

Views from the Street:

Needle Exchange Users in Glasgow

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1. Introduction

In 2004 Scottish Drugs Forum [SDF] and the Glasgow Involvement Group [GIG]¹ undertook a consultation exercise to identify the views of a sample of injecting drug users [IDUs] on existing needle exchange [NX] provision within Glasgow. GIG considered that previous studies had focused primarily on injecting practices but little research in Glasgow had looked at injecting practices in the context of service provision.

Within this context, the primary aims of the study were to gather the perspectives from IDUs on

- NX service provision
- Information given in relation to the promotion of safer injecting practices by services
- Information on Blood Borne Viruses [BBVs]

In line with the national framework for user involvement² it is expected that these service user perspectives will inform and add to the debate surrounding the effectiveness of NX provision in Glasgow and the expansion and development of effective harm reduction responses to the growing Hepatitis C virus [HCV] and HIV transmission rates.

1.1 Background

There are an estimated 4,908 IDUs in Greater Glasgow Health Board area.³ Figures for drug users testing positive for HCV vary but recent figures show that 4,237 drug users have

¹ GIG are volunteers consisting of ex/current addiction service users who are recruited, trained and supported by a User Involvement Development Officer [UIDO] to undertake activities that will impact on the planning and delivery of services.

² *Tackling Drugs In Scotland: Action in Partnership*, The Scottish Office, 1999/*Integrated Care for Drug Users :Principles and Practice*, Effective Interventions Unit, September 2002/*Modernising Community Care: An Action Plan* ,The Scottish Office, 1998

³ *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland: Executive Report*, University of Glasgow, Scottish Centre for Infection Control and Environmental Health and NHS Scotland. Hay G, Gannon M, McKeganey N, Hutchinson S, Goldberg D. [January 2005]

⁴ *Hepatitis C Surveillance In Scotland results to 31/12/03*,
<http://www.show.scot.nhs.uk/scieh/PDF/pdf2004/0426.pdf>

tested positive within the same geographical area.⁴ However it is fair to suggest that the actual number of people affected within the injecting drug using community in Glasgow could be much higher than the official figures suggest. Recent research has also shown that the number of new cases of HIV infection in Scotland has risen to the highest level since the 1980s⁵. It has been recommended that in order to stop people re-using and sharing injecting equipment, between seven and twelve million needles and syringes would be required to be distributed each year rather than the one million currently provided throughout Greater Glasgow. Without an increase in needles and syringes it would be 'likely that the transmission of HIV and particularly HCV will continue to grow.'⁶

Considerable attention has been given to researching the extent and nature of risk behaviours among IDUs. In line with this approach the Effective Interventions Unit [EIU] in 'Examining the Injecting Practices of Injecting Drug Users in Scotland' reported in greater detail the specific practices which may place intravenous drug users at risk of HCV acquisition and other BBVs.⁷ The findings highlighted that more effective ways to prevent HCV infection need to be developed. Concurrently the Royal College of Physicians in Edinburgh called for more effective engagement with the injecting drug community in a bid to tackle Scotland's growing HCV epidemic and the management of those chronically infected.⁸

⁵ *HIV/AIDS Quarterly Report to 30 September 2004, Aids [Control] Act Report 2002-2003*, National Health Service, Greater Glasgow 2004. The Scottish Centre for Infection and Environmental Health, www.show.scot.nhs.uk/scieh/infectious/aidshiv/infaids.html

⁶ *Aids [Control] Act Report 2002-2003*, National Health Service, Greater Glasgow 2004

⁷ *Examining the Injecting Practices of Injecting Drug Users in Scotland*, Effective Interventions Unit, February 2004. Taylor, A, Fleming, A, Rutherford, J, Goldberg, D.

⁸ Royal College of Physicians statement is available at www.rcpe.ac.uk/esd/consensus/hepc_04.html.

1.2 Methodology

The methodology chosen to undertake the fieldwork was the “Peer Research” method. This entailed members of GIG undertaking interviews with IDUs. GIG members have been trained by SDF to carry out survey work within a variety of settings within Glasgow and elsewhere. Prior to this study the group members had carried out 635 interviews [one to one or in group setting].

Data collection

Structured interviews were carried out with 76 IDUs. The questionnaire was developed by GIG in conjunction with the UIDO and SDF’s research officer. The main topics covered in the questionnaire were:

- Service Accessibility
- Service Provision
- Injecting behaviours
- Knowledge of blood borne viruses

The field work took place over a three week period between August and September 2004 on an outreach basis within the Glasgow area. The sites from which the IDUs were recruited were chosen by GIG members with knowledge of the street scene in Glasgow. The interviews were conducted in private [off the street] and each respondent was given a £10 voucher for participating in the study.

All respondents were provided with a study information sheet and written consent was given prior to the interview. No information has been used that could identify any individual.

The GIG members and UIDO performed data entry. A sample of data entry was checked by the Research Officer and Head of User involvement [HUI]. The data was analysed by the SDF Research Officer and HUI using SPSS v12.

