Consultation Response: 2010 Drug Strategy

KEY POINTS:

- **The adoption of harm reduction approaches by the Conservative government in the 1980s has been an overwhelming public health success.**
- **Any response which emphasises drug-free outcomes for individuals must also acknowledge and reduce the harms faced by those who are unable or unwilling to stop using drugs.**
- **There is strong national and international evidence of effectiveness and cost-effectiveness for interventions such as needle and syringe programmes, opioid substitution therapy and overdose prevention.**
- **Harm reduction therefore warrants inclusion as an explicit priority in the new Drug Strategy.**

ABOUT UKHRA

The UK Harm Reduction Alliance (UKHRA) is coalition of health and social care workers, criminal justice workers, academics, advocates and people who use drugs. It was founded in 2000 with the aim of ensuring that public health and human rights remain at the centre of drug treatment and services. Our work involves campaigns, publications, e-lists for drug workers and people who use drugs, and input into national policy consultations and discussions in order to support harm reduction and promote the evidence base.

ABOUT NNEF

The National Needle Exchange Forum (NNEF) is a forum for workers involved in harm reduction services across England. It was founded in the 1980s to actively promote and support the provision of high quality, comprehensive needle and syringe programmes (NSPs) as a key part of the UK Drug Strategy. The NNEF works with policy makers and a range of partners to identify and promote good practice through regular meetings and research.

In keeping with the expertise of these organisations, this response will focus only on the questions in the consultation that are relevant to harm reduction services and how they are delivered in the UK.

GENERAL REMARKS

UKHRA and NNEF both welcome the government plans to publish a new drug strategy. Following the previous UK consultation ("Drugs: Our Community, Your Say" in 2007), there was a strong sense in the harm reduction field that the resulting policy – "Drugs: Protecting Families and Communities" – failed to build upon major lessons from the past and was insufficient (despite the welcome emphasis on treatment quality, families and communities). Harm reduction in particular was massively under-represented in the final document despite the overwhelming public health success of this approach in the UK and the strength of national and international evidence. This consultation is an opportunity for the new government to adopt a more considered approach and achieve its aims of taking a "broad approach to preventing and reducing substance misuse".

Given its aims, the overall content and underlying themes of this consultation document are, however, disappointing. The reduction of drug-related harm is only referred to twice in the entire text and "harm

reduction" is not mentioned once. There is no information about the process by which themes, priorities and questions were selected, and the language used appears to disregard harm reduction and the crucial role that it has played (and must continue to play) in the UK. Instead, terms such as 'enforcement', 'prevention', 'rebalancing' and 'drug free outcomes' are repeatedly emphasised. These are important elements of a comprehensive strategy, but ones that will be compromised if attention is not also paid to the immediate harms faced by those who continue to use drugs, their families and communities. The consultation under-emphasises the need for proven and effective harm reduction interventions to protect people who will not or cannot become drug free in the immediate future. UKHRA and NNEF hope that this joint response will help to re-state the case for harm reduction and ensure its inclusion in the strategy as a platform for improving treatment outcomes.

VISION FOR THE NEW DRUG STRATEGY

The consultation opens by stating that "The Home Office will lead the new Drug Strategy to prevent drug taking, disrupt drug supply, strengthen enforcement and promote drug treatment". UKHRA and NNEF strongly believe that the Drug Strategy should be the mandate of the Department of Health or, at least, an equal partnership between this body and the Home Office. Drug use is primarily a public health issue and framing it this way allows for more pragmatic, rights-based, evidence-informed and cost-effective responses.

A1: Are there other key aspects of reducing drug use that you feel should be addressed?

Yes. Harm reduction should be one of the primary, explicit aims and priorities for the Drug Strategy in recognition of the existing clinical, social and scientific evidence for its effectiveness, cost-effectiveness and impact[1]. Harm reduction can be defined as "Policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption"[2]. The evidence for this approach has been building since the 1980s and has developed from small-scale pilots and trials, to larger national studies and evaluations, to international research, to reviews of this research, and most recently to reviews of these reviews. In 2009, after several such comprehensive assessments, the UN formally approved a "comprehensive package" of nine interventions for the prevention, treatment and care of HIV among people who inject drugs[3]. This includes needle and syringe programmes (NSPs), opioid substitution therapy (OST), condom distribution, HIV testing and treatment, and vaccination, testing and treatment for hepatitis and tuberculosis. According to the UN guide and the available evidence, these are the interventions with the best evidence in community, prison and outreach settings[4].

