

## Sandwell Harm Reduction Strategy 2006

“Harm reduction policies and services work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs”

### UKHPA 2005

A harm reduction approach in drug treatment aims to reduce the relative risks associated with drug misuse, from reducing the sharing of injecting equipment, through to stopping injecting, substitution on opioid drugs for heroin misusers and abstinence from illegal drugs. Furthermore, harm reduction can specifically aim to prevent blood borne diseases (most particularly HIV and hepatitis infections) and other drug-related harm, including overdose and drug related death.

*“Harm reduction should aim (at partnership or service level) to reduce or eliminate the harms (behaviours, diseases or deaths) associated with drug misuse.*

*Partnerships will need to develop a sophisticated and clear understanding of the population at risk and the risk factors/behaviours, and, drawing on the evidence base, implement a range of policies and initiatives which address them. “*

### NTA 2005

### **The principles of harm reduction:**

The following principles of harm reduction are adapted from those set out by The Canadian Centre on Substance Abuse (CCSA 1996), and Lenton and Single 1998:

#### **Harm reduction:**

- **Is pragmatic:** and accepts that the use of drugs is a common and enduring feature of human experience. It acknowledges that, while carrying risks, drug use provides the user with benefits that must be taken into account if responses to drug use are to be effective. Harm reduction recognises that containment and **reduction of drug-related harms is a more feasible option than efforts to eliminate drug use** entirely.
- **Prioritises goals:** harm reduction responses to drug use incorporate the notion of a hierarchy of goals, with the **immediate focus on proactively engaging individuals**, targeting groups, and communities to address their most compelling needs **through the provision of accessible and user friendly services**. Achieving the most immediate realistic goals is viewed as an essential first step toward risk-free use, or, if appropriate, abstinence.
- **Has humanist values:** the drug user's decision to use drugs is accepted as fact. **No moral judgment is made either to condemn or to support use of drugs**. The dignity and rights of the drug user are respected, and services endeavour to be 'user friendly' in the way they operate. Harm reduction approaches also recognise that, for many, dependent drug use is a long term feature of their lives and that responses to drug use have to accept this.
- **Focuses on risks and harms:** on the basis that by **providing responses that reduce risk, harms can be reduced or avoided**. The focus of risk reduction interventions are usually the drug taking behaviour of the drug user. However, harm reduction recognises that people's ability to change behaviours is also influenced by the norms held in common by drug users, the attitudes and views of the wider community. Harm reduction interventions may therefore target individuals, communities and the wider society.

- **Does not focus on abstinence:** although **harm reduction supports those who seek to moderate or reduce their drug use**, it neither excludes nor presumes a treatment goal of abstinence. Harm reduction approaches recognise that short-term abstinence oriented treatments have low success rates, and, for opiate users, high post-treatment overdose rates.
- **Seeks to maximise the range of intervention options that are available**, and engages in a process of identifying, measuring, and assessing the relative importance of drug-related harms and **balancing costs and benefits** in trying to reduce them

## **Specific harm reduction interventions in Harm Reduction**

- Needle exchange services i.e. the provision and disposal of needles and syringes and other clean injecting equipment (e.g. spoons, filters, citric acid) in a variety of settings. Harm reduction interventions such as needle exchange, advice and information on safer injecting, Needle exchange services often have contact with drug misusers who are not in touch with structured drug treatment services.
- Advice and support on safer injection and reducing injecting and reducing initiation of others into injecting
- Advice and information to prevent transmission of Blood Bourn Viruses (particularly hepatitis A, B and C and HIV) and other drug misuse-related infections
- Hepatitis B vaccination
- Access to testing and treatment for hepatitis B, C and HIV infection
- Counselling relating to HIV testing (pre and post test)
- Advice and support on preventing risk of overdose
- Risk assessment and referral to other treatment services.

## **Specific harm reduction interventions in Harm Reduction available in Sandwell:**

1. There are 19 community pharmacists providing Needle & Syringe Exchange; in 2005/6 they dispensed 15980 packs
2. There are 33 community pharmacists delivering supervised consumption of methadone or supervised administration of subutex; all new drug treatment prescribing is subject to this, for a minimum of 6 weeks. In each quarter 250 episodes of treatment occur and at any 1 time there are 100 patients on the scheme
3. Waiting times for drug treatment have been maintained to within the Government targets of 3 weeks since 2004
4. In 2005/6 800 problematic drug users accessed treatment; the target for 2006/7 is 1005
5. In 2005/6 72 % of drug users were retained in drug users in treatment for more than 12 weeks

6. Open access drug treatment is provided at a number of satellite locations in Sandwell by Addaction
7. There are specific drug treatment services commissioned to work with 'hard to reach/underserved' groups such as offenders; Black & Minority Ethnic groups
8. A full time Blood bourn virus nurse is located in the drug treatment service (The Anchor Project) providing advice, support and treatment
9. XXX GPs are involved in the drug treatment provision, xx%

