NEEDS ASSESSMENT OF HARM REDUCTION AND HEALTH CARE SERVICES FOR SUBSTANCE MISUSERS ACROSS WALES
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We would like to thank all those who assisted in the completion of this large and complex piece of work; primarily the users themselves, but also the various service staff who helped with initial contacts, the interview team, particularly Paul and Sonya, and Welsh Assembly Government as Commissioners.
EXECUTIVE SUMMARY

This report represents a summary of the findings from a survey of 500 community recruited current and ex-injecting (injected in the last year but not the last month) drug users from across Wales and examines the harm reduction and substance misuse related health care services from the perspective of users of these services within Wales.

This report aims only to provide a robust and contemporary evidence base for use by those working within or managing existing substance misuse and health related services, those responsible for commissioning services and for the development and commissioning of future services and policy development.

Key Aims:

- to evaluate needle and syringe exchange provision, including coverage, communication and education on wider health issues
- to evaluate access to substitution treatment including length of waiting lists
- to assess the knowledge of risk of infection with blood borne viruses and other injecting related infections and consequences including overdose from the perspective of current injecting drug users
- to assess provision of hepatitis B vaccinations within various settings
- to assess current care pathways for those tested for blood borne viruses, including pre and post test discussion, referral pathways to Clinicians and existing community support - availability and quality

Key Findings:

- One third of the current and ex-injecting drug users had experienced being in local authority care and over half had been expelled from school. One quarter had experienced both being in care and exclusion from school
- Two thirds were parents with an average of 2 – 3 children. Less than one quarter of these had their children living with them.
- Poly drug use was a major feature with three quarters using two or more drugs regularly
- Overall 37% used crack cocaine regularly with regional variation in rates of use
- 40% had injected a drug aged 18 or under
- Nearly half of respondents reported sharing injecting paraphernalia in the previous month
- 45% reported ever sharing needles and syringes with other injectors
- Over two thirds regularly reused their own needles and syringes
- Lack of range of harm reduction interventions available from pharmacy based needle exchange alongside issues of lack of confidentiality proving a barrier to use
Close to a half of the sample had experienced health problems as a result of their drug use.

- 42% had overdosed at least once

- Nearly three quarters of those that had been imprisoned reported continued use of drugs whilst in prison

- Less than one quarter were offered any follow up or aftercare following release from prison

- Only 20% remained drug free for one month or more following release from prison

- Close to half of the respondents were currently receiving substitute drug treatment

- Waiting times for assessment and treatment were seen as a barrier to accessing help and were subject to regional variation with the longest reported waiting times in Cardiff and South Wales Valleys

- Over half the sample felt it was a difficult and slow process to access treatment

- Less than one quarter of those currently in treatment felt that they were fully involved in decisions about their treatment, however three quarters reported receiving the treatment they wanted from drug services

- Half of the respondents had received one or more hepatitis B vaccinations with the main provider being Prison health care systems

- Only one third of respondents in regular contact with needle exchange or drug services reported discussion and information regarding hepatitis C

- Of those who had been tested for blood borne viruses and were positive for hepatitis C, less than one third had been referred to a specialist and none as yet had received any treatment

If services are to be effective, the views of the service users are important and all services should now consider: what the findings mean for them; what changes to service delivery are required to meet the needs of the served population; and how services users can be engaged in the future development and provision of services.
Introduction

This report represents a summary of the findings from a survey of 500 community recruited current and ex-injecting drug users from across Wales. The survey was commissioned by the Welsh Assembly Government and undertaken by National Public Health Service for Wales (NPHS Wales) and Hidden Populations Research Ltd. The survey formed part of a programme of research designed to inform the development of the ‘Blood Borne Viral Hepatitis Action Plan for Wales’, and examines the harm reduction and substance misuse related health care services from the perspective of users of these services within Wales. Harm reduction services include those providing education and information, needle and syringe exchange services and substitute drug treatment services.

Little research data is available to date as to the efficacy of the main pillars of blood borne viral hepatitis prevention within the injecting drug using population, namely needle and syringe exchange, substitution treatment and information and education in preventing blood borne viral transmission. The high prevalence of hepatitis C (HCV) reported from a range of settings across the UK\(^1\) would suggest that current service provision is insufficient to prevent transmission. This, however, may be due not to the suitability of these approaches in preventing transmission but rather to their quality and coverage on the ground. Injecting drug users are at particular risk from infection with blood borne viruses specifically Hepatitis B, Hepatitis C and HIV:

**Hepatitis B (HBV)**

The hepatitis B virus (HBV) causes hepatitis (inflammation of the liver) and can also cause long term liver damage. HBV can be prevented through vaccination. Mortality during the acute phase of infection is less than 1% \(^1\). In England and Wales in 2003 a total of 695 acute HBV cases were recorded and where risk factors were known, rates of 34% for England and 27% for Wales were attributable to injecting drug use transmission representing the main risk factor\(^1\). Failure to clear hepatitis B infection after six months leads to the chronic carrier state. Many people who become chronic carriers have no symptoms and are unaware that they are infected. These individuals remain infectious and will be at risk of developing cirrhosis and primary liver cancer.
Hepatitis C (HCV)

The hepatitis C epidemic is already well established in Wales. It is estimated that 0.4% of the population in Wales (approx 12,000 people) is chronically infected with HCV. If left untreated, HCV can cause serious liver disease in some patients, including cirrhosis and liver cancer. To date, the majority of HCV infections in the UK have occurred through the sharing of blood-contaminated needles and injecting equipment among injecting drug users. 92% of reports of hepatitis C infection in the UK, in which risk factors were reported, related to either current or previous drug use. Any sharing or re-using of injecting equipment that involves blood-to-blood contact is a very high risk factor for hepatitis C infection. The risk of transmission occurring in this way extends beyond needles and syringes to paraphernalia including spoons, water, tourniquets and swabs and snorting tubes.

HIV

HIV remains a serious communicable disease especially for injecting drug users, and rates appear to be rising within this population, with a current rate of one in 65 injectors infected within the UK. HIV infection is associated with morbidity, treatment costs are high and there is significant mortality and high number of potential years of life lost.

This survey was developed as a result of the experiences the research team (NPHS Wales) gained during the first phase of a large scale prospective cohort study of the prevalence and incidence of blood borne viruses within the current injecting drug user populations in South Wales. During the prevalence and incidence study a structured questionnaire was used to assess risk behaviour and awareness of blood borne viruses and other health related infection within this population. This research identified an apparent large scale lack of awareness of the risks of infection with blood borne viruses, transmission routes and the implications of these infections. Furthermore, concerns arose due to a number of observations recorded as to the quality and coverage of existing substance misuse and primary and emergency health care services. As a result of these concerns, and following funding support from Welsh Assembly Government, it was agreed that a community based survey be developed to address specifically the following areas:

- Evaluation of needle and syringe exchange provision, including coverage, communication and education on wider health issues
• Evaluation of access to substitution treatment including current waiting list times

• Assessment of the knowledge of risk of infection with blood borne viruses and other injecting related infections and consequences including overdose from the perspective of current injecting drug users in a range of settings across Wales

• Assessment of provision of vaccinations against other blood borne viruses e.g. Hepatitis B

• Assessment of current care pathways for those wishing to be tested for HCV, or those who are confirmed HCV sero-positive, including pre and post test counselling services, referral pathways to Clinicians and existing community support - availability and quality

The work was undertaken between the summer of 2005 and spring of 2006 and involved a team of interviewers comprising full time staff from Hidden Populations Research Ltd and Research Scientists from NPHS Wales. The approach involved a semi-structured questionnaire containing both quantitative and qualitative measures and was designed by the Research Team, ICDS, National Public Health Service for Wales.

