Relief at £3 million to fight AIDS . . .

Government advisers are guardedly optimistic that at last their warnings about the urgency of preventing drug-related HIV spread are being responded to. Combining his present and past ministerial experience, David Mellor (formerly drug misuse coordinator now Minister for Health with special responsibility for AIDS) announced in September[1] that £3 million was being made available to health authorities to help prevent the spread of AIDS among drug misusers. The money is for 1988/9 and for England only. A letter to health boards in Scotland announced a corresponding allocation of £300,000 (see opposite), while health authorities in Wales were invited to bid for £100,000 for AIDS/drug work.

The main theme of the English announcement and of the accompanying circular[2] giving guidance to health authorities is that "drug misusers must be encouraged to come forward for help". The £3 million is specifically to "enable services to expand and develop in such a way as to make contact with more drug misusers in order to offer help and advice on reducing the risk of HIV infection."

It's clear from Mellor's statement that drug misusers are being courted in this way because they are "likely to act as an important 'bridge' for the spread of HIV infection into the general population." New evidence indicates that misusers are "willing and able to change their behaviour" to reduce this risk: the £3 million is to set up services to help them along.

The English money will be divided among RHAs in proportion to their populations aged 15 to 34 years. The same method was used to divide up the £1 million already available. It takes no account of what are almost certainly wide variations in the degree of HIV risk among drug misusers in different regions.

Members of the group that produced the Advisory Council's *AIDS and Drug Misuse* report, though dismayed by the initial £1 million response, have been encouraged by this further £3 million. "It's good news that the money is being made available and that there is broad acceptance of the principles of the Advisory Council's report," said Gerry Stimson.

However, they point out that the money is to be spent in the remaining half of financial year 1988/9. Given the lead time to employ staff, some £6-9 million would be needed in following years to sustain programmes started in 1988/9. Department of Health addiction consultant John Strang emphasised that "any sensible use of the money by health authorities must involve spending that goes beyond the end of the year, so it's essential we know as soon as possible what will be available for future years." Without this the risk is that health authorities will be forced to splash the money on short-term or capital-intensive projects that do not commit them to continued funding.

In the circular to health authorities, syringe exchange schemes are identified as one way they can provide sterile injecting equipment to injectors. Guidance on setting up exchange schemes recognises that a 100% return rate may not be achievable and endorses harm-reduction advice on sterile injecting practice. "The most important qualification for staff to have is a friendly, non-judgmental approach," says the circular.

Official endorsement of syringe exchange is based on the Monitoring Research Group's evaluation of the 14 pilot schemes,[3] the results of which are summarised in the circular to health authorities. Over the summer the researchers were able to answer the crucial question of whether injectors attending schemes changed to lower risk behaviours. They found small but consistently positive changes over the three-month follow up period, but a disappointingly small proportion of attenders stayed on to achieve these changes.

Gerry Stimson of Goldsmiths' College heads the research group. He believes that over such a small time-period major changes could not have been expected and that many of the apparent drop-outs may in fact have been referred to further help.

Not mentioned in the circular was the fact that Stimson's group arranged interviews of 220 injectors not attending schemes and found their risk behaviours were almost twice as high as the injectors coming to the schemes. The implication is that exchanges are attracting people who are already moderate in their behaviour and are helping them to sustain and to some extent improve this behaviour.

The limited success of exchanges puts the spotlight on the two other ways of providing injecting equipment listed in the circular — pharmacy sales and GPs. Health authorities can use the new money to supply pharmacists prepared to sell syringes to addicts with information on drug services, health education literature and 'sharps' containers for used 'works'. Provision of injecting equipment free through pharmacies is not listed as an option.

Pharmacy sales are supported by the pharmaceutical profession's representatives. The viability of the idea is indicated by several existing schemes and by a survey of pharmacists in five south-east England health authorities which found 62 per cent of the sample were prepared to sell syringes to drug users.[4]

There is little corresponding indication that GPs will flock to take advantage of the Department of Health's instruction that "health authorities should consider favourably requests from general practitioners for supplies of injecting equipment and condoms for issue to drug misusing patients." English doctors on the BMA's general practice committee are reported to have called the guidelines "a whitewash . . . just a means of getting general practitioners to give out free needles and syringes."[5]

It could be that health authorities will have to consider innovative new ways of contacting drug users. The bleach'n'teach scheme, 'well users' clinic' and safer sex/drug use comic described elsewhere in this issue of *Druglink* are ways some health authorities are meeting the challenge.

1. DHSS press release 88/308, 27 September 1988.
2. Department of Health circular HC(88)53, LAC(88)18, September 1988.
3. In the first issue of *Druglink* in 1989 the Monitoring Research Group will report on behaviour change among exchange scheme attenders.
4. *Pharmaceutical Journal*, 13 February 1988, p.219.
5. *British Medical Journal*, 10 October 1988, p.861.

References for report opposite.