### **Prevalence data on Harm reduction**

#### **Injecting behaviour**

- ***Shooting Up (2004)***, a recent report by the Health Protection Agency (HPA), reported an increase in the sharing of injecting equipment amongst injecting drug users. An increase in sharing injecting equipment has been reported from 1997 to 2003, with 33 per cent of an anonymous sample reporting that they had shared injecting equipment in the previous four weeks. Recent research (Rhodes: unpublished) into drug injecting trends amongst those using heroin and crack/cocaine suggests a growing nexus of risks of blood-borne virus (BBV) transmission, infections and venous damage.

#### **Site infections**

- ***Shooting up (2004)*** notes an increase in injecting site infections of various kinds, including tetanus and wound botulism. This indicates both poor hygiene whilst injecting and also some contaminated doses of drugs (particularly heroin).

#### **Hepatitis C**

- ***Shooting Up (2004)***, also reported an increase in the prevalence of hepatitis C infection amongst injecting drug users both in treatment and out of treatment, from 36 per cent in 1998 to 41 per cent in 2003 (with only half of those hepatitis C seropositive being aware of this). Furthermore, an increase in the incidence of hepatitis C infection was reported amongst new injectors, indicating that transmission is increasing. There are marked regional variations in rates of Hepatitis C infection amongst injecting drug users, with prevalence rates of over 50 per cent found

in London and the North-West, and even higher prevalence have been seen in treatment populations Best *et al*, (1999)<sup>13</sup> found an 86 per cent hepatitis C prevalence rate in one London drug treatment service.

Alcohol use and misuse is the single biggest contributory factor to those with hepatitis C infection developing fatal liver disease.

- **Dr Chris Ford- Clinical Lead for SMM GPs & Dr Janet Gillespie GP ( Drink & Drug News 8/5/06)**

The prevalence of Hep C is between 0.7% - 1% of the UK population, equating to around 470,000 sufferers. Injecting drug use accounts for over 92% of cases. Shockingly Britain is the worst country in Europe at treating Hep C infection.....less than 10% of potential cases of infection have even been diagnosed.

- ❖ 200,000 people estimated to be chronically infected with Hep C
- ❖ Only 38,00 diagnoses have been registered
- ❖ Vast majority unaware of their infection, 80% no signs or symptoms
- ❖ Chronic infection 55-85% of those infected
- ❖ Deaths from chronic liver disease 1 - 5 % of those infected
- ❖ Mainly spread in England by injecting drug users (IDUs) sharing blood contaminated equipment
- ❖ If left untreated can cause serious liver disease including cirrhosis and cancer
- ❖ Prevalence in West Mids sample (n=3000) for a national survey found 28% had Hep C antibodies
- ❖ Estimated that 42% of IDUs are HCV+
- ❖ 2 – 10% of adults infected become chronic carriers of hepatitis virus
- ❖ 20 – 25% develop progressive liver disease
- ❖ HPA stats show the reported cases peaked in 1984 at 2000 case falling to 612 in 1995
  
- ❖ A higher prevalence rate of chronic Hep C exists amongst prisoners
- ❖ 60% of IDUs pass through the prison system at some
- ❖ Reproduce planning grid with suggested headings; commissioning and partnership structures, drug related death strategy, partner agency training strategy, workforce strategy, data collection, analysis and dissemination.

## **Hepatitis B**

- In 2003 infection rates for hepatitis B virus of 22 per cent were found amongst injecting drug users in England. Infection rates amongst new injectors were low but had risen from five per cent in 1998 to nine per cent in 2003. Increasing hepatitis B vaccination rates were reported by samples of drug users, rising from 25 per cent in 1998 to 50 per cent in 2003. However, amongst those injecting less than three years, only 42 per cent had been vaccinated.

*Models of care for the treatment of adult drug misusers: Update 2005 – consultation report 8/50*

## **HIV**

- Annual prevalence rates for HIV infection remain low and constant at about 2.9 per cent of injecting drug users in London and 0.5 per cent elsewhere in England. The prevalence amongst this group has not changed in recent years except in 2003 where, for those injecting for less than three years, a higher rate of 0.8 per cent has been found in England, which is the highest prevalence in this group since 1990.

## **Drug-related overdose deaths**

- Although all indications are that these continue to fall, from 1,565 in 2000 to 1,300 in 2003 (ONS 2005)<sup>14</sup>, these deaths are still preventable and continued efforts should be made to reduce these deaths.

## References

- ACMD Reducing drug related deaths 2000
- DH Immunisation against infectious disease date?

