



**FULL  
RESEARCH  
FINDINGS**

A snapshot of  
21st century  
injecting drug use

# AT THE SHARP END

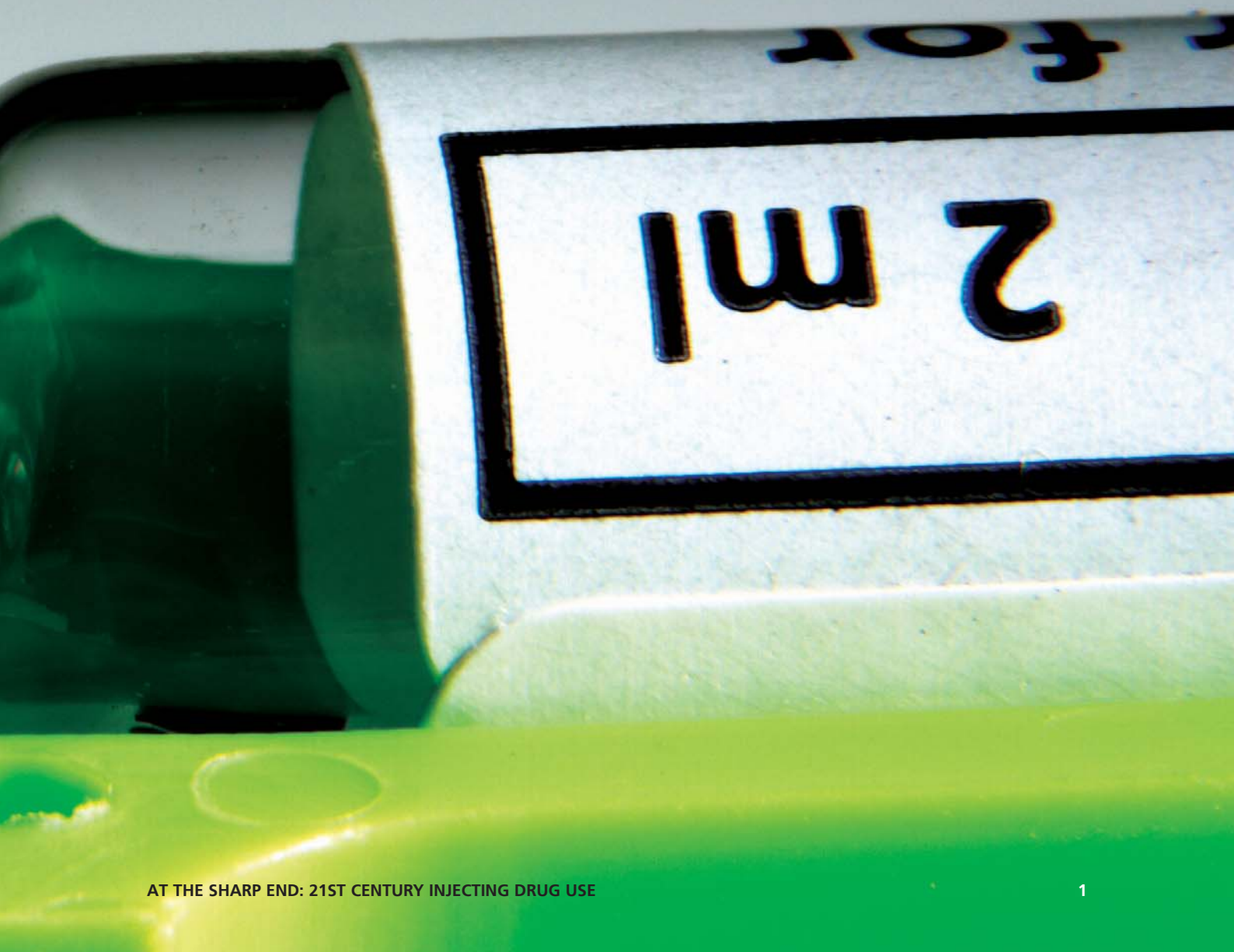
**TURNING  
POINT**  
turning lives around



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The statistics are startling, with half of injecting drug users estimated to have Hepatitis C, and a total of 6,000 new infections per year.



## EXECUTIVE SUMMARY

**Twenty-one years after the first needle exchange services were set up in response to the rise of HIV, there is now a generation of injecting drug users who are taking drugs differently and more dangerously. It seems they are too young to remember the HIV awareness campaigns of the 1980s and are at high risk from life-threatening blood borne viruses such as Hepatitis and HIV.**

The statistics are startling, with half of injecting drug users estimated to have Hepatitis C, and a total of 6,000 new infections per year. Current or ex-injecting drug users make up nearly 90% of all Hepatitis C infections in the UK (HPA, 2006). HIV rates are at their highest levels since 1993 among injectors, with anonymous surveys indicating that one in 50 current users has HIV (HPA, 2006a).

With 25 needle exchanges across England and Wales, Turning Point is coming into contact with more and more people facing damage to their health caused by risky injection practices. We believe this is a public health issue and there is an overwhelming case for improving service provision for this vulnerable group. Current drug policy is failing to protect people from the risks of blood borne virus infection, at huge cost to drug users, the community and the taxpayer. Access to testing and treatment for blood borne viruses is poor, with too many people living in ignorance of their illness.

Research undertaken by Turning Point reveals that worrying numbers of drug users are putting themselves at risk. Studies show an increase in the use of "speedballing" (injecting crack and heroin together), and widespread sharing of injecting equipment. Half the respondents in our research admitted to sharing drug taking equipment, a major cause of blood borne virus transmission. Many users are also starting to inject in the neck or groin, putting them at even higher risk of death and injury.

Needle exchange services provide much-needed support to injecting drug users, offering information and advice about safer injecting techniques, blood borne virus vaccinations and testing, and referrals to primary care when infections and injuries occur. However needle exchange provision in England is patchy. Out of hours access to services is poor and there are considerable disparities in the availability of injecting equipment. Less than half of all needle exchanges provide blood borne virus testing on site (NTA, 2007).

*At the sharp end* highlights the findings of our research and calls on the Government to urgently review its current drug strategy and prioritise blood borne viruses as a public health issue.

# BLOOD BORNE VIRUSES

**There are three main blood borne viruses that pose a risk to injecting drug users: HIV, Hepatitis B and Hepatitis C. A vaccine exists for Hepatitis B, but not for HIV or the Hepatitis C virus. There is currently no cure for HIV, but there are combinations of medicine that can stem the progression of the virus. Treatment exists for Hepatitis C.**

## **HIV**

HIV stands for Human Immunodeficiency Virus (HIV). The virus attacks the immune system, and the gradual deterioration of the immune system can eventually lead to Acquired Immune Deficiency Syndrome (AIDS), the most serious and often fatal stage of the illness. Because there can be a delay between the initial infection and the onset of illness, there may not be any signs of HIV infection for years. Anti-retroviral treatment is the main treatment for HIV. It is not a cure, but slows down the progression of the virus within the body. There is a regional variation in levels of HIV infection within the injecting drug user population, with levels of infection in London higher than elsewhere. In London, approximately one in 25 injecting drug users has HIV. Outside London, levels of HIV infection among injecting drug users have risen from one in 400 in 2003, to one in 65 in 2005 (HPA, 2006a).

## **Hepatitis B**

Hepatitis B is a virus that attacks the liver. The infection may have no symptoms, or it could cause serious illness with fever, muscle or joint pain, or nausea. Most adults will recover without any problems. If the virus remains in

the blood for more than six months, then a person has a "chronic infection" and risks developing cirrhosis, liver disease or liver cancer. Most people (90%) who are infected with Hepatitis B will recover and their immune system will protect them from future Hepatitis B infections. There is an effective vaccine against Hepatitis B. Information on levels of Hepatitis B infection in England and Wales is currently unavailable (HPA, 2006a).

