NHS

National Treatment Agency for Substance Misuse

# Good practice in harm reduction

HARM REDUCTION WORKS

National Treatment Agency for Substance Misuse

October 2008

## The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

## Reader information

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|---|---|
| **Document purpose** | To disseminate good practice identified from the joint NTA and Healthcare Commission service review 2006/07 |
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| **Description** | A good practice guide to harm reduction, based on practice in areas that performed well in the 2006/07 Healthcare Commission and NTA Improvement Reviews |
| **Cross reference** | Improving Services for Substance Misuse (Healthcare Commission & NTA, 2008)<br>Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006)<br>Good Practice in Care Planning (NTA, 2007)<br>Good Practice in Commissioning (NTA, forthcoming) |
| **Gateway number** | 10513 |
| **Contact details** | 8th floor, Hercules House, Hercules Road, London SE1 7DU.<br>Tel: 020 7261 8801. Fax: 020 7261 8883 Email: nta.enquiries@nta-nhs.org.uk<br>Website: www.nta.nhs.uk |

# Contents

# 1 Executive summary

## 1.1 Background

This report follows publication of the results of the 2006/07 service reviews on harm reduction carried out by the National Treatment Agency for Substance Misuse (NTA) and the Healthcare Commission, two government bodies operating across England.

The aim of this report is to highlight good practice in harm reduction, based on interviews with local drug partnerships that performed well in the reviews to identify good practice in interventions to reduce drug-related harm related to blood-borne virus and overdose.

### 1.1.1 Service reviews

Service reviews are designed to assess local drug services and systems against national standards. During 2006/07, the second of three service reviews assessed the performance of 149 local drug partnerships on two key areas – commissioning of treatment and harm reduction services. This report relates to the findings of the latter. A similar report relating to commissioning will be published soon.

### 1.1.2 Measuring harm reduction

Ten criteria were developed for service reviews. Six focused on commissioning and four on harm reduction. Each criterion was scored on the basis of several questions and each local drug partnership received a score based on these totals (up to a maximum of 40) and an overall score (from 1–4).

### 1.1.3 Interviewing high-scoring partnerships

Partnerships that scored highly on harm reduction were interviewed to find out about their strategies and practices, to determine what lessons could be learnt. Several types of drug partnerships (such as urban and rural) and a variety of staff were interviewed, in order to identify a number of common themes that the partnerships believed contributed towards good practice.

## 1.2 Key factors influencing good practice in harm reduction

### 1.2.1 Harm reduction embedded in the system

- Most local drug partnerships had harm reduction strategies that were developed and implemented by local expert groups
- Partnerships reported that the availability of good-quality local data was essential to assess the needs of their populations
- Many partnerships recognised that access to good drug treatment was essential to harm reduction, which in turn forms an integral part of a client's care plan
- Harm reduction was specified as a standard in all contracts with drug treatment providers, to ensure harm reduction was delivered by these services
- Almost all of the partnerships interviewed used a variety of funding sources for harm reduction services
- The involvement of service users in the planning, delivery and development of harm reduction services was seen as important. Many partnerships used forums and other feedback mechanisms as a check on the quality of the services provided
- The interviewed partnerships described a range of interventions that were delivered across local drug treatment systems, including assessment, healthcare, needle exchange, blood-borne virus testing and treatment pathways, and services for steroid users.

### 1.2.2 Prompt and flexible access

Making access to harm reduction services as easy as possible for clients was achieved in the interviewed partnerships through:

- Good coverage of specialist harm reduction services and pharmacies across the partnership area
- Specialist harm reduction services and pharmacies being open outside office hours
- Outreach services, such as vans and satellite clinics, to reach clients outside the treatment system
- Delivering a range of interventions in pharmacies, including:
  - Distributing injecting equipment and other injecting paraphernalia
  - Pharmacy staff referring clients to appropriate specialist harm reduction services
  - Drugs workers working in pharmacies to provide brief harm reduction interventions.
- All partnerships placed a high priority on testing for blood-borne viruses, with most aiming to test as many clients as possible and address blood-borne virus issues at initial assessment
- Most partnerships reported offering hepatitis A and B vaccinations to clients attending drug services. Vaccinations were usually carried out by nurses in specialist harm reduction services or other drug treatment services
- Hepatitis C treatment pathways were established in most of the areas interviewed, although all thought these could be improved. Methods found to help client engagement in hepatitis treatment included:
  - Staff or volunteers accompanying clients to hospital appointments

- Some partnerships were bringing hepatitis treatment back into community services to improve access.

#### 1.2.3 Action to reduce deaths from overdose

- Most of the partnerships interviewed had a strategy for reducing drug-related overdose deaths, usually as part of the harm reduction strategy. Some partnerships had joined up with neighbouring partnerships to have a wider strategic focus
- All of the partnerships provided overdose training for service users and carers
- Some areas had established enquiry processes for drug-related deaths and other areas were in the process of developing these
- The enquiry processes for drug-related deaths were reported to be more effective if there were good links with the coroner's office
- Most partnerships had plans in place to minimise the overdose risk for those leaving prison in their areas
- Many areas had done proactive work on drug-related death prevention, mainly through locally targeted campaigns.

#### 1.2.4 Competent staff

- Harm reduction training was standard for all drug treatment staff
- The harm reduction competences of non-drug treatment staff working with drug users was also addressed through multi-agency training
- Most areas had training programmes for pharmacy staff in contact with drug users to improve their skills and knowledge.

#### 1.2.5 Other factors

- All the partnerships employed staff in co-ordination roles to co-ordinate harm reduction services
- To achieve high returns of injecting equipment (even as high as 95–100 per cent), many partnerships had run campaigns to achieve high returns of injecting equipment
- Where drug litter was an issue, partnerships had identified hotspots and taken appropriate action, often in conjunction with the local authority
- Harm reduction interventions were also delivered in non-drug treatment settings; by criminal justice workers in police custody suites and housing workers in hostels for example.

# 2 Background

## 2.1 The purpose of this report

This report has been produced using the results of the 2006/07 service review on harm reduction carried out by the National Treatment Agency for Substance Misuse (NTA) and the Healthcare Commission. Its purpose is to highlight good practice in harm reduction, based on the local drug partnerships that performed well in the review and to identify the key factors that led to these partnerships scoring highly.

## 2.2 Focusing on harm reduction

The term harm reduction, as used in this report, is based on the description of harm reduction in Reducing Drug-Related Harm: An Action Plan (DH & NTA, 2007):

> *Harm reduction combines work aimed directly at reducing the number of drug-related deaths and blood-borne virus infections, with wider goals of preventing drug misuse and of encouraging stabilisation in treatment and support for abstinence. Providing effective substitution treatments and effective support for abstinence are complementary aims of such a balanced response.*

This report is one of the outputs from Reducing Drug-Related Harm: An Action Plan, which sets out the broad streams of action to be taken in England to enhance harm reduction activities within drug treatment services. The aim of the plan is to limit the number of drug misusers dying from drug-related causes or contracting blood-borne virus infections.

Harm reduction was selected as a priority for the 2006/07 NTA and Healthcare Commission service review because of concerns about the increasing incidence of blood-borne viruses, which has been recorded in recent years by the Health Protection Agency (2007) in its annual Shooting Up reports.

The government target on drug-related deaths was a 20 per cent reduction by March 2004. For England the baseline figure was 1,480 drug-related deaths and the target was to reduce drug-related deaths to 1,184 (an overall reduction of 296 deaths). Although drug-related deaths have gone down in recent years, government targets have not been met.

## 2.3 Service reviews

### 2.3.1 Background

In 2005, the NTA embarked on a three-year programme of annual service reviews in partnership with the Healthcare Commission. These reviews are a key element of the NTA's aim to enhance the quality, consistency and effectiveness of drug treatment.

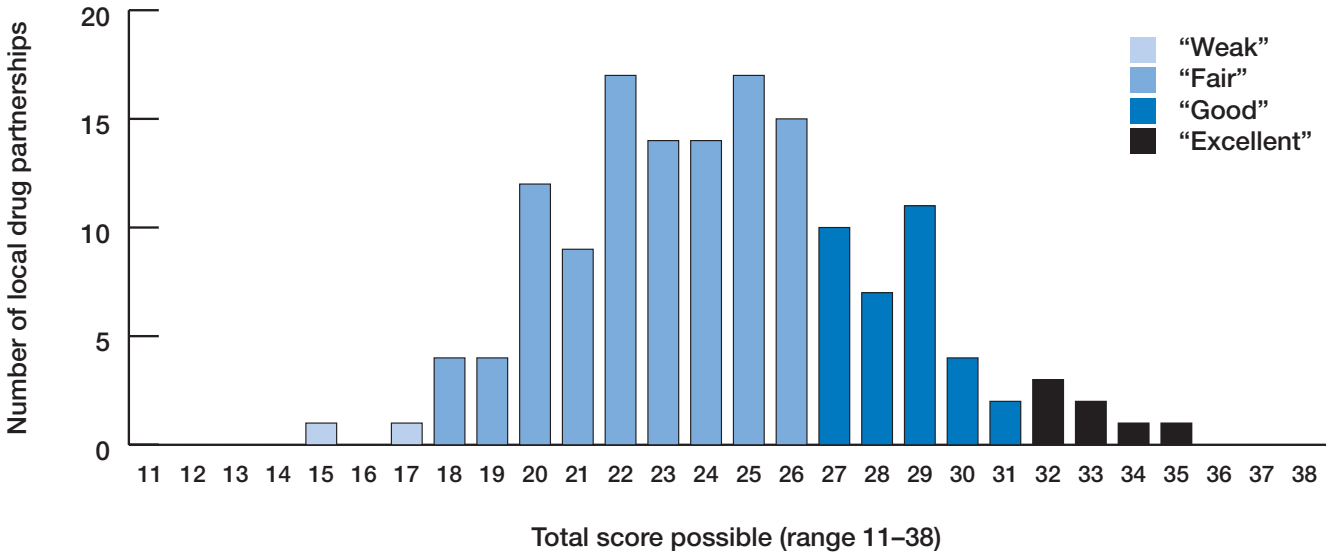


*Figure 1: Distribution of scores across partnerships*

Service reviews are designed to test the performance of drug treatment provision and commissioning against key indicators. They provide a benchmark of the quality of drug treatment and provide information on areas of weakness, against which improvement can be planned.