It is not the intention of this report to provide an outline of existing policy relating to substance misuse or health care provision within Wales. This reports aims only to provide a robust and contemporary evidence base for use by those working within or managing existing substance misuse and health related services, those responsible for commissioning services and for the development and commissioning of future services and policy development. If these services are to be effective, the views of the service users are important and all services should now consider: what the findings mean for them; what changes to service delivery are required to meet the needs of the served population, and; how services users can be engaged in the future development and provision of services.
Methodology

The methodology employed in this study is one designed specifically to access so-called ‘hidden populations’ or hard to reach groups. ‘Hidden populations’ is a euphemistic phrase applied to marginalised and excluded groups such as the homeless, criminal and deviant populations, sex workers and heavy-end drug users. In other words, groups that we are all aware of, sometimes have a specific remit to manage, yet know little about. Initial access to current and ex-injecting drug users populations in a given locality was often gained by conversations with users outside needle exchange services or treatment services; sometimes just by talking to ‘promising looking’ individuals on the street.

A total of 500 current and ex injecting drug users were recruited opportunistically and were drawn from urban, industrial and rural areas across Wales. Once recruited the participants were interviewed in a safe and confidential environment. The one-to-one interviews took on average 40 minutes to complete. All interviewees received payment for their time.

The community needs assessment questionnaire tool (see appendix 1) was developed to provide quantitative data on the following key areas:

- Demographic details
- Social Situation
- Drug use
- Injecting behaviour
- Experience and use of needle exchange services
- Health and contact with health services including mental health
- Hepatitis B and Hepatitis C
- Prison including health care and drug use
- Treatment for drug use and experience of drug services

In addition a number of questions requiring description or qualitative data were included to allow further insight into specific personal experiences or views.

The findings are stratified where relevant and appropriate by age, gender, injecting experience and from a range of predetermined geographical areas.
Section 1 - Demographic details / Sample characteristics

A total of 500 valid interviews were completed with ex and current injecting drug users opportunistically recruited from various localities across Wales.

Table 1: Areas covered by the survey.

<table>
<thead>
<tr>
<th>Region</th>
<th>Locality</th>
<th>Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West Wales</td>
<td>Anglesey, Bangor, Caernarfon, Conwy</td>
<td>75</td>
</tr>
<tr>
<td>North East Wales</td>
<td>Mold, Prestatyn, Rhyl, Wrexham</td>
<td>70</td>
</tr>
<tr>
<td>Mid and West Wales</td>
<td>Aberystwyth, Carmarthen, Haverford West, Llandrindod Wells, Milford Haven</td>
<td>75</td>
</tr>
<tr>
<td>Bro Morgannwg</td>
<td>Bridgend, Neath, Port Talbot, Swansea</td>
<td>70</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>Cardiff, Barry, Penarth</td>
<td>70</td>
</tr>
<tr>
<td>South Wales Valleys</td>
<td>Pontypridd, Aberdare, Merthyr Tydfil</td>
<td>70</td>
</tr>
<tr>
<td>Gwent</td>
<td>Abergavenny, Bargoed, Blackwood, Ebbw Vale, Newport</td>
<td>70</td>
</tr>
</tbody>
</table>

Age

The sample was made up of 76% (n379) males and 24% (n121) females. The ratio, just over 3:1, is in line with general National Drug Treatment Monitoring Service data and did not vary by region. The average age of the sample was 30.7 years with a range from 16-58 years of age. 27% (n136) of the sample were 25 or under.

![Age range of sample across Wales](chart.png)

Figure 1 – Age range of sample
Race/Ethnicity
82% (n414) described themselves as ‘White British’, 14% (n70) ‘White Other’ (most of these choosing to describe themselves as ‘White Welsh’) with 3% (n16) coming from other groups (7 White Irish, 4 Black British, 3 Mixed race, 1 Pakistani, 1 Black Caribbean).

Social Situation
Housing
Approximately half (46%, n228) of the sample lived in rented accommodation, the majority of which was local authority housing (n124). 22% (n112) lived with family and friends, 1% (n5) described themselves as owner/occupiers. The remaining 31% (n155) of the sample lived in either hostel accommodation (n75) or were currently homeless (n80). In Cardiff, the proportion homeless was higher with 63% (n44) of the sample falling into one of the two homeless categories above.

Experience of being looked after/local authority care.
32% of the sample (n160) had experienced being in local authority care as children.

Education
Over half of the sample (57%, n284) had been expelled from school at some time. In addition, 74% (n371) of the sample regularly truanted. Only 37% (n185) of the sample left school with any formal qualifications. A total of 129 (26%) participants had experienced both being in care and excluded from school.

Table 2: Risk factors as young people.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly truant</td>
<td>74% (n371)</td>
</tr>
<tr>
<td>Ever excluded from School</td>
<td>57% (284)</td>
</tr>
<tr>
<td>Ever been in Care</td>
<td>32% (160)</td>
</tr>
<tr>
<td>Excluded and been in Care</td>
<td>26% (129)</td>
</tr>
<tr>
<td>Leave school with any formal qualifications</td>
<td>37% (185)</td>
</tr>
</tbody>
</table>
**Parenting**

63% (n318) of the sample were parents with an average of 2 to 3 children. Only 24% (n75) of those who were parents had their children living with them. Many children not with their parent/s were either in care or being cared for by another family member.
Section 2 - Drug use

The sample were asked a number of questions relating to their drug use over the last year in order to gain insight into the full range of drugs currently used including method of intake and age of first use. Table 3 below indicates the main drugs used by the sample and Table 4 indicates frequency of use.

Poly drug use is a major feature of the sample with 78% (n390) using two drugs, 56% (n282) three drugs, 30% (n149) four drugs and 11% (n5) five drugs. Almost the entire sample (86% n431) used heroin, with 37% (n183) using crack cocaine.

Table 3: Drugs used regularly in the last year

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>86% (n431)</td>
</tr>
<tr>
<td>Crack cocaine / ‘Rock’</td>
<td>37% (n183)</td>
</tr>
<tr>
<td>Methadone (Prescribed)</td>
<td>34% (n174)</td>
</tr>
<tr>
<td>Subutex (prescribed)</td>
<td>7% (n34)</td>
</tr>
<tr>
<td>Cocaine powder</td>
<td>4% (n22)</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>18% (n89)</td>
</tr>
<tr>
<td>Benzodiazepines/Sleepers</td>
<td>30% (n148)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>42% (n208)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>20% (n99)</td>
</tr>
</tbody>
</table>

Table 4: Number of days per week using each drug.

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Days per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>6.3</td>
</tr>
<tr>
<td>Prescribed Methadone</td>
<td>6.7</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>3.2</td>
</tr>
<tr>
<td>Benzodiazepine/Sleepers</td>
<td>4.8</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>3.1</td>
</tr>
<tr>
<td>Cannabis</td>
<td>6</td>
</tr>
<tr>
<td>Alcohol</td>
<td>5.9</td>
</tr>
</tbody>
</table>
The reported use of crack cocaine varied between areas ranging from 49% in Cardiff to 21% in South Wales Valleys.

![Figure 2: Percentage of sample reporting crack use by area](image)

**Age of First Use**

Table 5, below, gives a breakdown of the age at which individuals within the sample first used each drug. 65% of those currently using heroin had used it before the age of 22.

**Table 5: Age of first use by drug**

<table>
<thead>
<tr>
<th>Age of 1st Use</th>
<th>Heroin</th>
<th>Crack Cocaine</th>
<th>Amphetamine</th>
<th>Prescribed Methadone</th>
<th>Benzodiazepines</th>
<th>Cannabis</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;19</td>
<td>41%</td>
<td>23%</td>
<td>57%</td>
<td>7%</td>
<td>49%</td>
<td>91%</td>
</tr>
<tr>
<td>19-21</td>
<td>24%</td>
<td>17%</td>
<td>16%</td>
<td>22%</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>22-25</td>
<td>14%</td>
<td>21%</td>
<td>17%</td>
<td>33%</td>
<td>17%</td>
<td>-</td>
</tr>
<tr>
<td>26+</td>
<td>21%</td>
<td>39%</td>
<td>11%</td>
<td>37%</td>
<td>16%</td>
<td>-</td>
</tr>
</tbody>
</table>

The substance career followed a common path with early cannabis use (90% of current users using it before age 19), closely followed by benzodiazepines and amphetamine then heroin and crack. Crack cocaine generally had a later age of...
first use. Crack cocaine, unlike many of the other drugs listed here, maybe a relative newcomer to Wales.