1. Scottish Home and Health Department circular, 30 September 1988.
2. This is an order of magnitude indication only. Its basis is that the method used in the *AIDS and Drug Misuse* report gives an estimate of 40,000-80,000 opioid injectors in the UK in 1987. A middle figure of 60,000 is assumed. The same report suggests as many people may misuse other drugs (excluding cannabis). Doubling the 60,000 to take account of non-opioid injectors gives an estimated 120,000 injectors in the UK. The McClelland report suggests at least 10,000 of these are in Scotland, leaving up to 110,000 in England. The CDSC's upper estimate of the rate of HIV infection in England is 5% (personal communication, 7 September 1988), so up to 5,500 of these injectors may be infected with HIV.
3. Scottish Committee on HIV Infection and Intravenous Drug Misuse. *HIV Infection in Scotland.* Scottish Home and Health Department, September 1986.
4. Scottish Office News Release 6, September 1988.
5. Scottish Home and Health Department. NHS Circular No. 1988 (GEN) 29, 30 September 1988.
6. Secretary of Scottish BMA reported in *Scotsman*, 15 March 1988.
7. Scottish Home and Health Department, NHS Circular 1988 (GEN) 19, 21 June 1988.

Evidence mounts that some

Evidence is mounting that British drug users are responding to the threat of AIDS by reducing their injecting and (to a lesser extent) their sexual risk behaviours. The reports mainly involve drug users in contact with helping agencies: some studies indicate that injectors not in contact with services are the least likely to have reduced their AIDS risk.

Before AIDS was a widely recognised risk among injectors, a study in Manchester revealed that people who continue to use drugs may nevertheless use less dangerously. Just 55 out of 129 drug users referred to (but not seen by) a drug clinic in 1981/2 were still using drugs two to three years later.[1] Of these 48 were injecting when first seen but at follow up 23 had either stopped doing so or injected less often. Just two had increased their injecting.

Out of a group of over 200 drug users attending three London clinics in 1987, three-quarters said they no longer used injection equipment after someone else; 41 per cent would not let someone re-use after them.[2] Over half the sample had changed their drug using habits because of AIDS, while three-quarters said treatment had helped them make beneficial changes.

Less reliant on the memories of its subjects was a study in Edinburgh which actually interviewed a sample of drug users before and after AIDS became widely publicised in the region.[3] When first interviewed at a GP's surgery in 1986, 55 per cent of the 49 drug injectors said they always shared and 39 per cent did so occasionally. 98 per cent had shared at some time, a startling reflection on the extent of risk-behaviour in the town.

Around a year later a fifth of the same group no longer injected, another quarter never shared, and just 13 per cent said they still always shared. All reduced significantly were the average number of injections, of sharing episodes and of persons shared with. The changes were most marked in those who'd been diagnosed HIV-positive (over half the sample). Encouragingly, these infected drug users had also reduced their numbers of sexual contacts.

. . . but Scots given just £300,000

The Scottish Drugs Forum says the £300,000 for drugs and AIDS work in 1988/9 announced on 30 September[1] is "desperately needed" but there is "a need to take account of the level of HIV infection in Scotland." Observers south of the border could be more outspoken. "The situation in Scotland remains very depressing," said John Strang, one of the authors of the Advisory Council's *AIDS and Drug Misuse* report.

The English £3 million is additional to the yearly £1 million for AIDS/drugs first given in 1987/8. A separate £5 million yearly is available to English health authorities for drug services in general.

In Scotland the £1.1 million yearly made available to health boards from 1987/8 is tied to support of drug misuse services established by the government's central funding initiative. This funding includes £300,000 a year for the extra load on the services due to HIV and AIDS. The £300,000 for AIDS/drugs work in 1988/9 is on top of this allocation: it is the only money health boards are free to use as they see fit to help prevent HIV-spread among drug misusers.

As in England, the emphasis is on improving the accessibility and attractiveness of services to help reach more drug misusers, and there is no guarantee that the new £300,000 will be repeated. A circular specifically advises health boards to concentrate on short-term initiatives such as improving premises and training programmes, which involve no major staff expansion.

According to the Scottish Home and Health Department, £300,000 was decided upon by applying a standard 10 per cent formula to the English £3 million. Apparently no account was taken of the evidence for the exceptional extent of the HIV infection and needle-sharing problem among drug misusers in parts of Scotland.

To the end of June 1988 the UK other than Scotland had reported 632 cases of HIV infection among drug injectors, while Scotland alone had reported 832. HIV infection rates among injectors in the regions around Edinburgh and Dundee are running at 40-60 per cent compared to 0-10 per cent in England. The Monitoring Research Group's recent survey of injectors not attending syringe exchanges revealed that the highest levels of sharing were in Scotland, despite the appalling HIV statistics.

Migration south away from stigmatisation and towards easier access to drugs and services means Scotland's injection-related HIV problem is becoming a problem for the UK as a whole. There is no confidence that the extra £300,000 will turn back the epidemic.

