 year old Koori male)

> I could have a shot at any time and if its twice as pure I'll die you know or I'll wake up in hospital again. I know that cause thats what happened last time - the drug was twice as pure. It must have. (Sherry, 31 year old Koori female)

> We take a chance every day of dying. Simple as that. You know, buy the gear and its a white powder and you throw it in the spoon and add water to it and it mixes up, you shoot it. What if its battery acid mixed up in it. All sorts of shit mixes up.
> (John, 27 year old Anglo-Australian male)

A related theme was that people who overdosed "didn't know their habits". This was linked to age and inexperience by both older and younger users alike. Many of the young people who knew the young woman who died attributed her death to "inexperience" - "She didn't know what she was doing". In contrast, those who knew the young man who died were puzzled as to how this had happened. As one of them put it, "I don't understand. He knew what he was doing". However, one young man who used with the deceased young woman on a regular basis had some insightful comments.

> People I've spoken to have sorta said she didn't know, she just didn't know what she was doing - she was too immature or too young to know and they think

> they're smarter. People do have that attitude. They think, they seem to think that they're invincible and I guarantee those same people will have OD'd themselves but they just don't like facing the truth. (Bon, 22 year Anglo-Australian male)

An interesting split occurred among the people who claimed to be close to the young woman with some (particularly other young women) claiming that she was murdered - i.e. that someone had deliberately given her a fatal dose or an adulterated dose (a "hotshot"). Perhaps this was the only way they were able to comprehend the sudden death of a close age and social peer.

> We heard that it wasn't an accident. [What do you mean?] Well, she didn't OD - these guys did it and then they dumped her at the hospital [What do you mean, they did it?] They gave her a bad shot. [C'mon, why would they want to do that?] They wanted her dead ... (Dee, 17 year old Anglo-Australian female).

> Everyone liked her around here and everyone, you know, felt, you know, that she's gone ... Everyone's well and truly aware of it and knows how shocking it is for a young person like to die. (Smiley, 14 year old Anglo-Australian female)

These young injectors are part of social networks which exhibit a high mortality rate. Perhaps the only way in which many young people can cope with the premature deaths of members of their age cohort is to distance themselves and their own drug use from that of their deceased peers - whether by pathologising the actions of the user or engaging in conspiracy theorizing. Certainly there is little evidence to suggest that the young people studied here modified their own drug using behaviours in the wake of these sudden deaths.

However, some of those who claimed to be close to the young woman claimed (probably accurately) that her death was the result of using heroin and benzodiazepines. Although rohypnol was the benzodiazepine of choice, rivotril (an anti-convulsant) was the most widely available and commonly used benzodiazepine during the study period.

> She told me herself only a month ago that she overdosed on pills. And that was because she took pills and gear together (Kylie, 17 year old Anglo-Australian female)

In fact the deceased young woman had described this earlier "overdose" to me during a taped interview recorded on the day of her death.

> I had fifteen rohies and the heroin the first time I took em. Fifteen rohypnols ... I woke up in the morning and I was in the hospital. Boyfriend's screamin' in me face "I'm gonna kill you". The doctors running up and down the stairs. (Keisha, 15 year old Koori female)

She also described how she routinely obtained heroin by trading rohypnol for caps with local dealers.

> I was just going [to doctors] and gettin em meself. I was going in and sayin I'm a junkie, I need pills so I can get to sleep. Cause me legs ache and I can't sleep. So he put me on rohies. I used to come out here and swap em for a cap. (Keisha, 15 year old Koori female)

Interestingly, it was mainly older users who identified the use of benzodiazepines as a factor influencing the likelihood of adverse health outcomes including "overdose", unsafe injecting and unsafe sex.

> You do stupid things you know. People say "Oh I let him sleep with me cause I was drink". With Serapax you could get gang banged and not remember it truly. You'd only know cause you're sore. Sore and smelly. (Kate, 31 year old Anglo-Australian female)

> I'm not knocking them or anything like that but a lot of people around Cabramatta you see them at the station and things and they're really smashed or throwing up. I used to think how are they so smashed, you know - we're scoring off the wrong people. I've since discovered that it's mainly rohies you know, they take pills with it. (Trisha, 31 year old Koori woman)

Two young people however, claimed that for them, the fear of being arrested with drugs in their possession had led them to use more than they would have ordinarily. Both these episodes resulted in "overdoses".