[1] See, for example, http://www.antidrug.health.am/eng/lib_eng/HR_Hunt.pdf
[2] http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf
[3] http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf
[4] See, for example, http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html

A3: What do you think has worked well in previous approaches to tackling drug misuse?

Since its incorporation into UK policy by the Conservative Government in the mid-1980s, harm reduction has been an unequivocal public health success[5]. Compared to many other countries, HIV prevalence among people who inject drugs in the UK has remained low. In 2008, only around one in 73 people who inject drugs in the UK were living with HIV[6]. In comparable countries which were slower to adopt harm reduction – such as Italy, Russia, Spain and the USA – the figure is between six and sixteen times higher than in the UK[7]. Since its adoption, the UK's harm reduction responses have been widely regarded as best practice around the world. Interventions such as NSP and OST have become well established in the UK and the evidence of their effectiveness and cost-effectiveness has grown accordingly (see below). It is crucial that this progress is not undone after more than two decades of success. Experience from cities around the world has shown that HIV prevalence among people who inject drugs can reach 40% in just two years in the absence of effective responses[8]. This would have catastrophic financial, political, health and social consequences for the UK.

A4: What do you think has not worked so well in previous approaches to tackling drug misuse?

- The continued focus on enforcement and criminal justice has not reduced drug use despite the significant cost of this approach.
- The Misuse of Drugs Act (1971) predates the HIV epidemic and is in urgent need of review. This will require strength of leadership from this government that has been lacking in recent years (as evidenced by the Home Office's recent suppression of an impact analysis on the Act[9]).
- Previous governments have often ignored scientific evidence and independent, expert advice from the ACMD on a range of drug-related issues. One example was the dismissal of evidence on the effectiveness of supervised injecting facilities in 2006[10]. The future strategy needs to be better informed by evidence and should also encourage research and debate.

STRENGTHENING ENFORCEMENT, CRIMINAL JUSTICE AND LEGAL FRAMEWORK

C3: Do you have a view on what factors the Government should take into consideration when deciding to invoke a temporary ban on a new substance?

Yes. Any decisions to ban new substances or change existing classifications must be based on existing evidence and recommendations from the Advisory Council on the Misuse of Drugs (ACMD). The evidence considered should include assessments of the population-level harm of a substance (rather than individual cases or disproportionate media attention) and the impacts (positive and negative) that

[5] Stimson GV. AIDS and injecting drug use in the United Kingdom, 1987-1993: the policy response and the prevention of the epidemic. *Social Science and Medicine,* 1995; 41(5): 699-716. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/7502102)

[6] http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1254510653792

[7] Mathers B et al. The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet*, 2008; 372(9651): 1733-1745. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/18817968)

[8] Stimson G & Choopanya K. Global perspectives on drug injecting. In: Stimson G et al (eds). *Drug Injecting and HIV Infection*. London: UCL Press, 1998.

[9] http://www.bbc.co.uk/blogs/opensecrets/2010/06/home_office_error_reveals_how_foi_request_handled.html?page=9

[10] http://www.jrf.org.uk/sites/files/jrf/9781859354711.pdf

a ban is likely to have. For example, banning a new substance could turn existing users toward more harmful alternatives. Objective evidence and assessment must take priority over concerns about media coverage.

REBALANCE TREATMENT TO SUPPORT DRUG FREE OUTCOMES

"Whilst reducing harm is an important component of treatment, promoting and supporting recovery and a drug free lifestyle is the ultimate aim".

