UKHRA is a campaigning coalition of drug users, health and social care workers, criminal justice workers and educationalists that aims to put public health and human rights at the centre of drug treatment and service provision for drug users.

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A public health aim for the national drug strategies of the United Kingdom:
a proposal for minimising harm to the health of individuals and communities arising from drug use

Harm reduction and the national drug strategies of the United Kingdom

The prevention of individual and public health problems does not feature prominently in the national drug strategies of the UK.

UKHRA believes the drug strategies in all parts of the UK should include the prevention of harm to the health of individuals and the public arising from drug use.

This document sets out a framework and targets for individual and public health for consideration by the UK governments, health and local authorities, prison services and drug service providers.

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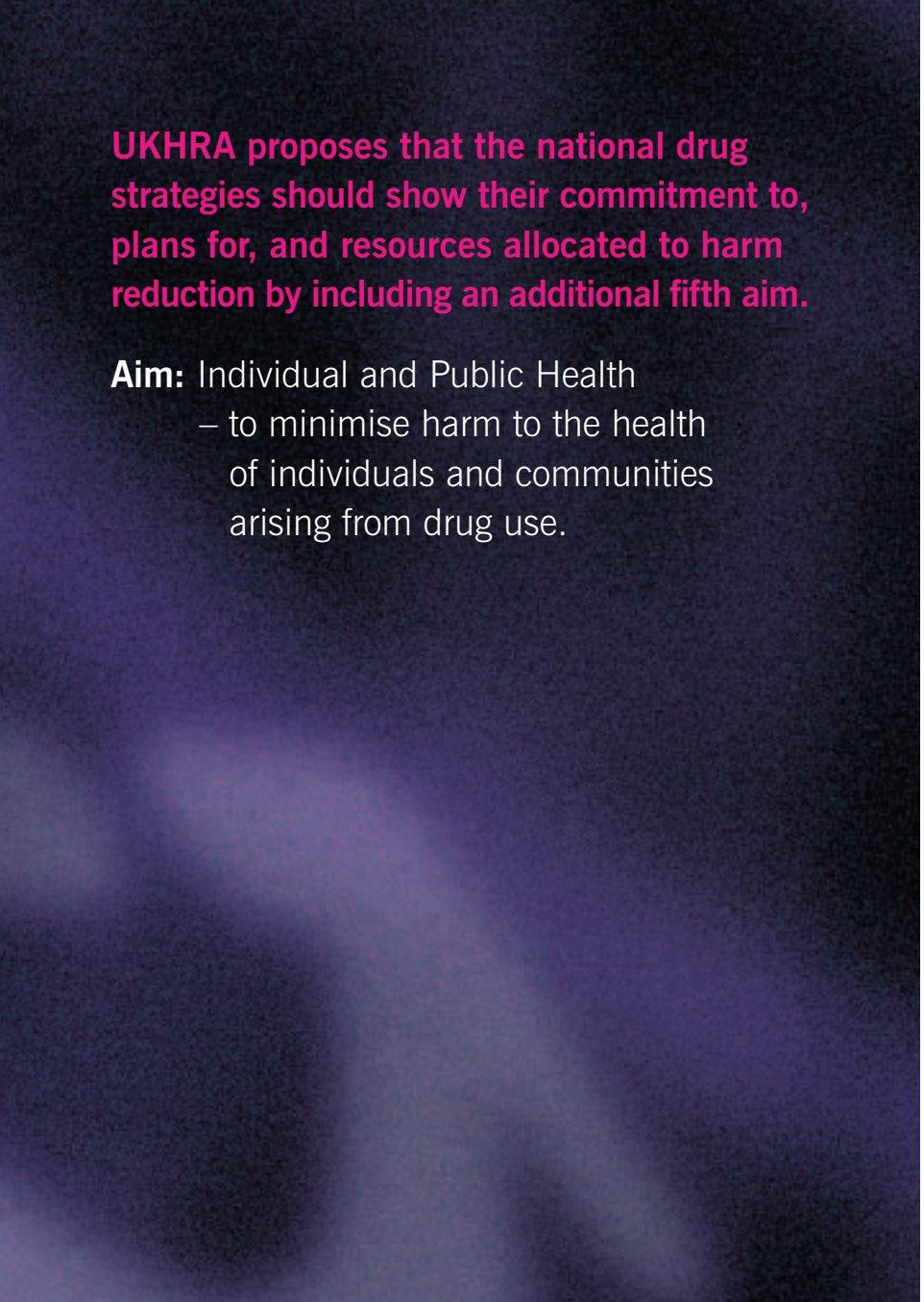
UK Harm Reduction Alliance
www.ukhra.org



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Aim: Individual and Public Health – to minimise harm to the health of individuals and communities arising from drug use.