Sample Profile

The following section describes the demographic profile of the sample of injecting drug users.

Gender

The gender ratio of the sample was 76% [58] male and 22% [17] female. One response was missing.

Age

Ages were distributed between 17 and 50 years. The mean age of the sample was 33; the median age was 34 and the modal age was 34 thus suggesting a good sample distribution.

Accommodation Status

The most common types of accommodation in which the respondents lived was

- Hostels [35%, N 27]
- Own home [22%, N 17]
- Partner's home [16%, N 12]
- Parent's home [8%, N 6]
- No fixed abode [7%, N 5]
- other people's home [5%, N 4]

Two people had been in prison for most of the previous six months. Five people reported living in two different addresses. Thus, the majority [54%, 41] were residing in temporary or unsecured/non-fixed accommodation.

Employment Status

Table 1 illustrates that the majority of the sample was unemployed [83%, 63]. Among this group, the vast majority [n=59] received government benefits. Thirty-seven people [49%] were involved in illegal activities.

Table 1 Employment Status

<i>Employment Status</i>	<i>Frequency</i>
Unemployed	61 [83%]
Receiving Government Benefits	59 [78%]
Benefits supplemented by Illegal activity	28 [37%]
Benefits supplemented by Big Issue selling	6 [8%]
Benefits supplemented by temporary work	2 [3%]
Other	2 [3%]
Illegal Activities [alone]	9 [12%]
Regular Income	6 [7%]
Salaried Employment	3 [4%]
Big Issue	3 [4%]

1.3 Drug Use

The following section is an analysis of the respondents reported drug use including prescribed and illegal drugs.

Illicit drug use

All respondents were using heroin at the time of interview. The next most common illicit drugs used were

§ Valium	68% [52]
§ Cocaine	39% [30]
§ Cannabis	37% [28]
§ Crack	14% [11]
§ Dihydrocodeine	12% [9]

Sixty three [83%] were poly drug users with Valium the most commonly used secondary drug.

Prescribed drug use

The majority of the sample was being prescribed methadone [62%, 47]. Among the 47 people on a methadone prescription, 39 provided their dose levels with the average level of methadone measured at 79 mgs. The range of methadone prescribed was between 18 and 160 mgs.

One quarter [19] of the prescribed respondents were prescribed more than one drug. Valium was the second most frequently prescribed drug with 15% [7] of those prescribed receiving Valium.

2. Study Findings

As noted in the introduction the primary aim of the study was to look at injecting drug users' views on NX provision in Glasgow. The following section will look at the respondents' views on

- NXs within Glasgow and where appropriate, compare and contrast pharmacy based and addiction service based NXs.
- injecting practices
- knowledge of BBVs and testing

Finally, there is a brief comparison of the injecting practices of the prescribed and non-prescribed respondents.

2.1 Needle Exchanges

The respondents attended 18 different NXs with the most frequently cited NX being at the Glasgow Drug Crisis Centre [GDCC], a service that is accessible 24 hours/seven days a week. There was an even split between those who used pharmacy NXs [n=37] and those who reported using addiction service NXs [n=37]; One response was missing and one person got their injecting equipment from friends.

Accessibility

Almost three-quarters of the respondents [70%, 53] could access a NX within 15 minutes of their accommodation.

The opening hours were suitable for 82% [62] of the sample. There was no significant difference in the responses based on type of NX. Only two respondents cited opening hours as a barrier to NX access but 16 people did suggest improving access through longer opening hours with 10 suggesting a 24 hour service/seven days per week.

Twice as many respondents [n 40] believed that there were sufficient places to get clean equipment as believed that there were not enough places [n 20].

In summary, the majority believed that there were sufficient NXs, did not have far to travel to them and believed the opening hours were suitable to them.

Barriers

In response to the question 'Are there any barriers to you accessing NX provision?', twenty-two [29%] people said they experienced no barriers.

A number of respondents [n=17] reported multiple barriers to accessing NX provision but the four most common barriers were:

§ Police	21%, 16
§ Fear of seeing drug worker &/or losing script	21%, 16
§ Stigma	17%, 13
§ Family	12%, 9

Childcare was a barrier for five individuals [4 females/1 male] and territorial issues [other drug users] was a barrier for four individuals.

A crosstabulation of the pharmacy and addiction service NXs resulted in some difference in responses which are detailed below.

Table 2 Crosstabulation of Barriers by NX

<i>Barriers</i>	<i>Total Sample N =74</i>	<i>Pharmacy Needle exchange N=37</i>	<i>Addiction service needle exchange N=37</i>
Police	21%	27%	13%
Fear of drug worker/losing script	21%	16%	27%
Stigma	17%	27%	8%
Family	12%	19%	5%
Territorial issues	12%	5%	19%
Childcare	7%	0%	11%
Location	8%	8%	8%

The majority of the sample experienced some form of barrier when attending NXs with more barriers being identified by people attending pharmacy based NXs. Police presence, stigma and the possibility of meeting family members were the main barriers to accessing pharmacy NXs. Fear of seeing a drug worker and/or losing a methadone prescription was the main barrier to addiction service NXs. Territorial issues, including 'drug dealers outside' was a barrier at mainly addiction service NXs. This sample suggests there may be different issues occurring at different types of NX that may impinge on the uptake of injecting equipment.

