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Injection Drug Users' Perspectives on Placing HIV Prevention and Other Clinical Services in Pharmacy Settings

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ABSTRACT *In their role as a source of sterile syringes, pharmacies are ideally situated to provide additional services to injection drug users (IDUs). Expanding pharmacy services to IDUs may address the low utilization rates of healthcare services among this population. This qualitative study of active IDUs in San Francisco explored perspectives on proposed health services and interventions offered in pharmacy settings, as well as facilitators and barriers to service delivery. Eleven active IDUs participated in one-on-one semistructured interviews at a community field site and at a local syringe exchange site between February and May 2010. Results revealed that most had reservations about expanding services to pharmacy settings, with reasons ranging from concerns about anonymity to feeling that San Francisco already offers the proposed services in other venues. Of the proposed health services, this group of IDUs prioritized syringe access and disposal, clinical testing and vaccinations, and provision of methadone. Pharmacists' and pharmacy staff's attitudes were identified as a major barrier to IDUs' comfort with accessing services. The findings suggest that although IDUs would like to see some additional services offered within pharmacy settings, this is contingent upon pharmacists and their staff receiving professional development trainings that cultivate sensitivity towards the needs and experiences of IDUs.*

KEYWORDS *IDU, Pharmacy, California, Qualitative, Prevention services*

INTRODUCTION

Lack of access to sterile syringes contributes to the high rates of HIV and viral hepatitis found among injection drug users (IDUs) in the USA.[1–3] While syringe exchange programs (SEPs) are recommended to provide easier access to sterile syringes and thus reduce injection-related HIV risks,[3–7] there are too few SEPs to meet the needs of IDUs in the vast majority of locations.

As SEPs are often limited in the amount of time they are open, it is difficult for them to provide a lot of additional services. In their role as a source of sterile syringes, pharmacies are ideally situated to provide additional services to IDUs. Expanding pharmacy services to IDUs may address the low utilization rates of

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healthcare services among this population.[8] Other studies have found that IDUs have poor access to preventive and primary care services,[9–13] as well as drug treatment programs.[14,15] Among 560 SEP clients throughout California, it was found that in the 6 months prior to their interview, nearly half had not received any of the recommended screening and counseling services such as testing for HIV, hepatitis C, hepatitis B, and sexually transmitted infections.[16] This suggests the need to increase the use of preventive health services among IDUs.

The expansion of pharmacy delivered primary care services to the general population has already been implemented in several settings. In one study,[17] a pharmacist evaluated five pediatric conditions and provided bilingual patient education materials among an underserved immigrant population in Seattle, WA, USA. Another study evaluated influenza vaccine delivery and relative contributions between pharmacist- and physician-delivered vaccines among adults in Washington (where pharmacists offer vaccination services) and Oregon (where those services are not offered).[18] Pharmacist-delivered vaccinations were found to be associated with more vaccinations among one high-risk and underserved population, patients younger than 65 years of age who take indicated medications for chronic diseases.

The two main legal sources of clean needles for illicit IDUs in San Francisco are SEPs and nonprescription syringe sales (NPSS) at pharmacies. SEPs and NPSS were authorized in 2000 and 2005, respectively. Details on these two policy changes have been published elsewhere.[19,20] Briefly, in 2004, California became one of the last US states to allow NPSS. Senate Bill 1159 authorizes licensed pharmacies to sell or furnish up to 10 hypodermic needles or syringes to a person 18 years of age or older without a prescription. A number of conditions need to be met before pharmacies can engage in NPSS, such as adopting a local county or city policy, registering with the local health department in the Disease Prevention Demonstration Project, and distributing verbal or written health information to NPSS customers.[21] Participating pharmacies also have to provide some type of syringe disposal option (on-site safe disposal program, mail-back sharps containers, or personal sharps disposal containers).

While some of the preliminary data about increased services at pharmacies is promising, it is critical to include the perspectives of IDUs on this topic in order to have a full understanding of the implementation issues involved. This paper will share the findings from qualitative interviews with IDUs in San Francisco that assessed the feasibility and desirability of using pharmacies as venues for providing on-site HIV and hepatitis C virus (HCV) prevention services and referrals to other needed medical, social, and drug treatment services.