Background

The UK and national drug strategies are structured around four similar key aims, focused on:

- young people;
- communities;
- treatment; and
- availability.

Although the prevention of individual and public harm to health is to some extent present in the national strategies (more so in Wales and Scotland than in England), there is no key aim which brings together public health and harm reduction.

Proposal

UKHRA proposes that the national drug strategies should show their commitment to, plans for and resources allocated to harm reduction by including an additional fifth aim:

> **Aim: Individual and Public Health – to minimise harm to the health of individuals and communities arising from drug use.**

Key objectives

- To reduce the number of deaths resulting from drug overdose.
- To minimise the risk of hepatitis and HIV infection in injecting drug users by:
  - reducing the overall prevalence of hepatitis C in injecting drug users to 25% by 2010; and
  - maintaining the prevalence of HIV-infected drug injectors at 1% or less.

Harm reduction: the facts

Harm reduction works in practice to protect individuals and communities from harm. By heeding advice outlined in the 1988 report of Advisory Council on the Misuse of Drugs (ACMD) 1988 report, AIDS and Drug Misuse Part 1, Britain has helped to lead the world by protecting its communities from HIV infection transmitted through injecting drug use.

But success has led to complacency and harm reduction has slipped down commissioners' agenda. A potentially dangerous situation is now present where HIV transmission through injecting drug use could rapidly escalate, as has occurred in some other countries.

Hepatitis B also remains endemic among people who inject despite the availability of an effective vaccine. In addition, we are now aware of a major epidemic of hepatitis C (HCV) infection in the UK. Official estimates suggest that 400,000 of the UK population have been infected with HCV, 80% of whom are believed to have obtained this infection through injecting drug use.

Furthermore, as has been described in the ACMD's 2000 report, Reducing Drug Related Deaths, overdose, often involving the use of opiates in combination with alcohol and other drugs, is increasingly recognised as a widespread and important cause of premature death in drug users.

Harm reduction is also an appropriate strategy for reducing potential problems with the use of drugs by non-injecting routes – i.e. use of drugs by smoking, inhaling, or swallowing such as heroin, cocaine and crack-cocaine, 'dance drugs' (ecstasy and other amphetamine-type stimulants and LSD) and cannabis.

In the light of these circumstances, we recommend the following.

- All drug users must have access to advice on how to reduce the risks of potential harms from drug use.
- The underlying principle which guided the 1988 ACMD report be restated as: 'The threat to communities and individuals from the spread of blood-borne pathogens outweighs the threat of illicit drug use.'
- The message that interventions to reduce the social, psychological and medical harm in injecting drug users should be an integral part of all treatment and care programmes, including those aiming to achieve abstinence.
- Drug users must have access to good general medical services.

Baseline measures of harm and implementation of harm reduction vary across the UK. Therefore the targets specified here are the minimum expected.

In this document 'government' refers to the governments and assemblies of the UK, Scotland, Wales and Northern Ireland; 'national' refers to Scotland, Wales, Northern Ireland and England; 'health authority' refers to health authorities and health boards; 'area' to the area covered by the authority; 'commissioners' refers to those at a national and area level who are responsible for commissioning services.

Programme of action

- **Quick and easy access to specialist advice and treatment for all drug users**. Policy makers and health commissioners must take steps to ensure a progressive reduction in waiting lists for treatment for those with drug problems with the ultimate aim of quick access to treatment for all drug users who are assessed as needing it.