## **Hepatitis C**

Hepatitis C also attacks the liver, but unlike Hepatitis B there is no vaccine. This is because there are at least six different types of the Hepatitis C virus (known as genotypes), and scientists have not found a vaccine that can protect against all genotypes. In the UK, the most commonly found genotype is Type 1. Following exposure to the Hepatitis C virus, approximately 20% of people recover. However 80% go on to develop a chronic infection, with risks of cirrhosis of the liver, liver cancer and liver failure. For people with chronic infection, approximately 25% will develop cirrhosis of the liver. Treatment for Hepatitis C is available, and genotype 1 is the most responsive, with 50-80% success rates in clearing the virus. A delay in seeking treatment, co-infection with another genotype of Hepatitis C, or co-infection with another blood borne virus are all factors that can affect the success of treatment. Half of injecting drug users are estimated to have Hepatitis C, and there are 6,000 new infections per year. Current or ex-injecting drug users make up nearly 90% of all Hepatitis C infections in the UK (HPA, 2006).

# INTRODUCTION

**It is estimated that there are approximately 300,000 problematic drug users in England and Wales, of which 161,200 are injecting drug users (EMCDDA, 2004). These are users who are often dependent on heroin and/or crack cocaine, and other drugs<sup>1</sup>, with high risks to their health. Many have limited social and economic resources. Low educational attainment, long-term unemployment and poor access to healthcare and housing often underlie and exacerbate problematic drug misuse.**

The main harms to health associated with drug use are overdose and unsafe using techniques, particularly injecting. In 2004, drug misuse was the third most common cause of death among young adults aged 15-34 (ONS, 2006). Injecting drug users are particularly vulnerable to harms arising from their drug misuse, as injecting presents a number of particular risks to the user. This poses challenges to policy makers and treatment providers attempting to reduce the harm that injecting drug use can cause.

Injecting drug users face a higher risk of overdose and of drug-related deaths than other drug users. Misjudgements about “safe” dosages can easily result in overdose, and can be fatal. Perhaps the most significant other harm posed by injecting drug use is from blood borne virus infections such as HIV or Hepatitis B or C, spread by the use and sharing of needles and contaminated equipment. Chronic infection with Hepatitis can lead to cirrhosis of the liver. One in four people who develop liver cirrhosis as a result of Hepatitis C, will develop liver cancer within five years of cirrhosis (Foster, 2006).

Other harms faced by injecting drug users include the immediate and ever-present risks of bacterial infections or the use of contaminated injecting equipment. Long-term injecting, especially if the injecting technique is poor or unhygienic, can lead to increased vein damage and the use of more dangerous sites such as the femoral vein (groin) or neck.

Injecting drug use not only damages the health of the user, but also impacts on families and communities. Most visibly, the community sees the harm through discarded needles and other injecting equipment in public places.

These risks can be managed and it is possible to work with injecting drug users to reduce the harm that their injecting drug use causes to themselves and their communities. Harm reduction includes the provision of needle exchange services which offer information and advice on safer injecting techniques to prevent vein damage, sterile injecting equipment to prevent infections, and first aid and referrals to primary care when injecting-related infections and injuries occur. Needle exchange services can offer structure for otherwise chaotic users and provide a bridge into treatment. However for some people, the circumstances of their lives are such that abstinence or maintenance on a substitute prescription is not a realistic immediate goal. Turning Point works with these people to keep them as safe and healthy as possible, until the time when they are ready and able to consider treatment. This is not in conflict with the aims of treatment.

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<sup>1</sup> Steroid injectors, although exposed to the same risks of injecting as other injecting drug users, are less likely to be affected by other risk predictors such as homelessness, poor diet or poverty. Less than 1% of the people in our research reported using steroids, and they are not a focus of this report.

## ABOUT THIS STUDY

There has been an increase in the rates of HIV and Hepatitis C infection among injecting drug users in recent years. Among current injectors, HIV rates are at their highest level since 1990, with anonymous surveys indicating one in 50 current users has HIV (HPA, 2006a).

The prevalence of Hepatitis C has increased from one in 25 in 1998 to one in two now (HPA, 2006a). It is estimated that half of all people who have Hepatitis C are unaware of their illness.

Previous research indicates that patterns of drug use are changing and suggest an increase in the use of "speedballing" or snowballing – the use of heroin and crack cocaine in combination (Lifeline, 2006).

This report is based on quantitative and qualitative research into the experiences of injecting drug users in England. Research was carried out between December 2006 and March 2007.

The aim of the research was to assess the prevalence of blood borne viruses and take-up of HIV and Hepatitis C treatment, to measure the extent of "speedballing" within the injecting population, and to determine if this injecting practice was linked with higher-risk behaviour than other injecting drug use. The research was conducted with current and former injecting drug users and Turning Point staff working in needle exchange services. It is based on a questionnaire that was distributed in ten Turning Point needle exchanges and four focus group discussions.

The questionnaire collected information from people who had injected an illegal drug in the four weeks. It asked about patterns of drug use, details of injecting practice including the sharing of equipment such as needles, syringes, filters or containers, and information about the physical location of injecting sites. It also looked at an individual's known blood borne virus status and whether they were accessing treatment for a virus.

Three focus groups were conducted with 18 current and former injectors in Sheffield, London and Somerset. One focus group was conducted with members of staff from Turning Point needle exchange services across the country. The focus groups provided a forum for discussion of blood borne viruses, injecting risk behaviour and harm reduction service provision. They explored people's knowledge and understanding of each virus, barriers to testing and treatment, attitudes to injecting risk and perceptions of the quality of services for injecting drug users.

This report contains an analysis of 874 questionnaire responses, analysed using the software programme SPSS 15.0, and 25 focus groups analysed using grounded theory method. Of the questionnaire respondents, 80% (681) were male and 20% (166) female. The majority of people described their ethnic origin as white British (92% / 798). The modal age range was 25-34 (48% / 374). Of the focus group participants, eleven were male and seven were female. The age range of focus group participants was 24-56.

## KEY FINDINGS<sup>2</sup>

- Half of all respondents shared needles or other injecting equipment. One in five (19.3%) report having shared needles and syringes, while nearly one in two (46.4%) had shared other injecting equipment.
- One in five injecting drug users (21.1%) report that they are Hepatitis C positive and are at risk of developing cirrhosis or liver cancer. More than one in four (26%) either do not know their status or have never been tested. One in 59 (1.7%) report that they are HIV positive. All drug users infected with HIV were co-infected with Hepatitis C.
- Take-up of testing for blood borne viruses is low. One in five respondents has never been tested for Hepatitis B or C (23.1 / 22.2%) and one in four (25%) has never been tested for HIV.
- The most commonly used drug is heroin (77%), but nearly one in five (19%) report speedballing as their main drug.
- People who report speedballing as their main drug are twice as likely to inject five or more times a day than those injecting heroin. One fifth of speedballers (21%) report injecting five or more times in the past day compared to one tenth (10%) of heroin users.
- Nearly two in five respondents (39%) inject in the femoral vein (groin).
- One in nine people report injecting in the neck (11%).
- People who report speedballing are more likely to inject in the femoral vein or neck.
- One in nine (11%) injected the last time they were in prison.
- There are wide regional variations across the country in the extent of risk behaviours such as speedballing or groin injecting. For example, the prevalence of speedballing ranged from 12% to 77% across needle exchanges. The prevalence of femoral injecting varied from 27% to 63%.
- Nearly half of all respondents (43%) want to see improvements to the service that they receive. Of these respondents, over one third (35%) would like to see a wider range of equipment, nearly one in seven (14%) want longer opening hours for needle exchanges, and one in ten (10%) called for more extensive provision of needle exchanges.

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<sup>2</sup> Some respondents did not answer every question. The percentage given is the percentage of the number of people who answered that question, not a percentage of the total number of respondents.