METHODS

As part of an overall study in five international cities to assess the feasibility of using pharmacies as public health venues to provide health-related services to IDUs, IDUs were recruited to describe their interactions with and perceptions of pharmacists, their receptiveness to pharmacy-based interventions, and perceived facilitators and barriers to service implementation. The principal investigators collectively identified the types of interventions to consider placing in pharmacy settings. Using quota sampling, we recruited a diverse sample of IDUs by selecting participants based on gender, race, education, drugs injected in the past 30 days, and prior use of pharmacies for syringe access. Saturation was achieved after 11 interviews.

Data were collected using a semistructured interview guide which included items about experiences accessing services in pharmacies and explored perceptions about

six different types of potential pharmacy-based interventions: enhanced syringe access, syringe disposal services, directly observed therapy for acute and chronic health conditions, dispensation of methadone or buprenorphine, overdose prevention education and naloxone distribution, and HIV- and HCV-related education and referral. For each participant, demographic and behavioral data was collected. The interviews were conducted in San Francisco between February and May 2010 at a community field site and a local needle exchange site. Informed consent was obtained from all participants prior to the interview, and they received $20 for their participation. Ethical approval for the study was obtained from the Internal Review Board at RTI International.

All interviews were conducted in English by one of the two interviewers (AL and AHK). The interviews were digitally recorded and transcribed verbatim. A template approach, coupled with thematic analysis, was used to analyze the data. Using a template approach,[22] the single coder (AL) defined the codebook a priori based on the research questions. The coder also used thematic analysis to identify additional themes that emerged from the data.[23,24] The final analysis was reviewed by the second interviewer (AHK) to ensure its accuracy. Transcripts were coded and entered into the qualitative analysis program NVIVO.[25]

RESULTS

Over half of the study participants were women and 36% were White (Table 1). The mean age was 39 years old (range, 23–57 years old), and the mean age of first injection was 19 years old (range, 12–38 years old). One male reported sex with other men and two women reported sex work. The median monthly income for this sample was $1,000 (range, $2–7,000). In the past 30 days, the mean number of days injected was 13.6 (range, 1–30 days). The majority of this sample (73%) had not used pharmacies as a syringe source in the 30 days prior to participation in the study.

Prior Experiences with Pharmacies

The beginning of each interview explored prior experiences with pharmacies. Three participants mentioned that their experiences at pharmacies have always been positive, and that they felt they were treated the same as any other customer picking up their prescription. The typical response among these participants is captured in the following quote from a woman who only goes to pharmacies to buy syringes. She shared that they treat her, "no different than if I was a senior citizen going there to get my medicine."

The other eight participants reported negative experiences. They shared how they felt that pharmacists and pharmacy staff are quick to judge them because of their drug use. As a 30-year-old Latina woman reflected:

> Like I don't consider them like a, a resource that's something that would actually like really, really help me. You know… I kinda feel like they give me second looks. You know. Like there's a quick judgment or a quick something in their head that says, "Oh, this person's a drug addict."

Another participant shared how she avoids certain pharmacies when they treat her inappropriately:

> No one likes to go somewhere where they're looked down upon or treated poorly… And it's like, you know, me and my husband, we don't go to the certain

TABLE 1 Demographics of study participants

Participant characteristics	$N=11$ (%)
Gender	
Male	36
Female	64
Race	
White	36
African-American	28
Hispanic	18
Multiracial	18
Education	
Less than high school degree	27
High school degree	18
Some college	55
HIV testing	
Prior HIV test	100
HIV-positive test result	0
Injection drug use (past 30 days)[a]	
Heroin	64
Methamphetamine	27
Other opiates	27
Primary drug injected	
Heroin	73
Opiate pills	9
Fentanyl patch	9
Crack cocaine	9
Pharmacy services	
Syringe access	27
Syringe disposal	9

[a]Possible to report more than one drug used in past 30 days

> stores because of the way they treat us. And we said, "You know, why spend your money just to have somebody treat you like crap?" (51-year-old White and Native American woman)

