1986

HIV and injecting drug use

It was in 1981 that the link was first made in the USA between injecting drug use and the risk of contracting HIV, with the first UK drug-related infections reported in Scotland in 1983. From this was born the notion of risk or harm reduction aimed at reducing the spread of infection and saving lives. It was an issue that *Druglink* would return to many times over the years, as the advent of needle exchanges, advice against sharing and maintenance prescribing became a central plank of the UK drug strategy response, which saw the UK experiencing some of the lower HIV rates among injecting drug users in Europe.

This was first article to appear in the revamped *Druglink* 1986, written by **David Turner**, former Director of the Standing Conference on Drug Abuse, who sadly died earlier this year. As well as being an important article, we are also publishing it as a tribute to David.

Professionals have many ideas for schemes meant to offer some protection against HIV infection and AIDS to those at greatest risk. There is, however, a major dilemma: measures which might limit the spread of the HIV virus in injecting drug users are in conflict with current good practice in the treatment of drug misuse.

For instance, shortage of needles and syringes is a factor in sharing injection equipment, but good treatment practice is seen as not prescribing injectable drugs and the means of injecting them.

Again, if the goal of treatment is seen as abstinence then drugs should not be prescribed as part of that treatment, but controlling the spread of infection may require prescribing oral substitute drugs for those not yet ready for abstinence or a rehabilitation programme.

The conflict is profound and challenging. Which approach should have priority? Limiting the spread of the virus, to which injecting drug users appear one of the most susceptible groups with a high mortality rate from infection? Or treating drug misuse, telling those at risk that the choice is theirs, but that injecting and sharing injection equipment can lead to and spread infection and result in AIDS, as well as other serious consequences?

This brief paper attempts to present some of the problems, to provide an update on a number of prevention initiatives, and to offer food for thought.

Infection increasing

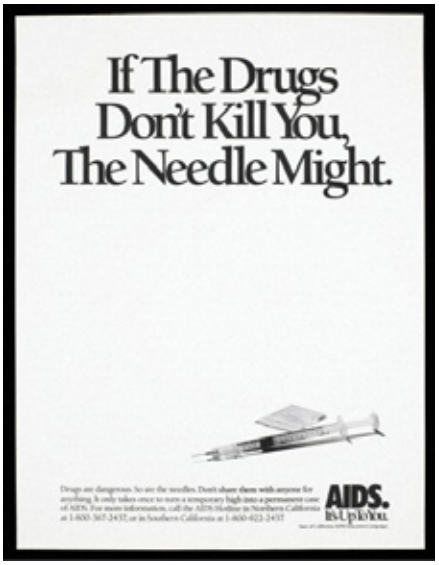
The incidence of HIV infection in drug users appears to be slowly increasing. Although some areas are showing much higher levels of infection than others, the virus is present everywhere.

Drug-free rehabilitation communities are admitting residents from all parts of the country who are later found to be infected. The last published estimate of HIV prevalence in drug users from the Public Health Laboratory Service, based on limited sampling and excluding areas of Scotland, shows a five to six per cent level of antibody-positive returns.

In 1985 much of the attention was focused on parts of Scotland where drug users had been screened for antibodies. Whether this screening was done with adequate pre- and post-test support is open to debate, but the results were of considerable importance.

Many cases of infection were detected in Edinburgh and Dundee, with some in Glasgow. Even assuming no rise in the number of drug misusers infected, it must be conservatively estimated that some 40–50 young drug users in Scotland alone will be suffering from AIDS within the next two to three years. Given that infection is almost certain to spread for some time, the numbers may well be higher.

The situation may be far more serious than has previously been believed in other areas outside Scotland. It is often difficult to reach injecting drug users at risk and to obtain the necessary support facilities for antibody screening. As a consequence, the information base in these areas is likely to be substantially less than that in areas where screening has been undertaken for some time.



Role of treatment centres

Drug treatment centres in the United Kingdom now recognise the need to act quickly to reduce risk and to prevent the spread of infection. However, they have a number of difficulties. The services they offer to injecting drug users are often perceived by those drug users as not worth pursuing. Clinics may still be some distance away and may have waiting lists which prevent the drug user getting attention until several weeks after the initial approach. Some will not prescribe substitute drugs while most will not prescribe drugs in injectable form. It is essential that no risk-reduction option is rejected out of hand because it conflicts with abstinence.

