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Access to harm reduction services in Atlantic Canada: Implications for non-urban residents who inject drugs

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ABSTRACT

Awareness of drug use in rural communities and small towns has been growing, but we know relatively little about the challenges injection drug users (IDUs) living in such places face in accessing harm reduction services. Semi-structured interviews were conducted with 115 IDUs in urban and non-urban areas of Atlantic Canada. In many instances, geographic distance to a needle exchange program (NEP) meant that individuals living outside of urban areas and who were not provided services through an NEP's outreach program were at a disadvantage in terms of an array of supports offered through many NEPs. These include access to free clean injecting equipment, and such ancillary services as clothing, food, referrals, information and social support. The integration of the services and approaches provided by NEPs into mainstream health services in non-urban places is one possible model for improving such access.

1. Introduction

Drug use has historically been studied and addressed as an urban problem, given that drug use is relatively concentrated and highly visible in urban centers (Canadian HIV/AIDS Legal Network, 2007; Health Canada, 2000). However, people living in rural areas also use drugs, including injection drug use (IDU), although we know relatively little about this population and their potentially specific challenges to safer use. The more "hidden" nature of drug use in those areas, as well as other social and geographic issues, may lead to distinct challenges for rural drug users and service providers.

Recent academic research and community reports have demonstrated that injection drug use exists in rural communities, but there is little information on access to harm reduction services and the realities of injection drug use in rural areas and small towns. In particular, there is limited information on injection drug users' experiences of practicing harm reduction within a rural or small town context. There is also a paucity of evidence on the needs of these individuals, which could inform potential solutions and expand the reach of harm reduction efforts. This paper will discuss the challenges to safer use highlighted by injection drug users living outside of urban areas in Atlantic Canada, and the complexities of accessing safer injecting equipment and other services in non-urban communities. It will also suggest strategies for enhancing access and expanding the reach of harm reduction efforts to non-urban areas, within and beyond Atlantic Canada.

As an approach to drug use, harm reduction favors pragmatic supports designed to minimize the harmful consequences of drug use, while suspending moral judgments and not requiring abstinence as a prerequisite for accessing programs, although abstinence is still one goal (Marlatt, 1996). Harm reduction programming includes, but is not limited to, needle exchange programs (NEPs), distribution of other materials such as condoms and alcohol swabs, methadone maintenance therapy, medically-supervised injecting facilities, and a range of other practical services and referrals. For the past two decades harm reduction programming has been a mainstay of health service delivery for drug-using populations in Canada and other countries. Evidence gathered during this period indicates many individual and community-level benefits achieved by applying a harm reduction approach to substance use. Such programs have been credited with reducing risk behaviors such as syringe sharing and unsafe disposal, thus reducing the risk of transmission of the Human Immunodeficiency Virus (HIV), and Hepatitis C (Hope et al., 2001; Jones et al., 2010; Kerr et al., 2009; Leonard et al., 1999; Van Den Berg et al., 2007). Research has shown that individuals who regularly access NEPs are less likely to engage in risky injection

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practices than other injectors, including those who receive clean equipment through other users (Cooper et al., 2009; Huo et al., 2005; Lorvick et al., 2006; Tyndall et al., 2002). Furthermore, NEPs are important sources of many other supports and services that help to improve IDUs' well-being, including food, counseling, basic medical care, housing assistance and referrals to other services (Grau et al., 2002; PHAC, 2006; Pollack et al., 2002).

Geographic proximity to an NEP site has been shown to be a major determinant of program utilization—even within urban centers, injectors who live further from the site are less likely to use it regularly (Cooper et al., 2009; Rockwell et al., 1999). Harm reduction programming is typically offered in urban areas (for example through fixed-site or mobile NEPs), as are most services targeting people who use drugs (Canadian HIV/AIDS Legal Network, 2007). Given the overall lack of harm reduction services and related programs in most rural Canadian communities, rural users are often at a distinct disadvantage for accessing an array of much-needed services aimed at reducing drug-related harms. However, very limited research has explored these challenges through the experiences of non-urban residents who inject drugs. For this reason, we were specifically interested in examining these issues through the data collected as part of our larger study on social relationships and injection drug use in Atlantic Canada. Other analyses and themes from our research have been presented elsewhere (see for example, Jackson et al., 2010; Jackson et al., in press), and data analysis and dissemination are ongoing.