**Main Modes of Administration**

Approximately three quarters of the sample (72%, n361) had injected a drug in the last month. 58% (n290) of those using heroin and 28% (n52) of those using crack cocaine injected their drugs. Again regional differences were shown with 25 of 52 participants (48%) injecting crack residing within the North East Wales region, a further 10 residing in Cardiff and 9 residing in North West Wales. The average daily expenditure for those where heroin was their main drug was £27.
Section 3 - Injecting drug use, risk behaviours and utilisation of needle exchange services

Preventing the sharing of injecting equipment is a major public health issue. One of the targets of the Welsh Assembly Government’s eight-year strategy, *Tackling Substance Misuse in Wales – A Partnership Approach*, is to “reduce the proportion of drug misusers who inject, and the proportion of those sharing injecting equipment over the previous three months”. Needle exchange services have a vital role to play in reducing the risks associated with injecting and the transmission of blood-borne viruses. This section includes reported use and barriers to use of needle exchange services across Wales.

Injectors
There were no major differences in the age of first injecting and length of injecting career by region although those interviewed in North East Wales were older and had longer injecting careers at point of interview. On average participants had been injecting just over 9 years.

Figure 3: Length of injecting career by area
The age range of the sample of injectors does not necessarily reflect the age profile of the underlying injecting population within each area. It is likely that recent onset or new initiates to injecting will be underrepresented within this study since individuals in the early stages of drug use tend to be less visible (not in contact with substance misuse / harm reduction services).

Of the sample, 72% (n361) had injected a drug in the last 4 weeks (‘current injectors’), the remaining participants had all injected within the last year. Across the sample, 40% (n200) had injected a drug aged 18 or under. This figure was highest in the South Wales Valleys at 50% (n35).

**Table 6: Age of first injecting**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 year and under</td>
<td>40% (n200)</td>
</tr>
<tr>
<td>19-21</td>
<td>20% (n100)</td>
</tr>
<tr>
<td>22-25</td>
<td>16% (n81)</td>
</tr>
<tr>
<td>26+</td>
<td>24% (n119)</td>
</tr>
</tbody>
</table>

Frequency of injection is shown in figure 4. Most injected 2-3 times per day. There were some regional differences with Cardiff and Bro Morgannwg users reporting highest average daily injecting episodes with figures of 3.3 and 3.2 times a day respectively. In Cardiff, this average may be skewed by crack injectors who can inject many times a day.

**Figure 4: Average number of injections per day**
Sharing behaviours

Indirect sharing (sharing of injecting paraphernalia e.g. Spoons, filters, water)

Those that had injected in the last four weeks (n=361) were asked with how many people they had shared injecting equipment. Just over half (55%, n=198) reported that they had not shared any equipment. The remaining 45% (n=163) indicated that they had shared spoons, filters and water in the previous month with the majority having shared with 1-2 people. There were no differences in reported sharing equipment by area.

Table 7: Number of people with whom injectors had shared injecting paraphernalia (indirect sharing) in the previous month

<table>
<thead>
<tr>
<th>Number of People</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td>57% (n=93)</td>
</tr>
<tr>
<td>2 people</td>
<td>21% (n=35)</td>
</tr>
<tr>
<td>3 people</td>
<td>13% (n=21)</td>
</tr>
<tr>
<td>More than 3 people</td>
<td>9% (n=15)</td>
</tr>
</tbody>
</table>

These injectors were asked under what circumstances sharing had taken place. Responses were fairly standard across all areas: sharing had occurred with partners, ‘close friends’, other users who have bought heroin together and sometimes with others when the user was ‘desperate’:

“Every day but only with my boyfriend”.

“With girlfriend. Score together and put it all on the same spoon”.

Share with close mate – goes half’s on everything and shares everything.

Typically share spoon with brother.

Depends who I’m with but about 5 close associates.

4 or 5 of us regularly use together and normally share spoons, filters and water.

Only if I’m sharing a bag. We throw it on the same spoon.

Depending on who I score with, sometimes we put it all on the same spoon. So many stops and searches from the police, that we don’t all carry needles.

Used others washout water when had no heroin.

Only with 3 people when sharing a score.

Depends on who I am with, I am homeless so always share scoring.
Direct sharing (sharing needle and syringe)

12% (n44) of current injectors reported that they had shared others needles and syringes in the previous 4 weeks.

45% (n163) of current injectors reported that they had shared needles/syringes in the past and were asked whom they shared with. Table 8 indicates their responses with the majority sharing with their partner and/or friends.

Table 8: With whom injecting equipment (needles / syringes) was shared

<table>
<thead>
<tr>
<th>Partner</th>
<th>42% (n69)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>52% (n85)</td>
</tr>
<tr>
<td>Other family member</td>
<td>7% (n12)</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>10% (n17)</td>
</tr>
</tbody>
</table>

(A number of people had shared with more than one group e.g. partner and friend, therefore the figures come to greater than 100%)

It is important to note that the direct sharing figures outlined above may well be an underestimation as users may be aware of the risks associated with sharing practices and do not wished to be judged by others for engaging in unsafe practices. To counter this problem an additional approach was used in the form of indirect questions on whether they had seen ‘others’ sharing needles and other forms of injecting equipment such as water, spoons and filters. The figures below show a high percentage, 65% (n234), of injectors, had seen others sharing injecting equipment in the last 4 weeks.

Table 9: Observed indirect sharing by other people in previous 4 weeks.

<table>
<thead>
<tr>
<th>Spoons/Filters</th>
<th>65% (n234)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water/Bleach</td>
<td>53% (n193)</td>
</tr>
<tr>
<td>Needles</td>
<td>34% (n121)</td>
</tr>
</tbody>
</table>

The inter-area variability is not significant although North East Wales does have the highest figure of 80% and South Wales Valleys the lowest at 51%. 
Re-use of own and others injecting equipment and methods for cleansing.

There was evidence of additional risk behaviours in relation to re-use of own and others needles/syringes and methods of cleaning between use. 65% (n235) of current injectors had re-used their own syringes/needles in the last four weeks. Each reused needle had been used an average of 2.6 times before being discarded. Figure 5 indicates the minor differences in re-use rates between areas, and Table 10 indicates method of cleaning the equipment before reuse.

![Figure 5: Percentage of users reporting re-use of own injecting equipment by area](image)

This level of regular reuse of injecting equipment may lead to additional health problems for the injector in relation to bacterial infection and increase damage to veins.

**Table 10: Cleansing methods employed by those re-using equipment.**

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold Water</td>
<td>65%</td>
</tr>
<tr>
<td>Boiling Water</td>
<td>31%</td>
</tr>
<tr>
<td>Hot tap water</td>
<td>9%</td>
</tr>
<tr>
<td>Other (including bleach)</td>
<td>4%</td>
</tr>
</tbody>
</table>

*(The percentage figures do not add up to 100% because people tend to use a number of methods)*
When we compare these figures to the smaller proportion (12%, n44), of those reporting re-use other people’s syringes in the last four weeks the picture changes again, as indicated in Table 11.

Table 11: Cleansing methods of those re-using others syringes by percentage.

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold Water</td>
<td>50%</td>
</tr>
<tr>
<td>Boiling Water</td>
<td>58%</td>
</tr>
<tr>
<td>Hot tap water</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>

(The percentage figures do not add up to 100% because people may use a number of methods)

There was no evidence that information about cleaning used needle/syringes was available within the injecting drug user populations or indeed that the required information and products were available from harm reduction services.

Utilisation of Needle Exchange Services

88% (n317) of current injectors within the sample reported using a needle exchange in the area regularly; this figure remained high across all areas.

Across all injectors, 19% (n68) said they relied on someone else to get needles and syringes for them. The reasons respondents gave for not accessing needle exchange services more included distance, travel, opening times and confidentiality/privacy:

I’m not supposed to coz I’m on a meth script.