# BACKGROUND

## Provision of sterile injecting equipment

Harm reduction support for drug users aims to prevent diseases from blood borne virus infections and other drug-related harm such as overdose. In England, *Models of Care* (NTA, 2002, update 2006) sets out the national framework for commissioning and best practice in the provision of drug treatment. It states that harm reduction interventions should be available at all treatment services within a local area and that specific interventions should be in place to reduce the risks of illness and death due to blood borne viruses. For injecting drug users, this requirement includes access to sterile injecting equipment, substitute prescribing, testing for blood borne viruses, vaccination for Hepatitis A and B, and referrals to treatment for those who test positive for HIV or Hepatitis C. In Wales, the Substance Misuse Treatment Framework sets out the need for provision at a similar level.

Needle exchanges were introduced in 1986 as a robust public health response to the spread of HIV, and marked the beginning of a different approach to drug treatment. This harm reduction approach recognised that drug misusers who could not be persuaded to stop injecting should have access to sterile needles and syringes on an exchange basis. It spearheaded a new approach of treating injecting drug users as people who could, and would, take active steps to protect themselves. From 1986, the UK led the way in developing a harm reduction approach, particularly in the prevention of HIV, averting an epidemic of HIV infection associated with injecting (Stimson, 1995). Needle exchanges have also provided a route into treatment and access to primary care. In 1997, there were 1,600

needle exchange outlets in England and Wales distributing approximately 26 million needles annually. These are predominantly distributed through pharmacies and specialist needle exchange services, but also from other sources such as Accident & Emergency departments, or outreach services.

In 2004-5, the National Treatment Agency (NTA) conducted an audit of needle exchange provision across the country (NTA, 2007). The same survey was replicated in partnership with the Welsh Substance Misuse Policy Development Team in Wales. Calculations derived from the English survey suggest that approximately 23 million needles and syringes are distributed annually.<sup>3</sup> This is less than the number distributed in 1997, despite the increase in injecting drug use. The National Treatment Agency found inconsistency in needle exchange practice, with considerable variation in the level of service provided. Despite making up approximately 80% of all needle exchange facilities, pharmacies distributed limited sterile injecting equipment to clients. Out of hours access to services was poor. Less than half of all services provided Hepatitis B immunisation or on-site testing for HIV, Hepatitis B or Hepatitis C. The level of needle distribution was such that, on average, each injector would have access to only one clean needle every two days. This is clearly insufficient to ensure a clean needle for every injection. Only one in four pharmacy-based needle exchanges provided sterile mixing spoons, fewer than one in five provided sterile filters, and only one in 12 provided sterile water. All of these items of equipment can be a source of blood borne virus transmission.

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<sup>3</sup> This figure of 23 million is an approximate calculation. The NTA report that within the 108 Drug Action Teams who responded, a median number of 149,950 needles were distributed annually. If this figure is recalibrated to reflect the provision of 149 DATs, then approximately 22 million needles and syringes were distributed in England. The 1997 survey reported that Welsh provision was 4% of the English total. This brings the total figure for England and Wales to approximately 23 million.

The NTA also found that specialist needle exchanges delivered a broader range of equipment than pharmacy-based needle exchanges, although there was wide variation in the level of service offered. In needle exchanges nearly half provided sterile mixing spoons, just over half provided sterile filters and one quarter provided sterile water. According to the audit there is “generally poor availability of needle exchanges outside office hours”. While “all” or “most” pharmacies are open until 6pm on weekdays, there were “few” or “none” available after 6pm or on weekends. Less than half of exchanges offered blood borne virus vaccination or testing on site.

Although the majority of Drug Action Teams have a Needle Exchange Coordinator, the NTA found that the role is often merged with other tasks, and is performed by people with varying levels of expertise and seniority. In partnership with the NTA, the Healthcare Commission has undertaken a review of harm reduction provision within England. The findings should be published in summer 2007.

Approximately two thirds of injecting drug users have a history of imprisonment, and will on average serve three sentences (Testa, 2007). A survey conducted in 2005 showed that over 70% of prisons do not provide injecting drug users with any means for ensuring that their injecting equipment is sterile (Prison Reform Trust and National Aids Trust, 2005). The Department of Health will soon begin providing sterilising tablets to prisoners to clean used injecting equipment, but needle exchange in prison is not part of current practice. Opposition to needle exchange in prisons centres on fears of an increased risk of violence, an increased consumption of drugs, the

initiation of current non-injectors to injecting practices, and concern that the implementation of prison needle exchange would undermine abstinence or substitution programmes (Canadian HIV/AIDS Legal Network, 2004).

However there have been at least six evaluations of a range of needle exchange systems in other countries (including Spain, Switzerland and Germany) and these have shown that prison needle exchanges do not endanger staff or prisoner safety, and in fact make prisons safer places to live and work. They do not increase drug consumption or injecting and they reduce risk behaviour and transmission of blood borne viruses (Canadian HIV/AIDS Legal Network, 2004; Dolan et al, 2003).

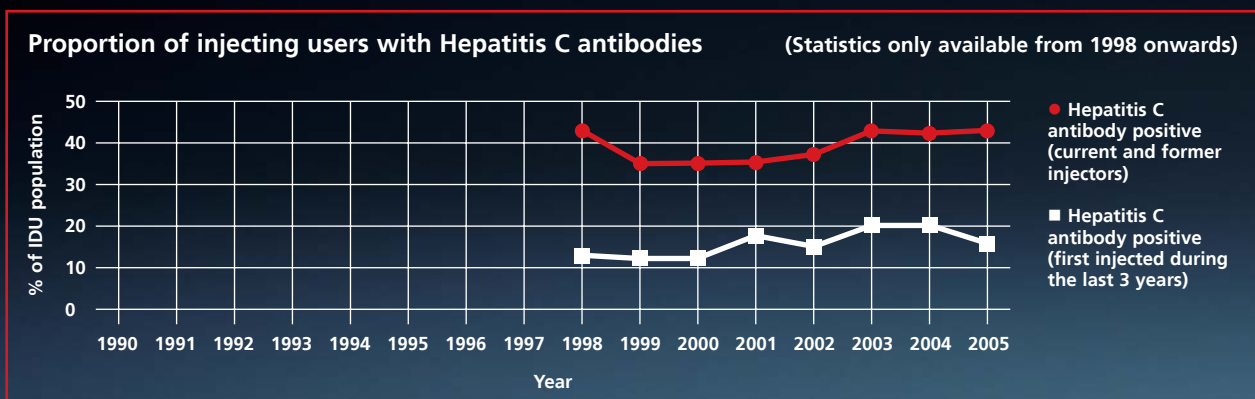
### **Blood borne viruses**

The Government’s response to blood borne viruses was initially set out in *Getting Ahead of the Curve: A Strategy for Combating Infectious diseases* (Department of Health, 2002). This highlights the need for greater uptake of Hepatitis B vaccination programmes, increased awareness of Hepatitis B and C and HIV among at-risk groups, such as injecting drug users, and an increase in testing for all blood borne virus infections. The strategy also established the Health Protection Agency, with responsibility for monitoring prevalence and trends in blood borne virus infection levels. These are published in an annual report, *Shooting Up*. The October 2006 report provides the most up-to-date prevalence statistics available, reporting data from 2005. Prevalence data for Hepatitis B are not available for 2004 or 2005. The most recent data (from 2002) on laboratory reports of acute Hepatitis B infection showed an increase in 43% (539 to 849) from the previous year (HPA, 2003).

