

'Heroin users not currently in drug treatment who decide they want to minimise their risks of infection also need to stop using street heroin altogether.'

Between 16 December and 25 January eight people in Scotland have died from anthrax related, it is suspected, to contaminated heroin (see page four). To date there are a further nine confirmed and 50 possible additional cases. Drugs workers across Scotland have been checking all injectors who attend services for signs of anthrax. Leaflets have gone out to drug users. Information has been cascaded through NHS structures. But despite this and recent improvements co-ordinated by Health Protection Scotland (HPS) and the Scottish Drugs Forum, the initial response was slow. By the time there had been seven deaths there was little if any information available on any of the key drugs websites, and the only advice available to drug users was to stop using heroin immediately and get into treatment.

'Heroin users not currently in drug treatment who decide they want to minimise their risks of infection also need to stop using street heroin altogether, but they may need to talk first to their local treatment service about how to engage with the available drug treatment options (such as abstinence-oriented support or, at least for a period, prescribed opiate substitution treatment),' says the HPS factsheet for drugs workers.

And it is obvious isn't it? If you stop using street heroin you cut your risk of getting anthrax to zero. Smoking anthrax spores seems to be pretty much as dangerous as injecting them, so advising people to smoke is probably not much

use. So what we need to do is get people to stop using heroin. Quickly. One wonders if 'abstinence-oriented support' is actually what is needed? Or if substitute prescribing – however much of a secondary option it may seem to the author of this advice – might actually be the way forward?

Currently in Scotland, waiting times to prescribed treatment – the point at which people can access medication – range from eight to 52 weeks. I was working with a group of drug users in Glasgow yesterday who, despite being committed to the recovery orientation of the Scottish Drug Strategy, also instinctively understood the need for Scotland to get better at providing basic healthcare, saying 'You could die in the time it takes to get a script here.'

The Scottish government has recognised this variation is problematic and that delays getting into treatment impact on community and individual outcomes. They've set new targets for drug treatment waiting times, but this will be too late for some users making the choice between using potentially contaminated heroin and going into withdrawal, like this teenage drug user quoted in *The Paisley Daily Express*:

'It's scary but the problem is that folk like myself just can't break their addiction to heroin. I'm still taking the drug, even though I'm worried that the batch I'm using might be contaminated. I just can't help myself. I would rather put my life at risk than do without my heroin.'

When the threat of HIV transmission in this country was at its height in the late eighties, the government invested in an approach to drugs called harm reduction. The problem, it was argued, was so pressing and so dangerous that we would be morally irresponsible if we allowed infection to spread. We needed to find a way to stop people using heroin so dangerously. The approaches we knew would yield results – keeping people alive – were substitute prescribing and honest and frank advice about injecting and support for people at whatever stage in their drug-using career they came for help. And it worked. Drug deaths reduced and HIV transmission rates to new users dropped. Record numbers of drug users contacted services. Lives were saved. Not just those of people directly affected by drug use, but those of people in the general population who may have become infected.

Maybe this is where there is a big difference. HIV is infectious. Anthrax isn't. In the same press release where we are told that drug users should stop using heroin we are also reassured that anthrax will not be passed to the general population and that they are at no risk.

If we know that providing substitute prescribing can save the lives of drug users at risk of dying from contaminated heroin surely we are doing it? Well, kind of. It's no secret that waiting times for drug treatment are significantly higher in Scotland than in England. In part the successes around this in England are due to a longer-



standing focus on substitute prescribing as a cornerstone of drug strategy. This is not without its costs and problems. However research from Scotland last year clearly demonstrates that methadone cuts the number of heroin use incidents and so cuts the risk of infection. It is clear that substitute prescribing is an invaluable part of our drug treatment options – and must remain so. It helps people become stable, it helps people get their lives back together and it helps people recover. Most importantly, in the context of the current public health risk in Scotland it brings people into services, it enables them to access healthcare and it swiftly and safely reduces the risk, well, of dying.

Treatment for anthrax can be successful – people can make a full recovery – if it's caught early enough. Ideally in Scotland now we do need people to stop using street heroin – and we also need to be realistic about how this is going to happen. We need those that continue to take this risk to be aware – fully aware and informed – about the danger signs. We need drug users to be confident in accessing healthcare if they think they're in danger.

A straightforward co-ordinated approach between drug services and public health can achieve much in terms of making sure the right messages get out to the right people. It seems the cascade of information to people in treatment has been reasonably effective. But what about those who aren't? Although data is a bit ropery, a generous estimate would suggest that around 60 per cent of the people who need to get this information will not receive it directly. It will come to them by word of mouth, on the internet, or through the newspapers. If at all.

Most importantly, people need rapid access to substitute prescribing. This has the advantage of not just stopping people using street heroin, but cutting dead in its tracks what must be a very lively street market at the moment. It would bring vulnerable people into treatment – some maybe for the first time – and hopefully, hold them there until a slot is available in a specialist service. Having made no comment on this for the first month of the Anthrax crisis, finally on 20 January the Scottish Government suggested:

'In areas where there are waiting lists for access to drug treatment and in particular substitute medication contingency measures may be required to ensure that all those who wish to stop using heroin, in order to avoid being infected with anthrax, have the means to do so.'

Good advice and necessary, but does it go far enough? And what took them so long?

One Scottish commentator suggested that maybe the reason for this lack of real interventions was the increasing emphasis on recovery and abstinence in Scottish drug policy:

'I wonder if this terrible anthrax chapter could be the Banquo's ghost of recovery? There is an increasing recovery discourse that is being shaped by story telling and soft-focused personal recovery narratives. This new discourse does not sit well next to impersonal epidemiological modelling... health protection and drug policy people seem to operate on different planets.'

So here we are, it's 9am on a Thursday morning and you're a heroin user waking up in Scotland. It's cold and you need a hit. You can get yourself down to the community addictions team but you know you're going to be facing a significant wait until you finally get a script. Even at the most optimistic, if you're using twice a day and waiting two months that's a potential 120 chances between now and getting treatment that you could become infected with anthrax. You can try and buy some methadone or some buprenorphine on the burgeoning black market for substitute drugs. You can get together with some mates and see if you can get a car drive down into England and buy in bulk down there. Or you can go out, take a chance and buy street gear. And you can hope that this isn't going to be your time.

Let's be realistic – this is a small number of deaths. It's not infectious. It probably relates to one batch of heroin. Sooner or later it will run out or be tracked down and destroyed. It may be sad, and there may be more we can do, but its not huge – yet – is it?

Well maybe all that is true, and maybe anthrax is not the issue. But what about the 1,000 new cases of hepatitis C in IDUs that are predicted in Scotland this year? Does our reaction to the anthrax crisis not reveal something quite troubling about our ability – and inclination – to respond to public and individual health crises related to injecting drug use?

However much we may want to recast our drug policies as being about recovery or abstinence, however uncomfortable we may be with needle exchange and substitute prescribing, we need to be realistic. If we don't develop our drug interventions within a framework of harm reduction – dealing with the public and personal health issues related to drug use as they are, not as we wish they were – people will die. Harm reduction and recovery are not mutually exclusive. They can and do exist side by side. But no amount of recovery coaching, marching or witnessing, will, in the end deal with an issue like anthrax. For that we need harm reduction – and the courage and vision to implement life-saving policies.

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The Scottish Drugs Forum have updated their website with new advice: visit www.sdf.org.uk

HIGH STAKES

Scotland's recent anthrax outbreak from contaminated heroin has raised urgent questions about forfeiting essential public health measures, says Sara McGrail