UKHRA and NNEF agree that supporting individuals to overcome personal problems with drug use must always be a priority, and the new strategy is an opportunity to re-emphasise this and further improve the response. According to Lenton and Single (1998), an effective harm reduction response "maximises the intervention options", with "abstinence orientated strategies" offered alongside interventions to reduce harm "for those who continue to use drugs"[11]. Individual needs must not be overlooked in favour of a "one size fits all" approach. In the same way that NSPs and OST are not appropriate responses for all individuals, neither are abstinence-based treatments or detoxification. The choice about how best to deal with drug use must be reserved for the individuals themselves (with impartial, quality support and guidance from the professionals working with them). It should not be made at a national policy level. In order to be effective in promoting recovery, the Drug Strategy must aim to provide a comprehensive 'menu' of interventions – including cost-effective harm reduction interventions that can save lives.

D1: Thinking about the current treatment system, what works well and should be retained?

As mentioned above, the adoption of harm reduction by the Conservative Government in the 1980s has proved to be a cost-effective and pragmatic response to emerging HIV epidemics among people who inject drugs. The positive health and financial impacts of this approach are still being felt today, and the UK has been acknowledged around the world in terms of good practice. Below, we elaborate on the evidence for some of the key harm reduction interventions that should be retained as part of a broad response to drugs. The list is by no means exhaustive but illustrates the value of harm reduction.

Needle and Syringe Programmes

- In 2009, the National Institute for Health and Clinical Excellence (NICE) published guidelines on optimal NSP provision[12]. Based on an extensive review of evidence, NICE concluded that NSPs can reduce HIV transmission, reduce injecting-related HIV risk behaviours, enable clients to access treatment and are cost-effective in terms of crime reduction and health protection. The guidelines recommended that NSPs provide a range of injecting equipment (such as sterile water, mixing containers and filters), interventions to encourage people to switch from injecting to safer methods of drug use, and tests and vaccinations for associated infections such as hepatitis B and C. NICE also found that effectiveness was optimized when NSPs are offered alongside OST.

[11] Lenton S & Single E. The definition of harm reduction. *Drug and Alcohol Review,* 1998; 17(2): 213-220.
[12] http://www.nice.org.uk/nicemedia/live/12130/43301/43301.pdf

- A recent scientific review in The Lancet concluded that "Strong evidence shows that [NSPs] reduce risk from injections" and reported links between NSPs and reductions in HIV incidence[13].
- In 2003, an ecological study of 99 cities around the world (including five from the UK) found that HIV prevalence among people who inject drugs had increased by an average of 8.1% per year in the 63 cities without NSPs. By contrast, the figure had fallen by an average 18.6% per year in the 36 cities with NSPs[14].
- A comprehensive review by the World Health Organization (WHO) in 2004 identified 48 scientific studies on NSPs from around the world[15]. There was strong evidence that NSPs directly impacted on HIV transmission and risk behaviours, reduced injecting frequency, increased referrals into treatment, and were cost-effective. In addition, there was "no convincing evidence" of negative consequences of NSPs. The accompanying policy brief concluded that NSPs are "essential components of HIV/AIDS prevention programmes"[16].
- A separate review by WHO also found that NSPs "are feasible in a wide range of prison settings" and reduce both syringe sharing and HIV transmission. Importantly, there was no evidence for prison NSPs having negative consequences[17]. Injecting remains a reality in UK prisons, yet NSPs are still not provided for prisoners.

Opioid Substitution Therapy

Methadone has been used to treat heroin dependence in the UK for decades and its use in community and prison settings is endorsed by the Department of Health[18], NICE[19] and WHO[20] among others (the latter having classed both methadone and buprenorphine as 'essential medicines'[21]). Numerous reviews have systematically examined the evidence concerning OST – these include, but are not limited to: two major academic textbooks[22,23]; two reports from authoritative bodies in the UK[24,25]; and three reviews in peer-reviewed scientific journals[26,27,28]. This evidence shows that methadone is beneficial and effective

[13] Degenhardt L et al. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *The Lancet,* 2010; 376: 285–301. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/20650522)

[14] MacDonald M et al. Effectiveness of needle and syringe programmes for preventing HIV transmission. *International Journal of Drug Policy*,2003; 14: 353–357. (Abstract: http://www.ijdp.org/article/S0955-3959(03)00133-6/abstract)

[15] http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf

[16] http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.03.pdf

[17] http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf

[18] http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

[19] http://www.nice.org.uk/nicemedia/pdf/TA114Niceguidance.pdf

[20] http://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf

[21] http://www.who.int/medicines/publications/essentialmedicines/Updated_sixteenth_adult_list_en.pdf

[22] Ball JC & Ross A. *The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcomes*. New York: Springer-Verlag, 1991.