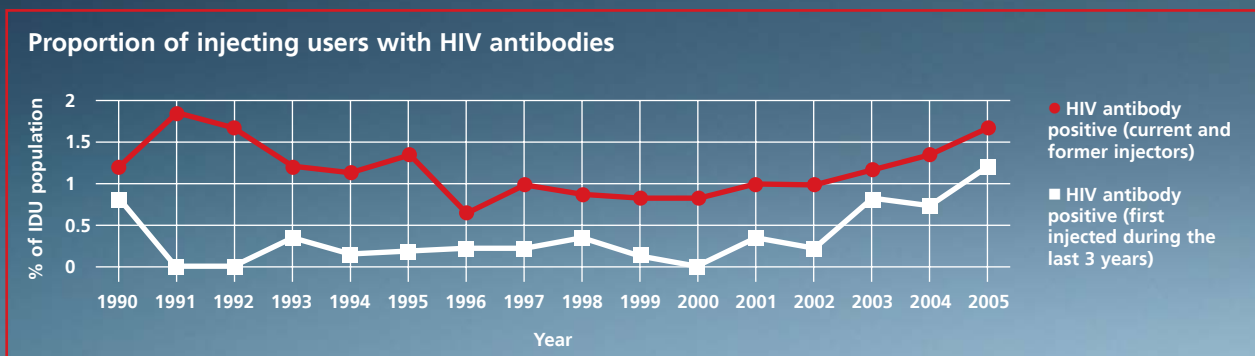
## BACKGROUND

Overall, approximately one in 50 injecting drug users has HIV. There are regional variations and London has the highest rate of infection with one in 25 infected. In Wales and England outside of London, prevalence rose from around one in

400 in 2003 to approximately one in 65 in 2005 (HPA, 2006a). Approximately one in two injecting drug users have Hepatitis C. There are marked regional variations, but overall prevalence has increased in recent years (HPA, 2006).



Source: Health Protection Agency, 2006a



Source: Health Protection Agency, 2006a

### Hepatitis B

Approximately 50% of injecting drug users have had a Hepatitis B vaccination (HPA, 2006). The prison-based Hepatitis B vaccination programme is widely credited for the uptake in Hepatitis B vaccinations among drug users. In contrast, access to Hepatitis B vaccinations in the community is poor. While approximately 40% of injecting drug users report having received a Hepatitis B vaccination in prison, fewer than 30% reported receiving a vaccination from a drugs service, around 17% from their GP and just over 10% from a needle exchange (Testa, 2007).

### HIV

The Government's response to HIV was set out most recently in *Choosing Health* (2004). On paper, funding for HIV/AIDS prevention and treatment services has been increased as a result of the *Choosing Health* agenda. However several charities are voicing concerns that money allocated to HIV prevention activities is being used to address deficits in other services. In a report of 2006, the National AIDS Trust (NAT) concluded that "Funding and commissioning of HIV prevention programmes are inadequate, failing to keep up with significant increases in HIV prevalence and risk-taking behaviour... Coercive, retributive or moralising responses are replacing actions based on public health and human rights" (NAT, 2006). In a study by the Terrence Higgins Trust in February 2007, nearly two thirds of responding Primary Care Trusts indicated that all or part of their *Choosing Health* money had been diverted away from sexual health services (THT, 2007). Although there are national targets governing access to sexual health (GUM) clinics, teenage pregnancy, gonorrhoea and Chlamydia, there are no specific targets for HIV/AIDS. In 2007, the AIDS Funders Forum published a report which concluded that "HIV is not a political priority, either nationally or locally" (AIDS Funders Forum, 2007). In 2006, levels of HIV/AIDS among injecting drug users reached their worst levels in a decade (HPA, 2006a). There is a regional variation in levels of HIV infection within the injecting drug user population, with levels of infection in London higher than elsewhere. Outside London, levels of

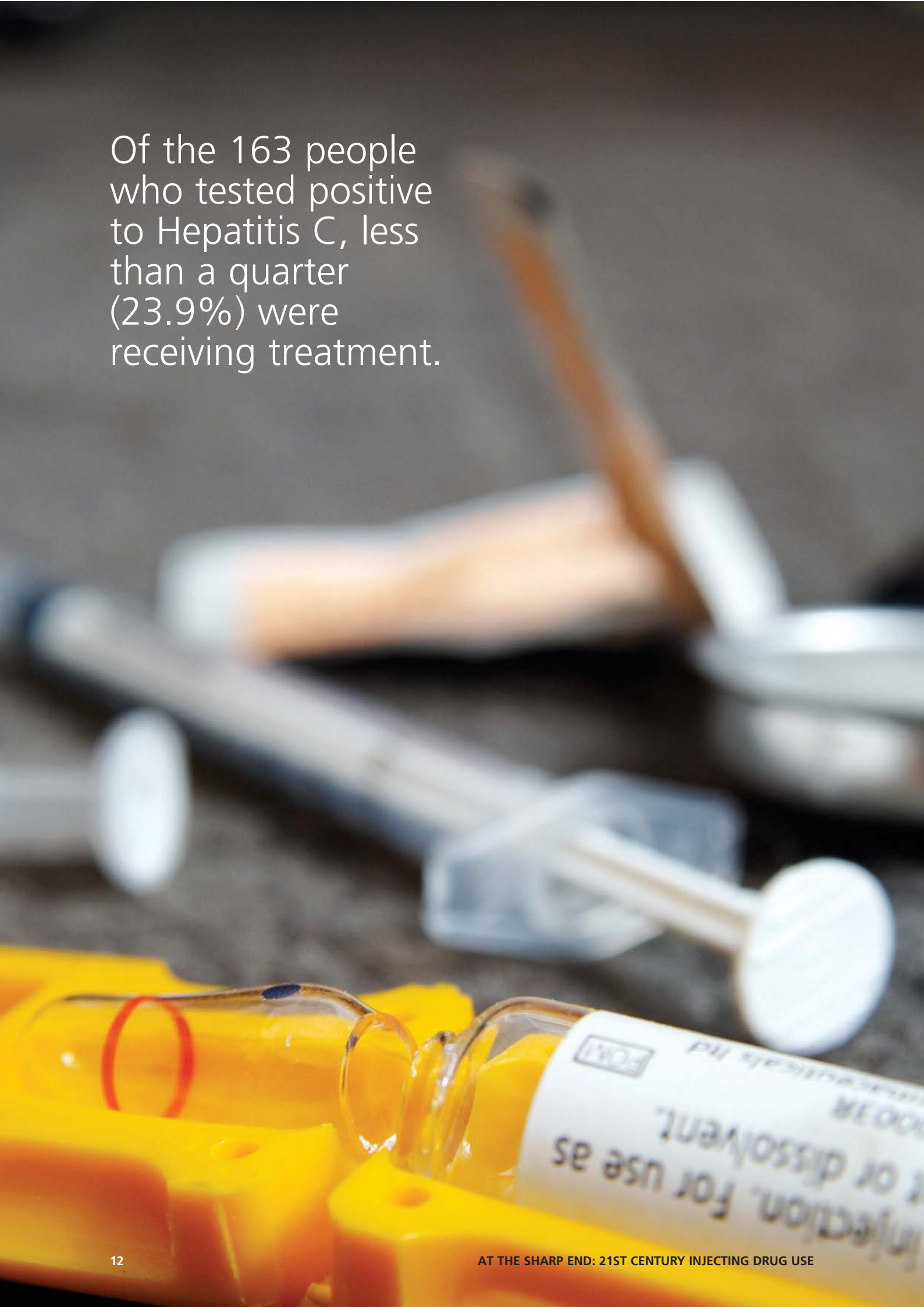
HIV infection among injecting drug users have risen from one in 400 in 2003, to one in 65 in 2005 (HPA, 2006a).

### Hepatitis C

*Getting Ahead of the Curve* (2002) stated that "in recognition of its public health importance" a specific strategy was needed to ensure an adequate response to Hepatitis C. *The Hepatitis C Strategy for England* (Department of Health, 2002) acknowledged that Hepatitis C presents a "major challenge" because of the high levels of infection, and the number of people who are unaware that they have Hepatitis C. The strategy sets out proposals to improve the effectiveness of prevention, diagnosis and treatment services for Hepatitis C, including the development of managed clinical networks to coordinate service provision. The success of the strategy is evaluated using National Outcome Indicators measuring prevalence of Hepatitis C infections, awareness of infections among injecting drug users attending treatment services, and prevalence of Hepatitis C among new injectors.