For those who reported negative past experiences, they expressed that pharmacists do not want them in their stores, and they do not think of pharmacies as a resource for IDUs. Overall, none of the 11 participants have been offered information by pharmacy staff about testing services, HIV risk reduction, or drug treatment services. Two of the three people who purchased syringes from a pharmacy in the last 30 days received the health information pamphlet that the Department of Public Health requires pharmacies to distribute to NPSS customers, and one characterized this as a problematic experience as he felt it was inappropriate for the staff to assume that he was an IDU and in need of that information. He shared that:

> I find it interesting that they just put in this pamphlet about getting clean if you want to, and just almost passing judgment. I mean, it's good to give out the information, but I, I thought that was interesting, that if you come in asking for insulin syringes that they just automatically assume you're not using it for that. (30-year-old White man)

Perspectives on Adding Services at Pharmacies

When asked about whether they would like to see more services for IDUs at pharmacies, there was a variety of perspectives. Many said "sure, why not" and indicated that any increase in services for IDUs is positive. Others felt that there are already ample services for IDUs in San Francisco, obviating the need for more services. Some felt that increasing services at pharmacies would be good for other IDUs but not for them personally, as they have their service needs met elsewhere or would not want to be that visible. A 30-year-old White man said:

> Me, I'd probably wouldn't use it so much. I'd prefer to come to a place like this [syringe exchange program] because who knows if—you know, sometimes I'd go into a pharmacy while I'm working and… I work in a commercial building, so who knows if there's another tenant, or something in there. And it's just not something that you wanna disclose.

Lastly, those participants who had already reported negative experiences in pharmacies, made the point that the proposed pharmacy-based interventions will only be of use to IDUs if the interventions are delivered in a professional manner and that they would not be interested in receiving services from people they felt were going to judge them.

Syringe Access

The idea of placing HIV and HCV risk reduction services in pharmacy settings received a mix of responses from the IDUs that we interviewed. Most of the participants responded favorably to expanding pharmacy syringe access. When given the option between purchasing syringes, turning in a coupon from a community-based organization for free syringes, or simply being able to go to a pharmacy to access free syringes, it is not surprising that most preferred the non-coupon, free syringe option. Several IDUs highlighted concerns with coupons (easy to lose, police may confiscate them, and there may need to be a log that keeps track of them) as influencing their preference for a non-coupon, free syringe service.

Syringe Disposal

The intervention that received the most support from participants was syringe disposal. They noted that because there are more pharmacies than SEPs, this would be a beneficial service. Many participants insisted that discretion is the key to this service. They would not want to dispose of their syringes in a highly visible place in the pharmacy. Rather, they would like to see the disposal box either posted on an outside wall of the pharmacy or would like it to be done in a separate, private room. It should be noted that the only participant who reported using pharmacies as a disposal site did not have encouraging things to say about her experiences:

> If I set it on the counter, they freak out and tell me to pick it back up. They'll call whoever, like a manager or whatever, and it's usually a big deal. And they're always like, "Get someone," like they all go talk in back—someone, one of the staff will be, like, obviously volunteered—they got volunteered and they'll come and take it and put it wherever… I've worked in so many Needle

> Exchanges that this shit doesn't bother me. I'm just like, "Like you guys can talk as loud as you want about needles and blah, blah, blah, and try and embarrass me out of your store"… Like they're quick to judge and not think about all the possible scenarios as to why someone's showing up and doing that. It makes me real mad. (27-year-old White woman)

While this woman did not let the reaction of pharmacy staff deter her from continuing to use pharmacies as disposal sites, if others faced this type of reception when trying to dispose of their syringes, they may not return.

Methadone/Buprenorphine

As buprenorphine prescriptions are already being filled at pharmacies in San Francisco, the participants focused their responses on methadone when responding to questions about incorporating these drug treatment services into pharmacies. Those who were currently on methadone were most excited by the idea of being able to access it at pharmacies since pharmacies are more convenient. These individuals envisioned that they would be able to go to any chain pharmacy during their open hours, which would free them from the constricting nature of methadone programs that require them to go to a specific location at specified times. Some also mentioned how it would be preferable to simply have a prescription for methadone that they could get filled and entirely eliminate the need to get a daily dose from a provider. A 30-year-old White man explained that being able to receive a daily dose of methadone would be:

> Convenient as hell. Especially for someone who works, like myself, you know; like that's ultimately, I think I got onto the pilot program [buprenorphine] because it was such a pain in the ass having to work around the methadone clinic's schedule… because my work schedule wasn't 9:00 to 5:00. It was—sometimes it would be 4:30 in the morning I'd have to work and I would miss out.