- DH Hepatitis strategy for England 2002
- Shooting Up
- NTA 2004 Commissioning services to reduce drug related deaths
- Hepatitis C Action plan for England 2004
- NTA Needle Exchange Survey 2006
- A Matter of Change 2006

## Commissioning & Partnership Structure

Objective	Action required & Milestones	By Whom/By When	Cost/Budget
Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements	<ul style="list-style-type: none"> <li>Implement &amp; Performance manage the adult drug treatment action plan</li> <li>Contract meeting/performance manage the providers</li> </ul>	<ul style="list-style-type: none"> <li>NTA?JCG?JCM/MoCM/DIP Manager/DIP data Manager</li> </ul>	£5m
. Harm reduction interventions integrated into structured drug treatment according to an individual client's needs and should be incorporated into a care plan agreed with the client.	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li>Providers of adult drug treatment</li> </ul>	
Write Sandwell Harm Reduction Strategy	<ul style="list-style-type: none"> <li>Draft</li> <li>Discussed</li> <li>Agreed and signed up to and implemented</li> </ul>	<ul style="list-style-type: none"> <li>JCM</li> <li>Partner agencies</li> <li>Partner agencies</li> </ul>	
Harm Reduction Conference	Organise for 22/9/06 – for 150 delegates	JCM/MoC M & partners	£5,000 PTB
Share good practice on harm reduction across the region	Attend bi-monthly meeting organised by DRM NTA	EW/DRM NTA	
Ensure drug users can access treatment for BBVs	Development of the treatment care pathway for drug users with hepatitis and HIV	MoCM/partner agencies	

Ensure Commissioned services are implementing the Harm Reduction Strategy	SLAs/Contract reviews	JCM	
The Harm Reduction Strategy to be cross referenced in all partnership agencies' plans	Audit undertaken Presented to DAAT/SSPE Implement actions form audit	Paper, from JCM, to be presented to SSPE August 2006	
Preparation for HCC Inspection	Ensure partnership have clarity on roles and responsibilities	JCM/ MoCM/HR Lead/SSPE Nov 2006	
The partnership to implement the D of H Hepatitis C Action Plan?			

## Drug Related Death Strategy

Drugs can kill suddenly and unexpectedly and can do so in many different and interacting ways, which can overwhelm many body systems, such as through overdose or can cause delayed death– blood borne virus', such as HIV, Hep B/C, as a result of drug use, may eventually lead to the death of an individual. Other drug related viral infections, such as septicemia may also be included in this category.

### High Risk Groups and factors contributing to DRDs

The Government highlighted the following groups as more likely to be at risk of drug related deaths:

- Injecting drug users
- Opiate users
- Drug users leaving prison or rehabilitation
- Poly drug users
- Drug users discharged prematurely from treatment

Objective	Action required	By Whom/By When	Cost/Budget
To prevent deaths as a result of contracting blood borne virus' such as HIV/Hep B/C among drug users and the general population	<ul style="list-style-type: none"> <li>• Introduction of BBV testing for all at risk drug users; leading to routine testing</li> <li>• Vaccination programme</li> </ul>	BBV Nurse, based at the Anchor Project	£80,000 PTB
Increase the number of problematic drug users in treatment to 65% of total by 2008	<ul style="list-style-type: none"> <li>• Maintain Government waiting times for</li> </ul>	Providers/DAAT	

	<ul style="list-style-type: none"> <li>drug treatment</li> <li>• Implement NTA Effectiveness strategy</li> </ul>		
Retain drug users in treatment for 12+ weeks- 85% by 2007/8	<ul style="list-style-type: none"> <li>• Implement NTA Effectiveness strategy</li> </ul>	Providers/DAAT	
Recording of DRDs and formation of a case review/Confidential Inquiry if necessary		MoCM	
Overdose training for users and carers, by users carers	Train Users & Carers and develop programme of implementation	Users, carers, MoCM, Drug Concern, Providers	£1,000 PTB
Rapid access to substitute prescribing for high risk groups e.g. released prisoners and premature leavers from residential rehabilitation?	Performance /Contract management of Addaction/Anchor	Addaction are the Lead for Through care/After care, Lead by JCM/DIP Manager - for DIP, on quarterly basis	
Clinical network established for care pathways of assessment and treatment as part of Models of Care framework	Work in progress	Work to continue ,Sharon Terzza ( Models of care Manager) & providers	
Establish referral pathways as part of MoC between primary care, specialist services, GUM clinics and hospital services (liver disease unit)?	Work in progress	Work to continue Models of Care Manager) & partner agencies	
Named links with key local and regional agencies established e.g. HPA, local treatment centres		HR Lead,JCM/MoCM	
Partnership Communication processes to	To continue, subject to	Lead Officer- MoCM,	

