feature

Dr Noel Craine, Dr Mark Walker, Dr Tom Carnwath, Professor Hilary Klee

Needle in a haystack

Rural injecting

Safer injecting in rural areas is not easy, geography, local businesses, and the closeness of communities can all cause problems

Dr Noel Craine is a research scientist, **Dr Mark Walker** is a Consultant Microbiologist at the Public Health Laboratory, Bangor, in North Wales, **Dr Tom Carnwath** is a Consultant Psychiatrist at Trafford, Manchester, **Professor Hilary Klee** teaches at the Psychology Department, Manchester Metropolitan University.

The provision of clean needles and syringes and information about injecting risk behaviour is of indisputable importance in reducing the transmission of blood borne viruses. The degree to which this is achieved may vary considerably throughout the UK.

This issue has arisen in research that we are currently carrying out on attitudes to hepatitis C and injecting risk behaviour among drug users in inner-city Manchester and the more rural areas of Northwest Wales.

Throughout the course of the study it has become clear that there are differences between the experiences of injecting drug users in rural and in city environments. There are problems surrounding availability and uptake of injecting equipment, which appear more prominent for rural injectors. Such problems are less acute for their urban counterparts.

Poor availability and restricted uptake of clean injecting equipment increase the risk of the continued spread of hepatitis C and hepatitis B infection among injecting drug users.

The prevalence of hepatitis C infection is high among injecting drug users. Data from the most recent survey showed that one third of injecting drug users attending specialist agencies in England and Wales had antibodies to hepatitis C and one-sixth of attendees had been infected with hepatitis B.[1]

This is likely to place a huge burden on health services some years ahead, when a significant number of them develop serious liver disease as a result of hepatitis C infection. It is thus extremely important to prevent this trend continuing within a new generation of users.

There is a continuing need for needle exchange facilities, for easy access to hepatitis B vaccination, for information and advice about hepatitis and injecting and for testing and treatment where appropriate.

Providing clean injecting equipment

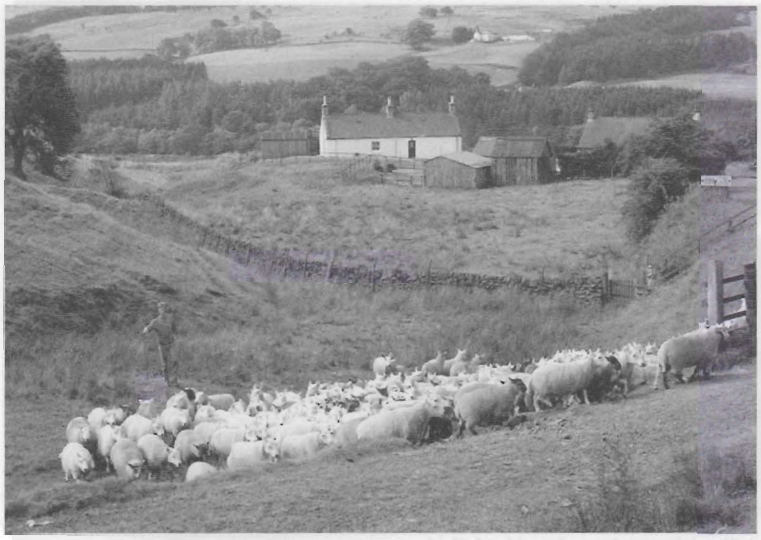
The National Assembly for Wales has recognised the importance of providing clean injecting equipment. When questioned on the subject, Health Minister Jane Hutt referred to the assembly's substance use strategy *Tackling Substance Misuse in Wales: A Partnership Approach*.[2] This acknowledges as a key task 'the provision of needle and syringe exchange schemes in each locality to allow safe disposal of injecting equipment'.

Responsibility for delivering the strategy lies with local bodies, including health authorities, which are expected to spend at least 0.4% of their discretionary revenue allocations on substance use treatment and prevention.

£4.5 million has also been made available over three years, 'to improve access to treatment, particularly for vulnerable young people'. She reported that in North Wales this money has funded the extension of a needle and syringe exchange scheme.[3]

The challenge is not so much in identifying the general strategy as in its implementation at local levels. Despite considerable and sustained efforts by the syringe exchange coordinator and by the drug services in Northwest Wales, access to clean injecting equipment in some areas is limited.