Don’t want to be seen at pharmacy.

Don’t want people to know that I inject.

Don’t want to go into the chemist as the staff know my family.

Don’t want any service knowing about my injecting with me trying to get access to my kids.

In an injecting partnership with older man. I get the gear and he gets the works. I can’t inject myself so don’t bother going to exchanges.
56% (n178) of those using a needle exchange used a drug service exchange, with 46% (n147) using a pharmacy based needle exchange and 9% (n29) using a mobile exchange. 14% (n45) of injectors reported that they often bought needles/syringes. Swabs, citric/vitamin C, water and tourniquets were not available in many areas.

The general perception was that a pharmacy needle exchange was a very basic service - ‘transaction not interaction’ - which was often not confidential and staff attitudes were problematic.

Staff look down at you. No engagement, bad attitudes. Staff attitudes need to change, more referral and service information available and medical advice or referral (Cardiff)

Don’t like going to chemist. Have got to get pins in front of public and they shout things out. Need a private room. (Cardiff)

Ask you questions “what’s that for” whilst other people are listening. A girl I went to school with has just started working there so that is embarrassing. (Bro Morgannwg)

1 mile away but they treat you well, they’re nice people who basically know what they are doing. More equipment, cookers especially and water for the homeless. (Bro Morgannwg)

It’s too public and doesn’t have enough in the kit. (Pontypridd/RCT)

Could be better. Stop shouting over the counter so everyone can hear them. (Pontypridd/RCT)

Friendly but not that good. Other customers know what you’ve gone there for. Don’t want member of family to see you. Better if take you in to another room and give you in private. (West Wales)

Attitudes could be much better. You ask for a pack of 1 mils, they look at you like they want to kill you. Should put citric in the kits. (West Wales)

Local Boots in Abergavenny is against drug users. Hands over needles in clear plastic bag so everyone else can see. No confidentiality at all. (Gwent)

Attitude of people could be better and more availability of citric and water could be better. Prefer not to use it. (Gwent)

Pharmacist bad attitude towards me, no discretion when giving you a kit. Just throws it on the counter no matter how many customers are in the store. (NW Wales)
Equipment was more available in drug service needle exchanges, though water was generally unavailable and in Gwent citric/vitamin C was not always given.

Nurses available for problems but you have to ask for it. Help and advice is there if you want it. Handy local service, too small – only room for 1. (Gwent)

Longer opening hours. Should give you citric so people don’t have to use lemon juice. (Gwent)

Alright. Could be better, open at night. (Pontypridd/RCT)

Very good service in drop-in in Riverside, without that there would be no services for us in Cardiff. (Cardiff)

Alright, plenty of equipment so better than the chemist. Staff – fine as known me for many years. 2 miles from home. Need a mobile service over weekend to give out equipment. (Bro Morgannwg)

Great service and do loads of training days lots of people take old pins back. 15 mins walk from home, referred me for treatment and support me even now. (Bro Morgannwg)

Very helpful and friendly. Easy to talk to most times. (NW Wales)

Everything there is fine. Good staff. (NW Wales)

It is worth noting the user views of the mobile needle exchange/harm reduction service available in North East Wales; the sample from this area universally found this service very worthwhile, praised the service and its staff in the most positive ways, their only complaint was that the service was not available more of the time:

Bloody good. Stopped sharing in the area. Could have a drop-in.

Very good, should have happened years ago.

Brilliant. Handy, reduces risks.

Good service, more time for you.

Very good service.

Really good job, it’s needed. Need more services, more mobiles. More private even though everyone knows what it is. Staff are ok.

Excellent, general good service and staff very helpful - could do with being here more often.

Mobile van - good service, take real interest in your health. Encourage vaccinations and tests and info. Encourage return sharps.
Good service - vaccinating and informing users - need it to come more often.
Mobile - good idea - friendly staff - knowledgeable - good equipment and range.

A range of effective harm reduction interventions were not always available at needle exchanges across Wales. Variability existing between drug service based exchanges by area, however there was no significant variation with regard to services available at pharmacy based exchanges. It should also be noted that all those that used needle exchanges in West Wales reported using pharmacy based services.

Table 12: Harm reduction interventions available at drug service versus Pharmacy based needle exchange services

<table>
<thead>
<tr>
<th></th>
<th>PHARMACY NEEDLE EXCHANGE</th>
<th>DRUG SERVICE NEEDLE EXCHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you get info on harm reduction/safer injecting techniques?</td>
<td>59%</td>
<td>77% (high: 86% mobile service in NE Wales, low: 56% Gwent)</td>
</tr>
<tr>
<td>Has the service talked about any infections/illnesses related to injecting?</td>
<td>9%</td>
<td>70% (high: 86% mobile service in NE Wales, low: 38% Gwent)</td>
</tr>
<tr>
<td>Anyone in service showed you how to inject more safely?</td>
<td>10%</td>
<td>50% (high: 62% Pontypridd, Low:21% Cardiff)</td>
</tr>
<tr>
<td>Can anyone deal with drug related health issues? (e.g. abscesses and vaccinations)</td>
<td>0%</td>
<td>42% (high: 79% mobile service in NE Wales, low: 14% Pontypridd)</td>
</tr>
</tbody>
</table>
Section 4 - Health Care Provision

In total 89% (n445) of those interviewed were currently registered with a GP, this figure did not vary significantly between areas; Pontypridd was lowest although still relatively high at 79%.

Nearly three quarters (72%, n362) had told their GP about their drug use and 71% (n353) had visited their GP in the last 12 months. The perceived attitude of the GP is indicated in Table 13.

Table 13: Users perceptions of GP attitudes

<table>
<thead>
<tr>
<th>Very Positive/Helpful</th>
<th>14%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpful</td>
<td>36%</td>
</tr>
<tr>
<td>Neutral</td>
<td>17%</td>
</tr>
<tr>
<td>Negative</td>
<td>14%</td>
</tr>
<tr>
<td>Very Negative/unhelpful</td>
<td>17%</td>
</tr>
</tbody>
</table>

A range of comments from the users reflect differing attitudes including a number of users who would not change their GP once they had a ‘good one’ even though they had moved out of the immediate area:

Really good GP, that’s why I haven’t changed to a Doctor closer to where I live. I’d rather travel. (West Wales)

Because I’ve moved 60 miles away from where I was living I still travel back to see my GP because I don’t want to risk changing surgery because the GPs where I’ve moved don’t want any users on their books. (West Wales)

Have stuck with GP in Leicester, do not have Cardiff GP. (Cardiff)

Doctor always been supportive for last 6 yrs. 30 miles away from home but I like GP. (Gwent)

Family Doc gave prescription when he first found out, he’s always been supportive. (Gwent)

Good GP. Took my girlfriend into Doctor as her GP is no good. My Doctor helped us straight away. (Bro Morgannwg)

Good, referred to psychiatrist. Very helpful, excellent Doc. (Pontypridd/RCT)
Whilst there are a number who have very positive experience with their GP there are a number of users in all areas who are not accessing primary care services because of the negative attitudes of the GP or other primary care staff:

It has created a bad atmosphere. They think you are real life scum when you are on gear. (Cardiff)

I find they treat me with suspicion at times. They are not clued up towards drugs and drug users. They are just normal GPs. (Cardiff)

My GP hates junkies, really bad attitude. (Cardiff)

My GP did nothing. He didn’t have a clue and just looked down on me. (Gwent)

GP hasn’t got a clue – looks down on me, won’t help with anything. (Gwent)

Family Doc never been very helpful and did treat me worse when she found out. (Gwent)

Never discussed drugs with him. I know he’d just shout at me. (Bro Morgannwg)

Have no time for users. (Bro Morgannwg)

Haven’t told Doctor. It’s my family GP and I don’t want my parents or family to know that I am still using. (Bro Morgannwg)

The GP I saw didn’t have a clue. No idea what he was doing it was like talking to a brick wall. (West Wales)

The last time I went to see him he referred me to go and see a drugs counsellor in Carmarthen. I had no chance of getting there. (West Wales)

“Do what I say or get out of my surgery” attitude. (Pontypridd/RCT)

Don’t want to know when they realize you’re a user, just want to get rid of you. (Pontypridd/RCT)

Scared to ask for anything coz they just see you as a user. (NE Wales)

When I did ask for help he didn’t want to know. (NE Wales)

Stopped anti-depressants because I missed appointment. Don’t help my mental state. Should listen more. (NW Wales)

If I told him, think he would tell my Mum. (NW Wales)

Drug related health care problems
As well as the risk of transmission of blood borne viruses there are a number of bacterial infections that may occur through non-sterile injecting or
contamination of the drugs being injected. Whilst severity of symptoms vary and depend on the type and extent of infection, the implications for injecting drug users may be serious if medical advice is not sought.