In 2006 the All-Party Parliamentary Hepatology Group published *A Matter of Chance*, which found that only 8% of Primary Care Trusts were implementing the Action Plan, and nearly half of the responding hospitals (46%) reported significant delays for patients wanting treatment. The Health Protection Agency reports that "the UK is the only major developed nation showing an upward trend in the numbers of deaths from liver disease" (HPA, 2006). They predict a 220% increase in the number of people with decompensated cirrhosis (serious scarring and impaired functioning of the liver) in the next ten years. A study by scientists in the US suggests that we would need to treat at least 10% of the Hepatitis C-positive population to reduce that number by 5%, and treat everyone if we wished to reduce it by half (Davis, 2003). Currently, the NHS is treating between 1% and 2% of the infected population. However, we do not know the nature and extent of the harms caused by injecting drug use as deaths from blood borne viruses are not currently included in the statistical reports of drug-related deaths.

Of the 163 people who tested positive to Hepatitis C, less than a quarter (23.9%) were receiving treatment.



# ANALYSIS OF KEY ISSUES

## Prevalence of blood borne viruses among injecting drug users

Our research found that one in 59 people (1.7%) knew that they were HIV positive, but one in four (25%) had never been tested.

One in five respondents (21.1%) knew that they were Hepatitis C positive, but slightly more (22.2%) had never been tested.

One in 32 (3.1%) had Hepatitis B, but nearly one in four (23.1%) had never been tested. These findings are broadly similar to data from the Unlinked Anonymous Prevalence Monitoring Programme (HPA, 2006a).

The high prevalence of blood borne viruses is the result of several inter-related facets of injecting drug use. Patterns of drug use, injecting sites, the sharing of injecting equipment, knowledge and awareness of blood borne viruses, access to testing, and treatment for infection are all factors that affect prevalence rates.

## Patterns of drug use

The research shows that heroin is overwhelmingly the most commonly injected drug, with over three quarters (77%) citing heroin as their main drug. In 2005, Turning Point reported that the increased availability of crack cocaine in the UK was dramatically altering patterns of drug use (Turning Point, 2005). This is evidenced by our research, which shows that combining heroin and crack cocaine (speedballing) is a widespread practice. Nearly one in five people (19%) report speedballing as their main drug and over a third (34%) said that they had injected both drugs together in the last month.

Speedballing presents particular risks to injecting drug users in comparison with using either heroin or crack cocaine separately. Speedballing increases the risk of overdose as the effect of both drugs combined is more difficult to assess than either drug individually.

Another difference between an injection of heroin compared to crack cocaine is that the effect of crack cocaine is extreme and short. This means that crack cocaine injectors are likely to inject more often to reduce withdrawal symptoms. Our research found that people reporting speedballing as their primary drug were more likely to inject more times a day than those using heroin on its own, thus increasing risk.

Crack cocaine, whether injected on its own or in combination, acts as a local anaesthetic at the injection site, meaning that injectors will not know if they have injected incorrectly, as they will not feel whether the injection has missed the vein. If using heroin and crack cocaine in combination, they will not know if they have used too much acidifier in the solution.

## Injecting sites

The physical location of an injection is significant because some locations such as the neck or femoral vein present higher risks of death or serious injury to the injecting drug user. The majority of respondents reported injecting in the arm, with 74% of people reporting that they had injected in their arm in the last four weeks. One third (30%) of respondents reported having injected in the legs in the previous four weeks.

Our research shows injecting in the groin and neck is common.

Nearly two fifths (39%) of respondents reported having injected in the groin in the last four weeks. Femoral injecting is risky because the femoral vein, artery and nerve are located so close together. Regular use of the groin can lead to an open wound (sinus) forming, with direct passage to deep tissue and the main circulatory system. The location is ideal for bacterial growth. The risks include abscesses and ulcers forming at the injection site, risk of arterial damage and an increased likelihood of paralysis and circulatory damage to the leg, including deep vein thrombosis.

Historically, femoral injecting was seen by injecting drug users as a method of last resort. However research has shown that attitudes to femoral injecting among injecting drug users have shifted over time. Rather than being predominantly a place of last resort, it tends now to be used for a variety of reasons, including ease of access, discretion, the perception that it is less vulnerable to infection and, in some cases, the site where people were first taught to inject (Rhodes et al, 2006).

Our research found that an injecting drug user will typically switch from sites such as arms or legs to higher-risk sites such as the femoral vein or neck, as other veins become unusable.

When we discussed femoral injecting in the focus groups, there were clear differences of opinion between those who did, and those who did not inject in the femoral vein.

In one discussion, one woman was visibly wincing as the discussion took place, stating "it doesn't agree with me, it doesn't agree with me at all". In another discussion a man said, "It's too dangerous. I've got friends who've lost legs. Those people you always see eventually end up on crutches."

For some, the lack of other usable sites was their motivation: "I couldn't see a vein but I still didn't go straight in my fem, I'd just check, I couldn't see one but I'd just feel around for if I could feel one. And both my arms would be bleeding, both my legs, and I still couldn't get it after two or three hours, and it would be a real pain, so I had to start going there, even though I didn't want to."

However others stated a variety of reasons for using the femoral vein, such as, "You've got no marks on your arms then, have you, if you go in the groin", or "It's easy. Quick and easy"; "[If] it's freezing cold and you can't get a vein, it doesn't matter if it's snowing, you can straight away"; "If you're in a dodgy place having a dig and there might be coppers or something around or security."

One in nine people (11%) said they had injected in the neck in the last four weeks. Injecting in the neck poses high risks. The veins are close to major arteries and tendons. The complications of injecting in the neck are similar to other sites, but more serious because of the location. For example, abscesses, cellulitis, vein damage and collapse are common risks of injecting, but an abscess on the neck may cause dangerous pressure on the nerves or obstruct the airway. Other risks include accidental injection into an artery – this would result in the contents of the syringe going directly to the brain, risking a range of neurological problems including strokes or aneurysm (a bulge in the blood vessel caused by weakening of the vein wall). Another risk is nerve damage, including a risk of vocal chord paralysis (Exchange Campaigns, 2003).

Combining crack cocaine with other substances adds to the health risks and leads to higher levels of risk-taking behaviour.

Speedballers were three times more likely to inject in the neck than those using only heroin. They were also more likely to inject in the groin and had injected more times in the last day in comparison to drug users who injected only heroin. One fifth of speedballers (21%) report injecting five or more times in the last day compared to one tenth (10%) of heroin users. Injecting drug users told us that they want more information on injecting techniques. Practical tips about injecting techniques, using the correct amount of acid to dissolve the heroin solution to prevent vein damage, and advice on cleaning injecting sites were suggestions given to help drug users maintain good veins in safer parts of their body. As one respondent said, "I have a lot of friends who are not injecting that long and already they are losing veins because they don't know what they are doing".

Several respondents wanted more advice about their injecting technique, with suggestions for more information and advice on safe injecting and specialist support from staff. One respondent called for "a full sized dummy showing injection sites" or "a nurse to assist and advise if help is needed". Staff can provide injectors with general information about how to inject safely to reduce the risks of infection and advice on the risks of different locations. They can also provide more specialist advice about injecting techniques such as how to ensure that the needle does not puncture the vein, and techniques to limit long-term damage.

Our research shows wide regional variations in the extent of risk behaviours. For example, the prevalence of speedballing ranged from 12% to 77% across needle exchanges, and the prevalence of femoral injecting varied from 27% to 63%. It is essential that there is good

communication between different needle exchange providers in an area, so that the services can respond to changes in local practices quickly, and with consistency. This process should be facilitated by the local Needle Exchange Coordinator where possible.