It appears that councils do not see helping people inject safely as a priority at present. Could it be that, because injecting drug use is rarely visible in some rural areas, it generates little concern among residents?



It is unlikely that the problem will go away. The poor quality of heroin in the rural market probably encourages injecting in preference to smoking and, increasingly, new users are reporting injecting as their first route into heroin use.

Problems of access

Needle exchange schemes are the central component of any effort to reduce injecting risk behaviour. Although such schemes are now widespread in northwest Wales they continue to encounter a number of problems, despite the commitment demonstrated by the participating pharmacies. The following cases illustrate the current situation:

- In one small town with an acknowledged injecting scene the only needle exchange is either in the local doctor's surgery, where limited opening times reduces the uptake of clean equipment, or at a weekly drop in centre. Furthermore the local GPs do not wish to be part of the shared-care scheme, necessitating a 45 mile round trip to the nearest specialist clinic offering methadone.
- In a number of small towns and villages in the region equipment is only available from the community drugs workers. They also arrange methadone prescriptions, so this puts out a mixed message to clients attempting to stop using heroin. Workers may adopt a relaxed approach to clients on prescriptions of methadone obtaining needles, but many users are nervous about letting it be known that they are 'topping up' with heroin.
- Recently a medium sized town in north Wales, with a large population of injectors, has lost its needle exchange due to pressure exerted on the pharmacy by local business. This problem is compounded by an absence of GPs prepared to prescribe methadone in the area. The needle exchange directly supplied 120 users. These individuals have 'disappeared' but subsequently the neighbouring small towns have seen a marked increase in needle exchange use. This in turn has triggered a similar local business backlash against the pharmacy. This domino effect is moving down the coast. The exchange coordinator has been forced into the unwelcome position of asking pharmacies to supply only their own local injecting drug users.
- In Bangor, the base of the regional drug service, needle exchange use dropped markedly after two security cameras were installed in the adjoining street.

Local geography and the limited rural public transport system can compound these problems. Considerable distances between villages mean that users often find it hard to get to an exchange facility at a time that suits them. Transport within a city is generally more straightforward.

In our research we identified a need for more flexible opening hours for needle exchanges, since the need for clean equipment did not always coincide with exchange opening hours (this is very common due to inadequate resources).

The problem of distance may also affect the uptake of hepatitis C screening and, when needed, specialist medical consultation about hepatitis C. We discovered that some users have been tested for hepatitis but have not received the result.

Users have reported other problems. The needle exchange transaction can be embarrassingly public for those living in small rural communities, where there is none of the anonymity of the urban pharmacy. Knowing someone who works in the chemist's – highly likely in a small town or village – is a further disincentive to needle exchange uptake.

Perceived fear of arrest or unwanted police attention for the possession of injecting equipment may also dissuade some users from carrying clean works around with them.

To set up an effective needle exchange scheme it is not enough for the Welsh Assembly to provide funding. Schemes are struggling against negative attitudes among local communities.

On the whole, such problems are no longer found in urban areas. In Manchester at least, police are fairly relaxed about injecting equipment and chemists see injectors as an important part of their business. In rural areas the fears surrounding the introduction of needle exchanges are strong and must be addressed if the situation is to be remedied.

In predominantly rural northwest Wales injecting drug use is widespread. It is essential that new injectors avoid infection. If this is to be achieved, committed leadership is required from pharmacists, health authorities, GPs, Local Action Teams (LATS) and Drug and Alcohol Action Teams (DAATs) to try to overcome these barriers.

At present in some areas clients have to be very motivated both to access needle exchanges and to enter treatment. We suspect these problems are very similar to those that would be found in other rural areas.

Maybe the time has come to remove needle exchanges from the pharmacy and surgery to areas more accessible to the public. There appears to be a strong case for the installation of discretely placed dispensing machines ■

1. The Prevalence of HIV and Hepatitis Infection in the United Kingdom 1999 *Annual Report of the Unlinked Anonymous Prevalence Monitoring Programme.* November 2000 Department of Health

2. *Tackling Substance Misuse in Wales: A Partnership Approach.* The Welsh Assembly. (2000)

3. Proceedings of Welsh Assembly. (2000) *Written answer to Question WA5789,* 9–15 June 2000