- **Good national and local area coverage by needle exchange services**. Policy makers and health commissioners must take steps to ensure accessible and adequate needle exchange and specialist harm reduction services for each area. These should address safer injecting, overdose and provide access to hepatitis B immunisation. A comprehensive quality standards approach for the delivery of needle exchange services should be developed. No injector should live more than five miles from a static or mobile needle exchange service. In addition each area should have:
  - one 24-hour needle exchange facility;
  - both community and specialist service-based needle exchanges; and
  - at least 12 pharmacy-based needle exchange services to provide geographical coverage.

- **Regular and targeted health education and promotion campaigns**. These should be aimed at reducing harms from all drugs by all routes. Focused campaigns should also cover overdose, avoiding injecting, reducing the sharing of injecting equipment and encouraging people to be tested for HIV and hepatitis and to present for treatment. Campaigns should be both national and local, and drug users should be involved in planning their content and delivery. The following factors should be highlighted:
  - shared injecting paraphernalia, such as filters, spoons, stirrers, and shared water from a cup and tourniquets, as well as needles and syringes, should be considered capable of transmitting blood-borne viruses;
  - of the 300,000 people in England and Wales who are officially estimated to be infected with hepatitis C, only about one in 20 know this and should be made aware of the steps they can take to protect themselves and others from harm;
  - morbidity, including the severity of other viral infections, could be reduced by a hepatitis B information and vaccination campaign;
  - many drug users are unaware of loss of tolerance to opiates and the consequent risk of accidental overdose death on release from prison or following detoxification.

- **Legislative barriers created by the 1971 Misuse of Drugs Act, as it relates to the distribution of spoons, sterile water, filters, etc., should be removed** so that prosecutions for the possession of paraphernalia can no longer occur, drug traces on paraphernalia cannot be used as evidence of drug possession, and existence of paraphernalia cannot not be used as evidence of drug taking on premises.

- **Drug users should be involved in service development**. Under the NHS Plan and other recent social policy pronouncements, the governments of the UK have stated their intent to work in partnership with communities to reduce health inequalities. As evidence of this DATs should be required to ensure that drug users are involved in local service development, health promotion planning and peer education.

- **Provision of information on sexual transmission of HIV and HBV**. Every DAT should ensure by 2002 that all services involved in the treatment and care of drug users, including drug treatment and advice agencies, needle exchanges, general practices and prisons, provide information on sexual transmission of HIV and HBV and provide condoms, and that sexual health advice is a routine part of the counselling of drug users.

- **Expansion of outreach services, peer education and a review of prescribing practices to engage the hardest to reach groups**. Drug injectors and those at risk of injecting need to be brought into contact with services and, where appropriate, offered treatment. Those not in treatment are more likely to die and to engage in high-risk behaviour that is harmful to individual and public health. Outreach and peer education services in the UK are currently inadequate and need to be expanded rapidly. Treatment services are seen by many drug users as inappropriate or 'methadone only' services that do not cater for their needs. Guidance on prescribing practices with regard to injectable drugs and various substitute medications, including diamorphine (heroin), dexamphetamine, benzodiazepines and dihydrocodeine should be reviewed with a view to bringing more drug users into treatment.

- **Continuation of substitute prescriptions on entry to and release from prison** to reduce the risk of blood borne virus (BBV) infection in prison and the risk of accidental overdose on release. Strong warnings about reduced drug tolerance should be given to prisoners about to be released.

- **The right of all prisoners to have access to investigation, treatment and care for hepatitis B and C and HIV infections, and arrangements to reduce BBV transmission must be enshrined within national prison policies**. Adherence to this should be ensured through the arrangements for the independent inspection of prisons.

- **Every DAT area should have a local strategy for the prevention and treatment of hepatitis C** by 2002.

- **Every health authority and DAT must submit plans for a local publicity campaign on hepatitis C** before March 2002 and begin their campaigns before June 2002.

- **Every health authority and DAT must submit plans describing their local arrangements for reducing drug-related deaths** before June 2002 and have in place programmes to reduce drug-related deaths by 2002/3.

- **Governments should introduce national action plans to reduce drug-related deaths** which should include as a minimum:
  - to launch in 2002 an individual and public health component in national drug strategies;
  - to launch in 2002 a health promotion campaign targeted at young injectors;
  - to launch in 2002 a health promotion campaign to inform drug users of the loss of drug tolerance and risk of overdose death following detoxification or release from prison;
  - to produce in 2002 guidelines on peer education to prevent drug-related deaths;
  - to define the structure and extent of outreach services required in the UK, and the relationship between outreach and peer education;
  - to produce guidelines to encourage engagement and retention of hard to reach drug users;
  - to launch national hepatitis C strategies in 2002;
  - to launch a public information and targeted testing campaign on hepatitis C in 2002.