### **Sharing of injecting equipment**

Sharing injecting equipment is the main risk factor for blood borne viruses for injecting drug users. When needle exchange programmes were first introduced, the Hepatitis C virus was unheard of (it was first identified in 1989). It was initially presumed that what had been effective against HIV would be equally effective against Hepatitis C. However, in 2001 researchers published a study suggesting that 54% of infections among those who did not share needles or syringes could be attributed to the sharing of cookers and filters (Hagan et al, 2001). It is now clear that for an effective blood borne virus prevention strategy, injecting drug users must have access to the whole range of sterile injecting equipment, including swabs for cleaning injection sites, sterile water, spoons in which to mix the solution and filters to remove particles from the drugs solution. Section 9A of the Misuse of Drugs Act 1971 has been revised to allow legal provision of these items. Some services will provide equipment which is not explicitly permitted by the legal framework, such as tourniquets or aluminium foil.

Ideally, provision of all this equipment should be managed by a Needle Exchange Coordinator within each Drug Action Team or Community Safety Partnership. The coordinator should ensure access to an out of hours service, access to blood borne virus testing and vaccination, and sufficient level of provision to ensure clean equipment is available for each injection. This should be incorporated into the treatment plans for each area.

Our questionnaire asked respondents whether they had shared needles, syringes or any other injecting equipment in the last four weeks, and in the focus groups we explored the reasons behind sharing. One in five (19.3%) people reported sharing needles or syringes but, more worryingly, nearly half (46.4%) reported sharing a filter, spoon or water. One in nine (11%) reported sharing injecting equipment the last time they were in prison. In an open-ended question about improvements to service provision, over one third (35%) called for a wider range of equipment, one in seven (14%) suggested longer opening hours and one in ten (10%) requested wider provision of needle exchanges.

In the focus groups one participant commented, "if you're miles away from a chemist, you're not going to go there if you can just share a needle. I'm not saying that everybody does that, but a lot of people do stuff like that." Staff are also concerned about the limited availability of injecting equipment. In the focus group with staff, one Team Leader said "there's no money in our budget to buy spoons. We may sneak in some filters but that's as far as we can go. We can't supply cookers and we're asking people, advising people not to share equipment and then they are in situations where it's impossible not to share equipment."

It is clear from the NTA's audits of needle exchanges and our own survey of injecting drug users, that current needle exchange provision is not sufficient to prevent the sharing of injecting equipment. Improving access to sterile injecting equipment must be a commissioning priority. The role of the Needle Exchange Coordinator within each Drug Action Team needs to be reviewed to ensure that the position is filled by someone with sufficient seniority and expertise. Commissioners must ensure that sufficient resources are allocated so that full access to a comprehensive range of sterile injecting equipment can be guaranteed, to reduce the transmission of blood borne viruses.

### Awareness of blood borne viruses

It is essential that injecting drug users have an awareness and understanding of blood borne viruses, including how to reduce the risks of infection, the health implications of infection, and what treatment and vaccinations are available. Over a third (36.7%) of respondents to the research questionnaire had never been tested for one or more viruses. If an injecting drug user does not know their status, it puts them and others at greater risk. This is particularly true of Hepatitis C. Continued alcohol use by someone who has Hepatitis C also dramatically increases the risks of liver damage.

Poor awareness and understanding of blood borne viruses impact on the behaviour of injecting drug users in a variety of ways. First, they may not know that they are at risk and will not consider the need to be vaccinated against Hepatitis B, or to take a test for any of the viruses. Even if they do have a test and it is positive, they may not be aware of the implications of that result. In the focus groups, a man told us how he felt when he heard that he had Hepatitis C. "When I first found out I had it, I was a bit freaked out. I didn't know nothing about it. I'd thought I was invincible." People also need to understand the illness, its symptoms, how to cope with the illness and, for Hepatitis C, how to access treatment.

During our research we found significantly varying levels of knowledge about Hepatitis C. In the focus groups, many were unaware that there are different genotypes of Hepatitis C. In two of the focus groups, there were participants who had attended previous workshops or training sessions about blood borne viruses. They appeared more knowledgeable about the differences between viruses and their different health effects, and were confident in talking about the issues within the group discussions. This is important, as co-infection with different genotypes of Hepatitis C has a significant impact on the

likelihood of treatment success. An injecting drug user who is aware that they have Hepatitis C, but is unaware of genotypes, may continue to share because they are already infected, unwittingly exposing themselves to further risk.

Younger injecting drug users engage in higher-risk behaviour, and there is a correlation between age of first injection and injecting risk behaviour (Videl-treacan, 1998 and Battjes, 1992, cited in Craine et al, 2006). Yet in our focus groups, participants reported that they did not access needle exchanges until they had begun to experience complications as a result of injecting: "I don't really think you start getting involved looking for that information until you start having problems." Peer education – training injecting drug users to deliver safer injecting messages to other injecting drug users – is a key way to ensure that new injectors are taught to inject safely.

Levels of funding for HIV/AIDS awareness campaigns are difficult to assess, and data is not recorded by central government. Grants are distributed to statutory and voluntary organisations from a range of funding sources, although statutory funding comes predominantly from the Department of Health, and to a lesser extent the Department of Communities and Local Government. However, funding is allocated through local structures, such as Primary Care Trusts or Local Authorities (AIDSFF, 2007). Department of Health funding for Hepatitis C awareness has increased considerably in the past five years, from £30,000 in 2000 to £1.5 million in 2006. The current Hepatitis C information campaign is using a mix of mass and targeted messages. Launched in December 2004 it includes a website, a telephone helpline, radio and newspaper

adverts, as well as a leaflet and poster campaign. Turning Point believes that needle exchange services should deliver awareness sessions about Hepatitis C-specific educational group work, and promote uptake of testing and treatment. In addition, peer-education programmes (where injecting drug users are trained to educate other injecting drug users) could offer an added value to a professionally led service.

#### **Access to testing for blood borne viruses**

One positive effect of increased awareness of blood borne viruses is an increase in the uptake of testing. Testing is important as it ensures that people know their status and can access treatment if needed. However, our survey shows that one in five respondents have never been tested for Hepatitis C (22.2%) or B (23.1%) and one in four have never been tested for HIV (25%). This indicates that there is clearly a need to increase uptake of testing, and ensure that routine testing becomes the norm within the injecting drug using population. The main factors preventing an uptake in testing include access to testing services and the method of the test itself, which involves an injection to take the blood sample. Access to testing is also limited as a nurse is required to perform the test.

The NTA's survey of needle exchanges demonstrates that provision of testing within needle exchange services is poor. Just over half of all needle exchanges provide on-site Hepatitis B (54.5%) or C tests (51%), and less than half (39%) provide HIV tests (NTA, 2007). Outside of specialist drug services, testing is offered in sexual health (GUM) clinics, or at GP surgeries. Sexual health clinics can be ill-suited for the needs of injecting drug users, as waiting lists and appointment systems can act as a barrier to those with chaotic lifestyles.

Respondents in our focus groups wanted services to be offered on a drop-in or rapid access basis. One participant stated, "Like with John, he said oh, I want a hep C test and he says next week. Well next week you might not be bothered about it. It's too late; you've lost that person then." Another added, "If you're clucking when your appointment's due, you're more interested in getting some gear than your appointment, aren't you?"

The service needs to be easy to navigate. Talking about her experience in the local sexual health clinic, one participant explained how she failed to get her results after being tested, "You've got to go back. You can't use your name, you've got to make sure you keep that number haven't you? That's what I did, I lost my number." Providing testing through GP surgeries poses similar problems in terms of appointment systems. In addition, respondents told us that they are either not registered with a GP, or that GPs are reluctant to work with them. One participant commented, "It's hard work to get a test though. I asked for it the other day. It's like, ask your doctor. But I don't see my doctor."