Service reviews are based on a standardised approach and consist of three parts:

1. Review criteria are developed in consultation with the field and piloted in some local partnerships and services
2. Assessments are carried out on the unit of assessment, which are local drug partnerships. The partnerships and service providers are assessed against an agreed framework of key criteria
3. Follow-up work is carried out with the minority (about 10–15 per cent) of partnerships and services that have the weakest assessments, who may require help to develop action plans to improve performance.

### 2.3.2 The 2006/07 service review

During 2006/07, the second joint Healthcare Commission and NTA substance misuse themed service review took place. This review assessed the performance of 149 local drug partnerships and focused on two key areas:

- Commissioning and systems management
- The provision of harm reduction services.

Within these two themes, ten criteria were developed that were indicators of effective commissioning and harm reduction provision. These criteria were developed in collaboration with a wide range of professionals (including service providers, commissioners and other experts) and service users. Forty-five questions assessed how well local drug partnerships performed against these criteria. These question scores were then used to calculate criteria level and overall scores for each local drug partnership, using the same scale. Each criterion was scored on a four-point scale from "weak" to "excellent" (1–4).

### 2.3.3 Criteria and scoring

There were then criteria developed for the service reviews on commissioning and harm reduction. Criteria 1–6 focused on commissioning. Criteria 7–10 were developed to assess harm reduction interventions and were:

- Criterion 7: Service providers deliver harm reduction interventions embedded in the whole treatment system
- Criterion 8: Service users have prompt and flexible access to needle exchange services, vaccination, testing and treatment for blood-borne viruses
- Criterion 9: Service providers take action to reduce the number of drug-related deaths
- Criterion 10: Service providers have staff competent to deliver effective harm reduction services.

Within each criterion, there were a number of questions, which contributed to the score for that criterion. The questions are set out in section 3.2.

Each local drug partnership and mental health trust received a cumulative criteria score (the maximum possible score was 40) and an overall score (from 1–4). The full national results – including overall score, total score and the scores for each of the ten criteria – were published for every local drug partnership area in England on the Healthcare Commission website (www.healthcarecommission.org.uk) in May 2008. The harm reduction results are included in Appendix 4.

#### 2.3.4 Action planning to improve poor performance

When each partnership area was scored (overall and total scores), the worst performing partnerships (10–15 per cent of the total number) received additional help to improve the ways they provided and commissioned drug treatment services, including assistance with producing a detailed action plan to demonstrate how they can improve the areas where they were rated as "weak". The partnerships produced action plans which were signed off by the review leads at the NTA and Healthcare Commission, and shared across both organisation's regional teams and the strategic health authority.

The NTA regional teams have used the results of the service review to inform their work with local drug partnerships, as part of the treatment planning process. Partnerships have developed action plans for 2008 in response to the review results and subsequent improvements. Their performance will continue to be monitored by the NTA regional teams and regional stakeholders through quarterly reviews.

### 2.4 Rationale and methodology for this report

#### 2.4.1 Identifying good performance in harm reduction

In addition to targeting the poorest-performing areas, for the purposes of this report the NTA identified the areas that scored highest in the service review, specifically against harm reduction criteria. From these it was possible to identify potential good practice and the factors in local treatment systems that contributed towards making these areas score highly. This was similar to the rationale used to produce Good Practice in Care Planning (NTA, 2007a), based on the results of the 2005/06 reviews. The report identified common themes across various areas that scored highly for care planning in the review and highlighted these as important factors that contributed to these partnerships performing well on care planning.

As with the care planning report, the aim was to speak to people in a number of the high-scoring partnerships, gain information about their strategies and practices, and determine what lessons could be learnt. Partnerships that scored well on harm reduction were selected by examining in detail at the scores across the individual criteria. This produced a shortlist of partnerships, which were interviewed to obtain more information on their drug treatment systems and harm reduction practices (for more information on these areas, and how they were selected see Appendix 2).

#### 2.4.2 Interviewing local drug partnerships

Many types of local drug partnerships were interviewed for this report; in urban and rural areas, new and well-established treatment systems, and NHS and third sector providers.

The interviews were conducted with a range of staff in the local drug treatment systems, including joint commissioning managers, partnership strategy managers, harm reduction leads, needle exchange co-ordinators, clinical leads, other clinicians, harm reduction service managers, and user and carer representatives. These meetings were arranged in collaboration with the relevant NTA regional team, involving the NTA deputy regional manager responsible for covering the particular partnership. All of the interviews took place with all relevant key staff in a meeting using a set of questions as the basis for discussion.

From the interviews, a number of common themes were identified that were believed by the partnerships to contribute towards good practice in providing harm reduction services. These themes are set out in section four. There are also a number of case studies from specific partnership areas, which have features and policies that were considered good practice.

## 3 Summary of the 2006/07 service reviews

### 3.1 Results

The overall results of the service reviews, which included harm reduction and commissioning, showed that just over a third (34%) of partnerships scored "excellent", almost half (45%) scored "good", and just over a fifth (21%) were "fair". No partnerships or primary care trusts (PCTs) scored "weak" in this review. The highest total score by any partnership was 38 (out of a maximum of 40) and the lowest was 18. Table 1 shows the distribution of

| | Local drug partnerships | | Primary care trusts | |
|---|---|---|---|---|
| | Number | Percentage | Number | Percentage |
| 1. Weak | 0 | 0% | 0 | 0% |
| 2. Fair | 31 | 21% | 34 | 22% |
| 3. Good | 67 | 45% | 63 | 41% |
| 4. Excellent | 51 | 34% | 55 | 36% |
| Total | 149 | 100% | 152 | 100% |

*Table 1: Distribution of overall service review ratings across partnerships*

overall scores and Figure 1 shows the distribution of the total scores across all partnerships. (Due to rounding up or down, the percentages may not total 100 per cent.)

The results of the review show that the vast majority of partnerships were performing within acceptable levels, although there was room for improvement. Although no partnerships had an overall score of "weak", the review revealed that the majority of partnerships had some deficits in key areas and demonstrated the need for partnerships to develop targeted action plans to address the gaps in commissioning practice and the provision of harm reduction services.

## 3.2 Results by harm reduction criteria

As demonstrated in Table 2, the strongest criterion in the review was action taken to reduce drug-related deaths, with 61 per cent scoring "excellent" and 18 per cent "good". Scoring was also strong on criterion 10 – whether service providers had staff which were competent to deliver effective harm reduction services. The weakest criterion was 8, which relates to access to harm reduction services – over half of partnerships scored "fair" or "weak" for this criterion. Within this criterion, almost all partnerships failed to score well on responses to hepatitis. 96% scored "fair" or "poor" for their testing for hepatitis B and C and hepatitis B vaccination, and 98 per cent scored "fair" or "poor" on their response to hepatitis C. A third of partnerships scored "fair" or "weak" on the criterion of whether or not harm reduction interventions were embedded in the whole system.

More information on performance against each question making up the criteria is set out in section 4.

## 3.3 Key findings

The key messages and findings from the review, in relation to harm reduction, were:

- Vaccination for hepatitis B and testing and treatment for hepatitis C were not provided widely enough by local drug treatment systems. Almost all (95.3%) of local drug partnerships had less than three-quarters (75%) of their service users being offered a hepatitis B vaccination and twenty-nine per cent did not have a protocol relating to hepatitis B. The vast majority (95.3%) of partnerships reported that less than fifty per cent of their service users had a recorded test date for hepatitis C. This is a clear national priority for improvement in the light of the scale of infection amongst injecting drug users
- In many local drug partnerships, harm reduction interventions were not provided broadly enough across the treatment system or sufficiently integrated into it
- Nearly half of service users surveyed thought that the harm reduction services they received were not comprehensive enough
- There is a clear deficit nationally in the provision of out-of-hours needle exchange, with just under half of local drug partnerships scoring "weak". Only 21 per cent had most of their needle exchange services open on Saturday and two per cent on Sunday
- Community prescribing services were assessed as providing, in the main, a good range of harm reduction interventions
- While strategic planning for harm reduction services was generally good, the scale of both preventable and treatable blood-borne virus infections, and the high rates of overdose deaths, call for additional action by local drug partnerships
- While local drug partnerships have made significant progress in developing systems and protocols to reduce the number of drug-related deaths, more needs to be done to reduce these drug-related overdoses even further. Only sixty-eight per cent of local drug partnerships had a multi-agency strategic plan for reducing the number of drug-related deaths.

