Views from the street

Provision of needle exchanges in Glasgow has tripled during the last seven years – but are service users getting what they need? April Shaw shares results of a survey that highlights some of the gaps and barriers in services.

Glasgow Involvement Group (GIG) carried out a snapshot survey with a sample of 76 injecting drug users (IDUs) in Glasgow in September 2004 on existing needle exchange (NX) services and blood borne virus (BBV) information within Glasgow.

GIG is a volunteer group of ex/current addiction service users who are recruited, trained and supported to undertake activities that will impact on the planning and delivery of services. The structured questionnaire used in this study was designed by GIG in collaboration with Scottish Drug Forum's User Involvement Team. The sites from which the IDUs were recruited were chosen by GIG members with knowledge of the street scene in Glasgow.

The Glasgow area has increased its NX provision from eight in 1997 to 24 in 2004; this increase was regarded positively by the respondents in this study. Although access to NXs, including numbers of NXs and opening hours were good for the majority of respondents, they identified a number of gaps and barriers in the provision of NX services. Among these gaps was the continuing lack of spoons, acidifiers, filters and water ampoules used in the preparation process.

The main barriers to Glasgow's NXs for this sample of users included police presence, fear of losing their methadone prescription and stigmatisation. Barriers differed according to the type of NX. Stigma and police presence presented barriers to pharmacy access; fear of losing a prescription was the main barrier to treatment based NXs. In addition, 'lack of privacy' was an impediment to many of the pharmacy NX users. Alternative sources for obtaining sterile equipment suggested by the respondents included mobile NXs, vending machines and home deliveries.

GIG sought to explore the respondents' views and experiences on safer injecting information and BBVs given the rising numbers of IDUs infected with Hepatitis C (HCV). The findings suggest there is a lack of information regarding safe injecting practice and injecting techniques. Only four people said they had ever been shown how to inject safely; however when asked, two-thirds of respondents stated they would access safer injecting training whilst three-quarters would access overdose training. Less than half the sample had received information on BBVs.

Respondents were asked whether they had been tested for BBVs and the outcome of the test. Almost three-quarters had been offered a BBV test, most frequently through statutory health and prison services. While one third of the total sample had received a positive test result for HCV, only eight people reported being offered post-test counselling despite Department of Health guidelines that state '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.' 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.

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The results obtained in this study suggest that the respondents' knowledge of BBVs is not impacting on their injecting behaviour even among those who have tested positive for HCV. Among those who did test positive, almost one quarter had shared needles within the last month, whilst almost two-thirds had recently shared paraphernalia. Nevertheless, as other research has shown and as this sample reported, many crucial factors can impinge on safer injecting practice, most notably withdrawals, not having needles/paraphernalia of their own and convenience of access to clean injecting equipment.

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. Distribution of paraphernalia should be re-examined in light of the 2003 Amendment to Misuse of Drugs Act that allows services to widen provision to include acidifiers and spoons. Given the clear desire among the sample for increasing the supply of both needles/syringes and paraphernalia, further impetus should be given to proposals to allow the widening 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.

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. This would provide a valuable opportunity to engage with IDUs and offer information and counselling to help reduce risk behaviours and 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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