> [So what you scored off this guy on the train?] Yeh. He needed the money to pick up again - to buy another half. He was short. It was a pretty big rock. He goes $80. I go yeh alright. I bought it off him and I went to the toilet [in Cabra]. It didn't seem like much but there was a lot there - about five caps. I thought I'll have it cause I thought if I get stoned and I carry it around I might get caught or something so I had it and I was walking from the toilets from BKK and I got to the centre [of the plaza] and I felt this tingle going up me spine and then it just hit me and I just dropped. When I woke up I had a needle in me. Look there's still a yellow stain there from the narcan, where they gave me the narcan. (Peter, 19 year old Serbian Australian male)

4.0 DISCUSSION

In contrast to epidemiological and survey approaches, ethnographic research has the potential to assess emerging trends in illicit drug use environments and, in particular, to document changes in patterns of consumption, modes of administration and risk behaviours, as well as the vectors by which drug use is diffused to new populations of users. Epidemiological and survey approaches, when used alone, have often mistaken the extent of use, how users are initiated, how they switch between drugs or modes of administration and use patterns, how much they use, how and why they desist, who drug distributors are, how they operate and how particular markets function. While these approaches may detect greater availability and increased consumption of illicit drugs, they are unable to explain the dynamics of particular markets, grasp the characteristics of new users, explore the sources of demand or tap into emergent rituals and norms which energize new use patterns. The principal drawback of these methods, and one which ethnography is potentially able to correct, is that large-scale surveys cannot comprehend the contexts of social life in which drug use and distribution takes place, their complexity and situational aspects, and their economic and cultural dimensions.

The ethnographic component of this trial has been successful in gaining access to a relatively "hidden" group of recent initiates to heroin use. These users, the majority of whom are still in their teens, are not well represented in either treatment statistics or the research literature. They are however, beginning to show up in the criminal justice system (e.g. see Cain 1994). They also illustrate the diversity of ethnic backgrounds involved in heroin use in South West Sydney. Indeed, the picture suggested by this research indicates that this population may differ from the heroin users encountered in the literature (e.g. Darke et al. 1990, 1992, 1994; Loxley et al. 1995). Specifically, the results of this preliminary study suggest that heroin users in Cabramatta may be significantly younger, have lower levels of education and higher levels of unemployment, be more likely to be female, less likely to be Anglo-Australian, more likely to have initiated heroin use by smoking rather than parenteral use, more likely to be involved in crime (including drug distribution and sales activity), more likely to engage in high risk injecting episodes and to have little or no experience of treatment.

The young people described here are worthy of further study from both a public health and a criminological perspective. The prevalence and incidence of heroin use is probably such as to indicate a new cohort of heroin users, many of whom have initiated use through smoking. If heroin were suddenly to become scarce or increase in price, many of these young people would be under increased pressure - to quit, commit more crime or commence injecting. While there is some evidence to indicate that anti-injecting sentiment may be culturally specific with some ethnic groups more likely to inject than others, for all groups the likelihood of injecting probably increases over time (Griffiths et al. 1994). For young people, exposure to both street-level dealing and methadone programs may increase the likelihood of intravenous use through increased contact with injecting populations.

Cabramatta itself is also worthy of further study. Many of the factors identified here, including drug acquisition routines, collective injecting episodes, use settings and law enforcement practices, represent components of a neighbourhood risk environment

which is highly conducive to the transmission of HIV and other blood-borne viruses. The development of a large open air drug market has led to the emergence of a street-based injecting culture which draws heavily on young people from the local area. The density of these networks and their convergence in collective injecting episodes may have important implications for public health. Future research should attempt to investigate the ways in which different local or neighbourhood risk environments influence individual risk behaviours.

Similarly, the fact that Cabramatta is a major centre for both legal and illegal commerce raises interesting questions about the links between formal and informal sector economic activity and the transfer of human, social and economic capital in and out of particular neighbourhoods and regions. What does it mean to have a large street-level drug market in an area characterized by a relatively young and ethnically diverse population with high levels of unemployment? What are the likely effects of various law enforcement strategies? Who are the consumers of policing in this context? Which types of strategies will do least harm?

In summary, there is much to be learned about new users of heroin in South West Sydney. What is the prevalence and incidence of heroin use in this area? Who are the "new" users and how do they differ from the "old" users? What is the age, gender and ethnic distribution of new users? What other drugs do they use or have they used and how do they use them? What are the routes of administration and the nature of transitions between different routes of administration? In what ways are new heroin users involved in the informal or illegitimate economy? How likely are they to seek treatment and what is their knowledge and understanding of HIV and other blood-borne viruses? Future research that focused on a particular neighbourhood, such as Cabramatta, utilised both qualitative and quantitative methods, was conducted by a research team that included indigenous fieldworkers and provided some level of service to the population, could attain a degree of involvement in user's lives that would encourage them to share their experiences of drug use (Ouellet et al. 1995).

5.0 CONCLUSION

The ability to tap into "hidden populations" is one of the principal benefits of street ethnography. While the focus of this component has been on young injectors, the use of targeted sampling has ensured that a small number of heroin smokers and older users, as well as several subjects from areas outside South West Sydney, were also included in the study.