2.1.1 Quality of Service

In order to assess the respondents' views on the quality of NX services in Glasgow, GIG asked a number of questions they felt were important to measuring service quality; these included

- Information provision
- Staff attitudes
- Privacy, confidentiality and safety.

Analysis based on the different types of NXs was undertaken where appropriate.

Information Provision

Table 3 [below] illustrates the respondents provided a largely negative response when asked to rate the information that had been provided to them and the majority rated the information as poor or very poor in the physical and sexual health categories.

Table 3 Information Provision

<i>Information Provision</i>	<i>Total Sample [% poor /v.poor rating]</i>	<i>Pharmacy NX [% poor/v.poor rating]</i>	<i>Addiction Service NX [% poor/v.poor rating]</i>
injecting techniques	45%	58%	33%
physical health	51%	68%	36%
sexual health	53%	68%	39%
abscess/wound advice	49%	71%	28%
general drug information	45%	62%	29%

The table also illustrates that the level of information provided by pharmacy based NXs was consistently rated lower than that provided by addiction service NXs across all categories.

Staff Attitudes

Table 4 [overleaf] illustrates that the majority of respondents rated the staff attitudes positively [45%, n=33] rather than negatively [9%, n=7].

Table 4 Staff Attitudes

<i>Staff Attitudes</i>	<i>Total Sample [%]</i>	<i>Pharmacy NX [%]</i>	<i>Addiction Service NX [%]</i>
Good/Very Good	45%	49%	40%
OK	46%	35%	57%
Poor/ Very Poor	9%	16%	3%

The table also illustrates that, as with information provision, a greater number [n 6, 16%] of respondents who attended pharmacy needle exchanges rated pharmacy staff attitudes as

poor to very poor. Only one respondent rated addiction service staff attitudes as poor to very poor.

Privacy

Whilst the majority of respondents felt there was enough privacy at NXs [62%, 47], there were substantial differences in the responses dependent on the type of NXs being used; 92% [34/37] of the sample attending addiction service NXs felt there was enough privacy but only 39% [14/37] at pharmacy NXs felt there was enough privacy. The most common reason for there not being enough privacy at pharmacy NXs was the lack of any private space [e.g. a booth].

Confidentiality

Almost three-quarters of the respondents believe that the personal information they provide to NX staff is treated in confidence [74%, 56]. There was little difference between pharmacies [73%] and addiction service NXs [79%].

Safety

In terms of safety 20% [15] had concerns about their safety when attending NXs. However in contrast to the previous categories, pharmacy NXs fared more positively; for example 30% [11/37] of addiction service NX users had concerns about their safety compared to 11% [4/37] of pharmacy clients.

The most frequent concerns regarding safety related to

- Other service users
- Police [male respondents only]
- Fear of losing script

Almost one quarter of male respondents [24%, 14/58] had concerns for their safety compared to just one female.

2.1.2 Service Provision

The interviews also focussed on NX policy and whether what was being provided by NX was what was needed by this sample of NX service users. Thus, the following analysis focuses on

- Return policy
- Training for Service Users
- Service provision/service demand

Return Policy

The respondents were asked their views on the return policy operated by NXs. 47/76 [62%] respondents *always* return their used needles and syringes. Only one person *never* returned their needles/syringes. When asked for their opinions on the return policy the majority viewed the policy positively. Only three people were dissatisfied with the return policy; one person was dissatisfied with lack of choice of needle sizes, one with the policy of non-returns receiving only five needles and one person who was homeless said, '*I'm not always able to return my needles and then I don't get any off the pharmacist.*'

A higher proportion of pharmacy NX users [68%, 25] *always* return their used needles compared to addiction service NX users [59%, 22]. These findings are in line with a profile of Glasgow NX service users that compared pharmacy and drug treatment service NXs. The analysis of activity data found a higher return rate at the pharmacy NXs in comparison to the total returns to the treatment service exchanges.⁹

Service User Training

When asked if they would access three types of training, if provided, the following responses were received:

- 79% [N 60] would access overdose training
- 63% [N 48] would access safer injection training
- 50% [N 38] would access first aid training

⁹ Cameron, J, Gilchrist, G, Roberts, K. Needle Exchange Services: a profile of service users in community pharmacies and other settings, *International Journal of Pharmacy Practice*, 12: 211-215 [2004]

Service Provision/Service Demand

Table 5 highlights two features in the provision of injecting equipment and information that is being provided through NXs:

- Parity in provision of injecting equipment and swabs across the two types of NXs but a disparity in the provision of acidifiers and safer injecting information between the types of NXs. Far fewer respondents receive acidifiers from addiction service exchanges compared to pharmacies whilst respondents were more likely to receive safer injecting information from addiction service NXs compared to pharmacies.
- Less than 8% of respondents received filters, water or tourniquets and no-one received spoons or containers for mixing drugs