include an early warning system to cover issues of contamination, purity and acute risks?	review	DAAT	
Monitor the supply of Needle Exchange packs, in terms of ensuring that they supply good quality products in an efficient way	Maintain and review the contract with Daniels Healthcare	JCM/MoCM	
Geographical coverage of community pharmacies to improve access to needle Exchange packs and ensure pharmacies promote Harm reduction	Maintain and review the contract with pharmacists	SCMG	
Geographical coverage of community pharmacies to provide supervised consumption/administration to prevent overdose/medication entering the market	Maintain and review the contract with pharmacists	SCMG	
Monitor services commissioned to provide outreach services targeting high risk, in terms of effectiveness	<ul style="list-style-type: none"> <li>- Performance manage the SLA with ACHIS, who provide drug advice and support to the Black Communities in Sandwell.</li> <li>- Performance manage the SLA with SY&amp;CC, who provide drug advice and support to the South Asian Communities in</li> </ul>	JCM- Contract review in accordance with SLAs	

	<p>Sandwell.</p> <ul style="list-style-type: none"><li>- Performance manage the SLA with the Gateway project, who provide drug advice and support to the PPOs in Sandwell</li><li>- Performance manage the SLA with Addaction, who provide drug advice and support , on an outreach basis, to all communities in Sandwell</li></ul>		
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## Partner Agency Training Strategy

Objective	Action required	By Whom/By When	Cost/Budget
<p>That the partnership have a generic training programme for staff employed in partners agencies to cover:</p> <ul style="list-style-type: none"> <li>• overdose prevention and management</li> <li>• disposal of paraphernalia,</li> <li>• sexual health,</li> <li>• safe storage and use of medication?</li> <li>• Reduction in BBVs</li> </ul>	<p>The partnership to develop a specific training programme for critical frontline agencies e.g. Police, Ambulance, A&amp;E and Primary Care staff</p>	<p>Partnership to identify leads to work with the DAAT</p>	<p>Partnership</p>

## Workforce Strategy

Objective	Action required	By Whom/By When	Cost/Budget
<p>Ensure staff involved in adult drug treatment are trained to deliver Harm Reduction advice:</p> <ul style="list-style-type: none"> <li>• Advice on BBV (Hep B &amp; C and HIV)</li> <li>• Advice on sharing needles, syringes, filters, spoons and water</li> <li>• Advice on safer injecting techniques</li> <li>• Advice on the increased risks of overdose due to injecting</li> <li>• Advice on the increased risks of overdose due to mixing with alcohol and benzos</li> <li>• Advice on overdose links when tolerance is low eg after prison, detox etc</li> <li>• Advice on health issues linked to drug use</li> <li>• Advice on alcohol &amp; drug use</li> <li>• Advice on safer sex and contraceptives</li> <li>• Health information linked to injected sites</li> </ul>	<p>Undertake training needs assessment of treatment staff and then training strategy</p>	<p>Lead by providers and monitored by Workforce Strategy Manager/JCM</p>	<p>Contained with Contract price</p>
<p>The workforce/training strategy to include a cross-agency training programme</p>	<p>Workforce training needs assessment currently being undertaken for adult drug treatment staff- Workforce Development Manager recruited to, to commence employment</p>	<p>Adult drug treatment Workforce Strategy to be developed</p>	<p>Workforce Development Manager, providers, DAAT Dec 06</p>

	Sept 06		
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**Data Collection, Analysis and Dissemination.**

Objective	Action required	By Whom/By When	Cost/Budget
Partnership group/meeting in place to take the lead role in receiving the monitoring reports and how frequently are they received?	DAAT/NTA monitors some performance data on quarterly basis to lead The NTA require us to collect the following data on a quarterly basis: <ul style="list-style-type: none"> <li>• Number of individuals offered Hep B Virus (HBV) vaccinations</li> <li>• Number of individuals who take up HBV vaccinations</li> <li>• Percentage of current or ever injecting drug users tested for HCV</li> <li>• Number of individuals receiving a general healthcare assessment</li> <li>• Number attending specialist needle exchange</li> <li>• Number in contact with pharmacy exchange schemes</li> <li>• Total number of pharmacies in</li> </ul>	SCMG/JCG to develop their remit to include this but attendance by public health colleagues required  To continue to performance manage this data in conjunction with the providers.	HR Lead/Clinical Lead to ensure, by Sept 06 & ongoing

	partnership area <ul style="list-style-type: none"> <li>Percentage of pharmacies in scheme</li> </ul>		
Explicit data collecting processes, analysis, dissemination and reporting responsibilities	The above data goes to JCG/NTA/SSPE	For this to continue	Providers and EW to continue to provide the data to JCG/NTA/SSPE
Evidence of dynamic use of the monitoring information as indicators of local drug using population trends and changes	This feeds in to the Needs Analysis processes @ DAAT	For this to continue	A review of Needs Assessment information/data to take place in October- lead by EW all partners to attend