Like the English money, the Scottish allocation is shared out according to a standard formula. This gives the hardest hit Lothian region around Edinburgh £47,562. Using Gerry Stimson's estimate of 1000 infected drug users in the area, this averages £47 a head. On current estimates the corresponding figure for England is over ten times higher.[2]

Because HIV spread is more closely associated with drug misuse in Scotland than in the rest of the UK, it's probable that more of the general AIDS allocation to the health service is spent in the drugs field there than in England. How much this counterbalances the apparent stark discrepancy in funding is impossible to establish.

The pattern of HIV/drugs services in Scotland as well as their extent appears to be diverging from the English model. English authorities are emphasising syringe exchanges while in Scotland the push is towards pharmacy and GP-based syringe distribution methods — both involving little or no staff costs and more in tune with the Scottish bias towards community-based initiatives.

Two years after the McClelland report on *HIV Infection in Scotland*[3] called for GPs to issue needles and syringes to injectors, Scottish Health Minister Michael Forsyth announced he would "shortly" authorise health boards to supply the necessary equipment (plus condoms) to GPs free and "on request".[4] On 30 September the authorising circular[5] went out with a report from the National Medical Consultative Committee on the doctor's role in dealing with drug abuse. Forsyth was responding to pressure from Scottish GPs' representatives who six months before had submitted the plan as "a matter of urgency".[6]

In June a circular to Scottish health boards asked them to report back by the end of September on the need for pharmacists to supply injecting equipment to drug users and on how many were prepared to do so.[7] The Government "expect that retail pharmacists will become the main sources of clean injecting equipment for drug misusers in Scotland." The responsible official at the Home and Health Department said early in October that boards had "made a good deal of progress" in recruiting pharmacists and that the signs were "reasonably hopeful".

The plan is that health boards will provide participating pharmacies with supplies of leaflets giving health education advice and the addresses of local help services. The leaflets are to be given out when injecting equipment is sold to misusers. Pharmacists will also be supplied 'sharps' bins for returns. Official guidelines are that pharmacists and doctors should supply no more than five syringes and needles to each person on each visit.

These requirements are partly to avoid the attentions of the Lord Advocate. Doctors and pharmacists have been deterred from supplying syringes by fears that they could be prosecuted under Scottish common law on "reckless conduct". Now the Lord Advocate has made it known that while there can be no general immunity, doctors and pharmacists would only be prosecuted in "exceptional" circumstances and would be safe if they adhered to the official guidelines.

Gerry Stimson points out that AIDS prevention services in Scotland are having to build on an almost non-existent base of specialist drug services. Dave Liddell of the Scottish Drugs Forum fears the community-based drug agencies running on a shoe-string budget will "fall apart" without the specialised and in particular the medical back-up needed to cope with HIV and AIDS.

References on opposite page.

users are cutting HIV risk

The authors of the Edinburgh study conclude that behaviour change took place rapidly in this group of injectors as they became aware of the risks and as help (eg, supplies of injecting equipment) was made available to enable them to reduce these risks.

Back in London, a later study sounds a warning that such positive results may only be found among injectors in contact with drug services.[4] Over half of 115 current or former drug injectors interviewed in 1986-7 said they had made changes which would substantially reduce their risk of AIDS. About half of these had done so because of their concern over the disease. Just one in eight had actually stopped injecting, but another 40 per cent had at least stopped sharing. Nearly another third had reduced the extent of their sharing, and all of these had done so because of AIDS.

However, while nearly two-thirds of the group in contact with agencies had substantially reduced their AIDS risk, just 40 per cent of those who steered clear of help had done so. Over half those not receiving help still shared with people other than their partners compared to a quarter of the group in touch with agencies. Unavailability of clean equipment appeared to be the main reason for continued sharing.

John Strang of the Maudsley Hospital has commented that such studies give "reason to be optimistic" about the chances of persuading injectors to reduce their risks of becoming infected with HIV.[5]

1. J. Strang *et al.* "Habit moderation in injecting drug users." *Health Trends*: 1987, *19*, p.16-18.
2. A.H. Ghodse *et al.* "Effect of fear of AIDS on sharing of injection equipment among drug abusers." *British Medical Journal* 1987: *295*, p.698-9.
3. J.R. Robertson *et al.* "HIV infection in intravenous drug users: a follow-up study indicating changes in risk-taking behaviour." *British Journal of Addiction*: 1988, *83*, p.387-391.
4. R. Power *et al.* "Drug injecting, AIDS and risk behaviour: potential for change and intervention strategies." *British Journal of Addiction*: 1988, *83*, p.649-654.
5. J. Strang. "Changing injecting practices: blunting the needle habit." *British Journal of Addiction*: 1988, *83*, p.237-239.

How the drugs/AIDS money has been allocated

	1987/8	1988/9
England		
— drugs	£5 million	£5 million
— AIDS prevention	£1 million	£1 million
		£3 million
Scotland		
— drugs	£1.1 million*	£1.1 million*
— AIDS prevention		£300,000

* Includes £300,000 to help drug services cope with their HIV/AIDS-related workload.