Of the sample 43% (214 of 500) had suffered from health problems as a result of their drug use. 30% (152 of 500) had suffered from an injecting problem (Abscess/Deep Vein Thrombosis/Septicaemia) in the last 3 years. Of these 68% (103 of 152) had sought medical advice. The remaining individuals (n49) dealt with their abscesses themselves. Table 13 outlines the services attended to deal with the drug related problems.

**Table 13: Where users seek help with injecting related health problems**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle exchange</td>
<td>2%</td>
</tr>
<tr>
<td>Drug service</td>
<td>19%</td>
</tr>
<tr>
<td>GP</td>
<td>22%</td>
</tr>
<tr>
<td>Hospital</td>
<td>57%</td>
</tr>
</tbody>
</table>

Clearly there is significant burden placed on the Emergency Departments within hospitals to deal with these injecting related problems. Combined with overdose, 25% (124 or 500) of the total sample had attended A & E in the last 3 years. Experience and perception of staff attitude and care within A & E departments are outlined in Table 14. Due to the lack of health care services / wound clinics within Drug agencies, and a reluctance to attend GP surgeries for these infections, health issues tend not to be dealt with early on leading to more serious infection and illness.

**Table 14: Users perception of A+E staff attitudes**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Positive/Helpful</td>
<td>14%</td>
</tr>
<tr>
<td>Helpful</td>
<td>33%</td>
</tr>
<tr>
<td>Neutral</td>
<td>28%</td>
</tr>
<tr>
<td>Negative</td>
<td>21%</td>
</tr>
<tr>
<td>Very Negative/unhelpful</td>
<td>4%</td>
</tr>
</tbody>
</table>
Again, a range of comments were made by users about the response of staff, some of them very positive; the overall picture, however, is one of a lack of a systematic response and many missed opportunities for harm reduction interventions.

*Gave me a bollocking and sent me home. No follow up. Nothing.* (Bro Morgannwg)

*Just brought me round then sent me home the same night. Got me a taxi as they needed the bed.* (Pontypridd/RCT)

*Wanted to take care of me. Did help me while I was in hospital.* (West Wales)

*Being treated for abscess in groin area. Recently back on streets. Wound still open. Not much support.* (Gwent)

*As soon as they found out I was a heroin addict the alarm bells rang – they don’t want to know then.* (Cardiff)

*Didn’t have time for me, they look and treat you like it’s your own fault.* (NE Wales)

*Treated me terribly – ‘bag head can wait’ attitude.* (NE Wales)

*Not happy. One of the three nurses that helped Doctor was in the same school as me (2 yrs older). She told sister-in-law and parents who live in the same village as my parents that I was a heroin user and what I had done in hospital. No patient confidentiality.* (NW Wales)

*Treated fairly. Better than they used to be years ago.* (NW Wales)

5% (n4) of those entering A & E were offered clean needles and syringes.

**Overdose**

42% of the sample (208 of 500) had overdosed at least once as a result of their drug use. Accounts from the users of the factors leading to overdose are in line with known risks including recent release from prison and mixing opiates with alcohol and/or benzodiazepines.

*Both times just got out of prison – after drinking then taking £20 of heroin I OD’d.* (Cardiff)

*Four times – Coming out of prison.* (Cardiff)

*2 times – Done too much heroin and took Valium on top both times.* (Gwent)
4 times – Mixing heroin with Temazepam (Jellies) years ago. (Gwent)

Loads of times usually with alcohol. Hospital about 7 times. (Bro Morgannwg)

Coming out of prison and taking too much heroin. (Bro Morgannwg)

Tolerance was down after being released from prison. Underestimated strength of gear. (West Wales)

7 to 8 times – 4 times through mixing Valium and temazepam with alcohol, 3 to 4 times with mixing heroin with alcohol. (West Wales)

Taking too much medication – valium, dihydrocodeine and heroin. (West Wales)

1 time - Just done a detox. Spent 4 days doing £5 bag in the morning and £5 bag at night. Thought I’d be ok doing £10 in a day but went over. (Pontypridd/RCT)

4 times - Came out of prison, strong gear the cause but friends brought me around. (Pontypridd/RCT)

5 times – combinations of valium and drinking and heroin. (NE Wales)

Drought – then strong gear afterwards. (NE Wales)

Four times – once I just got out of prison and three times being greedy and mixing diazepam (NE Wales)

Once – Had been drinking alcohol first, drunk and strong gear. (NW Wales)

3-4 times. Benzo’s still in my system when I had a hit. (NW Wales)

However, when looking in more detail at the comments made by users about their overdoses, it was apparent that a significant proportion of the events were the result of deliberate suicide attempts rather than accidental.

Once was accidental after release from prison. The second due to withdrawals from heroin was intentional. (Cardiff)

I just wanted a way out. I couldn’t live without my kids and I wouldn’t be here if it wasn’t for my husband (Cardiff)

First on release from prison March 2005, second accidental with heroin and alcohol together in last 12 months and lastly on purpose last summer when boyfriend went to jail. (Cardiff)

Last time deliberate OD ¼ gram in works and went to hospital (Gwent)

Deliberate. 1/16th heroin in one dig. Woke up 4 hrs later. (Gwent)

Couple of times deliberate really. Others accidental with meth on top. (Gwent)
Once on purpose as I’d had enough of life. The other two was accidental as hadn’t used for a while. (Bro Morgannwg)

3 times – deliberate attempts at suicide all occasions. Overdose of tablets. In hospital each time. (Bro Morgannwg)

Once in a suicidal bid – 50 valium, 50 mogadon and ½ a gram of IV heroin. (4 yrs ago). (Bro Morgannwg)

Twice sharing gear, once tried suicide (West Wales)

First time is too much heroin and second ended up in a coma for 36 hours as had taken 100 carbamazepine. Found out daughter had been abused. (West Wales)

Deliberate – Depressed and lonely. (Pontypridd/RCT)

Off heroin at the time. Took tablets (felt depressed) had a hit and went over. (Pontypridd/RCT)

Twice - once was deliberate and once I just had too much. (NE Wales)

4 times – once deliberate. 3 times methadone plus alcohol (NE Wales)

Twice – suicidal, tried to OD. (NW Wales)

Mental Health Services

Nearly half (48%, n240) of those interviewed felt that in the past they needed help with mental health issues. Only 66% (n161) of these had received help / support for these issues, many being dealt with at the first point of contact by their GP with limited referral to a local psychiatrist. Most were given help within a 4 week period. Almost all the individuals seeking help were given either anti-depressants or sleeping tablets.
Section 5: Prison, drugs and healthcare

Across Wales 69% (n=347) of the sample had served a term of imprisonment, of which, over 50% had spent over 2 years in prison. Figure 6 shows the number of times those imprisoned had received a custodial sentence, with 68% (n=236) being sentenced at least 4 times. 72% (n=251) had been imprisoned before the age of 22.