To increase uptake in testing for blood borne viruses, all needle exchanges should be staffed and funded to offer testing on site rather than having to refer clients to a GP or local sexual health clinic.

In addition, the discomfort of the test itself acts as a barrier to increased uptake. It involves taking a sample of blood, and for many injecting drug users with severely damaged veins this can be extremely difficult: "People who've been using as long as us haven't got any veins and don't want to go to the doctor and have them poking around." There are two options which could improve the testing process. The Health Protection Agency (HPA) has conducted a trial of dried blood spot testing, which involves taking only a pin-prick of blood. The pilot suggests that this method could increase uptake. The HPA is also investigating dried blood spot testing for HIV and Hepatitis B.

Turning Point also recommends that the Department of Health pilot self-testing for HIV. The advertising and sale of HIV testing kits directly to the public was prohibited in 1992, primarily because of concerns over their accuracy, and because of the perceived need for pre- and post-test counselling. Face-to-face counselling and follow-up are important for the majority of people. However they are not necessarily essential for everyone. Turning Point believes that self-testing kits should be piloted among long-term injectors with a history of routine HIV testing.

The National Institute for Health and Clinical Excellence (NICE) has drafted recommendations to improve the physical health of injecting drug users, reduce risk behaviours such as sharing of injecting equipment and increase take-up of blood borne virus testing and vaccination. NICE recommended the use of incentives to encourage Hepatitis and HIV testing. The final guidelines will be published in July 2007. Turning Point recommends that this approach is adopted by needle exchanges.

### Access to Hepatitis C treatment

Treatment for Hepatitis C is vital because chronic infection can lead to long-term liver damage and liver cancer. Anti-viral treatment with interferon and ribavirin is successful in treating up to 60% of people with Hepatitis C, curing them of the virus and preventing cirrhosis and potentially liver cancer. For people with different "genotypes" of Hepatitis C, their chance of being cured can be as high as 80%.

Delays in accessing treatment negatively affect treatment outcomes. Of the 163 people who tested positive to Hepatitis C, less than a quarter were receiving treatment (39 / 23.9%).

There are a number of reasons for not receiving treatment. At the early stages of infection the illness itself may have no symptoms; therefore people may make a decision not to seek treatment.

The treatment experience itself is unpleasant. Side effects can be intolerable for some and act as a disincentive to take up treatment. These

include muscle aches, fatigue, nausea, headaches, loss of appetite and depression.

Some people may not be deemed eligible for treatment, although current alcohol and drug use are not exclusion criteria. The most recent NICE guidance on the use of anti-viral treatment for Hepatitis C states that current alcohol or drug use are not, in themselves, exclusion criteria as long as the patient is judged by the clinician to be able to comply with the treatment regime (NICE, 2006). This may involve a clinician's judgement as to how stable or chaotic a client is or whether they are likely to stay in regular contact with the service. Exclusion criteria (because of the side effects of treatment) include severe depression or psychosis, heart disease, decompensated cirrhosis (the liver is severely scarred and unable to function properly) or eye disease.

Responses to our questionnaire reflect a wide range of reasons for not accessing treatment.

For some people it was a choice not to have treatment: "not bothered"; "have no problems at present"; and "side effects" were some of the individual reasons given.

Others were not currently receiving treatment but were on a waiting list.

Our research suggests that people with Hepatitis C are not being offered the option of Hepatitis C treatment because of current alcohol or drug use. One response stated that "the doctor was dismissive and did not offer treatment or discuss options". Three people reported that they did not know there was treatment available.

A minority of people were not accessing treatment because they were still using alcohol or drugs. "[I] feel services are not interested if still using", was one response, and another was "still using and advised to stop before having treatment". Similar testimony came from the focus groups. One woman reported that she had been advised that she would need to be abstinent from drugs for six months before she would be put on the local waiting list for

Hepatitis C treatment: "I've got to be clean for six months before they'll think about doing it ... [being put on the waiting list] Giving up ain't that easy, is it? ... I managed two months clean, but still couldn't ... If they say, give up and we'll give you treatment, you can't give up just like that."

There was also evidence that treatment services are not flexible enough to work around the chaotic lifestyles of this client group – one respondent "has missed some appointments so has been struck off the list"; another stated "missed appointment". Two people indicated that they had started treatment in prison, but this had not been continued on their release.

There are areas in the country where services have been configured in such a way that they can meet the needs of people who are still using alcohol or drugs. Two drugs services, one in East London and one in Nottingham, use an assertive outreach model with nurses working within the drug service, blood tests delivered in the community, and texts and written reminders for appointments. Both report retention rates equivalent to the general treatment population, suggesting that the chaotic lifestyle of this client group need not be a barrier to treatment for Hepatitis C.

Hepatitis C treatment should be more accessible for drug users. Turning Point recommends that assertive outreach services are provided to ensure engagement with those with chaotic lifestyles and provide a route into treatment for them.

The cost of treatment depends on the genotype of Hepatitis C, and the severity of the infection. It varies from £1,657 to £13,468 (NICE, 2006). However, the costs to the NHS of late interventions or not treating infections are greater. Cirrhosis of the liver is irreversible, and liver cancer is very difficult to treat. A liver transplant costs approximately £18,000 (NICE, 2006). By 2008, the cost to the NHS of liver transplants alone is estimated to be £123 million (British Liver Trust, 2002). The cost to the NHS over the next 30 years is estimated to be at least £4.1 billion (Hepatitis C Trust, 2006).

## OTHER FINDINGS

The focus of our research was on the relationship between drug use and sharing equipment. However, a number of other themes appeared regularly in the questionnaire responses and the focus groups, including access to prescribing, Drug Consumption Rooms and access to mainstream healthcare services.

### Access to prescribing

Access to substitute prescribing has improved considerably in the last ten years. The NTA target is that access to GP prescribing should be within two weeks, and access to specialist prescribing should be within three weeks. However in some parts of the country there are waiting lists of up to three months. In the same areas, the Drug Intervention Programme facilitates rapid access to prescribing if a drug user declares an offending history, or is arrested and referred into the Drug Intervention Programme. Draft NICE guidelines recommend that “for people who misuse drugs, access to and choice of treatment should be the same whether they participate in treatment voluntarily or are legally required to do so” (NICE, unpublished). Turning Point recommends that the provision of prescribing services is constantly monitored to ensure that all injecting drug users, in all parts of England and Wales, have equal access to treatment, whether referred via the criminal justice system or voluntarily in the community.

### Drug Consumption Rooms

Drug Consumption Rooms (DCRs) provide a place where people can inject in a sterile environment and receive practical advice about their injecting techniques. They have been successfully set up in Germany, Switzerland, the Netherlands, Spain, Norway, Luxembourg, Australia and Canada. They are widely thought to prevent drug-related deaths through overdose, and prevent the transmission of blood borne viruses by providing a sterile environment in which to inject. By providing an opportunity to supervise injections, drugs workers are able to improve users’ injecting techniques and prevent vein damage.

The piloting of DCRs was initially recommended by the Home Affairs Select Committee in 2002. The Government rejected the Committee’s recommendations for a number of reasons, including a lack of evidence of their efficacy, the “honeypot” effect – namely that local drug dealers would be drawn to an area where a DCR was located, and the likely public hostility.

In 2006, the Joseph Rowntree Foundation published a report by an Independent Working Group which considered in detail each of the Government’s objections, with a review of the evidence base from DCRs in other countries, and through the commissioning of research to address questions specific to the operation of DCRs within the UK. They concluded that DCRs are “a rational and overdue extension to the harm reduction policy” and offer “a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society”. The Government rejected the findings.