The service review provides a helpful national picture of strengths and weaknesses in harm reduction and commissioning. The review indicates that progress is being made on vital issues but there are still a number of areas for improvement.

| | Weak | Fair | Good | Excellent |
|---|---|---|---|---|
| 7. Service providers deliver harm reduction interventions embedded in the whole treatment system | 1% | 32% | 34% | 34% |
| 8. Service users have prompt and flexible access to needle exchange services, vaccination, testing & treatment for BBV | 1% | 50% | 43% | 7% |
| 9. Service providers take action to reduce the number of drug-related deaths | 2% | 19% | 18% | 61% |
| 10. Service providers have staff competent to deliver effective harm reduction services | 0% | 30% | 50% | 20% |

*Table 2: Overall harm reduction results by criteria*

| | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 |
|---|---|---|---|---|---|---|
| **Weak** | 25% | 15% | 15% | 23% | 11% | 21% |
| **Fair** | 9% | 7% | 83% | 7% | 29% | 48% |
| **Good** | 17% | 23% | 2% | 20% | 39% | 31% |
| **Excellent** | 50% | 55% | 0% | 49% | 21% | 0% |
| **Mean** | 2.9 | 3.2 | 1.9 | 2.9 | 2.7 | 2.1 |

*Table 3: Responses to criterion 7 (harm reduction embedded across the treatment system)*

The full results of the review can be found in the report Improving services for substance misuse: Commissioning drug treatment and harm reduction services (HC & NTA, 2007).

# 4 Factors influencing good performance

## 4.1 Introduction

This section presents the findings of the interviews with the high-scoring partnerships, and links them directly to the criteria and questions from the service reviews.

## 4.2 Criterion 7: Harm reduction embedded across the treatment system

Criteria question scores are shown in Table 3.

1. Does the local drug partnership have a harm reduction strategy informed by internal and external data?
2. Did the local needs assessment establish the level of need for harm reduction interventions?
3. Where are harm reduction interventions provided in the treatment system?
4. Which harm reduction interventions are provided in community prescribing services?
5. Do service contracts include harm reduction?
6. How comprehensive are harm reduction interventions as experienced by service users?

### 4.2.1 A strategy informed by internal and external data

Having a harm reduction strategy informed by data was an area that scored well in the service review – two-thirds of partnerships scored "excellent" or "good".

Almost all of the partnerships interviewed for this report had a written harm reduction strategy, which was reflected in most scoring "excellent". Most of these strategies had been developed in the past year or two. The harm reduction strategies had all been preceded by a needs assessment that had identified the areas for development.

For most areas, the harm reduction strategy was developed by a local expert harm reduction group and overseen by a harm reduction strategy group, by another type of implementation group, or by using existing partnership subgroups. These groups met regularly and fed in through local structures. Partnerships reported that there was good engagement of key local partners in these groups and some used action plans to implement harm reduction strategies.

### 4.2.2 An assessment to establish the levels of need

This was another question for which most scored well in the service review – 78 per cent scored "excellent" or "good".

All the partnerships interviewed had local needs assessment processes in place; again, reflected in most of them scoring four. These needs assessments were managed by the partnerships, who utilised a range of local data sources and was passed through local expert groups to analyse and make recommendations. The quality of the harm reduction needs assessments was generally believed to be dependent on the quality of the data available. All the partnerships collected at least some data on clients using needle exchange services, although the amount of data collected varied from area to area. Most areas collected basic information from clients such as their initials, postcode, drugs used and ethnicity.

There were also varying degrees of complexity of databases and data collection systems for harm reduction data. Most areas had separate databases for pharmacy and specialist needle exchange activity. A few areas, which had a greater focus on data collection and use, had a combined (specialist and pharmacy needle exchange) harm reduction dataset.

At a very basic level, the data from needle exchanges in the interviewed partnerships was able to show the levels of activity and numbers of packs distributed from pharmacies, which was the basis for payment to pharmacies. However, most partnerships wanted to do more with their needle exchange data and used it for a variety of strategic purposes, including:

- Monitoring activity in harm reduction services
- Analysing local trends relating to harm reduction services
- Carrying out needs assessments for harm reduction
- Feeding into wider drug treatment needs assessments
- Creating regular reports on harm reduction activity

- Correlating with prevalence data – the "Glasgow data" (NTA, 2006b) or other local prevalence data – to check the penetration of harm reduction interventions into the drug using population
- Correlating with other relevant local data such as police and local authority data as well as their NDTMS treatment data
- Obtaining comprehensive records of interventions service users had received, to enable better assessments and more targeted interventions
- Tracking service users through the local treatment system – this could only be done if the services used a more complex local harm reduction database.

As well as data on clients in harm reduction services, data on discarded needles was also collected by most partnerships. This needle finds data was used to locate local hotspots and target these accordingly. More information on this issue is in section 4.6.2.

Some partnerships had dedicated research staff to analyse treatment and harm reduction data.

Case study: Bradford harm reduction database

The local drug partnership in Bradford set up a comprehensive harm reduction database, which has a full range of information on clients, from pharmacy and specialist needle exchange services.

Harm reduction services collect a range of client data as well as asking the client for a password, which enables staff to identify their records on the database on each visit. Data collected includes personal client information (e.g. date of birth, postcode area and ethnicity) and the injecting equipment and paraphernalia they receive and return.

Recording the client's drug of choice enables treatment staff to monitor whether clients are being given the right equipment. Information recorded on the distribution of paraphernalia can be used to check if enough is being given out to reduce the risk of blood-borne viruses.

The database is live, so once the data is uploaded, drug service staff across the city have access to it. The database allows client tracking across the local treatment system and makes a range of information available so clients, reducing the need for clients to be asked the same questions repeatedly, as well as prompting staff to current issues relating to that client, such as vaccination schedules and health problems).

Since it was implemented, staff and clients have reportedly received the database positively.

### 4.2.3 Where interventions are provided

Criterion 7 as a whole, which focused on harm reduction being embedded in the whole treatment system, scored well in the service review (over two-thirds of partnerships scored "excellent" or "good"). However, this particular question did not score well at all, with almost all (98%) partnerships scoring "fair" or "weak". The question was asked to find out whether harm reduction interventions were being provided by services across the local treatment system (as recommended in Models of Care (NTA, 2006)), and not just being provided in open-access services.

Despite most of the interviewed partnerships scoring "fair", the majority of them expressed the importance of good drug treatment in reducing harm, with the point regularly made that the most effective form of harm reduction is to keep people in treatment. In relation to this, some partnerships pointed to high numbers of people in structured drug treatment as an important factor in harm reduction. Others mentioned local prescribing audits, which had showed patients on doses of medication within current guidelines and this was considered an important harm reduction measure.

Case study: Wigan criminal justice harm reduction services

Wigan has an integrated system of criminal justice and treatment services, which includes extensive harm reduction through the criminal justice system. The drug treatment services work closely with the police though the Tough Choices project, which due its consultative approach has not alienated the service user group.

The Tough Choices staff work in custody suites to initiate conversations with substance misusing clients about blood-borne viruses, safer injecting and making them aware of drug services in the community. The Tough Choices workers also accompany clients to appointments in the community. Outreach workers attend drug raids to ensure that punitive measures are carried out in the most supportive way. For those people who are not imprisoned, engagement with services is strongly encouraged. Following imprisonment individuals are referred to CARATs or DIP.

A good culture of partnership working was reported across the partnership, which is strengthened by the local area agreement.

Some of the areas interviewed, which had a long history of providing drug treatment services, pointed to an established culture of harm reduction among treatment services and staff who all saw it as an integral part of all their work. In these areas, the commissioners also felt that they were part of this culture.

Many of the treatment services in these areas grew out of existing harm reduction services or were developed by organisations and trusts that already had experience of doing harm reduction work.

These harm reduction and treatment services had usually been in place for a long time, allowing a wealth of expertise to build up among the staff, many of whom had been in their posts for number of years. Some areas thought that this longevity and consistency was important, allowing well-established relationships with clients and promoting the staff's ability to share their knowledge and expertise with newer team members.

All the areas interviewed said they recognised that harm reduction is more than just needle exchange, viewing harm reduction services as an integral part of the local treatment system, not a separate adjunct confined to standalone harm reduction services. These areas all had discrete specialist harm reduction services, but also emphasised the importance of harm reduction interventions throughout all the local treatment services in Tiers 2, 3 and 4. Harm reduction was also seen as an integral part of a client's care plan, being flagged up at the client's initial assessment and always discussed throughout its development.

Some of the treatment services interviewed reported the need to strike a balance between providing a confidential harm reduction service to clients and being able to give out needles and injecting equipment to clients who were already on substitute prescriptions. They talked about managing potential client unease around receiving injecting equipment from staff who may also be involved in their other treatment interventions, or being seen to attend a needle exchange. Although harm reduction was considered to be an integral part of the whole drug treatment system, some partnerships thought that it was important to have specialist harm reduction services and pharmacy schemes physically separate from structured drug treatment services. However, there was always a strong emphasis on very close working links between these harm reduction agencies and the treatment agencies, so that there would be easy assessment and referral into structured treatment if the client desired, and easy access across treatment and harm reduction agencies for clients who were already in structured treatment. The importance of having both specialist standalone harm reduction services and harm reduction integrated into the treatment system was continually emphasised.