![Figure 6: Frequency of imprisonment]

Substance misuse within prison

From the sample that had been in prison, 71% (248 of 347) continued to use illicit drugs whilst in prison. Of these, 29% (71 of 248) stated that they smoked just cannabis, with the remaining 71% (177 of 248) reporting use of heroin and cannabis during their sentence/s. From this last group, 9% (16 of 177) reported injecting heroin the last time they were in prison. This equates to 2.6% (16 of 347) of the total sample who had been imprisoned. This figure may represent an underestimation of the true level of injecting within prisons. There were a few reports of sharing in prison:

My friend had a works in Eastwood Park prison so we used it. Not sure how many others had used it. (Cardiff)

Loads of drugs in prison, everyone sharing – 1 pin between 6 of you. (Cardiff)

Have seen home made syringes and proper ones in every prison have been in. (West Wales)
Substance misuse treatment and throughcare in Prison

Those respondents who had been in prison (n=347) were then asked a number of questions relating to any treatment / through and after care received for their drug use during and after their sentence. 82% (285 of 347) disclosed their drug problems to the prison authorities however only 21% (61 of 285) were actually offered any follow up treatment on release. There are particular problems reported by respondents in Bro Morgannwg and West Wales with only 11% reported being offered follow up treatment.

In terms of what follow-up treatment was available to the small overall percentage that were offered it, 70% (43 of 61) were offered an appointment with a drug team and 28% (17 of 61) were offered Naltrexone.

Relapse / continued drug use following release from Prison

Of the sample who had been in prison 77% (264 of 347) stayed clean (did not use illicit substances) for less than 4 weeks, with many using within the first week. A full breakdown of these results can be seen in Table 15 below.

Table 15: Duration of abstinence following last release from prison

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a week</td>
<td>60% (n206)</td>
<td></td>
</tr>
<tr>
<td>1-4 weeks</td>
<td>17% (n58)</td>
<td></td>
</tr>
<tr>
<td>1-3 months</td>
<td>9% (n30)</td>
<td></td>
</tr>
<tr>
<td>3-6 months</td>
<td>5% (n18)</td>
<td></td>
</tr>
<tr>
<td>Over 6 months</td>
<td>7% (n25)</td>
<td></td>
</tr>
</tbody>
</table>

Prison and Hepatitis

Hepatitis B

43% (148 of 347) of those imprisoned reported that prison staff talked to them about Hepatitis B. Of this sample 89% (131 of 148) were offered Hepatitis B vaccinations, with only 57% (n=75) receiving all three injections.
Hepatitis C

27% (n92) reported being offered a Hepatitis C test in prison of which 75% (n69) took a test. Only 48% (n33) of those taking a test actually received their result in prison with a further 6% (n4) receiving their result after they had left prison leaving 46% (n32) unaware of their test results. Of those that had tested positive (n11), only one was referred / offered an appointment with a Hepatitis C specialist.
Section 6 - Treatment for drug use and experience of drug services

Across Wales 74% (n368) of the sample had contacted a drug service or GP for help in dealing with their drug use, however there were regional differences.

Table 16: Services contacted for help by percentage.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Service Statutory</td>
<td>70% (n258)</td>
</tr>
<tr>
<td>Drug Service Voluntary</td>
<td>20% (n75)</td>
</tr>
<tr>
<td>DTTO</td>
<td>29% (n107)</td>
</tr>
<tr>
<td>GP</td>
<td>27% (n98)</td>
</tr>
</tbody>
</table>

(A number of people had contacted more than one service for help, therefore the percentages do not add up to 100%)

Table 17: Regional variation in ever and current contact with services for drug use.

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage ever contacted drug service or GP for help with drug use</th>
<th>Percentage ever on prescription for drug use eg. Methadone</th>
<th>Percentage currently on prescription for drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East Wales</td>
<td>77%</td>
<td>70%</td>
<td>36%</td>
</tr>
<tr>
<td>North West Wales</td>
<td>89%</td>
<td>87%</td>
<td>68%</td>
</tr>
<tr>
<td>Mid &amp; West Wales</td>
<td>73%</td>
<td>68%</td>
<td>52%</td>
</tr>
<tr>
<td>Bro Morgannwg</td>
<td>53%</td>
<td>54%</td>
<td>29%</td>
</tr>
<tr>
<td>Cardiff</td>
<td>76%</td>
<td>51%</td>
<td>34%</td>
</tr>
<tr>
<td>South Wales Valleys</td>
<td>54%</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>Gwent</td>
<td>86%</td>
<td>79%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Overall 46% (n228) of the sample were currently receiving a prescription for their drug use, three quarters of which was delivered via drug treatment service. The overall figure disguises some variation between areas: the samples taken from the South Wales Valleys (including Pontypridd and Merthyr Tydfil) and Bro Morgannwg indicated that just over half had contacted any service for help or support with their drug use and a third had ever received
substitute drug treatment despite an equivalence in length of injecting careers with other regions of Wales. These regional variations may reflect sampling bias or the degree of penetration local services have achieved with current and ex-injecting drug users in their areas, or more probable in this survey, a combination of the two.

**Figure 7: Contact with service for drug use and currently substitute drug treatment by area**

It is important to note that many individuals may contact drug services or their GP for different types of support or advice regarding their drug use, not necessarily for substitute drug treatment.

The perception of drug services and ease of access to treatment as well as other issues of privacy, confidentiality and potential consequences as a result of contact with a drugs agency (voluntary or statutory) all impact on an individuals decision to seek help with their drug use. One of the most frequently mentioned barriers to accessing treatment was that of waiting times to accessing treatment and support. Below Figure 8 indicates reported waiting times within each region.
To examine the extent of the waiting list, respondents were asked how long they waited last time they received treatment. There is always the possibility that some users do not accurately recall the length of time they waited or it might have been some time ago and they have not tried since then, as they assume long waiting times are still the norm. Whatever the causes for this perception, as stated above, if the users believe that waiting times are long, they may be more reluctant to approach services when they are in need.

![Average number of weeks waiting time for assessment / substitute prescription drug treatment by area](image)

**Figure 8: Average number of weeks waiting time for assessment / substitute prescription drug treatment by area**

(N.B the results for South Wales Valleys may not present an accurate measure of the waiting times in this area as only 10 (of 18) respondents from this area indicated the length of time they had waited to receive a substitute drug compared to an average of 26 respondents each for the other regions).

Waiting times for treatment were reported as a potential barrier for many of the sample. Users from most areas accepted that waiting lists were long; as stated elsewhere, the users’ expectation of services seems remarkably low:
They said they didn’t have the medical services. They told me at Kaleidoscope I was on HARPS waiting list, waited 6 months and went down to HARP and my name wasn’t even on. (Gwent)

Told it was because of funding. (Gwent)

Long waiting list. (West Wales)

Waiting lists!! Got referred by homeless nurse, waited 3 months for initial assessment and 5 months after that for treatment. (Cardiff)

Waiting list - kept getting me put back in priority. (NE Wales)

I had to wait because no new places were available and I had to wait for someone else to mess up and get thrown off their script and treatment to get some treatment myself. (NW Wales)

Went there a year ago, waited 6 months for the appointment. I missed it and went there the day after but was told I had to go back to the bottom of the list (Cardiff)

Just put my name down with C.A.U for substitute treatment, hopefully subutex, but been told to wait 6-12 months for script. (Cardiff)

Overall, 57% (131 of 228) of those receiving substitute drug treatment reported that it was fairly difficult/slow to get into treatment currently. Reported differences between areas are again significant, most noticeable if we examine the percentage of users reporting that access was easy:

Figure 9: Percentage of users reporting that access to services was ‘easy and quick’, by area
Those respondents who had previously received or were currently receiving substitute drug treatment in the form of methadone or subutex were asked to indicate what effect the drug treatment had on their use of their primary and other drug taking. The findings are outlined in Table 18

**Table 18: Perceived effect of substitute drug treatment on drug use**

<table>
<thead>
<tr>
<th>Effect described</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stops me injecting heroin and reduces or has no effect on my use of other drugs.</td>
<td>34%</td>
</tr>
<tr>
<td>Stops me injecting heroin but increases the amount of other drugs that I use.</td>
<td>3%</td>
</tr>
<tr>
<td>Reduces the amount of heroin I inject and reduces or has no effect on my use of other drugs.</td>
<td>45%</td>
</tr>
<tr>
<td>Reduces the amount of heroin I inject but increases the amount of other drugs I use.</td>
<td>5%</td>
</tr>
<tr>
<td>Has no impact on the amount of heroin I inject but increases the amount of other drugs I use.</td>
<td>13%</td>
</tr>
</tbody>
</table>

