AIDS AND INJECTING

AIDS FILE will bring *Druglink* readers British and world literature on the single most serious health threat to drug users. First is Dave Turner's call for drug agencies to practice risk-reduction to save lives. We also see how such practices — including new syringes for old — have been working in Amsterdam.

David Turner

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 in all parts of the country.

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. In 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.

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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 alterna-

AIDS = acquired immune deficiency syndrome. An invariably fatal syndrome of diseases resulting from damage to the immune system caused by infection with the HIV virus.

Immune system = body systems responsible for maintaining resistance to disease.

HIV virus = human immunodeficiency virus. Formerly known as the HTLV III virus and sometimes called the 'AIDS virus'. In Britain about one in ten people infected with the HIV virus develop AIDS and a larger proportion (about one in three) develop less serious illnesses.

HIV antibody = the antibody produced by the body in response to the HIV virus. Tests for HIV infection rely on detecting the presence of this antibody. Absence of the antibody does not necessarily mean the individual is clear of infection.

tives 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.

Based on 'HTLV III infection and AIDS in injecting drug users: report from the Standing Conference on Drug Abuse' in: *Proceedings of the AIDS Conference 1986*, Peter Jones *ed*, Newcastle upon Tyne: Intercept, 1986, pages 249-253. Full conference proceedings available from Intercept, P.O. Box 2, Ponteland, Newcastle upon Tyne, NE20 9EB.

PREVENTING AIDS IN AMSTERDAM

Amsterdam has taken three measures to prevent the spread of human immunodeficiency virus (HIV) among drug addicts — a publicity campaign; an exchange system for syringes and needles; and the distribution of condoms among addicted prostitutes.

In the publicity campaign leaflets are being distributed and meetings are held to inform workers in the drug field and addicts themselves about AIDS.

Among drug addicts HIV is mainly transmitted by sharing of contaminated needles and syringes,[1] so the provision of sterile equipment might slow the spread of the virus in this group. To avoid increasing danger that people might inadvertently prick themselves with carelessly discarded syringes and needles, a strict exchange system was adopted. This was introduced in Amsterdam in 1984, organised by the Municipal Health Service in cooperation with the Association of Drug Addicts ('junkies' union'): addicts receive a sterile syringe and needle free of charge when they return a used syringe and needle.

Studies from Africa strongly suggest that HIV can be transmitted by heterosexual contact and that prostitutes and their male customers in Africa should be regarded as at high risk of AIDS.[2,3] Thus in western countries prostitutes who use intravenous drugs could be a link in the spread of HIV to the general population. The Municipal Health Service now provides free condoms to addicted prostitutes.

These measures need to be viewed in the context of Amsterdam's approach to the drug problem. Because the results of drug-free treatment were disappointing and few addicts were being reached, Amsterdam revised its policy in the late 1970s towards a more pragmatic, non-moralistic approach. The principle is: that if it is impossible to cure a drug addict one should at least try to create a situation that greatly reduces the risk that the addict harms himself or his environment.

Besides drug-free treatment programmes and resocialisation projects, much emphasis is put on getting in touch with addicts through streetwork, medical assistance to arrested addicts, special attention to those admitted to general hospitals, and an outreaching 'low threshold' methadone programme (like 'methadone by bus project').

Once in contact, we persuade the drug addict to stabilise their addiction and life-style by regular methadone use and less involvement in illegal drugs, by regular medical check-ups, and by attention to his or her social circumstances (housing, money, and 'normal' social relationships).

Although it is early days, the effort to contact as many drug addicts as possible seems to be successful. In 1985, 60-80 per cent of the city's drug addicts were in touch with the Amsterdam helping system. The AIDS publicity campaign could therefore be reaching a substantial proportion of the target group.

In 1985 some 100,000 syringes and needles were provided in the exchange system and there has been no evidence of an increase in 'needlestick' accidents among the general population. Nor has the fear that this approach would encourage drug addicts to inject and not become involved in treatment come true so far. The number of addicts who use intravenous drugs did not increase in 1985 (25-30 per cent inject, 70-75 per cent inhale heroin or 'chase the dragon'). Therapeutic programmes report that more clients than ever are being motivated to enter treatment. The number of drug addicts in Amsterdam has stabilised over the past few years at 7000-8000.

In Amsterdam only two AIDS cases have been diagnosed among drug addicts. When sera taken from drug addicts at the end of 1983 and the beginning of 1984 were tested for HIV antibodies (R.A.C. and J. Goudsmit, unpublished), five (3.4 per cent) of those from 145 addicts entering a methadone programme and 12 (23 per cent) of those from 52 addicted prostitutes were positive.

In December 1985 a large epidemiological study began. The prevalence, incidence, and risk factors of HIV infection among drug addicts in Amsterdam are being studied and the influence of the preventive measures now adopted will be assessed.

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