Table 5 Service Provision

<i>Injecting equipment/services provided</i>	<i>Pharmacy NXs</i>	<i>Addiction Service NXs</i>
Sterile Injecting Equipment	100%	97%
Alcohol Swabs	92%	86%
Acidifiers	89%	22%
Safer Injecting Information	24%	49%
Filters	3%	8%
Water	5%	3%
Tourniquets	3%	0
Spoons	0	0

The low level of provision of some injecting paraphernalia is identified further when analysis is done on the IDUs' responses as to what items should be provided by NXs; 26% – 34% would like to be provided with filters, water and spoons.

The respondents were given a variety of options on services and equipment that they would like to be provided with by NXs. The respondents were asked to choose the top five items they would most like to be provided with. Table 6 shows the items most frequently requested by the respondents.

Table 6 Service Demand

<i>Items/Services respondents would like to see provided by NXs</i>	<i>%</i>
Sterile Injecting Equipment	59%
Acidifiers	41%
Spoons	34%
Injectable Drugs	34%
Water	26%
Filters	26%

Alcohol swabs	21%
Referral to another agency	20%
Information on BBVs	18%
Tourniquet	17%
Testing for BBVs	17%
Safer Injecting information	16%
One-to-one counselling	15%
Crisis Support	7%
Condoms	7%
Don't know	5%
First Aid Training	4%
Drug use information	3%

Among the top four most frequently requested items, the demand for sterile injecting equipment and acidifiers is being met, albeit that there appears to be less provision of acidifiers within addiction service NXs.

A comparison of tables 5 and 6 demonstrates that spoons, water and filters are considered priority items although presently NXs are not meeting the demand for these items to this particular sample of IDUs.

Closing Questions

The final section looking at NX provision allowed the respondents to give their

- Positive/Negative Views on NX provision
- Recommendations

Positive views on NX provision

The respondents were asked, 'what would you say is good about NX services in Glasgow?' Seventy-four respondents provided a response to this question, including three responses that there was "nothing good about the service". The responses are shown in order of frequency.

Table 7 Positive Views on NX Provision

<i>What would you say is good about NX services in Glasgow?</i>	<i>Addiction Service NX [n=37]</i>	<i>Pharmacy NX [n=37]</i>	<i>% Total</i>
Access to and availability of free clean needles	11	11	30%
Help prevent the spread of Blood Borne Viruses.	9	6	20%
Increased availability of NXs	5	9	19%
Stops sharing/using dirty needles	4	2	8%
Advice and support	5	0	7%
Health reasons	3	1	5%
Confidentiality	1	1	3%
Return policy	1	1	3%
Good staff attitudes	0	2	3%
User friendly	2	0	3%

Access to clean injecting equipment and the prevention of BBVs are the most frequently cited positive aspects of the NX services, with little difference across the types of NXs. There are though different responses, dependent on type of NX, in terms of availability of NXs and advice and support. The pharmacy users view the increase in NXs as positive whilst the respondents who attend addiction service NXs view the advice and support that they receive at their NX as a good aspect of the service.

Negative views on NX provision

The respondents were asked ‘what would you say is bad about NX services in Glasgow?’ Seventy-four people responded to the question, including eleven responses that there was “nothing bad about the service”, nine of which were from addiction service NX users. The responses are shown in order of frequency.

Table 8 Negative Views on NX provision

<i>What would you say is bad about NX services in Glasgow?</i>	<i>Addiction Service NX [n=37]</i>	<i>Pharmacy NX [n=37]</i>	<i>% Total</i>
Not enough privacy	4	11	20%
Lack availability of NXs	7	5	16%
Stigma [public perceptions]	4	7	15%
Lack of information on location of NXs	4	4	11%
Opening hours	2	5	9%
Attitude of staff	3	4	9%
Lack of sterile water, citric etc.	4	1	7%
Other drug users	3	1	5%
Fear of losing script	1	2	4%
Police	0	1	1%
Confidentiality	1	0	1%

Lack of privacy in NXs, especially pharmacy based NXs, and a lack of available NXs were the two most frequently cited negative aspects of NX service provision in Glasgow. In total 11 respondents specifically said the 'stigma' attached to attending NXs was a negative aspect with 7 of those attending pharmacy NXs. There was an even split between the two samples of respondents in terms of information provision on the location of NXs.

Improvement Recommendations for NXs

The respondents were asked, 'what recommendations would you suggest to improve NX services in Glasgow?' Seventy-six respondents made recommendations for improving NX provision in Glasgow.

The recommendations are listed in order of frequency:

- Expand the provision of NXs in Glasgow [47 responses, 62%]: Suggestions that were offered were outreach schemes and vending machines.
- Extending opening hours [9, 12%]
- More privacy in the NXs [8, 10%]
- All chemists should provide a NX service [7, 9%]
- Increase information on location of NXs in the city [5, 7%]

2.2 Injecting Behaviour

In addition to looking at the respondents' views on NX provision, the questionnaire included questions on injecting practices and blood borne viruses.