Interventions which were delivered across local treatment systems in the interviewed partnerships included the following:

*Advice and information*

All areas provided a range of harm reduction advice and information to drug users – both in specialist harm reduction services and in structured community treatment. This included basic drug information and advice on safer injecting and overdose prevention. Some services provided structured training to service users on safer injecting and overdose.

Some areas provided telephone helplines for information and advice. The exact nature of the helplines varied, but they included:

- Harm reduction advice for drug users
- Advice for family and friends
- Info about local harm reduction services
- Help with what to do about discoveries of discarded injection equipment.

*Screening and assessment*

It was reported that when clients first make contact with drug services, their basic details are taken, which usually included the initials of their name, drugs of use and their injecting history. Clients were also given a basic healthcare assessment, screening assessment and triage assessment for entry to structured drug treatment. The assessment would identify a client's particular harm reduction needs and appropriate interventions could be then offered.

*Healthcare*

Some partnerships made it a priority to ensure that every client entering drug services for the first time received a general healthcare screening or assessment. These screenings were usually carried out by keyworkers, although sometimes the healthcare assessments were done by harm reduction nurses. Staff in the drug services also regularly provided interventions such as checking injecting sites and advising about how to rotate these sites. Many services also had nurses providing wound care to service users.

The partnerships reported that if it was not possible to provide wound care in the drug treatment or harm reduction service, it was usually available through referral to local health centres or hospitals. In some areas, the healthcare needs of drug users were mainly met in primary care, with specialist nurses running specific clinics in primary care services. Some areas had begun projects working with district nurses to provide healthcare interventions to drug users.

### Case study: Knowsley home outreach service

Knowsley provides a home outreach service comprising of nurses and outreach workers. The service is a partnership between the Lighthouse Project (the community drug services provider) and Knowsley PCT. The nurses have a general nursing background and have experience of working with drug misusers. The outreach workers and nurses visit clients in their homes and deliver a range of harm reduction interventions including blood-borne virus testing, hepatitis B vaccination, wound care and safer injecting advice.

This outreach serves both to provide interventions to clients who are unable to attend the fixed-site harm reduction services, and to encourage people who are resistant to come into the fixed site services to attend these services in the future and benefit from the full range of harm reduction interventions available.

Some partnerships perceived harm reduction as a partnership venture with primary care and emphasised the necessity of strong links between drug services and primary care services.

In addition to drug-specific harm reduction services, some services also gave sexual heath advice and a few services had links to genitourinary medicine (GUM) clinics.

*Needle exchange*

All areas interviewed provided a range of needle exchange services, usually based at either fixed-site harm reduction services linked to specialist treatment services, or in pharmacies (often these were also the pharmacies which were involved in supervised schemes for consumption of prescribed opiates).

The specialist needle exchange services all provided a wide range of injecting equipment, giving clients a choice of needles and syringes and other equipment such as Stericups, filters and citric acid as well as harm reduction information leaflets. Some also provided free condoms. The pharmacy needle exchanges mostly only provided packs, which included needles and syringes and often a sharps bin to return used works and information leaflets. However, a few pharmacies had a small amount of individual syringes for clients to take as extras and some provided packs of paraphernalia.

The provision of a range of needle exchange services was deemed very important by all the partnerships interviewed because they believed that it was necessary to have a comprehensive coverage of services and that clients get a choice of what type of service they use. There was usually a balance of coverage between specialist needle exchange and pharmacy-based services. How these were used depended on the areas. In some places, the specialist services were more popular with clients, and in other areas the pharmacy services were better attended. This was due to a number of factors, including location, historical patterns of service use, and desire for anonymity.

*Blood-borne virus testing and treatment pathways*

All partnerships reported that they tested clients for blood-borne viruses, mainly hepatitis B and C. Most areas aimed to test many clients as possible. They also aimed to provide as many vaccinations as possible for hepatitis B and provide pathways to treatment for hepatitis C if the clients tested positive for this virus. Testing and treatment for blood-borne viruses are covered in more detail in sections 4.3.5 and 4.3.6.

*Harm reduction nurses*

All high-performing partnership areas employed harm reduction nurses to carry out a range of interventions. These nurses were usually based at the main fixed-site harm reduction service or the community drug team, although they would often work at satellite clinics at other locations in the partnership area. They saw clients on both an appointment (following referral) and drop-in basis.

The harm reduction nurses were responsible for a range of interventions including:

- Conducting healthcare assessments
- Wound care
- Checking with clients about previous tests and vaccinations
- Sexual health screening, testing and providing related information
- Blood-borne virus testing and vaccination – in some areas, nurses were trained in phlebotomy (if this was not the case, clients were referred to other health services to have bloods done)
- Pre- and post-test counselling for blood-borne virus testing
- Referral to other services.

Case study: Harm reduction nurses in Tameside

Tameside runs a nurse-led harm reduction service, which has two full-time harm reduction nurses based in local treatment services and working across the local treatment system.

Partnership representatives reported that having two nurses enables better access to services, allowing one nurse to run satellite services and work with primary care services, and the other to cover the substance misuse service and needle exchange. This means that there is always usually a nurse available for drop-in appointments when clients attend the needle exchange. A full range of harm reduction interventions are offered, including blood-borne virus testing, vaccination, and wound care and dressing.

The harm reduction nurses see clients on both an *ad hoc* and appointment basis and run clinics in conjunction with the doctors' clinics, so that clients can address a range of issues together and are able to see the doctor, their keyworker and the nurse all in one visit.

The nurses also do home visits, mainly for clients with children and those who are ill. These visits are done in conjunction with either the family liaison team or the client's keyworker.

*Services for steroid users*

All partnerships reported that steroid injecting was a problem in their area, with the majority reporting that it was an issue of rising importance. Some had seen an exponential rise in steroid use in recent years, with steroid users responsible for more than half of needle exchange activity in some services. A number of areas had developed, or were in the process of developing, services for steroid users. These included needle exchanges or mobile needle exchanges in local gyms, outreach and satellite services in gyms, special steroid clinics at the harm reduction service and the provision of advice and information to steroid users.

Steroid misuse is not currently within the remit of the NTA, although non-prescribed anabolic steroids and other performance and image enhancing drugs are under review as part of the forthcoming NICE guidance on needle and syringe programmes.

### 4.2.4 Interventions provided in community prescribing services

This question scored reasonably well, with over two-thirds (69%) of partnerships scoring "excellent" or "good".

All the partnerships interviewed reported that they provided a good range of harm reduction interventions within community prescribing services, which was backed up by their review scores. These interventions were usually carried out by a combination of keyworkers and nurses. The majority of the harm reduction interventions were delivered by drugs workers in the context of keyworking relationships with their clients. This included screening and assessments (healthcare assessments and substance misuse assessment), harm reduction advice and information, advice about safer injecting and avoiding overdose. More specialist harm reduction interventions such as testing for blood-borne viruses, hepatitis B vaccinations and wound care were done by harm reduction nurses working with the substance misuse services.

For more detail on these interventions, see section 4.2.3.

### 4.2.5 Harm reduction in service contracts

The issue of having harm reduction in service level agreements was one that scored reasonably in the service review, with 60% of partnerships scoring "excellent" or "good".

Across the partnerships interviewed, the review scores showed a mixed picture, although all the partnerships reported that harm reduction was specified as standard in all contracts and service level agreements with their drug service providers, even to the extent of having explicit harm reduction statements or clauses to ensure delivery of harm reduction interventions. This was standard for all community services commissioned through the local joint commissioning groups because commissioners wanted to be sure that harm reduction was being delivered in all commissioned services, not just those traditionally seen as Tier 2 services.

However even in the high-scoring partnerships interviewed, very few had specifically required harm reduction in contracts for Tier 4 or abstinence-based services. Most partnerships cited difficulties in specifying harm reduction in Tier 4 contracts, particularly residential rehabilitation, due to the *ad hoc* way these services were purchased as well as potentially conflicting views on the importance of harm reduction with some Tier 4 providers. In addition, most residential rehabilitation was purchased by local authorities outside of local drug partnership commissioning arrangements.

Almost all of the partnerships interviewed used a variety of funding streams for harm reduction services. The majority of the funding for these services came from the adult pooled treatment budget (PTB), but most areas also had a substantial contribution from the PCT, with a few areas having as much as a 50-50 split between the PTB and PCT or other partner's funding of harm reduction services. In these local drug partnership areas, there was always a strong partnership between the drug treatment commissioners and their health partners, and the mainstream health bodies (including public health) were well aware of the importance of funding harm reduction.

More widely, there was also plenty evidence of strong working relationships with other partners in the local drug partnership and joint commissioning group, with the vast majority of the interviewed areas also receiving funding for harm reduction

services from other DAT partners who were signed up to the harm reduction agenda and were willing to contribute resources. This included Drug Interventions Programme (DIP) monies as well as funding from local authorities (social services and environmental health), probation and police.

Many areas talked the advantages of having a strong joint commissioning group. They reported that a lot of work had been done with partners to ensure that harm reduction was seen as everyone's responsibility.