As can be seen from the responses to the alternatives offered above, the majority, 79% (180 of 228), of those currently on substitute drug treatment felt that their prescription did eliminate or reduce injection of heroin with a reduction or no effect on the other drugs used. However, 21% (48 of 228) felt that it increased the amount of other drugs used. When we look more closely at dosage for those on methadone: out of 201 people on methadone, 52% (n105) were on less than 60mls. In Gwent 59% (20 of 34) of respondents on methadone were on doses of less than 60 ml as were 65% (18 of 28) of those in West Wales. Whilst lower doses would be expected for those just beginning their substitute treatment, or those trying to reduce / come off their methadone, it is unlikely that within this sample these groups are overrepresented.
Suspension / Ban from treatment services and prescription

We also asked those who had contacted a service whether they had ever been banned or suspended from a service and for what reason. Of those who were currently in treatment, a third (31%, 71 of 228) had been banned or suspended at some point. 42% (n30) had been banned or suspended for being late for or missing an appointment, 27% (n19) for failing to provide a clean sample and 14% (n10) for missing a pick up.

Of those who had been in treatment at some point (n312) the majority have had between 1 and 3 treatment episodes.

Table 19: Reported number of treatment episodes for those who had been in treatment by percentage (n312).

<table>
<thead>
<tr>
<th>Number of Treatment Episodes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 times in treatment</td>
<td>77% (n242)</td>
</tr>
<tr>
<td>4-6 times in treatment</td>
<td>14% (n43)</td>
</tr>
<tr>
<td>7-10 times in treatment</td>
<td>9% (n27)</td>
</tr>
</tbody>
</table>

One of the key issues for the success of treatment is patient involvement in decision making. Respondents were asked to rate on a scale of 1 -5 (with 1 being not involved to 5 being completely involved) to what extent they felt involved in decisions about their treatment.

![Figure 10 – Scale of patient involvement in treatment decisions](image_url)
From the responses indicated in figure 10, less than a quarter (23%) felt completely involved. Over half of the users in Bro Morgannwg (56%, 39 of 70) and Cardiff (52%, 36 of 70) reported not feeling involved in planning their care.

**Observed consumption.**

Observed consumption is used extensively in Wales with 62% (142 of 228) of those currently in treatment being supervised at their local pharmacy; even though over three quarters (77%, n 110) had been receiving methadone for 3 months or more.

55% (n78) had to travel more than one mile to be observed at the pharmacy. Indeed, some travel up to 20 miles (round trip). This is a particular issue in Gwent where of the 44 respondents on supervised consumption, close to half (45% n20) were required between 5 and 20+ miles to obtain their methadone.

The two main areas of concern for users were confidentiality or privacy and the travel necessary:

| Have to consume in public – Needs to be private. Should be a service nearer. (Cardiff) |
| It is in a very public environment. Take it right in the middle of the shop. Should be more private. (Cardiff) |
| I absolutely hate it. It is a breach of medical privacy. I work for a living and do not want to be recognized. (Cardiff) |
| It takes all my time and money to get it. (Bro Morgannwg) |
| Sometimes I don’t want to leave the house, but I’ve got to get my script - come across lots of users on my way down. (Pontypridd/RCT) |
| Not happy about it. I don’t want to come to Town every day, I see people in Town I don’t want to see (users). (West Wales) |
| Don’t like having to drink it in front of everyone in the chemist. Would prefer to take it home. (West Wales) |
| Being on supervised doesn’t bother me in principle, but I’ve got to travel miles and miles everyday to get my methadone. Should be a local chemist to dispense and a GP to test. (Gwent) |
| Don’t mind being supervised but don’t like travelling as I have to travel so far to do it. (Gwent) |
Don’t mind, does my head in sometimes. If there are loads of people in the chemist it is not discreet as there is no booth or side room. (NE Wales)

Don’t like it. No special room to go in to take it. Everyone can see you. (NW Wales)

Don’t like it. Quite embarrassing having to take it in front of customers and staff. (NW Wales)

Treatment options

Respondents were asked if they felt they got or are getting what they wanted from treatment having contacted drug services. From a total of 297 respondents, 74% (n=220) stated that they had got what they wanted from drug treatment services, 21% (n=61) indicated that they had not got what they wanted with the remaining 5% (n=15) still waiting for treatment. Table 20 outlines the services that respondents requested and those that they received.

Table 20: Treatment requested and received

<table>
<thead>
<tr>
<th>TYPE OF TREATMENT</th>
<th>WANTED</th>
<th>RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Maintenance treatment</td>
<td>238</td>
<td>235</td>
</tr>
<tr>
<td>Methadone Reduction treatment</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>In-patient detox</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Community detox</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Residential Rehab</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Counselling/ Advice/Information</td>
<td>78</td>
<td>51</td>
</tr>
<tr>
<td>Aftercare / follow up support</td>
<td>23</td>
<td>11</td>
</tr>
</tbody>
</table>

(The majority of respondents wanted more than one type of treatment so the figures add up to more than the number of respondents)

The majority (83%) of respondents wanted methadone maintenance treatment with around one third requesting counselling / advice / information alongside the methadone treatment. However, the availability of both in-patient and community detoxification programmes, residential rehabilitation and aftercare were restricted.

Improving treatment options

When asked how services generally could be improved, many users’ comments addressed accessibility and the broader treatment system required. A selection of these comments are listed below by area.
### Cardiff:

- **Waiting times are crap. No psychiatric help after my suicide attempt.**
- **Told by Housing it would be quicker if I went to prison. Then I’d be a priority - even though my son was with me.**
- **More places where you can get clean equipment. Doctor’s to be more involved in prescribing. More housing available for users.**
- **More than 200 street/hostel homeless in Cardiff and 90% using drugs. There needs to be better provision because the problem is growing and people coming to Cardiff to be homeless from all over because they think we have loads of hostels and we haven’t.**
- **Waiting lists are ridiculous. GP’s should get trained properly to treat drug problems and ease the problems and ease the pressure on services.**
- **Probation need to change the way they house people when they come out of prison. I have been put in hostels when I am clean of drugs and put right by where drug users are known to hang out.**
- **When you inject at 13/14 you don’t want anyone to know so you don’t go to the services. Maybe young persons outreach – I know 20 young 16/17 years old IV users in Central Cardiff and there are probably loads more.**

### Bro Morgannwg:

- **On housing list, still waiting. Need a house/flat so my kids can come and stay. That would help me sort myself out.**
- **Drug services need some proper ex using staff to teach the other staff that we ain’t all liars. Services need to be more organized about getting people busy – users need something to do – not sit drinking coffee and having acupuncture. Housing needs sorting as well coz loads of homeless in Swansea and they all end up using anyway.**
- **Housing is no good. Don’t help anybody. How are you supposed to come off heroin on the streets? Lost my daughter.**
- **People who use shouldn’t leave their pins lying around. Should be a safe place for the homeless/ users go to inject.**
- **Huge drop in centre with plenty of activities or where you can just chill out, too many users on the streets grafting.**
- **Make it easier for people to get scripts so they don’t have to go and commit crimes to get on to a DTTO as the only (or quickest) way to get a script.**
- **I need to get help. You need to get in trouble to get help. I don’t have an address so I can’t get anything.**
South Wales Valleys:

Mental health services not good, could do a lot more.

Should be housing for everyone that’s in hostels or homeless/NFA.

Should have more help for kids who leave care, don’t just throw them out on to the streets at 16. Help them.

Feels the best way to get help at the moment is to go and get caught shoplifting or stealing because then the process would be shorter.