Of the 76 individuals who reported injecting only one person was not injecting heroin; this individual was injecting Temgesic.

The most commonly injected drugs were

- Heroin [99%, 75]
- Cocaine [35%, 27]

Additional injected drugs were Valium, amphetamine sulphate and crack cocaine. It was noted by GIG members that injecting Valium and crack cocaine was extremely difficult and unlikely. However the UIDO checked the responses with the interviewers and the responses

were recorded accurately. Although intravenous crack use is less common, a study on homelessness reported that one fifth of their sample had injected crack cocaine.¹⁰

The most frequently injected drugs by individuals were

- Heroin [93%,71]
- Heroin and Cocaine [speedballing] [5%, 4]

Forty-nine [65%] of those injecting heroin originally smoked it whilst 22 [45%] of those who initially smoked, moved to injecting within 6 months. Almost a quarter injected heroin the first time they used it.

Almost half of the sample was injecting at least twice a day [48%] and the average daily injecting rate was 2.8 times a day. One quarter were injecting more than three times per day with 4% injecting more than six times daily.

Twenty seven of the 30 people using cocaine were injecting the drug. The average daily injecting rate rises slightly to 3.4 times per day. 44% [12/27] inject more than three times per day and 10% [3/27] reported injecting more than six times daily.

Reasons for Injecting

The most common reason for injecting was peer pressure [30%, 23/76] followed by a 'better hit' [26%, 20], 'cheaper' [16%, 12] and 'partner injecting' [14%, 11]. Other reasons included curiosity, 'couldn't smoke it' and traumatic experience.

Three quarters stated that it was a "spur of the moment" when first injected compared to 22% who stated it was 'planned'.

GIG felt it was important to explore whether people had been shown how to inject and by whom and whether they have ever been shown how to inject safely by a worker. The respondents had been shown how to inject by

- Friend [38%, 29]
- Associate [24%,18]

¹⁰ Jane Fountain & Samantha Howes, *Home and Dry? Homelessness and Substance Use*, National Addiction Centre [2002]

- No-one [13%,10]
- Partner [10%, 8]
- Family member [8%, 6]
- Observation [5%, 4]

Only four [5%] said that they had ever been shown how to safely inject but 63% [48] would access safer injecting training if available

Sharing Behaviour

The most recent statistics from the Information and Statistics Division [ISD] report that 59% of new service users nationally had shared needles/syringes; in Glasgow the corresponding figures for new service users was 67%.

Regarding injecting paraphernalia [spoons, water and filters] ISD figures for new service users nationally was 71% had shared paraphernalia compared to 75% in Glasgow.

On both the national and local level there were lower levels for recent sharing of needles in the last month compared to recent sharing of paraphernalia. Nationally 34% of new service users had shared needles and syringes in the last month; Glasgow's figures were 36%. In terms of sharing paraphernalia, nationally 49% had shared in the last month compared to 47% in Glasgow.¹¹

Sharing Needles/Syringes

The cohort of injecting drug users that were interviewed for this study was asked about their injecting behaviour: 70% [53] had ever shared needles/syringes and 24% [18] of the total sample had shared in the previous month.

The respondents were asked why they shared needles and syringes. Some individuals noted multiple reasons for sharing:

- 'Not having my own needles' [51%, 27]
- 'Convenience' [45%, 24]
- 'Withdrawal's [30%, 16]
- 'share with people I know' including partners [28%, 15]
- One person 'always' shares

¹¹ Information and Statistics Division Scotland, *Scottish Drug Misuse Database*, [2004]

Of the 53 people who have shared needles all bar one [52] have shared paraphernalia.

Sharing paraphernalia

Of the total sample 87% [65] had ever shared paraphernalia whilst 58% [44] of the total sample had shared in the previous month.

Of the 65 injectors interviewed who shared paraphernalia, the paraphernalia most frequently shared were:

- Spoons and acidifiers [91%, 59]
- Filters [89%, 58]
- Water [86%, 56]
- Tourniquets [60%, 39]
- Alcohol swabs [23%, 15]

An observational study of Glasgow IDUs found that in over 90% of preparation episodes involving more than one IDU, cookers, filters and water were shared among participants.¹²

Asked why they shared paraphernalia, the reasons given were

- 'Share with people I know' including partners [52%, 34]
- 'Convenience' [43%, 28]
- 'Withdrawal's' [15%, 10]
- 'Always share' [11%, 7]
- 'Didn't have my own paraphernalia' [11%, 7]

Other reasons given were because one person '*wouldn't know how to get clean tools*' and one person said they didn't know about the health risks at the time they shared. One person stated that they shared with their brother because "*I know I can't pass anything on to him*".