### 4.2.6 Service user opinions and involvement

The service review used data from the NTA 2006 user satisfaction survey (NTA, 2007b) for this question, which showed that over two-thirds (69%) of partnerships scored "fair" or "weak". However, despite these low scores, most of the partnerships interviewed reported general user satisfaction with their harm reduction services. Most of these partnerships had mechanisms in place for regular user consultation and feedback on local drugs services, including harm reduction services. These usually included regular meetings between the DAT and user representatives, feedback from local user groups and forums, and information provided though advocacy services.

The involvement of service users in the planning and delivery of harm reduction services was an issue that emerged strongly across all the partnerships interviewed. Many of these partnerships stressed the need for service users to be enabled to become partners in the development of local harm reduction services and effect change in services. User involvement in local commissioning structures was reported to be an important part of this process.

In most of the partnerships interviewed, service users were seen as natural partners in the planning and delivery of harm reduction and drug treatment services. Many of the partnerships utilised service user feedback through forums and individual feedback as a useful check on the quality of the services being provided. A number of examples were given of instances when user feedback had raised awareness of local problems with harm reduction services and how the partnership was subsequently able to take quick action to address these service issues. These included reported negative attitudes of pharmacists, or particular services not being made available to service users. After this was reported to the partnership, action was taken to rectify the situation.

There was also evidence that service users had helped to identify the need for new harm reduction services or staff posts and had also helped to advise on what materials were given out by needle exchange services, particularly the contents of needle exchange packs (for example, the inclusion of citric acid, or a range of needles).

Other service user and carer initiatives reported in the interviews included the following, which were funded by the partnerships:

- Regular surveys of service user views by the partnership
- Using service user groups to deliver harm reduction messages (such as blood-borne virus testing and vaccination) and to publicise and encourage access to harm reduction services among their peers
- User-run peer education programmes
- A user-run needle exchange operating on weekends
- Providing training to users, particularly on blood-borne viruses and overdose.

**Case study: Kirklees user involvement initiatives**

Service user consultation was reported to be at the heart of service development in Kirklees. The partnership has put user involvement in place across the board in local treatment system.

There is an annual user survey, carried out by service users, through the local user forum. The survey also targets people who are not currently in drug treatment.

The partnership also uses the local service forums and advocacy groups to obtain regular feedback on services, including harm reduction services, and can take action to remedy any problems. The advocacy service supports and enables service users to speak out about issues that concern them. User feedback has been responsible for the development of new harm reduction services, including the advocacy service and a mobile needle exchange serving rural areas.

As well as initiatives, it was often the quality of the relationships between service users and staff that was highlighted as one of the most important features of user involvement. Some partnerships had put a strong emphasis on the quality of relationships, and working with service providers to improve them where necessary.

The involvement of carers was also viewed to be an important aspect of providing good harm reduction services. Some carer initiatives funded by the partnerships included:

- Overdose training provided to carers
- A carer-run 24-hour telephone helpline
- Drop-in family support services.

## 4.3 Criterion 8: Prompt and flexible access to harm reduction services

Results of these questions are shown in Table 4.

1. What proportion of injecting drug users access needle and syringe exchange services?

| | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 |
|---|---|---|---|---|---|---|
| **Weak** | 24% | 44% | 9% | 5% | 26% | 95% |
| **Fair** | 14% | 44% | 4% | 9% | 70% | 3% |
| **Good** | 14% | 12% | 28% | 30% | 0% | 1% |
| **Excellent** | 48% | N/A | 58% | 56% | 4% | 0% |
| **Mean** | 2.9 | 1.7 | 3.4 | 3.4 | 1.8 | 1.1 |

*Table 4: Responses to criterion 8 (prompt and flexible access to harm reduction services)*

2. Do dedicated and pharmacy-based needle and syringe exchange services provide out-of-hours services to service users?
3. Is harm reduction fully covered in the in the needle exchange services?
4. What services do pharmacy-based needle and syringe exchange services offer to needle exchange clients?
5. How many service users have been tested and/or vaccinated against hepatitis B virus?
6. What is the partnership's response to hepatitis C and HIV?

### 4.3.1 Uptake of needle and syringe exchange services

Access to harm reduction was an issue that scored well in the service review, with almost half (48%) of partnerships scoring "excellent" on the proportion of injecting drug users accessing needle exchange schemes in their area. Most of the partnerships interviewed reported that they had good coverage of harm reduction services across their areas, enabling easy access for clients to services.

The interviewees aimed to make accessing services as easy as possible for clients. This was achieved in a number of ways. In addition to out-of-hours service provision (see section 4.3.2), most partnerships also provided outreach services to engage with clients who were outside treatment and were unwilling or found it difficult to access treatment services and fixed-site harm reduction services.

*Outreach services*

Despite the extended opening of specialist and pharmacy needle exchanges, in some areas there were still identified access needs for particular communities or users. For these areas, outreach services were provided to meet this need. Outreach is a delivery mechanism for a range of interventions and services. In the interviewed partnerships, these services covered four main areas:

- Mobile needle exchange vans, which were not specifically labelled as needle exchange vans, but focused on providing general health and drugs information, with needle exchange facilities available
- Domiciliary interventions, where harm reduction outreach workers would bring injecting equipment to the homes of clients. Some services would also provide home visits to clients to deliver harm reduction interventions, including blood-borne virus testing and vaccinations
- Detached outreach workers, providing a basic needle distribution and harm reduction services to clients on the street
- Satellite clinics – some areas had harm reduction nurses and drugs workers running satellite clinics in areas which had limited access to fixed-site services (for example a drop-in based in a health centre on particular days).

### 4.3.2 Out-of-hours provision

This question did not score well in the review with the vast majority of partnerships (88%) scoring "fair" or "weak" (though a score of "excellent" was not possible due to the way the scoring was constructed). The scores for the partnerships interviewed was a mixed picture, though all reported that there was a good range of out-of-hours services made available. Out-of-hours service provision was covered by the following:

*Out-of-hours specialist harm reduction services*

All of the partnerships had specialist harm reduction services which opened outside of normal office hours to enable better client access. Usually this meant having one or two evenings a week where at least one service was open late (up to 8pm), and opening on Saturdays (mainly Saturday mornings).

*Out-of hours pharmacies providing needle exchange*

The issue of out-of-hours opening times was covered in most areas by pharmacies which opened early and late. The majority of pharmacies were open outside office hours and there were also many instances of needle exchanges in 100-hour pharmacies, and even one in a 24-hour pharmacy. In many areas, the partnership had strategically ensured coverage by recruiting pharmacy needle exchange services in parts of the borough or county that had been shown to have less-easy access to drug services. Some areas had the pharmacies providing needle exchange opening late on a rota basis.

Case study: Kensington and Chelsea peer-run needle exchange

The Kensington and Chelsea peer-run needle exchange started after a need was identified through a weekend user-run social club, based at one of the local voluntary sector treatment services. The user group running the social club was regularly asked about the availability of needle exchange facilities and as a result the user group worked with the treatment service to open the existing needle exchange on Saturday and Sunday afternoons. During these times, the needle exchange is run by members of the user group who have been trained in needle exchange assessments. The service now acts as a first point of contact for many people who are not in the local treatment system.

### 4.3.3 Harm reduction in needle exchange services

This question scored well in the review with over half (58%) of partnerships scoring "excellent" and only 13% "weak" or "fair". This meant that needle exchange services were generally providing a full range of harm reduction interventions, as well as giving out injecting equipment. This was confirmed by the interviews where almost all achieved the maximum score and all of them could point to a wide range of harm reduction interventions being delivered from their specialist harm reduction services. Often their pharmacy needle exchange services were able to deliver a range of harm reduction interventions as well. For more information on the range of harm reduction services delivered see section 4.2.3. For further information on the services offered in pharmacy needle exchanges, see section 4.3.4.

### 4.3.4 Services offered to pharmacy needle exchange clients?

The review showed that the majority of partnerships were performing well on this question, with the vast majority (86%) scoring "excellent" or "good". The interviewed areas performed well on this issue, again almost all scoring four, and pointed to the following issues relating to their pharmacy-based harm reduction services.

*Pharmacy participation in needle exchange schemes*

Most of the partnerships interviewed reported a good participation from pharmacies in pharmacy needle exchange schemes and coverage of the whole local drug partnership area had been made possible by a spread of these services. The partnerships had taken a strategic view as to where the pharmacy services were located, so that if a particular part of the borough or county was identified as having poorer access, more effort was made to recruit pharmacies to offer a needle exchange service in that locality. The majority of pharmacies that took part in supervised consumption schemes also offered needle exchange, although usually more pharmacies in a given area provided supervised consumption than needle exchange services.

There were differences in the numbers of pharmacies involved in needle exchange schemes, but the number of pharmacies involved was not the important factor, because geographical area and population size varied and all the partnerships interviewed believed that they had good coverage of their area though a combination of pharmacy and specialist needle exchange services. Only a small number of partnerships felt that they needed more pharmacy services to maximise coverage. Some areas reported that they had not always had good coverage, and as a result had made a concerted effort to recruit more pharmacies to the scheme.