- **Every health authority must submit details of arrangements for confidential testing facilities for HCV and other BBVs** by March 2002.

- **To establish a comprehensive national hepatitis B immunisation programme in childhood** as occurs in most other European countries.

- **All DATs to have in place hepatitis B immunisation programmes for injecting drug users** by 2002. Although targeted hepatitis B vaccination for injecting drug users is a step forward, the immunisation takes successfully only in about half of all cases or less due to compounding adverse factors of increasing age and tobacco smoking. It is no substitute for childhood immunisation (above).

- **Local public health departments throughout the UK will be requested to report to government on the adequacy of local prison policies to reduce BBV transmission**. For each prison there should be a report on the viability of methadone maintenance treatment, condom availability and other actions to reduce the spread of BBV infections. Each prison should also be required to report on the percentage of HCV-positive prisoners attending specialist services for the assessment and treatment of hepatitis C.

Assessment

- To reduce the number of overdose deaths resulting from illicit drug use. **(KEY OBJECTIVE)**

- To increase the proportion of drug injectors in contact with services who have completed a course of hepatitis B vaccination and have seroconverted. **(KEY OBJECTIVE)**

- To reduce the overall prevalence of hepatitis C in current injecting drug users to 25% and of hepatitis B to 10% by 2010. [To be monitored by community and treatment surveys of injecting drug users] **(KEY OBJECTIVE)**

- To ensure that the prevalence of HIV-infected drug injectors remains below 1%. **(KEY OBJECTIVE)**

- To reduce the number of injectors in treatment and in the community who report sharing injecting equipment.

- To increase numbers of needles and syringes distributed by 50% by 2003 (to be monitored by the National Treatment Agency in England and the relevant government departments in Scotland, Wales and Northern Ireland).

These assessment criteria will be open to public scrutiny and will be published annually.

Research and information

To support this public health strategy, government should make use of the best available sources of information, establish reliable baselines and plan as a priority to commission additional research as follows.

- Research to obtain the prevalence of hepatitis C within the general population of the UK. This should be repeated every two years.
- Research to annually monitor the incidence of hepatitis C among current injecting drug users (including those who are not attending drug services).
- Further research into the transmission of BBVs within a prison setting, including a pilot prison needle exchange.
- Paediatric surveillance of hepatitis C and research into more effective treatment of children infected by the hepatitis C virus.
- Research to identify strategies for service delivery that most effectively improve hepatitis B immunisation coverage for injecting drug users.
- Research to identify strategies for service delivery that most effectively improve the treatment of HCV among current drug users and injecting drug users.
- Research into strategies that most effectively prevent overdose deaths among drug users who are both in and out of treatment.

The essential components of a good harm reduction strategy are:

- All drug users, whether or not attending services, must have good access to ongoing harm reduction advice and appropriate evidence-based treatment.
- Good access to robust needle exchange for all injecting drug users, with comprehensive national and local coverage.
- National strategies to counter the hepatitis C epidemic.
- A comprehensive strategy to address the prevention and treatment of blood-borne virus infection in UK prisons.
- Training and supervision of all generic and specialist staff who work with drug users in effective methods to:
  - reduce the risk of transmitting or receiving BBV infection through sharing injecting equipment or unsafe sexual practices;
  - discourage the use of drugs by injection;
  - encourage change from injecting to safer routes of administration; and
  - reduce the risk of death from overdose.

The most important things that need to be done this year are:

- Add an individual and public health component to national drug strategies.
- Substantially increase the proportion of the national ‘drugs budgets’ spent on harm reduction.
- Devise national strategies for hepatitis C and ensure adequate funding for these.
- Set up national implementation groups to ensure adequate local monitoring of overdose deaths and the establishment of evidence-based initiatives to prevent them.
- Create a comprehensive strategy to address BBV infections in UK prisons.
- Substantially increase the funding of needle exchange services.

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