In terms of sharing behaviours, while the figures in the GIG study are slightly higher than the ISD figures they do reflect the same trend in terms of recent sharing of needles/syringes and

¹² *Examining the Injecting Practices of Injecting Drug Users in Scotland*, Effective Interventions Unit, February 2004. Taylor, A, Fleming, A, Rutherford, J, Goldberg, D.

paraphernalia in that the recent sharing of paraphernalia is higher than recent sharing of needles/syringes.

2.3 Blood Borne Viruses

The peer researchers asked the respondents whether they had been tested for BBVs and the circumstances and outcomes of the tests. We anticipated that there might be some difference in sharing behaviour between those respondents who had tested positive and those who had not.

BBV Testing

The majority of respondents [82%, 62] had been offered a BBV test. The tests were most frequently offered through statutory health and prison services:

- Hospital 29% [18]
- Prison 21% [13]
- GPs 21% [13]
- Drug worker 14% [9]
- Residential rehab 10% [6]

The remaining three people had been offered tests at Base 75, the Sandyford Initiative and one person self referred for a BBV test.

Table 9 shows that more than half the respondents had been tested for the three blood borne viruses – HIV, Hepatitis B and HCV. The majority of those who were tested received their test results, although those receiving results for HCV were less than for the other BBVs. No-one from the sample who had received their test results tested positive for HIV and just two people received a positive test result for Hepatitis B. However over half of the respondents who had received a result for HCV tested positive.

Table 9 BBV Testing and Results

<i>BBV</i>	<i>Numbers Tested</i>	<i>% received results</i>	<i>% received positive result</i>
HIV	44	91% [40]	0
Hep B	41	90% [37]	5% [2]
Hep C	51	88% [45]	58% [26]

Less than half the sample of respondents who were tested for BBVs were offered pre- and post-test counselling; 19 people were offered pre-test counselling and 17 were offered post-test counselling. Furthermore, of the 26 respondents who tested positive for HCV, only eight were offered post-test counselling. The Department of Health has suggested in its *'Guidelines on Clinical Management'* that:

'Injecting drug users...who seek testing should be offered well-informed advice and should be made aware of the implications of a positive test...those who test positive will need advice on ways of minimising the risk of transmitting infection to others.'¹³

Hepatitis B Vaccine

Over half the sample stated that they had received a Hepatitis B vaccine [54%, 40]. Vaccinations had been received in prison [47%, 19] and from GPs [30%, 11]. A number of respondents had also received the vaccine from residential rehabilitation units, addiction service NXs and hospitals.

Asked if they had returned for their booster injections 32 [80%] respondents replied that they had.

BBV Information

According to the respondents fewer than half the sample [47%, 36] had received information on BBVs. Most information had been received in the form of leaflets [34%, 12/36], advice from a worker [12%, 4/36] and booklet [3%, 1/36].

The information received was rated good to very good by 25% [9] of those who received information, OK by 56% [20] and poor to very poor by 19% [7].

Knowledge of transmission routes

Whilst the majority of the sample appears to be well-informed about the risks associated with sharing needles/syringes they were less informed about the risks associated with the sharing of paraphernalia particularly the sharing of water.

¹³ Department of Health et al, *'Drug Misuse and Dependence - Guidelines on Clinical Management'*, 1999

There is a greater awareness of the risks of BBV infection involved in injecting with over 97% of the sample thinking HIV and HCV are *'easy to catch'* from sharing needles. Conversely regarding the sharing of paraphernalia the knowledge appears sketchier particularly in the case of HIV. For example, only 59% think it is *'easy to catch'* HIV from sharing spoons, 63% *'easy'* from filters and 50% from sharing water.

In terms of contracting HCV from paraphernalia the respondents' knowledge seems better with 85% thinking it is *'easy to catch'* from sharing spoons; 89% thinking it *'easy to catch'* from sharing a filter; and 71% thinking it *'easy to catch'* from sharing water which someone else has used.

The remaining respondents believed it was *'not easy'*, *'no risk at all'* or *'don't know'* how easy it was to catch HIV/HCV from the sharing of needles/syringes and paraphernalia.

Hepatitis C and risk behaviours

Further analysis of the findings showed that of the 26 people who tested positive for HCV, six [23%] had shared needles within the last month and 17 [65%] had shared paraphernalia within the last month. As noted earlier, less than a third [8/26] of people who tested positive were offered post-test counselling. Of this sub sample, one person had shared needles and six had shared paraphernalia in the last month.

There was very little difference in the knowledge of transmission routes between those who tested positive for HCV and those who had not.

In order to assess whether there were any barriers that may inhibit the use of NXs among the respondents with HCV, access to NXs was analysed among this sub group.

- 73% [19/26] can access a NX within 15 minutes
- 77% [20/26] reported that this was their nearest NX
- 54% [14/26] said there were enough places to get clean needles
- 88% [23/26] said the services opening hours were suitable for them

The three main barriers that exist among this group were

- Fear of seeing drug worker and losing prescription 19% [5/26]
- Location of NXs 15% [4/26]
- Police presence 15% [4/26]

Thus, there is no greater identification of barriers to accessing services among those with HCV than among the whole sample.