Struck off housing list in Merthyr because I was a user. Had to go out of the area. While I was on the waiting list, I became pregnant, so I went to Drug Aid and told midwife, told I was on priority list – because no help was given sooner, I was withdrawing and sadly miscarried.

Services like housing and drugs should be combined to offer treatment but also accommodation. They don’t work together and connect and it causes problems. Surely it’s common sense? Drug service, mental health, housing: a combined unit, with good links, cutting down referral and time to get help.

Listen more to users in general. Listen to our opinions.

West Wales:

Think there should be more facilities – i.e. – youth clubs for youngsters. Some empty buildings could be used for it. Groups should be involved in a project of some sort. At the moment you have to be criminalized to get help quickly otherwise you go on a waiting list which takes 6 to 12 months.

More workers and more things to do. Counsellors could do things like they do in a hostel – e.g. – Art work.

Housing situation is difficult for me at the moment and not getting much help from the council. On a waiting list for a house at the moment.

More detox support needed. Waiting lists are long – friend was waiting for detox – 5 months. Travellers don’t get much help.

Gwent:

People need something to do – activities, outdoors stuff. There’s loads of things to do round here. Drug services are just happy to give you meth and have you coming back every day so you are on the end of a string.

Housing and probation could be improved because if on streets more likely to inject. Easier than smoking it.

Housing and probation could do a lot more because homelessness creates drug use. I am trying to get in to treatment at the moment.
More places with smaller waiting lists. More help in the valley’s especially Blackwood where there’s nothing!

The homeless people need help in Newport, loads are using and being homeless just makes you use more gear.

Should have a drug service/drop in Abergavenny. The travelling to Newport when you want to see anyone is a problem.

A drop in centre is needed around here, somewhere you can go for help, script (if you want one) and Needle Exchange.

North East Wales:

Some sort of guidance to activities for users. More follow up for people in and out of rehabs and prisons.

More connection between treating drug use and homelessness together.

Should be a day centre for hanging around, coffee, food and laundry especially for the homeless people of which there are many.

Users do not get fair treatment from council – would not listen to us when in arrears. Got evicted coz of drugs suspicion. Know many other people with greater arrears who are still tenants.

Drug service waiting list just put me off. Not enough services, people can’t get right equipment. Housing always a problem, not had a settled address for several years. Exclusion is a big problem.

Lack of information generally at CDT especially infectious diseases. Lots of people using don’t even know CDT exists. More advertising awareness – more drop-in centre’s/needle exchanges/qualified staff guidance in to help/treatment. A better location for CDT – central.

More organized facilities and especially education. 3 deaths in the last 6 months, something needs to be done. People are sharing pins regularly.

Reducing my script when I give positive test is stupid, they should give me more methadone not less.

North West Wales:

Housing is a huge problem and police are very unfair and intolerant towards drug users in the City of Bangor.

Help should be speeded up. Shorter waiting times.

Housing in Bangor is terrible. Just lost my house. Police are very intolerant to users. Drug service is good for me.
Should have ex-users as drug counsellors, they’d know where you are coming from.

Housing terrible. No help available for homeless people.

Courts could be more lenient. How are users supposed to pay £100 fines without going out to graft to make money to pay fine? Catch 22 situation.

Help there when you want it, not three months later. A lot can happen within that time. Friends of mine waited for 6 months. He’d gone to prison just before his name was next on the list….He went straight back down to the bottom of the list again.

Would like to see more well informed drug workers. (i.e. Ex users).

Housing non-existent. Social services – I asked for help but made things worse. Tried to take my kids off me when I was being honest and asking for support.
Section 7: Hepatitis in Focus

Hepatitis B
All respondents were asked if their or drug service or GP/practice nurse had encouraged them to get vaccinated for hepatitis B. Overall only 43% (216 of 500) had been encouraged to get vaccinated however this figure does mask considerable inter-area variability as outlined in figure 11.

Figure 11: Percentage of users reporting encouragement to have a Hepatitis B vaccination by Drug Services or GP by area

Just under half (49%, 246 of 500) had received one or more hepatitis B vaccination and of these, 72% (176 of 246) had finished their course of Hepatitis B vaccinations with the remaining 28% (70 of 246) having started the course and not completed it. Table 21 indicates where hepatitis B vaccinations were received.

Table 21: Venue for receiving Hepatitis B vaccinations.

<table>
<thead>
<tr>
<th>Venue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison</td>
<td>48% (n117)</td>
</tr>
<tr>
<td>GP</td>
<td>23% (n56)</td>
</tr>
<tr>
<td>Drug Service</td>
<td>19% (n46)</td>
</tr>
<tr>
<td>Other inc. GUM</td>
<td>11% (n27)</td>
</tr>
</tbody>
</table>
Whilst Prisons provided the greatest coverage of hepatitis B vaccination overall there was regional variation particularly with drug service provision. Of particular note is the provision of this service within drug services in Mid and West Wales, and within the drug services especially the mobile unit in North East Wales. Regional variation is outlined in Figure 12.

![Figure 12 – Provision of hepatitis B vaccination by service by region](image)

**Hepatitis C**

Respondents were asked a number of questions on awareness and availability of information regarding blood borne viruses, specifically hepatitis C including the question ‘if you are aware of hepatitis C and have not been tested, why is this?’ Responses included fear of a positive result, lack of knowledge and awareness about Hepatitis C and feeling that they’re injecting / sharing practices were safe enough to avoid contracting hepatitis C:

- *Scared to know if I’ve got it and not really aware of the treatment from what I have read and seen. (Cardiff)*
- *I can’t get it, only ever shared with my boyfriend, he’s really clean. (Bro Morgannwg)*
- *Never been offered. (Bro Morgannwg)*
- *Never had the bottle to get one to be honest. (South Wales Valleys)*
Don’t share but also scared at the moment to take any kind of tests like that. (Pontypridd/RCT)

Because when I last shared Hep C wasn’t talked about. They don’t ask/wouldn’t ask now because I no longer inject. (NW Wales)

Been too scared to go for one. (NW Wales)

 Haven’t wanted one, try not to think about it. Been pretty careful over the years. (NW Wales)

Not tested - not aware. (NE Wales)

Rather not know. (NE Wales)

Not got round to it or been encouraged to get one by GP or drugs counsellor (West Wales)

Never thought about it to be honest. (West Wales)

Not got around to it yet but could go to GUM clinic. (Gwent)

Not had the chance, don’t know where to go. (Gwent)

From the total of 500 current and ex-injecting drug users, only 35% (n174) reported that their drug service, GP/Practice nurse or prison healthcare staff had discussed with them the option of having a hepatitis C test. However, close to half of the total sample (47%, 236 of 500) reported having had a blood test for hepatitis C. There were some regional differences in the rates of testing with the lowest rates reported in Bro Morgannwg (36%), South Wales Valleys (40%) and Gwent (44%) and the highest in Cardiff (60%). Given that the average length of injecting career from the sample was just over 9 years, the rates of testing and levels of awareness of blood borne virus transmission and infection are low.

All those who had undertaken a blood test for hepatitis C were then asked a series of further question about the treatment or advice they had received. Of those that had been tested, the majority (65%, 153 of 236) had undertaken just one blood test.

A crucial part of the process of undertaking a blood test for hepatitis C, as for HIV, is the provision of appropriate and thorough pre and post test discussion.
This discussion ensures that the patient is clear about the process of testing and of risk factors that may lead to a positive result, the implications of a positive result and support and treatment available. Only 62% (147 of 236) of those having taken a blood test reported receiving pre and post test discussion. 14% of those tested (32 of 236) did not receive their test results. Of the 204 respondents that had been tested and received their results, 24% (n48) were positive for hepatitis C.

Of those that had received their result, 82% (n167) felt they understood what their result meant with most individuals discussing this with family and friends or their drug worker, and of those who had tested positive, 84% (n40) of them had informed their GP. However, only 31% (n15) of these individuals had been referred for an appointment with a specialist doctor or Hepatitis clinic. Waiting times for an appointment ranged from 6 months to over 2 years and none have received any treatment as yet.
References