*Equipment distributed*

All pharmacies gave out packs of needles and syringes (and usually a sharps bin), although some also retained a small stock of individual needles and syringes to give to clients as extra if required. Some also gave out packs of other injecting equipment (citric acid, Stericups and filters). In all areas interviewed, pharmacists were paid by the number of packs given out.

*Signposting to drug treatment services*

All partnerships interviewed thought that it was important that all pharmacy staff (pharmacists and counter staff) working with drug users had at least a good working knowledge of the local drug treatment system and were able to refer clients to appropriate specialist harm reduction and drug treatment services. More formal links between pharmacies and specialist harm reduction and drug treatment services had been established in many areas, such as drugs workers providing interventions in pharmacies. Where necessary, training was provided to build pharmacy staff knowledge and understanding about local services and the mechanisms for referring clients (see also section 4.5.3). Some areas had produced service directories or signposting documents with information on local harm reduction and drug treatment services that could be easily used by pharmacy staff to refer clients.

*Specialist harm reduction interventions in pharmacies*

Some areas had drugs workers providing brief harm reduction interventions in pharmacies and a few other areas intended to make this type of service available in the near future. These brief interventions – such as providing basic advice and information, safer injecting and overdose advice, and even healthcare assessments – were thought to be important in assisting pharmacy staff by providing more specialist help to clients, and offering the opportunity of a one-to-one session in private if required.

Specialist drug interventions would normally require a private consulting room in the pharmacy where the client could see a practitioner. The partnerships reported that not all their pharmacies had this facility, but most partnerships aspired to having private rooms in all their pharmacies where physically possible. One partnership would not accept pharmacies to be part of their supervised consumption scheme unless they had a private area, although this was not a requirement for needle exchange.

### 4.3.5 Hepatitis B vaccination and testing

This was one of the poorest-scoring questions in the review with 96 per cent of partnerships scoring "fair" or "weak". Despite most of the interviewed partnerships scoring two (two scored four), they held the issue as high importance. They pointed to the following issues, which they considered to be important in providing a good blood-borne virus service to clients:

*Blood-borne virus testing and vaccination*
All partnerships interviewed placed a high priority on testing for blood-borne viruses, with most reporting that they aim to test as many drug users as possible. As far as they were able, drug services offered tests for hepatitis B and C to all clients entering harm reduction or drug treatment services. In some services, they also offered tests for hepatitis A, HIV, or sexually transmitted infections if appropriate or required. Most of the services interviewed reported trying to make sure that blood-borne virus issues were raised by staff at the client's first assessment, or as soon as possible afterwards.

Most services reported offering pre-test counselling before clients took tests, which would be carried out by harm reduction nurses or drugs workers. For the actual testing, partnerships reported a mixture of oral swab testing and blood testing for hepatitis. Some areas used swab testing in order to enable easier testing and to test as many clients as possible. Other areas preferred blood tests because of greater accuracy and because in most cases, blood tests would have to be done to confirm the results of swab tests anyway. If the first test was positive, the client would need to get a PCR test. Most partnerships used local hospital labs for test analysis.

All areas reported providing post-test counselling. If the test was negative, the client would receive post-test counselling. If the test was positive, the client would also receive post-test counselling and would be referred to the nearest hepatitis C treatment clinic, which was usually at the local hospital.

Most partnerships reported offering hepatitis A and B vaccinations to clients in drug services. Some also reported offering tetanus. Vaccinations were usually done by nurses in the specialist harm reduction or substance misuse service, but sometimes the vaccination would be done in primary care services. The usual reported practice was to offer three types of hepatitis B vaccinations depending on the client's assessed risk of disengaging with the programme of vaccinations. The options were the regular, rapid and the accelerated programmes. The rapid or accelerated programmes were offered to clients who were assessed as possibly having difficulties completing the regular programme.

### 4.3.6 Partnership responses to hepatitis C and HIV

This was the question which showed the poorest performance in the whole review, with almost all (98%) partnerships scoring "fair" or "weak" and none scoring "excellent". The issue of good hepatitis C pathways was one that even the highly rated partnerships interviewed admitted they struggled with, with all scoring one and none reporting that they had a fully satisfactory pathway. However, it was an issue that many of them had put a lot of work into, and they were in the process of developing more robust responses to hepatitis C locally, which included the following aspects.

*Hepatitis C treatment*
Hepatitis C treatment pathways for drug misusers were established in most of the areas interviewed, however this was an area that all partnerships felt could be improved. Some partnerships were more confident than others about the quality and robustness of the process and the hepatitis treatment the clients were receiving, and many felt they still had a lot of work to do in this area.

The partnerships reported that a crucial component in hepatitis C treatment for drug users was the relationship between the drug treatment services and the hepatologist or other doctors running the local hepatitis treatment services. Most partnerships reported a good relationship with these clinicians with the specialist hepatitis doctors generally favourably disposed towards the client group. A few areas had worked hard to establish or improve this relationship and had been successful in doing so. However, even when there was a good relationship with the clinician, the partnerships reported that there could still be issues with clients actually getting the necessary hepatitis C treatment, mainly because of waiting lists for treatment, or lack of accessibility of the hepatitis clinic.

In most areas, it was the hepatologist who made the decision whether to treat a particular patient. This was reported to be a particular issue for patients who were still injecting drugs or drinking heavily. It was also reported in a few areas that people would sometimes be excluded from hepatitis treatment because their drinking or drug use were deemed to be incompatible with the interferon treatment. This practice is not consistent with the NICE guidelines on treatment for hepatitis C (NICE, 2004; 2006)

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Weak** | 6% | 22% | 25% | 10% |
| **Fair** | 33% | 3% | 11% | 23% |
| **Good** | 37% | 1% | 3% | 67% |
| **Excellent** | 24% | 74% | 61% | NA |
| **Mean** | 2.8 | 3.3 | 3.0 | 2.6 |

*Table 5: Responses to criterion 9 (action to reduce drug-related deaths)*

However, some partnerships pointed out that clients sometimes excluded themselves from hepatitis treatment. In most areas it was reported that even when some clients tested positive for hepatitis C, they did not want to take up the treatment. It was generally agreed that the issue of hepatitis C-positive clients continuing to inject is something to be taken up in keyworking relationships, where the client could be encouraged to stop injecting or drinking alcohol.

*Ensuring compliance with hepatitis C treatment*

Some partnerships noted that there was often a problem with clients not attending appointments at the hospital for hepatitis C treatment. This was particularly a problem when the client had to travel a long distance to reach the hospital, which was the case in the majority of areas. Some services had put measures in place to try to ensure attendance, the most common of which was a "buddying" system where the client was accompanied to their hepatitis treatment by a volunteer buddy. This system was reported to generally work well, and encourage clients to attend appointments. Other measures used to help clients keep appointments included being accompanied by nurses or keyworkers where they were able to spare the time to attend.

### Case study: Stockton buddying scheme

The local drug treatment service set up a buddying scheme to help people through drug treatment. Initially set-up to be delivered by a professional worker, once it was up and running it was taken over by volunteers and the service users themselves. It is a buddying scheme for drug treatment generally, but it has a particular relevance for clients attending hepatitis C treatment, who receive support and help in attending appointments at the hospital in Middlesbrough.

To maximise client engagement in hepatitis treatment, some partnerships reported starting or being in the process of setting up community-based hepatitis treatment services, for example a system where after the initial hospital appointments, clients could continue to receive their treatment in local community services, administered by nurses.

### Case study: Nottinghamshire hepatitis treatment service

In Nottinghamshire county, hepatitis C treatment is provided in the community for people who are not able to access the secondary care treatment service. The Direct Access Harm Reduction Service operates clinics running alongside existing drug treatment clinics, needle exchanges and drop-ins to maximise access. Clients are referred to the harm reduction clinics for blood-borne virus interventions, including hepatitis B and C testing, hepatitis B vaccination and referral to hepatitis C treatment.

If a clients test positive for hepatitis C, they will receive a pack with information about living well, reducing the risks of transmission to families, hepatitis C treatment and what to expect. The hepatitis C treatment service is delivered in a drug treatment agency in the north of the county, and is nurse-led with supervision provided by the consultant hepatologist. Clients who would find it difficult attend hospital-based hepatitis treatment will receive their hepatitis C treatment there.

*Hepatitis support groups*

Some areas had set up hepatitis support groups. Not all of these were specifically for drug users with hepatitis C, though the groups were felt to be of great benefit to all clients going through hepatitis treatment, enabling them to discuss a range of issues, including difficulties (such as depression) they were experiencing with the treatment.

### Case study: Calderdale hep C support group

Calderdale has a peer-run hepatitis C support group. The group was originally set up to be a stand-alone group, and it has evolved over time. It is currently a support group for people undergoing hepatitis C treatment with its own constitution. The support to start up the group was provided by a professional, but once established with a constitution it became peer-run. The group is not exclusively for drug users, but they make up the majority of the group. The focus of the group tends to be on new diagnosis. The group is expected to continue to evolve.

## 4.4 Criterion 9: Action to reduce drug-related deaths

Results of the following questions are shown in Table 5.

1. Does the partnership have a written multi-agency strategic plan for reducing drug-related deaths?

2. What proportion of paramedics in emergency ambulance crews in the area have been trained in the use of naloxone?
3. What proportion of police custody officers have been trained to deal with overdose incidents?
4. How many service users and carers have been trained during 2005/06 to deal with overdose incidents?

