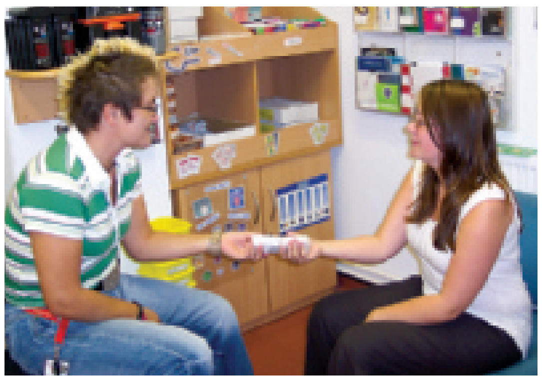
The works party comedown

Despite its position on the frontline in the battle against blood-borne viruses, needle exchange is being hampered by apathy and blinkered thinking. **Jamie Bridge** warns there is much to be done if we are to combat the spread of Hepatitis and HIV

If the success of needle exchanges is determined in terms of HIV prevalence amongst injectors, it is one of the most successful public health campaigns in UK history. Despite a recent increase, British HIV prevalence remains extremely low by international comparisons. Therefore, on its 20th anniversary, while you'd think there was much to be proud of, there are reasons not to be so cheerful. Picture the scene: the guests have arrived, there are balloons everywhere – but someone has forgotten the cake.

NEW THREAT

In the 1980s, Hepatitis C – a more contagious, more prevalent, potentially more costly and longer living virus than HIV – was unheard of. This is just as well, because if needle exchange success had been determined in terms of Hepatitis C transmission, it is questionable whether the intervention would have reached the big 'two-O'. Currently, more than 40 per cent of injectors are infected with Hepatitis C and, with the sharing of needles and syringes still common, this prevalence is rising – alongside HIV and Hepatitis B. Essentially, needle exchange is failing to control this new epidemic.



Vital service: clean syringes being provided at Turning Point's upgraded needle exchange in Sheffield

Logically, in order to completely eliminate virus transmission, needle exchanges must distribute enough paraphernalia so that injectors always have enough new equipment around and never need to share. Admittedly, one clean needle and syringe per injection may be a pipedream, but we can certainly and significantly improve on the current coverage, which the NTA calculated as just one needle per injector every two days.

Distributing needles needs to be just one part of a wider harm reduction system that includes paraphernalia supply, vaccinations, blood testing, advice, counselling, access into treatment and ideally even drug consumption rooms, the "rational follow-on to needle exchanges", according to Dame Ruth Runciman.

You would hope that the UK would learn from international experiences such as Vancouver, where rising HIV and Hepatitis C prevalence was reported in the mid-1990s despite a long-established needle exchange programme – the coverage was poor, services were inflexible to rises in stimulant injecting and there was inadequate access to treatment and testing. You would also hope that the UK would take heed of warnings from experts such as Andrew Preston, harm reduction activist and co-founder of Exchange Supplies, who says "we should constantly bear in mind that we are on the brink of an HIV epidemic the whole time". However, these lessons and warnings are falling on deaf ears.

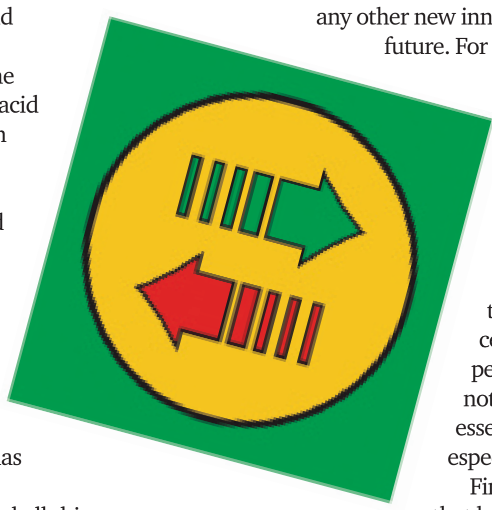
ALARMING

It is perhaps timely that the NTA has recently published its national audit of needle exchanges, which attempted to survey every DAT and specialist and pharmacy-based needle exchange in the country. The results are an alarming reminder that needle exchange is still immature for a 20 year old. Only around half of them responded. The audit describes a "mixed economy" of exchanges with huge variations in practice. Less than half of the specialist exchange supplied cookers, one in five did not stock citric acid, and four per cent did not even give out 'sharps bins' – the numbers are even more alarming amongst pharmacy exchanges – and there is an unacceptable postcode lottery for injectors. In one area, for example, one town's injectors have easy access to needles and syringes, various paraphernalia, advice and counselling. But injectors 30 minutes down the road have no specialist exchanges, poor treatment access and may even be resorting to sharpening old needles. Pleas from local staff for a solution have fallen on deaf ears for various reasons but the issues are often not financial, as some DATs would have you believe – the majority underspent in 2005 – it is down to a lack of will.