Access to the group of young, relatively "new" heroin users described in this study was only possible because of ongoing fieldwork based in Cabramatta. This fieldwork forms the basis for several ongoing projects including a study of drug use and economic behaviour funded by the National Drug Crime Prevention Fund and a cross-cultural comparison of HIV risk practices funded by the United States National Institutes of Health (NIH) . Therefore, the usual problems and delays involved in gaining access and establishing relations of trust and credibility with subjects were avoided by "piggy backing" on existing research actively engaged in recruiting, interviewing and observing street-level drug users in the area. The establishment of a field site in Cabramatta has also yielded benefits for the IDRS project in terms of the assessing the validity of these data. Data for the IDRS trial were triangulated both internally and against data collected for other projects utilising the same field site.

Finally, it is important to note that the costs associated with this component of the research ($3,000) do not reflect actual costs involved in conducting ethnographic research. While the budget for the IDRS trial covered direct payments to subjects and travel expenses, it did not involve any of the indirect costs associated with ongoing ethnographic research. These costs (salaries, storefront rental and equipment costs) were absorbed by existing funding. The costs of transcribing tape-recorded interviews (approximately $4,000) were met by NDARC. Intangible indirect costs mentioned above, including the benefits of 12 months fieldwork in the study site, are also not included.

The ethnographic study of drug use and distribution is time consuming and expensive. It requires professional ethnographers and field staff dedicated to penetrating and immersing themselves in the worlds of their subjects. The issues raised here are not insignificant in assessing the feasibility of an ethnographic monitoring component to the proposed IDRS. It may be that future ethnographic contributions to the IDRS will only be possible where there are existing projects involving ethnographers in the field. An alternative for ensuring at least some ethnographic input into the IDRS would be to interview ethnographers as part of the key informant component (Hunt 1994). However, if the proponents of such a system are serious about seeking to develop a comprehensive drug monitoring system, the potential benefits of street ethnography in contributing to the success of this endeavour cannot be ignored.

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APPENDIX ONE

LOCAL DRUG MARKET CONDITIONS QUESTIONNAIRE

Dr. Lisa Maher
National Drug and Alcohol Research Centre
University of New South Wales

ID Number:
Subject Code Name:
Date of Interview:
Location:
Cross Refs:

I. DEMOGRAPHICS

1. ID Number: _____

2. Sex :

Female .....0 Male 1

3. Date of Birth: ____/____ /____

4. Culture/Ethnicity: _____

5. Marital Status:

Single 0
Married 1
Defacto 2
Separated 3
Divorced 4
Widowed 5

6. Current Residence (Postcode): _____

7. Last year completed at school: _____

8. a) Employment Status:

Employed F/T 0
Employed P/T 1
Unemployed 2
Student 3
Home Duties 4
Pensioner .....5 (Invalid, sickness, parent)

b) If unemployed: Have you ever had a paid job? No.....0 Yes.....1

c) If unemployed: How long have you been without work: _____

9. a) If employed, type of work: _____

b) If unemployed, what is/was your usual occupation? _____

II. DRUG MARKET CONDITIONS

What we are interested in is what people pay for their drugs around this area and what kinds of things affect these prices. The questions I'm going to ask all apply to the last time you bought drugs - the most recent occasion on which you scored. (Do not include purchases where subject did not use any of the drug purchased).

10. What was the last day on which you bought drugs?

Mon Tues Wed Thurs Fri Sat Sun

11. How many days ago was this? _____

12. Which drug did you buy? _____

13. How did you pay for this drug?

Cash 0
On credit/tick.....1
Swap/barter/trade.....2 (Specify _____)
Other .....3 (Specify _____)

14. If the drugs were bought with cash or on credit, how much did they cost?

$_____

15. If you paid with cash, did you contribute all the cash yourself?

No 0
Yes 1

16. If no, how many others contributed funds? _____

Specify amounts contributed : Self _____

Person 2 _____
Person 3 _____
Person 4 _____
Person 5 _____

17. What quantity of the drug did you buy? _____

18. Was the purity of the drug?

Normal 0
Less than normal 1
More than normal 2

19. What was the culture or ethnicity of the dealer? _____

20. How old do you think the dealer was?

Under 20 0
20-30 1
30-40 2
Over 40 3

21. How often do you buy drugs from this particular dealer?

Always 0
Usually 1
Occasionally 2
Never before 3

22. Where did the dealer take the drug from?

Mouth 0
Pocket 1
Nose 2
Package on the ground 3
Other .....4 (Specify_____)
Don't know 5

23. On what side of the station was the purchase made?

CBD side 0
other side 1

24. How long after the purchase did you use the drug?

Less than 15 minutes 0
15 - 30 minutes 1
30 - 60 minutes 2
1-2 hours 3
2-4 hours 4
6-10 hours 5
10 or more hours 6

25. Did you use the amount you bought in one go/at one time?

No 0
Yes 1

If no, how long did you take to use it? _____

26. How did you use/take the drug?

Inject 0
Smoke 1
Snort/sniff 2
Other .....3 (Specify _____)

27. Did you use it alone or share it with others?

Alone 0
With others 1

28. If used with others, how many others did you share the drug with? _____

29. If you shared, how would you describe your relationship(s) to the persons(s) you shared the drug with on this occasion?