In our focus groups, more than 30 respondents called for “somewhere clean and safe to inject” or “supervised injecting to learn how to inject properly” and “a sterile environment to inject in”. There is clearly an unmet need, and a definite opportunity for the Government to pilot DCRs. These pilots should be evaluated on their ability to reduce the sharing of injecting equipment, reduce the number of injections taking place in public spaces, and improve injecting techniques.

### Access to mainstream healthcare services

Access to mainstream services is not a main focus of this research. However, the attitudes of primary healthcare staff towards injecting drug users was a common theme raised in all the focus groups. Several participants commented on the negative attitudes of hospital staff when seeking treatment for injecting-related wounds or infections.

One participant commented: "I went down to hospital with a tennis ball [swelling as a result of infection] on my arm, and they turned me away. Three times they turned me away. Then, when I finally did get in, I had three operations. I had septicaemia. I was in there for two weeks with tubes coming out of my neck."

Another participant reported how her brother "got an infection in his leg and he got turned away from treatment". Someone else told us: "A little while ago I went to have an operation on my arm. It was nothing to do with heroin but I needed methadone. And because they found out that I needed to get some methadone, they gave me a real hard time about it. They had a real attitude."

In another focus group, participants reported how a service user forum provided a platform from which to campaign for change. "We went to the drug forum and we complained about being treated like shit when you go to hospital. Because you're a drug user, so automatically they treat you like shit. Well, it's changed now ... we get treated like human beings now."

# RECOMMENDATIONS

## Recommendations for Government

The Government should prioritise tackling blood borne viruses as a public health issue.

Given the worrying upward trends in blood borne virus prevalence, the new drugs strategy, due in 2008, needs to set out a clear commitment and targets to reduce the transmission of HIV, Hepatitis B and Hepatitis C and improve access to treatment.

There should be increased and sustained investment to reduce the disparities in the provision of equipment, including support for innovative services promoting access to hard-to-reach injecting drug users.

The HIV/AIDS prevention budget should be expanded to become a "blood borne virus budget" with a new emphasis on the prevention of Hepatitis C.

Innovative ways of providing access to support for drug users could help to prevent transmission of blood borne viruses and promote access to testing, thus reducing the harm to injecting drug users. The Government should pilot needle exchange in prisons, self-testing for HIV, and Drug Consumption Rooms.

The Government should record deaths from drug-related Hepatitis B and C and drug-related HIV.

The Government should review how the Drug Harm Index is calculated to ensure that the health impacts of drug misuse are given due consideration in the Government's attempts to reduce drug-related harm.

## Recommendations for commissioners

All injecting drug users should have access to testing for Hepatitis C and HIV and better access to treatment. Outreach services should be expanded to engage hard-to-reach injecting drug users.

Drug Action Teams and Community Safety Partnerships, led by a Needle Exchange Coordinator, should ensure sufficient funding for and distribution of injecting equipment including needles, syringes, sterile water, filters, sterile wipes to clean injecting sites, mixing spoons, Vitamin C/ citric acid and condoms.

Commissioners must collect better information on changing patterns of drug use to ensure a coordinated and timely response to local injecting habits, for example increases in speedballing or increases in femoral vein (groin) injecting.

Commissioners should ensure that needle exchange services offer a consistent level of service across the country.

Commissioners should consider the following measures to increase access to and take-up of blood borne virus testing and treatment:

- Increase the availability of testing for injecting drug users within needle exchanges.
- Pilot the use of self-testing schemes for injecting drug users.
- Implement peer education programmes (where injecting drug users provide advice and information to other injecting drug users) offering harm-reduction advice and information.
- Pilot the use of contingency management techniques to enhance take-up of testing and treatment of blood borne viruses.
- Agree protocols and processes with GPs and drug services for referring injecting drug users to treatment.
- Promotion of local education campaigns such as peer education programmes to respond to injecting risk behaviour.

**Recommendations for providers**

All services (both pharmacy-based and specialist needle exchanges) should be staffed and equipped to provide:

- Information and practical advice on safer injecting practices, avoiding site infections, prevention of blood borne virus transmission, safe disposal of used equipment.
- On-site Hepatitis B vaccinations.
- Easy access to health checks.
- Treatment for injection site infections.
- Diagnostic tests for Hepatitis C and HIV and support in referring and accessing treatment.
- Targeted provision through outreach and satellite services.

Services should work with other local agencies to ensure a coordinated approach and share knowledge of changing drug trends.





## CONCLUSION

After 21 years of needle exchange provision, there is now a new generation of injecting drug users who are using drugs in a different way, and who are too young to remember the HIV awareness campaigns of the 1980s. Sharing equipment is widespread and drug users are at high risk of infection with HIV and Hepatitis B and C.

Our research shows that there are worrying levels of HIV and Hepatitis B and C within the injecting drug using population, coupled with high levels of risk-taking behaviour. Injecting in the groin and neck are common. There is an overwhelming case for improvement in service provision for this vulnerable group.

There is now a strong evidence base for how to work with injectors to reduce the harm that their drug use causes to themselves and others. Teaching safer injecting techniques can reduce the risks of long-term vein damage. Ensuring sufficient supply of sterile injecting equipment is essential to prevent infections. Raising awareness of blood borne viruses can promote safer practices. Improving access to testing and treatment for blood borne viruses will ensure that injecting drug users receive the medical support that they need.

Current drug policy is failing to protect people from the risks of blood borne virus infection. The future costs of cirrhosis, liver cancer and liver disease will bear down on the NHS unless there is a concerted effort to improve prevention interventions, and a significant increase in the uptake of Hepatitis C treatment.

The Government must take a more sophisticated approach to enable today's injecting drug users to avoid the risks of blood borne virus infection. In the light of this report, we are calling on Government to urgently revise its current drug strategy and prioritise blood borne viruses as a public health issue.

## GLOSSARY OF TERMS

**Acidifier:** An acid used to break down the impurities in street drugs when preparing them for injection. Ascorbic acid and citric acid are acidifiers.

**Blood borne viruses:** A blood borne virus is a virus that lives in the bloodstream. HIV, Hepatitis B and Hepatitis C are all blood borne viruses.

**Cirrhosis:** Cirrhosis of the liver is when the liver becomes scarred and less able to function. Cirrhosis is generally irreversible once it occurs, and treatment generally focuses on preventing progression and complications. In advanced stages of cirrhosis the only option is a liver transplant.

**Contingency Management:** A system of incentives and rewards used to promote behavioural change.

**Drug Harm Index (DHI):** A Government index that measures the harm generated by the problematic use of drugs. It combines indicators such as drug-related crime, community perceptions of drug problems, etc. into a single-figure time-series index.

**Filters:** Filters are used to extract impurities from a drugs solution when preparing the drugs for injecting.

**HIV:** Human Immunodeficiency Virus. The virus destroys the white blood cells until someone is no longer able to fight off even mild infections. Left untreated it can eventually develop into AIDS.

**Hepatitis:** Hepatitis means “inflammation of the liver”. **Hepatitis B** and **Hepatitis C** are both blood borne viruses which attack the liver. Other types of Hepatitis are A, D and E.

**Speedballing:** Also known as snowballing, speedballing is the practice of injecting heroin and crack cocaine in combination.

**Spoons:** Also known as mixing cups or cookers, spoons are used to dissolve heroin in water when preparing the drugs for injection.

**Sterile Water:** Water that is free from bacteria. It is used to dissolve a drugs solution when preparing the drugs for injecting. Tap water is not sterile.

**Swabs:** Swabs are sterile wipes used to clean an injecting site prior to injection.

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## About Turning Point

We turn lives around every day, by putting the individual at the heart of what we do. Inspired by those we work with, together we help people build a better life.

Turning Point is the UK's leading social care organisation. We provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

Turning Point is the country's largest third sector provider of drug services. We run services across the full range of drug treatment interventions, both within the community and through the criminal justice system.

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