[23] Ward J et al. *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Amsterdam: Harwood, 1998.

[24] http://www.nap.edu/openbook.php?record_id=1551&page=R1

[25] Advisory Council on the Misuse of Drugs. *AIDS and Drug Misuse Update Report*. London: HMSO, 1993.

[26] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541312/pdf/bmj00461-0035.pdf

[27] Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. *Addiction*, 1998; 93(4): 515-532. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/9684390)

in reducing heroin use, crime, risk behaviours and HIV transmission among other things. In addition, a Cochrane review of studies published up until 2008 concluded that "methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use"[29]. The cost-effectiveness of methadone and buprenorphine treatment has been reviewed by NICE, who reported incremental cost-effectiveness ratios for methadone and buprenorphine of £13,700 and £26,400, respectively, per additional quality adjusted life year (QALY) gained[30].

A review of international evidence in 2010, published in The Lancet, found that OST reduces drug use and injecting, increases safe injecting practices, improves health and social functioning, and reduces HIV risks. The outcomes are further enhanced when OST is delivered alongside psychosocial interventions[31]. As part of their 'Evidence for Action' series[32], WHO conducted a comprehensive review of the evidence for OST and stated that "Policy-makers need to be clear that the development of drug substitution treatment is a critical component of the HIV prevention strategy"[33]. In a separate review, WHO also concluded that OST is feasible in prison settings and is effective in reducing injecting drug use and syringe sharing which, in turn, will reduce the risk of blood-borne virus transmission. Other benefits of prison OST include lower re-incarceration rates for OST clients and improved prison safety[34]. In England, a national objective to increase OST in prisons is included in the Integrated Drug Treatment System.

Although OST will not be the appropriate approach for every client seeking help with their drug use, it is an important part of the treatment journey for thousands of people who might ultimately seek drug-free recovery. As such, it must remain a core element of the UK Drug Strategy on the basis of maintenance or reduction depending on the wishes and needs of the patient him/herself (identified through comprehensive assessment based on the guidance which already exists within the UK[35]). Individual choices regarding OST must not be made by national policy through arbitrary limits on treatment length or dose – nor should OST be the only option available to any client.

Heroin Prescribing

In recent years, a number of small but important trials have taken place in the UK, such as the Randomised Injecting Opioid Treatment Trial (RIOTT) that compares the effectiveness of injectable medicinal heroin and injectable methadone among 127 long-term heroin users for whom other OST

[28] Amato L et al. An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment*, 2005; 28(4): 321-329. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/15925266)

[29] Mattick RP et al. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews*, 2009. (Abstract: http://www2.cochrane.org/reviews/en/ab002209.html)

[30] http://www.nice.org.uk/nicemedia/pdf/TA114Niceguidance.pdf

[31] Degenhardt L et al. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *The Lancet,* 2010; 376: 285–301. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/20650522)

[32] http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html

[33] http://www.who.int/hiv/pub/idu/drugdependence_final.pdf

[34] http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf

[35] http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

interventions have failed[36]. Based on the positive findings of this study, UKHRA and NNEF would like to see the new Drug Strategy support this intervention. A Cochrane review in 2005 concluded that heroin-assisted treatment – as an intervention for long-term drug users who have repeatedly failed with other OST approaches – can increase retention in treatment and reduce drug use and imprisonment[37].