Friends 0
Partner/lover 1
Acquaintences 2
Strangers/people just met 3
Other .....4 (Specify _____)

30. Where abouts did you go to use the drug?

Toilets .....0 (Specify _____)
Flats 1
Abandoned house 2
Friend's place 3
Your place 4
Other .....5 (Specify _____)

31. Did you have to pay anyone or give a taste to be able to use there?

No 0
Yes .....1 (Circle CASH/TASTE)

32. Was this location in Cabramatta?

No .....0 (Specify _____)
Yes 1

33. Have there been any police activities in the last three months that have affected your access to heroin?

No 0
Yes 1

34. Last question - Are there any comments you would like to make about drugs, drug treatment services or the police in Cabramatta?

_____

_____

_____

[i] This study, funded by the National Drug Crime Prevention Fund, is investigating the economic behaviour and lifestyles of street-level drug users.

[ii] By this is meant a sampling frame established prior to, and independent of, the process of ethnographic fieldwork.

[iii] Three were Indo-Chinese males, one was an older Indo-Chinese woman and one was a young Pacific Islander woman.

[iv] I wish to thank Matthew Sutton and Ann Line Bretteville-Jensen for generously providing me with copies of questionnaires used in their research, from which I adapted the current questionnaire.

[v] The original proposal estimated that subjects be paid $50 for a single interview. In order to avoid both setting a precedent for future research and potential conflict in relation to the principal research project (which recompenses subjects $20 per interview) it was decided to separate the data collection exercise for the IDRS and to recompense subjects at the rate of $20 for the completion of an in-depth interview and a further $20 for the questionnaire.

[vi] In general, Indo-Chinese males have proven difficult to recruit and have been under-represented in research efforts to date.

[vii] According to Pearson and Gilman, micro-diffusion is "the means by which drugs and drug practices move within friendship networks within a locality" (1994:105).

[viii] For example Katz, Levin and Hamilton (1963) define diffusion as "the acceptance, over time, of some specific item - an idea or practice - by individuals, groups, or other adopting units, linked to specific channels of communication, to a social structure, and to a given system of values, or culture" .

[ix] An exploratory study investigating patterns and contexts of heroin smoking and injecting among 200 users in South West Sydney is currently being conducted by myself and Wendy Swift. This study will also address transitions between routes of administration.

[x] This hypothesis forms the basis of a pending grand application (Maher, Swift, Chesher and Dawson) to investigate the purity, composition and smoking efficiency of heroin in Cabramatta.

[xi] Based on a collection of 299 samples of heroin obtained in Cabramatta as undercover purchases or recovered from persons arrested for heroin possession, Weatherburn and Lind (1995) estimated the average price per gram of heroin to be $1,309 with a range of $118 to $11,667.

[xii] In fact recent research in North America suggests that, in many drug markets, gang sales are loosely organized with individual members engaged in feelance, not organized drug sales (Hagedorn 1994). Similarly, fieldwork in Cabramatta suggests that gang involvement in drug distribution and sales is oriented toward the economic survival of individual members and may be best understood as a response to high levels of unemployment and economic and social marginality. In particular the 5T, as a "cultural gang" (Skolnick 1989), exists prior to and independently of the illegal activities in which it is involved and is perceived by many young Vietnamese as a familial resource which places strong emphasis on loyalty (brotherhood), respect and physical protection.

[xiii] The social history and evolution of this particular drug market is beyond the scope of this report.
[xiv] As Koester has pointed out, "By studying the context in which syringes are 'shared' and by eliciting injector's own explanations for this behavior, ethnographers have demonstrated that sharing needles is not an essential trait of a deviant subculture" (1994:287)
[xv] Although the possession of used needles and syringes is not an offence under Section II of the NSW Drug Misuse and Trafficking Act 1985, Section 12 provides that the possession of used needles and syringes can be used as circumstantial evidence for the charge of self administration.
[xvi] Prices for 1ml syringes from local chemists ranged from $1-00 to $3-00. However, the minimum unit available for purchase from the after hours chemist is a three-pack costing $5-00.
[xvii] For a review of this literature and its relevance to the local context, see Weatherburn and Lind (1995). On drug law enforcement more generally see Manning (1980), Reuter and Kleiman (1986), Moore (1990), Dorn et al. (1992) and Collison (1995).