Many professionals believe that this new and potentially lethal threat of HIV infection makes it all the more important to induce those at risk to make contact with agencies and treatment centres. They are, however, divided on how this should be achieved.

Some argue that offering substitute drugs to be taken by mouth is a strong inducement to drug injectors to stop their primary AIDS-risk behaviour (unless they are also homosexual) – the using and sharing of injection equipment. Others argue they are in the business of helping people to get off drugs, not of providing drugs which help perpetuate drug dependence.

Yet others argue that where infection is spreading rapidly but is not yet endemic among drug users, the provision of injectable drugs with injection equipment, or at least easier access to injection equipment, is a method of prevention which is well worth trying.

The need to fund large-scale programmes to counsel drug users and offer the antibody test was widely recognised at a recent meeting held at the Public Health Laboratory Service in London. No plans have yet been made to accomplish this. It is unrealistic to expect the sexually transmitted disease clinics to continue provision of counselling and testing for injecting drug users, especially in Metropolitan areas: services designed for drug users will have to become involved.

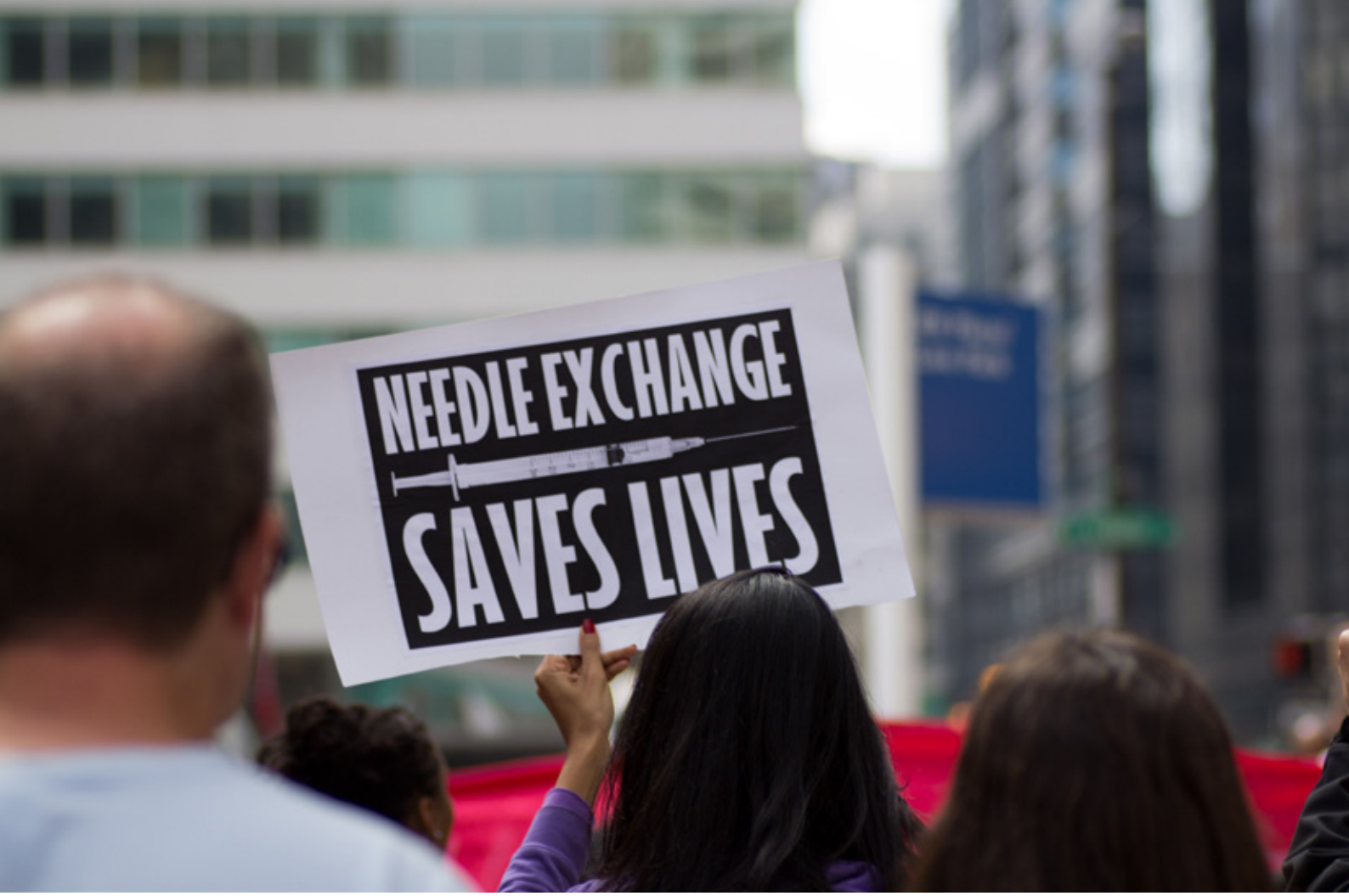
Preventing spread

So the difficulties in preventing spread of infection are considerable. Although currently injecting drug users who share injection equipment are most at risk of becoming infected or infecting others, those who have injected in the past may already be infected. They risk infecting others through intercourse and are a potent group for spreading infection more widely into the population generally believed not to be at risk.

Prevention has two goals: first, to limit the spread of infection among the most at-risk groups, namely those injecting drugs and sharing equipment; second, to limit the spread of infection from drug users to the general population through counselling and advice about safe sexual practices.

Motivating those who are drug dependent to understand that there are alternatives to continued drug use is usually a long and involved task. Abstinence may be the ultimate goal, but it is rarely achieved quickly and harm-reduction as part of the process leading to abstinence is an essential element in any treatment intervention.

With HIV infection now such a real threat, can we allow ourselves the luxury of refusing to deal with drug users except from a position of saying 'Abstinence is the only goal and everything we do will be designed to achieve this as speedily as