Participants noted that some of the benefits of keeping the service contained to methadone clinics are that they feel comfortable receiving services from the providers at community clinics.

Referrals, Information, and Education

Many of the participants said that referrals to and information about medical, social services, or drug treatment would be best disseminated through bulletin boards or information kiosks in the pharmacy. Participants felt this was preferable as it would allow individuals to access the information on their own and if they wanted more information they could use the distributed materials as a point of reference in conversations with pharmacy staff.

While the majority of participants thought that overdose education and safe injection information are needed to reduce risk for IDUs, they did not consider pharmacies to be the best place to deliver that information. The main concern was about the lack of privacy in pharmacies. To feel comfortable receiving this information in a pharmacy, some participants suggested that pharmacies would need to have a private room where they could host classes and trainings. Others questioned the need for these services to be offered at a pharmacy since they are already being provided in San Francisco by SEPs and community-based organizations. An alternative that one participant proposed is to have IDUs participate in a

SEP-conducted training about overdose prevention and naloxone, and then the SEP would provide people who completed the training with a coupon they could take to a pharmacy to exchange for free naloxone. Others suggested that pharmacies could hand out written materials about safe injection techniques and overdose prevention to anyone purchasing syringes or medications that have an overdose potential, and then if someone wanted to know more they would have an easier way to start the conversation by referring to the distributed materials.

Clinical Testing and Vaccinations

One of the most well-received expanded service option for pharmacy settings was clinical tests and vaccinations. Participants liked the potential convenience this option would afford them. Speaking to this, one of the men reflected:

> Now that, that'd be cool right there. Yeah, you, you can go in and, you know, (snaps fingers) stop in real quick and check and see if you're pregnant, or how's your Hep C coming along. Or, you know, like they doing the high blood pressure thing. And, and you can go in and say, "I need to take me a HIV test," you can go and they can do like a quick swab and stuff, and then you, you can get the results right there on the spot, right—that'd be cool. (46-year-old African-American man)

The participants identified the key to implementing these services as the ability for IDUs to receive the services without having to disclose that they are IDUs.

Directly Observed Therapy

Directly observed therapy, where patients are observed taking their medication, for acute and chronic health conditions like HIV, tuberculosis, or antibiotics for abscesses, was the one service option that received the most animosity. Most of the responses focused on whether IDUs would want to use the service. A number of participants said that it seemed overly patronizing, that if they wanted to take their pills they would, and they did not need someone standing there watching them. "I don't think people would really want people watching them for that long, seeing if they take their medicine, because then you're gonna feel like a kid or something," explained a 51-year-old multiracial woman. Others had economic reasons that influenced their response. These participants felt that it would disrupt their income generated from the underground economy. As a 27-year-old White woman very succinctly said, "I hate that. Because I sell my pills. I don't eat them."

IDUs' Priorities for Expanded Pharmacy Services

Towards the end of the interview, participants were asked to prioritize aforementioned services for placement in pharmacies. A number of them prefaced their response with reiterating the importance of receiving nonjudgmental services. As a 46-year-old African-American man mentioned, he wants to receive services at pharmacies without

> ...any extra lip service or attitude… I'd like a person to be—have compassion. You know? Or some type of understanding and quit forming an opinion of a person just because they doing this or that.

In addition to the ways in which services are provided, most of the participants prioritized syringe access and disposal, methadone treatment on site, and clinical testing and vaccinations.

Service Implementation: Facilitators and Barriers

For these services to be incorporated into pharmacy settings, the participants had several suggestions for ways to facilitate this that would increase the likelihood of their participation. All 11 participants felt strongly that there would need to be a separate, private room for services like clinical testing, vaccinations, and counseling and education. Similarly, if pharmacies are going to distribute health information or referrals, participants felt that pharmacies will need to dedicate space in their store to make this information accessible to those who are interested. The sense that pharmacists do not want to work with IDUs led participants to suggest that pharmacists would need to receive trainings that address how to work with IDUs in a culturally competent and nonjudgmental manner.