FOOT DRAGGING

In many cases, needle exchange simply isn't as high a priority for local policy makers and purse-holders as it used to be in the 'good old days'. As Jon Derricott, co-founder of syringe distributors Exchange Supplies, describes: "There was an energy for something new and that inevitably had to go." As far as some DATs and organisations are concerned, simply having an exchange is enough – but it's not. In order to combat rising viral transmissions, needle exchanges need a boost to improve their coverage, appeal and accessibility. They need to be expanded with more mobile units, outreach programmes and targeted interventions for hard-to-reach groups. They must also be comprehensive – offering their clients blood testing, paraphernalia, treatment, advice and support.

Yet this message isn't getting across. In one service, the funders have decreed that citric acid sachets are 'luxury items', rather than proven interventions to reduce injecting related eye infections which can lead to blindness. In London's West End, the Home Office-funded 'Project Lilac' warned that a fixed-site specialist exchange was crucial. Yet this has been ignored by the local council, which, according to one local worker, is "strong-armed by champagne socialist local residents". In fact, despite localised rises in Hepatitis C infection and young injectors, the area's existing mobile service has had its hours cut.



You'd be forgiven for thinking you've heard all this before. In Druglink this time last year, the cover story compared UK harm reduction to a restaurant with fancy menus but 'muck' for food. There have been countless other commentaries and presentations saying the same thing – bemoaning the lack of passion and innovation in today's needle exchanges. However, speaking from personal experience, the passion is undoubtedly still there - it is just being quashed because the 'powers-that-be' aren't interested.

'Essentially, needle exchange is failing to control this new epidemic'

TARGETS

So how do we fix this? National guidelines and minimum standards for needle exchanges will eliminate the postcode lottery farce and support people who are currently banging their heads against walls trying to improve the situation for their clients. Such documents should realistically come from the NTA and should ensure that every specialist exchange has the full complement of paraphernalia, testing and vaccination facilities and access to treatment and counselling as standard. DATs and service management need to be held accountable through specific targets for needle exchanges, including huge improvements in coverage and data management. This should shake them up and reawaken their enthusiasm for needle exchange: suddenly it will all seem important again – no more frozen posts or restricted budgets. However, extreme care has to be taken to ensure that, on the front line, needle exchange remains entirely client-focussed in order to be effective. Some may disagree, but I believe that this is a situation that can be achieved.

Secondly, there is one section of legislation that needs scrapping if needle exchange is to remain innovative and flexible. Section 9a of the Misuse Of Drugs Act (1971) prohibits the supply of any item for the purposes of drug use. Exceptions were made for needles and syringes. In 2003 after lengthy campaigns, swabs, cookers, citric acid, filters and sterile water – with ascorbic acid following in 2005 – were also exempted.

But for needle exchanges, this legislation is a barrier to effective health interventions and creates a wall of red tape and fear of prosecution for any service wanting to distribute foil (to encourage non-injecting drug use), single-use crack pipes (to prevent injuries and virus transmission), tourniquets, sterile water and any other new innovation that comes along in the future. For example, in 2003, the updated law specified that 2ml ampoules of water were permitted, but this led many exchanges to stop supplying their 1.4ml and 5ml plastic containers. With no readily available 2ml alternative to stock, the law change had unintentionally done more harm than good. In the NTA survey, 75 per cent of specialist exchanges and 87 per cent of pharmacy exchanges did not supply water, despite it being an essential item of paraphernalia, especially for homeless injectors.

Finally, there is one constant problem that has to be addressed by needle exchanges – drug litter. A disproportionate amount of media coverage is inevitably given to this subject and it is often the focus of complaints from local residents. At a recent meeting of the National Needle Exchange Forum, Susan Waldron demonstrated how this issue has been overcome in Redbridge, east London through partnerships with local government. Drug litter is by no means an easy issue to tackle, but is one that cannot be overlooked if needle exchange is going to move forward with the support of the public, media and politicians.

NEW ERA

I hate to be a party pooper, however, and there are a lot of positives to be taken from the current situation as well. Reassuringly, the NTA audit reported that every UK DAT had at least some needle exchange provision. There were also numerous examples of good practice across Britain- including services with long-established vaccination or social inclusion programmes. The sterile water fiasco has been temporarily addressed with 2ml glass ampoules, although there are concerns about safety and discarded ampoules. The NTA appear to be moving towards producing national standards, guidelines and targets in the aftermath of the audit, which has at least quantified and publicised the problems. I have only been a needle exchange worker for the last two years and have so much admiration for everyone who played a role in its heyday. Provided needle exchange adapts and refreshes in the near future, we can make sure that Britain once again leads the world in harm reduction and that needle exchange has 25th, 30th and 40th birthdays with even more to celebrate. ●

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The International Harm Reduction Association is the leading organisation in promoting the reduction of drug and alcohol-related harm on a global basis. For more information (including membership), please visit **www.ihra.net**