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▶ An examination of injection drug use trends in Victoria and Vancouver, BC after the closure of Victoria's only fixed-site needle and syringe programme.

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Until June 2008 Victoria in Canada had a comprehensive extended hours needle exchange at a fixed site in the city. Neighbourhood pressure led to closure, creating a natural experiment in the withdrawal of services. The result seemed to be more sharing of injecting equipment entailing a greater risk of infection.

Summary Needle and syringe distribution programmes offer infection-free injecting equipment to injectors to prevent the spread of infection (mainly HIV and hepatitis; of the latter, hepatitis C is the variant of the greatest concern) due to the sharing of used equipment.

Since 1988 such services have been offered in the city of Victoria, capital of the province of British Columbia in Canada, but at the end of May 2008 pressure from local businesses and residents led to the closure of the city's only fixed-site programme. Since then services have been offered through a variety of mobile and satellite programmes, but the number of needles distributed dropped by about 40% and remained lower than before closure. This gap in service remained despite 13% of the city's injectors being infected with HIV and 63% with hepatitis C.

Over the same period the fixed-site needle and syringe distribution programme in the nearby city of Vancouver continued to operate, along with mobile services and premises in which injectors can legally inject under medical supervision.

The featured study took this opportunity to investigate the consequences of the closure in Victoria, contrasting trends in the sharing of injecting equipment there before and after the closure with what happened during the same period in a city which had no such

disruption in services. It took its data from a twice-yearly survey of adult injectors (and later other drug users too) in each city which began in 2007, recruiting participants via street agencies. The featured study limited itself to those who had injected in the last three months (288 in Vancouver and 291 in Victoria). Nearly 70% of participants were men and they averaged 40 years of age. Over 70% of in both cities said they were homeless or unstably housed.

Main findings

Despite some demographic differences, in both cities about two thirds of survey respondents were daily injectors. However, in Victoria the odds of them having shared versus not shared a needle in the past 12 months were two to three times higher after other factors had been taken in to account. Of greatest interest was how sharing varied before and after closure of the needle exchange centre. Though not statistically significant, in Victoria the proportion having shared rose from 9.5% in early 2008 just before the closure to 20% in late 2010, while in Vancouver the proportion remained relatively steady at under 10%.

Another finding was that people who had injected crack or oxycodone in the previous month were much more likely than other injectors to have sharing needles in the past 12 months.

After the closure in Victoria participants were asked how this had affected them and what changes they had noticed. Many but not all talked of difficulty getting clean needles or of sharing needles more often.

The authors' conclusions

This study confirms the contribution to public health made by needle and syringe distribution programmes by reducing injecting-related risk behaviours such as needle sharing and re-use. It draws attention to the substantial and persistent problems associated with injecting drug use in Victoria following closure of the fixed-site needle and syringe distribution centre. The increase there in needle sharing from under 10% in early 2008 to 20% in late 2010 is troubling. Accounts of injectors raise concerns about difficulties accessing clean needles and a tendency to be more likely to share needles. Furthermore, the most recent national Canadian study tracking infection risk behaviour among injectors found that 23% (up from 19% in 2006) of participants in Victoria reported sharing needles, while 22% who knew they were infected with hepatitis C still passed their used needles to others.

It should be acknowledged that these results derive non-random samples of injectors and may have been influenced by changes in the samples at different time points. A study like this can only produce findings *consistent* with a causal relationships between the needle and syringe distribution centre's closure and trends in injecting drug use, not *prove* there was such a relationship.

FINDINGS This study took advantage of a 'natural experiment' which threw in to relief the value of an accessible and well staffed central location for obtaining injecting equipment and allied advice and care. Mobile services reach people not reached by a fixed centre, but a centre offers a hub at a known location and known times, and a place to stay and talk and receive other services.

The implications are at least twofold: first that such services are very vulnerable, occupying a narrow tolerance zone almost at and often beyond the edge of public acceptability; and secondly, that accessibility is the key to getting enough infection-free equipment to injectors to prevent the spread of infection. These two considerations came in to conflict in Victoria.

It was a small study whose findings cannot securely establish the consequences of the closure, partly for the reasons given by the authors, but also because from their own account drug use patterns were changing in Victoria (the increase in crack injecting) in ways which might have affected the sharing of injecting equipment regardless of the closure. Nevertheless the study is valuable because 'intentional experiments' randomly allocating areas or people to have or not have needle exchange services are extremely rare.

To interpret the findings it is essential to know what was lost − not an hour or two a day office-hours service, but a comprehensive extended hours operation. As described in another report on the closure, the centre was open seven days a week from 3pm to 11pm, staffed among others by 'street nurses' who offered health services and referrals. The centre also offered a range of welfare services. Closure of the needle exchange was forced by the landlord in response to complaints from neighbours about open street drug use, loitering and garbage. Attempts were made to compensate with mobile and outreach services, but pressure from neighbourhood groups also led to the banning of any needle exchange services in the vicinity of the centre, injectors found it hard to remember where mobile services were and when or could not get to them at those times, and the nature of these services was that contact was fleeting with no space for confidential counselling and private medical care. A "safe haven from the street that provided a trusted point of access to services" had gone. The number of needles distributed plummeted by 40% and the number of clients served fell by over a quarter. The ease and convenience balance was tipped between obtaining fresh injecting equipment versus used equipment more immediately available from another injector. Ironically, a closure intended to prevent drug-related nuisance led to more nuisance (loitering and disturbances) in neighbouring areas. Resistance to reopening a fixed site service elsewhere left this gap for at least three years.

For more on needle exchange generally and in Britain in particular see this recent Findings analysis. For other city-based case studies of the impact of the availability and non-availability of needle exchange services see this Findings review, one of a series of four on needle exchange and hepatitis C.

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