In addition to the concern about pharmacists' willingness and suitability to provide culturally sensitive services to IDUs, the participants also mentioned other barriers. While most responded favorably to increasing syringe access at pharmacies, several highlighted concerns about how this would be implemented. For example, participants wanted to know if syringe access would include a limit on the number of syringes a person could access at any given time, and if there was a specified limit, how pharmacies would enforce that policy. Concerns were also raised that some IDUs would abuse the system of free syringe access at pharmacies and sell pharmacy-acquired syringes on the street. Others expressed concerns that with increased services for IDUs at pharmacies, there would be an increase of individuals gathering outside of pharmacies to engage in underground economic activities such as selling their pills or other drugs. Participants also wanted to know how much personal information would be required in order to receive syringes. A few participants did not want to have any verbal interaction with the pharmacist or pharmacy staff and suggested the idea that there could be a sheet to fill out at the pharmacy that specified the number, type, and gauge-size of the syringes requested and that the individual would simply hand that to the person working at the pharmacy.

DISCUSSION

This study offers a first look at IDUs' perceptions about using pharmacies as venues for providing onsite health services and referrals to a variety of services. While the participants expressed a clear interest in seeing increased syringe access, syringe disposal, clinical testing and vaccinations, and pharmacies dispensing methadone, they raised some important concerns about feasibility. Other studies have found that pharmacists who view drug use as a public health issue are more likely to support services like NPSS.[26,27] This strongly suggests that any implementation of IDU-specific services must rely on an opt-in approach among pharmacies to ensure the participation of those pharmacists who are eager to provide needed health services to IDUs.

Coupled with the opt-in approach, it is clear from our findings that increased educational efforts directed at pharmacists are needed. Even if pharmacists want to work with IDUs, they may not know how to do this in a culturally competent manner and it is unlikely that pharmacists or pharmacy staff have received any type of training about how to work with marginalized, stigmatized populations in general, and IDUs in particular. Efforts need to be made to ensure that pertinent research findings about IDUs' pharmacy utilization experiences are brought to the attention of pharmacists who are committed to the health of the communities they serve. These pharmacists may be motivated to enhance their ability to work with

IDU communities when they learn that negative experiences, such as unsuccessful attempts to purchase syringes at a pharmacy, may increase the odds of both injecting with a used syringe and giving away a used syringe.[28]

A question that many participants raised was why San Francisco needs these services in pharmacies if other service providers currently offer them. While this is a valid point, it is important to note that with 27% of this sample being recruited from syringe exchange programs, and 55% self-reporting involvement in a methadone maintenance program, a substantial number of participants were connected to local services. In our interviews, we unfortunately did not collect more detailed information on the other types of harm reduction services the participants may be accessing. However, it has been found that nearly half of SEP clients throughout California had not received the recommended screening and counseling services.[16] This suggests that even though this sample is connected to SEPs and methadone clinics, it does not necessarily indicate that their service needs are being addressed. A potential benefit of increasing services at pharmacies is that IDUs, whether they are connected to other community services or not, would have an additional option of where to receive services. While some may never access these proposed services for fear of being identified as an IDU, if the recommendations from this sample are taken into account, self-identification as an IDU should not be a prerequisite for receiving services. In that case, anyone could go to a pharmacy and request an HIV test or vaccinations for hepatitis A or B, for example, and that may provide enough cover for a certain population of IDUs to feel comfortable accessing services.

Hearing IDUs perspectives on these proposed services is important. Equally important is learning from pharmacists about their willingness and ability to incorporate more services. The next phase of this study will assess pharmacists' perceptions about these proposed interventions and their willingness to provide services to IDUs. Through qualitative and quantitative interviews we will examine pharmacists' and pharmacy staff's attitudes about IDUs. This information could be used to create training opportunities that will fulfill continuing education requirements and address concerns about providing services to IDUs, in addition to working towards implementing some of these proposed interventions into pharmacies.

These data have several limitations. The participants' responses may be biased by social desirability. While quota sampling provided a diverse group of participants, it is still a nonrandom sample so the findings may not be generalizable to other IDU populations. However, key recommendations and suggestions from IDUs about the feasibility of expanding pharmacy-based interventions for IDUs are useful in considering how to implement such services. Appropriate, nonjudgmental services delivered in pharmacies to IDUs have significant potential to improve the health of this vulnerable population.

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