possible, whether or not you are ready to accept it'?

More resources are needed. Many drug users who seek help with their drug problem cannot be accepted into treatment or rehabilitation because services are full. But there is also a need to develop existing treatment services which can counsel drug users, advise them on risk-reduction in drug use and sexual behaviour, offer alternatives to continued dangerous injecting practices and, if necessary, offer injectable drugs and the means of injecting them.

The use of drugs is not going to suddenly cease because of society's disapproval. Drug use, particularly by injection, is an unsafe activity – especially when someone who knows little about drugs and the dangers associated with injecting chooses to experiment indiscriminately – but we cannot afford to ignore the facts. It is essential that no risk-reduction option is rejected out of hand because it appears to conflict with a service's stated goal of abstinence.

Our own feelings and attitudes to drug use can cloud our judgment when it comes to devising strategies to beat the AIDS virus.

A range of options might be considered. For instance:

- providing health education about infection and the risks associated with injection;
- working with local pharmacists so that risk-reduction literature was provided to anyone buying needles and syringes;
- arranging with a pharmacist that s/he would sell needles and syringes to someone referred by a drug agency;
- providing needles and syringes on a new-for-old exchange basis.

In any risk-reduction package, it is important to counsel about safe sex activities and the package might include providing or making arrangements for the supply of condoms.

The tests of any intervention should be:

- Has the drug user ceased sharing injection equipment?
- Is s/he aware of the risks involved in sharing injection equipment?
- Are his/her drug using friends aware of these risks?
- Has s/he ceased taking drugs by injection?
- Has the drug user become more controlled in his/her drug use?
- Has abstinence from drug use become a goal for the drug user?

These tests are not incompatible with the goals of drug treatment, but they do challenge the limited alternatives offered by many drug services.

It is understandable that the idea of supplying or arranging the supply of needles and syringes or of prescribing substitute drugs may be unpalatable and seen as in conflict with good treatment practices.

However, is it not better to have uninfected drug users who may survive their addiction than to have infected drug users who may not? To combat the spread of AIDS a much greater range of options needs to be available to drug users, attracting them into treatment rather than deterring or excluding them.