The results showed that this was the strongest criteria and nationally, partnerships had made significant progress in developing systems and protocols to reduce the number of drug-related deaths.

### 4.4.1 Strategic plans to reduce drug-related deaths

This issue scored reasonably in the review, with 61 per cent of partnerships scoring "good" or "excellent". However, this was still an area for improvement in many areas with a third or partnerships scoring only "fair".

Most of the partnerships interviewed had a strategy for reducing drug-related deaths, with almost all scoring highly for this question. Usually, the drug-related deaths strategy was included as part of the harm reduction strategy, rather than as a separate document. This strategy was developed in the same way as the harm reduction and other local partnership strategies using a combination of data analysis and expert groups and implemented and monitored through specific groups, often specifically focusing on drug-related deaths. Some partnerships had joined up with neighbouring partnerships to form groups with a wider strategic focus on drug-related deaths.

### 4.4.2 Naloxone training for paramedics

This question was scored reasonably well across partnerships, with three-quarters (75%) scoring "good" or "excellent".

The interviewed partnerships all scored the maximum for this question and reported that their local ambulance services carried naloxone and paramedics were trained in its use. Naloxone training for ambulance crews was carried out within the ambulance service. None of the areas interviewed had made take-home naloxone available to service users or carers, but some were interested in investigating this further.

### 4.4.3 Overdose training for police custody officers

Almost two-thirds of partnerships (61%) scored "excellent" on the issue of police custody officers being trained to deal with overdose. The interviewed partnerships mostly scored four.

This training took place in different ways in the interviewed partnerships. Usually, it was a multi-agency initiative, with police receiving training from local partners such as drug treatment and harm reduction service providers. This was reported to work best when there were good partnership arrangements in place between drug treatment and criminal justice agencies. In other areas, the training was done in-house by the police force.

### 4.4.4 Overdose training for users and carers

Two thirds of partnerships (67%), including all of the partnerships interviewed for this report, achieved the maximum score on service users and carers being trained to deal with incidents of overdose.

All of the high-scoring partnerships interviewed provided training for users and carers that addressed issues of overdose. These training courses were commissioned by the partnership in consultation with local user groups and forums and delivered in a variety of ways across the local treatment system. Some courses were held in neutral non-treatment venues if the local drug services knew that this would improve attendance. In other areas, the training was held in local treatment services because of relative ease of access and familiarity. The courses were delivered by a mix of local service providers; the ambulance service, contracted trainers, and service users themselves, depending on the particularly identified local needs.

### 4.4.5 Other relevant action on drug-related deaths

As well as the above areas under scrutiny in the service review, the interviewed partnerships pointed to a number of other issues that they believed were important in tackling drug-related deaths locally.

*Confidential enquiry processes*

Some, though not all, areas had established a confidential enquiry process for drug-related deaths and other areas were in the process of developing them. These processes varied, but usually involved a nominated partnership lead on drug-related deaths and an expert group. The drug-related deaths lead would usually be the person who would liaise with the coroner's office and obtain information on local deaths.

The main function of these processes was reported to be the investigation of local drug-related deaths and identify any appropriate lessons that could be learnt. The expert groups were either set up specifically for these investigations, or were groups that operated within existing local clinical governance structures. The groups included representatives from relevant local bodies, such as the partnership, drug services, the PCT, public health and social services. Drug-related deaths would usually be reported thorough the nominated lead and the group would look at each death to examine the surrounding circumstances around it and identify any recurring trends and patterns. These groups were normally responsible for the production of reports on drug related deaths, which were made available through local strategic groups and actioned as appropriate.

**Case study: Stockton enquiry process**

To assist with the confidential inquiry process in Stockton, a nominated post was created in conjunction with three other Teeside partnerships (Middlesbrough, Hartlepool and Redcar & Cleveland). This person is the nominated co-ordinator for drug-related deaths across the four partnerships. This post provides the crucial link with coroner's office and is supported by public health.

There is a cross-partnership drug-related deaths group including representation from the local drugs partnership, police, mental health, public health, probation and social services. Information from the coroner comes back to this group. The co-ordinator is informed of drug-related deaths and then informs the rest of the group. The co-ordinator will obtain relevant information from local services which have had contact with the person who had died.

The group has a monthly meeting, whether a death has occurred or not. If there is no immediate death to investigate, the group will review previous cases.

*Relationships with local coroners*

An important factor in all enquiries into drug-related deaths was reported to be the relationship or links with the local coroner's office. Most areas had good links with coroners and were able to work with them to access relevant information and participate in enquiries. Other areas, however, had a more difficult relationship with the coroner and were not able to access relevant information. Added difficulties sometimes arose because coroners usually cover more than one local drug partnership area.

The nature of partnerships' relationship with coroners was an issue that varied widely according to the interviewed partnerships. However, some partnerships had worked hard to build up a better relationships and had been successful.

One of the main issues that arose was how drug-related deaths were recorded and what level of detail was given in coroners' reports. There was no sense of any consistency across the partnerships in how deaths were recorded and this was viewed to be an ongoing issue.

*Working with people leaving prison*

All partnerships reported that reducing the overdose risk facing people leaving prison and residential treatment was a major issue in tackling the incidence of drug-related deaths. Most of the areas had processes in place to ensure that people leaving prison had rapid access to treatment services if required, Some of these schemes included:

- Pick-up at the prison gate: the prisoner being released would be met at the prison gate and accompanied to a drug service. This would be done with the client's consent in partnership with DIP and the CARAT teams
- Ensuring that a triage assessment was already done before the client left prison, enabling an appointment with a doctor in the community to be set up in advance
- Having available slots in substance misuse clinicians' timetables at particular times to allow people newly released from prison to have immediate access to treatment

*Proactive work and drug-related deaths campaigns*

Many areas reported that they had done proactive work on drug-related deaths, which mostly meant specific targeted campaigns to their service users about risks of death. This included raising awareness and providing information and advice on safer injecting and overdose as part of regular keyworking and times when the client was at more risk of overdose, such as after leaving prison, detoxification or residential rehabilitation.

*Ambulance protocols*

Most areas had developed a protocol between the local police and ambulance service where the police would not routinely attend a 999 call which was for a drugs overdose. This was felt to have encouraged drug users to call 999 when a friend overdosed, without the fear of arrest.

## 4.5 Criterion 10: Staff competences

The results of these questions are shown in Table 6.

1. Are there protocols in place to ensure staff safety in relation to blood-borne viruses?
2. What training and experience in harm reduction do staff in non-pharmacy fixed-based needle and syringe exchange have?
3. What training and support is provided for pharmacy staff providing needle exchange services?
4. Do service users feel respected by pharmacy staff?
5. What is the level of training or experience in harm reduction amongst staff working in specialist community prescribing services?

### 4.5.1 Protecting staff from blood-borne virus exposure

This was an issue that scored reasonably well in the service review with over half (52%) of partnerships scoring "excellent". The interviewed partnerships mostly achieved the maximum score.

| | Q1 | Q2 | Q3 | Q4 | Q5 |
|---|---|---|---|---|---|
| **Weak** | 6% | 13% | 17% | 30% | 17% |
| **Fair** | 37% | 16% | 3% | 28% | 26% |
| **Good** | 5% | 59% | 26% | 40% | 43% |
| **Excellent** | 52% | 12% | 55% | 1% | 14% |
| **Mean** | 3.0 | 2.7 | 3.2 | 2.1 | 2.5 |

*Table 6: Responses to criterion 10 (staff competencies)*

### 4.5.2 Staff competency in non-pharmacy needle exchanges

This was another area which scored reasonably well in the review with over two-thirds (71%) of partnerships scoring "excellent" or "good". In the partnerships interviewed for this report, all scored highly and all put a strong emphasis on the importance of training their local treatment staff in harm reduction. Harm reduction training was generally delivered across local drug treatment systems, not by providing separate training for staff working in needle exchanges and those working in drug treatment services (see section 4.5.5 for information on treatment system-wide training). However, it is worth noting that some partnerships confirmed that staff working in more specialist harm reduction services, or who had contact with more chaotic drug users, received more in-depth training than colleagues who were working with more stable clients.

### 4.5.3 Training and support for pharmacy staff providing needle exchange

Training and support for pharmacy staff providing needle exchange services was an area which scored well in the review, with well over three-quarters (81%) of partnerships scoring "excellent" or "good", a much higher score than for training for staff working in specialist harm reduction services and drug treatment services.

All the partnerships interviewed performed well on this question (almost all scored four) and reported putting a strong emphasis on ensuring that staff working with drug users in pharmacy needle exchange services were adequately trained in harm reduction and working with drug users. This applied to pharmacy counter staff as well as the pharmacists. To meet ongoing training needs, most areas had a rolling training programme for pharmacists and counter staff.

It was felt important by partnerships that all new pharmacists coming onto the needle exchange scheme receive training. The training input began when the pharmacies first started providing needle exchange services. Some areas provided resources for pharmacies new to the scheme. One area had set up a 24-hour helpline to assist pharmacists with drugs issues.

In most partnerships, pharmacists dispensing prescriptions to drug users were required to have some kind of certification. Some partnerships insisted that the lead pharmacist had a certificate from the Royal Pharmaceutical Society, and other areas insisted that pharmacists involved in the needle exchange scheme go through some sort of accredited training. Often this was Centre for Pharmacy Postgraduate Education (CPPE) accredited training, but some areas in the north-west used the Harmonisation of Accreditation Group (HAG) course, which is a fully accredited rolling programme.