Overdose Prevention

Drug overdoses remain a major, but overlooked, harm for people who use drugs across the UK. As release from prison[38] and relapse after drug-free treatment[39] are known risks for overdoses, it is essential that the Drug Strategy seeks to prevent this harm if it chooses to emphasise criminal justice approaches and abstinence-based interventions. People who use drugs, their families and friends should be educated in overdose prevention and how to respond[40]. For opiate users, a 'cure' exists in the form of naloxone – the widespread provision of which is practiced in many countries and backed by numerous studies[41]. With results due from the NTA pilots of naloxone distribution, UKHRA and NNEF strongly recommend the inclusion of this life-saving and inexpensive intervention in the new Drug Strategy. In 2008, there were reported to be 1,617 deaths related to drug misuse in England[42] – many of which could have been prevented. Reductions in drug mortality should be a major indicator for success for UK drug policy: people cannot recover from problem drug use if they are dead.

User Involvement

The UK has made great strides toward empowering and engaging current and former drug users in policy, planning and implementation. The opinions and expertise of these groups are essential to the success of interventions to reduce harm and tackle drug use. As such, user involvement should be explicitly supported and valued in the new Drug Strategy, not least because it can dramatically increase programme effectiveness[43].

D7: We want to ensure that we continue to build the skills of the drug treatment and rehabilitation sector to ensure that they are able to meet the needs of those seeking treatment. What more can we do to support this?

The government is in an enviable position – it already has a highly skilled and committed workforce in the drug field. The roll-out of 'Drug and Alcohol National Occupational Standards' (DANOS) has helped ensure that all workers, regardless of their background, work with common core competencies and

[36] Strang J et al. Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial. *The Lancet*, 2010; 375(9729): 1885-1895. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/20511018)

[37] Ferri M et al. Heroin maintenance for chronic heroin dependents. *Cochrane Database of Systematic Reviews*, 2005. (Abstract: http://www2.cochrane.org/reviews/en/ab003410.html)

[38] Farrell M & Marsden J. Acute risk of drug-related death among newly released prisoners in England and Wales. *Addiction*, 2008; 103(2): 251–255. (Abstract: http://www.ncbi.nlm.nih.gov/pubmed/18199304)

[39] http://www.bmj.com/content/326/7396/959.full.pdf

[40] http://www.harmreductionjournal.com/content/pdf/1477-7517-6-26.pdf

[41] See, for example, http://www.ihra.net/contents/717

[42] http://www.nta.nhs.uk/uploads/number_of_deaths_related_to_drug_misuse_by_gender_in_england_1993_2008.pdf

[43] http://www.emcdda.europa.eu/attachements.cfm/att_101264_EN_emcdda-harm%20red-mon-ch12-web.pdf

principles. For the past ten years, these professionals have worked with their clients to deliver a comprehensive treatment package. The government does not need to "build" a skilled workforce, it just needs to invest in further developing the existing workforce. As part of a comprehensive 'menu' of interventions, workers in all areas of drug treatment and harm reduction must be better supported to attend training, learn skills, engage in policy discussions, work in collaboration with one another and learn from (and share) good practice and new research (i.e. through networking events and conferences). By fostering partnerships, the government can bring the best out of its existing workforce.

D9: How do you believe that commissioners should be held to account for ensuring that outcomes of community-based treatments, for the promotion of reintegration and recovery, as well as reduced health harms, are delivered?

A survey of NSPs by the National Treatment Agency in 2005[44] reported a "mixed economy" in terms of the equipment and services provided. Nearly half of the responding services did not provide condoms. In addition, more than half did not provide acidifiers, filters, mixing cookers or sterile water – which are essential items for injecting and are approved by UK paraphernalia law[45]. Further, a survey by the National Needle Exchange Forum in 2008 found that only 15% of respondents were providing aluminium foil to clients to promote safer non-injecting methods of drug use[46] (an intervention backed by evidence[47]). The new Drug Strategy should include measures to prevent a 'postcode lottery' of services. For example, it could establish an evidence-informed core package of interventions that each local authority must provide (whilst taking care not to hinder local innovations and developments). This will help to improve service quality and ensure that harm reduction remains a key component of the government's "broad approach to preventing and reducing substance misuse".

All references retrieved 28/09/2010.

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[44] http://www.nta.nhs.uk/uploads/nta_nes1_needle_exchange_survey.pdf
[45] http://www.legislation.gov.uk/uksi/2003/1653/regulation/2/made
[46] http://nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf
[47] http://www.harmreductionjournal.com/content/pdf/1477-7517-5-24.pdf