More than half the group lives in temporary/unfixed accommodation. The accommodation status of the group was

- Hostel 42% [11/26]
- Own home 27% [7/26]
- Partner's home 11% [3/26]
- Parent's home 8% [2/26]
- No fixed abode 8% [2/26]
- Someone else's home 4% [1/26]

As stated elsewhere, homelessness can lead to outdoor injecting where there is no access to running water. Anecdotally, homeless drug users have used puddle water to prepare their injection.

The results of this sample suggest that the respondents' knowledge of BBVs is not impacting on their injecting practice. Ninety-seven percent of the respondents know the risks of sharing needles [that Hep C and HIV are easy to catch] but 34% have still shared needles recently. The sharing of paraphernalia was higher than needle sharing despite the knowledge of risk with 68% having shared paraphernalia recently. Furthermore, almost one quarter of respondents who reported testing positive for HCV had recently shared needles and syringes and almost two-thirds had recently shared paraphernalia.

2.4 Prescribed and Non Prescribed Respondents and the Impact on Risk Behaviour and Injecting Practices

Given that the majority of the sample were being prescribed methadone, it was felt necessary to look at whether there was a positive impact in terms of being on a methadone programme and reducing harm around injecting behaviour. However this section is written with the caveat that this is a small sample of injecting drug users and therefore the findings represent only a snapshot and cannot be generalised across Glasgow City's entire IDU population. The results are not an attempt to directly link the impact of prescribed methadone with an increased propensity to inject and share needles and paraphernalia but what they do show is that for this group of people on methadone, being part of the methadone programme has not reduced the risk taking behaviour. A chronological review of the histories of methadone prescribed clients and their injecting/sharing behaviour would be

a worthwhile study. It would require a more detailed study of methadone prescribing including dosage changes to establish the nature of any links between prescribed drug use and injecting behaviour.

Among this sample the prescribed respondents are more likely to have *recently* shared than those not prescribed: for example 14/47 [30%] of prescribed respondents had shared needles in the last 3 months as against 4/29 [14%] of those not prescribed to.

Of the prescribed users 64% [30/47] have shared paraphernalia in the last 3 months compared to 31% [9/29] of those not prescribed to. Further analysis by methadone is shown below in table 10.

Table 10 Methadone dose levels and recent sharing

<i>Methadone dose</i>	<i>Shared needles in last 3 months</i>	<i>Shared paraphernalia in last 3 months</i>
Less than 60 mls	33% [4/12]	58% [7/12]
60 – 120 mls	30% [6/20]	60% [12/20]
More than 120	29% [2/7]	86% [6/7]

A sub sample of prescribed respondents reveals that

- 25% [3/12] prescribed less than 60 mls inject more than 3 times daily.
- 10% [2/20] prescribed between 60 & 120 mls inject more than 3 times daily.
- 42% [3/7] prescribed a dose higher than 120 mls inject more than 3 times daily.

Further analysis of the high dose sub sample reports that of the 3 people injecting more than 3 times daily, two respondents most frequently inject cocaine.

There was no significant difference in the reasons for continued sharing of needles and paraphernalia between the prescribed and non-prescribed respondents, with lack of sterile injecting equipment, prevention of withdrawals and convenience being the main reasons for sharing.

Without a more complete history of the respondents' drug use and social circumstances it would be imprudent to prejudge the effectiveness of their treatment and their reasons for injecting.

3 Main Findings

This section will outline the main findings from the study covering the views of a sample of injecting drug users regarding the NX service they receive in Glasgow whilst also identifying issues that require discussion.

Main Findings

The main findings about the existing Needle Exchange provision were:

- There were reported differences in the quality and nature of service provision between pharmacy based and addiction service based NXs. Addiction service NXs were viewed more favourably in most categories.
- Access to NXs was sufficient for the majority of respondents although almost two-thirds recommended expanding their provision; respondents did not have far to travel to them and believed the opening hours were suitable although one fifth suggested longer opening hours.
- Vending machines and outreach schemes were suggested as a means to expand NX provision in Glasgow.
- While NXs were deemed to be mostly accessible, the majority believed there were barriers to attending NXs. The main barriers were police presence, fear of losing their drug substitution prescription and feelings of stigmatisation.
- The information provided by NXs on a range of issues such as injecting techniques and physical health is not rated favourably, especially the information provided by pharmacy based NXs.
- Staff attitudes were positively rated particularly in terms of treating personal information in a confidential manner.
- The majority of addiction service NX clients felt safe while attending NXs and that there was sufficient privacy, although the majority of pharmacy NX users felt there was insufficient privacy.
- The majority of respondents viewed the NX return policies positively [73, 96%]. The majority of respondents [47, 62%] *always* returned their used needles and syringes.
- Spoons, water and filters were considered priority items although NXs were not meeting the demand for these items to this particular sample of injecting drug users.