2. Background

2.1. Injection drug use outside of large urban areas

It is generally difficult to know the extent of drug use in non-urban areas, as this use is less concentrated and typically more "hidden" or less visible than in cities, often taking place in homes and other private spaces (CHALN, 2007; Health Canada, 2000). Nevertheless, a growing body of research has confirmed that rural communities also experience drug use and related problems. Various studies have highlighted significant prevalence rates and social problems related to drug use in rural areas of numerous countries worldwide (Berends, 2010; Draus et al., 2005; Falck et al., 2007; Holland et al., 2006; Lawrinson et al., 2006; Leukefeld et al., 2002; Liu et al., 2006; Mojtahedzadeh et al., 2008; Peltzer and Cherian, 2000). Many of these studies have pointed to alarming localized trends including problematic drug use in certain rural areas or "hot spots"; in many areas it has been suggested that the extent of rural drug use may be comparable to what has been observed in nearby urban areas (see, for example, Dew et al., 2007; Holland et al., 2006; Thomas and Compton, 2007). Despite similarities in the prevalence of drug use, most research has highlighted some differences in "drug of choice" and use patterns between rural and urban residents. For example, an analysis of national survey data in the US found that rural youth were more likely to report non-medical use of prescription drugs than their urban counterparts (Havens et al., 2011). An Australian study by Aitken et al. (1999) found that rural residents were more likely to use amphetamines while urban residents were more likely to use heroin. In one study, incarcerated drug users who were from rural areas of the US were found to have more severe drug-related problems than urban prisoners (Warner and Leukefeld, 2001). Rhew et al (2011) found that the prevalence of inhalants and other illicit drugs were higher among high school-aged youth living on farms than for their peers living in towns, suggesting that different degrees of rurality may result in distinct use patterns.

Despite growing awareness of non-urban drug use, there is very little information specific to injection drug use—many of the American studies have highlighted rates of drug use or problematic drug use, but make no mention of injecting versus oral administration (Borders and Booth, 2007; Gfroerer et al., 2007). Research dating back as much as 20 yr pointed to injection drug use as a growing contributor to HIV epidemics in rural settings in the United States, but a large share of this contribution was attributed to individuals who were infected with HIV through IDU in a city before migrating to a rural area (Cohen et al., 1994; Fordycee et al., 1997; Grace et al., 2000; Graham et al., 1995), or to engaging in risky sexual activities in order to procure drugs or while under the influence of drugs (Clayton et al., 2007). Nevertheless, a limited body of recent research and community reports has begun to reveal the extent of injection drug use taking place in non-urban communities, but there remains a lack of reliable, consistent data (CHALN, 2007; Fischer et al., 2005; Leukefeld et al., 2002). An Australian study by Havens et al. (2011) found that the rate of fatal overdoses associated with injecting prescription opioids was increasing at a startling rate for rural users—many times greater than the increase seen among urban residents (Havens et al., 2011; Paulozzi and Xi, 2008).

Despite a lack of in-depth information, it is clear that injection drug use and its associated harms exist in non-urban communities. Of particular concern for rural areas is the fact that local health and social services may be ill-equipped in terms of resources, knowledge and experience to manage the harms related to problematic and less safe injection drug use, since injection drug use is typically seen as the domain of urban areas (Dew et al., 2007; Falck et al., 2005). Given that drug use, including injection drug use, clearly exists outside of major urban centers, efforts to reduce drug-related harms must focus not only on urban populations, but also on individuals living in rural areas (Leukefeld et al., 2002).

2.2. Access to services for rural residents

Under a system of universal health care (as in the Canadian context), primary care is available to all citizens, at least in theory. However, specialized health services tend to be centralized in urban locations where the demand is more concentrated (Bickerton, 1999; Hanlon and Skedgel, 2006). Generally, the small number of widely-dispersed patients requiring a given specialized service in a rural place is not enough to justify the overhead costs of practitioners, administration and equipment (Hanlon and Skedgel, 2006). In addition, rural communities frequently face challenges to recruit and retain specialized health professionals (Clark et al., 2002).

Research has demonstrated that the costs (including lost work time) associated with accessing specialized health care can pose significant challenges for rural residents (Alston et al., 2006; Bourgeault et al., 2006; Harrold and Jackson, 2011; Panelli et al., 2006). Further, rural Canadians are typically of lower socio-economic status than their urban counterparts (Canadian Institute for Health Information, 2006), making the costs even more prohibitive. A substantial body of research has demonstrated that reliable, affordable access to transportation remains a key barrier to access specialized care for rural residents, in particular for those with low incomes (Arcury et al., 2005; Basu and Mobley, 2007; Buchanan et al., 2006; Elliott and Larson, 2004; Hanlon and Skedgel, 2006; Jensen and Royeen, 2002; Skinner and Slifkin, 2007; Wellstood et al., 2006). Research on specialized health care services has also revealed that concerns related to confidentiality, anonymity and stigma are common among rural residents accessing certain specialized services (Bourgeault et al., 2006; Chipp et al., 2008; Ekeland and Bergem, 2006; Harvey, 2007), in particular those related to conditions or activities that are stigmatized, including HIV infection, men who have sex with