The main findings about injecting behaviour and blood borne viruses were:

- All respondents bar one were currently injecting Heroin. Forty-nine [65%] of those injecting heroin originally smoked it, whilst 22 [45%] of those who initially smoked moved to injecting within 6 months. The average daily injecting rate was 2.8 times a day.
- 90% [27 responses] of those currently using cocaine were injecting the cocaine. The respondents who were injecting cocaine as well as heroin were on average injecting more frequently [3.4 times per day].
- Only four [5%] said that they had ever been shown how to safely inject but 63% [48] would access safer injecting training if available. 47 respondents [62%] had been shown how to inject by friend [38%]/associate [24%]
- Almost three-quarters [74%, 56] of the respondents had been offered a BBV test and more than half the respondents had been tested for the three blood borne viruses – HIV, Hepatitis B and HCV.
- 58% of the respondents who had received a result for HCV tested positive. Only eight of the 26 respondents who tested positive for HCV, were offered post-test counselling. The limited provision of post-test counselling is contrary to The Department of Health's 'Guidelines on Clinical Management'.
- Fewer than half the sample [47%, 36] had received information on BBVs. The information received was rated good to very good by 25% [9] of those who received information, OK by 56% [20] and poor to very poor by 19% [7].
- Whilst the majority of the sample appears to be well-informed about the risks associated with sharing needles/syringes they were less informed about the risks associated with the sharing of paraphernalia, particularly the sharing of water. There was very little difference in the knowledge of transmission routes between those who tested positive for HCV and those who had not
- The respondents' knowledge of BBVs is not impacting on their injecting practice. The majority [97%] of respondents know the risks of sharing needles [that HCV and HIV are easy to catch] but 34% have still shared needles recently.
- Among those who have tested positive for HCV, a sizable minority [23%] have recently shared needles and syringes and almost two-thirds [65%] have recently shared paraphernalia.

Conclusion

The study has raised some important points for discussion about NX provision, including the continued provision of needles and syringes, as well as the potential increase of 24 hour access. Innovative ways to achieve this have already been mentioned in this study including vending machines and outreach schemes.

The distribution of paraphernalia should be re-examined in light of the 2003 Amendment to Misuse of Drugs Act [1971] that allows services to widen provision to include acidifiers, sterile water and spoons. Unlike injecting equipment and alcohol swabs, spoons, water and filters are currently not available to the vast majority of IDUs in Glasgow although these were items the respondents would like to see provided. Conversely, a recent survey of 39 NX providers in Scotland found that fewer than 30% supplied citric acid and only one supplied sterile water. The majority stated that they would like to supply sterile water and citric acid and half would like to supply stericups and filters. Despite amendments to the Misuse of Drugs Act, organisational and financial issues were both viewed as the two main barriers *and* solutions to expanding the provision of additional paraphernalia.¹⁴ Given the clear desire among the IDUs interviewed in this study for increasing the supply of both needles/syringes and paraphernalia, further impetus should be given to proposals to allow the expansion of the supply of sterile water by NXs and other non-clinical treatment workers. Furthermore, increasing access to sterile equipment and paraphernalia will be required if injecting cocaine use becomes more prevalent as is being predicted.

It is also clear that a consistent policy of BBV testing and counselling needs to be developed. Less than a third of the respondents who tested HCV positive were offered post-test counselling. It has been reported elsewhere that there is currently no consistent policy regarding screening for HCV in IDUs and that there is widespread variation in the provision of testing. According to Craine et al, 'Face to face informing of test results is essential and needs to be done with a view to imparting risk reduction messages.'¹⁵ Furthermore, a recent report from the Department of Health noted the high costs of drug treatments [up to about £12,000 per patient], whilst other medical interventions and liver transplants represent a substantial burden on the NHS.¹⁶ In addition to the economic costs we should also consider the indirect costs of the disease to the individuals and their families that are less easily quantified but have a severe impact on those whose lives are affected. A consistent strategy

¹⁴ *A brief survey on Drug Paraphernalia Distribution following Amendments to the Misuse of Drugs Act [1971]*, Scottish Drugs Forum, February 2004

¹⁵ Craine, N. Walker, M. Carnwath, T. Klee, H. Hepatitis C testing and injecting risk behaviour: the results of a UK based pilot study *International Journal of Drug Policy* 15: 115-122 [2004]

¹⁶ *Hepatitis C: Action Plan for England*, Department of Health [July 2004]

of pre and post- test counselling would provide a valuable opportunity to engage with IDUs and offer information and advice to help reduce risk behaviours which may then mitigate the spread of infection among the wider IDU population.

In essence, needle exchanges provide a valuable service for injecting drug users and for some users this may be their main service contact [particularly for those not in treatments]. It is therefore essential that the role of needle exchange providers, both addiction service and pharmacy based are provided with the resources to widen the distribution of all necessary injecting equipment and paraphernalia. Moreover, the direct and indirect costs of blood borne viruses are potentially huge and as such needle exchanges can play a vital role in the supply of information on both safer injecting practices and BBVs.

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