The training events were held at regular intervals with a variation across the partnerships as to when and how they took place. Some areas ran evening courses so the pharmacists and other staff did not have to take time out of work to attend. Other areas ran courses during the day and these partnerships would usually pay for locum cover while the pharmacists were in training (sometimes this cost was covered by the PCT). In some areas, pharmacists would receive payment for attending courses. It was understood that these training courses for pharmacy staff were popular and well attended. Some partnerships had recognised the need for training locum pharmacists in harm reduction and were taking steps to meet this particular need.

In many areas, these training courses involved staff input from local specialist drug treatment and harm reduction services. This also helped to create good links between the pharmacies and the drug services. Service users' input was also part of many of the training courses.

Case study: Tameside pharmacy training

Tameside requires all of their pharmacists and pharmacy counter staff to go through the accredited HAG (Harmonisation of Accreditation Group) course. The HAG is a task group to harmonise specific enhanced service accreditation and competence requirements for community pharmacies within the north west. Tameside works with HAG and other local drug partnerships on the accreditation of pharmacists across Greater Manchester. This accreditation is not substance misuse specific, but there is a harm reduction component. This course provides substance misuse training with a focus on harm reduction.

The course is fully evaluated and run as a rolling programme. Staff from the specialist drug services also attend this course in order to improve relationships and links between specialist services and pharmacists.

Pharmacists are trained on areas including working with the client group, injecting techniques and injecting equipment. The service user group is involved in the training, which is believed to be helpful because pharmacists can receive direct input from the service users and have some of their questions answered, and the service users are able to see the training pharmacists receive and better understand the pressures faced by pharmacy staff.

#### 4.5.4 Respect from pharmacy staff

This was an issue that did not generally perform well in the service review with over half (58%) of partnerships scoring "fair" or "poor". This may have been due to poor training of pharmacy staff in working with drug-using clients. Only one of the partnerships interviewed scored four and the rest showed a mixed picture. Some of these areas reported that pharmacy staff attitudes to service users had been a problem in one or more of their pharmacy services, but often this was reported to the partnership through user consultation mechanisms and they were able to deal with problems by liaising with the relevant pharmacies and providing training where necessary.

#### 4.5.5 Harm reduction training in specialist community prescribing services

This issue scored adequately in the service review, with just over half (57%) of partnerships scoring "excellent" or "good". The interviewed partnerships again displayed a mixed picture, with scores ranging from one to four.

Staff competence in providing harm reduction across the local drug treatment system was an important issue for all partnerships interviewed. It was standard practice for all substance misuse staff to receive some harm reduction training. Many partnerships also pointed to the importance of harm reduction training for the wider group of health, social care and criminal justice staff working with drug users.

Regular harm reduction training for drug service staff working with drug users was provided across all of the partnership areas, funded by the joint commissioning group. Examples of this included:

- Comprehensive harm reduction training, provided by in-house by experienced staff or by external training providers
- Blood-borne virus training, sometimes specifically focusing on particular viruses
- Overdose and overdose prevention training delivered in-house or sometimes by ambulance staff
- Safer injecting training
- Updates to previously received harm reduction training
- Harm reduction training for police dealing with drug users custody suites, as well as non-police staff working in custody suites
- Harm reduction training for other non-drug specialist staff working with drug users, such as housing, probation and other Tier 1 healthcare staff.

The training was usually provided based in identified training needs and commissioned by the partnership, and delivered in a variety of ways including in-house training for larger agencies and multi-agency training across a range of local treatment providers, or other professionals working with drug users. Often there was a specific minimum level of training provided, for example a specific number of days for each staff member.

Some areas had created a specific post that was responsible to co-ordination of local training, including working with services to identify training needs, organising the delivery of the training, contracting with training providers where necessary and delivering training courses.

Some areas pointed to consistency of staffing as an important factor in good performance in harm reduction. Treatment staff who were in place for a long time in services were believed to have had the opportunity to build up longer-term relationships with the clients as well as with other people in partner agencies. There was also a case made for consistency in staffing at the centre of the local drug partnership contributing to good performance in the service review.

### 4.6 Other contributory factors

In addition to the issues that correspond to the criteria and questions used in the service review, there were some other issues which were raised in the interviews, which were thought to be relevant to the partnership's good performance on harm reduction.

### 4.6.1 Co-ordinated harm reduction services

All of the partnerships interviewed employed people in co-ordination roles to oversee and run the local harm reduction services, but these roles varied from area to area. In most places, the specialist harm reduction services and the pharmacy needle exchange services were separate and few areas had a single needle exchange or harm reduction co-ordinator who oversaw the whole local system (specialist and pharmacy services). However, all of the interviewed areas had a co-ordinator for the pharmacy exchange system. The nature of this post varied across partnerships and was the responsibility of a range of staff such as harm reduction nurses, drugs workers and people whose specific role was to co-ordinate the local pharmacy system. Most of these co-ordinators were employed by the statutory drug service or PCT, but there were examples of the co-ordinator being part of the local voluntary sector community service.

*The needle exchange co-ordinator*

All areas had a specific post for the co-ordination of pharmacy needle exchange. This person had a range of responsibilities, depending on the area, but usually included the following:

- Dealing with stock and equipment supply to pharmacist – the co-ordinator would visit pharmacies regularly to deliver packs and other equipment
- Collecting needle exchange activity data which would be used to decide payments and to monitor clients in the pharmacy system and fed into local harm reduction databases
- Dealing with queries from the pharmacies
- Recruitment of new pharmacies and maintaining relationships with pharmacies already in the scheme
- Providing training and ongoing support to pharmacists – this involved making regular visits to pharmacies to discuss staff training needs. One area had a separate needle exchange mentor to assist pharmacists and staff with harm reduction issues
- Delivering one-to-one training interventions with pharmacy staff
- Liaison across pharmacies, specialist treatment providers and service users
- Meeting with local pharmaceutical committee representatives
- Delivering opportunistic one-to-one harm reduction interventions with service users in pharmacies, if the co-ordinator was competent to do this.

### 4.6.2 Distribution and return of injecting equipment

*Ensuring widespread distribution*

There was a division among the interviewed partnerships on policies for the distribution and return of injecting equipment. Some areas had an expressed intention to give out as much equipment as possible, regardless of the number of returns, to ensure that injectors has as much access to clean equipment as possible in order to reduce the potential for contracting blood-borne viruses.

*Secondary distribution*

This was another issue that showed differences between high-performing partnerships. Some services actively encouraged secondary distribution in the quest to get as much clean injecting equipment as possible out to drug users. Other areas did not encourage this practice, mainly because they were uncomfortable with the idea that people might be using injecting equipment without any advice or information on how to use it correctly or safely. The areas that encouraged secondary distribution reported that they utilised peer education and training, where a number of service users were trained in safer injecting who could then educate their peers in safer injecting.

*Encouraging returns*

Generally, the return rates of injecting equipment reported were fairly high, with some areas reporting return rates as high as 95–100 per cent. Some partnerships had run campaigns to encourage returns. Although campaigns were found to be effective, there was a stronger emphasis on the relationship between staff in harm reduction services (including pharmacy staff) and the service users, as being important in encouraging returns. Through these relationships with clients, the staff usually found it possible to discuss issues relating to discards and the importance of safe disposal and returning used works. If there were problems in getting returns from some clients, staff often would emphasise how discarded needles can have a negative effect on the needle exchange service's reputation and thus threaten the future availability of the service. One area had done presentations on injecting equipment found in particular areas to bring the issue closer to home to service users, especially since these were often the areas where the clients lived. It was also felt useful to have thank you messages on posters and other material to encourage users who were returning equipment, to continue to do so.

*Dealing with drug litter*

There were differences between partnerships on whether discarded injecting equipment was a problem or not. In many areas, it was reported as not being significant. In other areas there were more drug litter issues, but the partnership and services had been able to identify particular hotspots and take

appropriate action. In both types of area, there were usually good links with the local authorities through the environmental health and waste management department.

For the areas that had problems with discarded needles, a number of ways of tackling this were used.

- One area had a 24-hour helpline where community members could inform the DAT about discards and raise other concerns
- User involvement in collecting discards – one area had a team of trained service users who collected discarded sharps. This kind of involvement raised awareness among other users and had helped to bring down discards overall through a form of peer pressure
- Direct work with users through relationships and discussions – one area used images of discards to bring the reality of the problem home to service users
- Placing of secure public sharps bins in hotspot areas to enable easier returns. In one area, this included a sharps bin in a hospital that had been identified as having a problem with discards
- One area had set up a specific drug litter group involving environmental health
- In some areas, local community wardens and park wardens were trained in disposal of injecting equipment
- Active attempts by service users to deal with the problem of discards were found to help with local attitudes towards drug users. To promote this, one partnership did a survey with local shopkeepers; an exercise which in itself also helped to improve relationships.

#### 4.6.3 Harm reduction in non-drug treatment settings

There were discussions about a variety of different harm reduction interventions in non-drug treatment settings. The most common of these were harm reduction interventions provided by criminal justice workers in police custody suites (see also section 4.4.3). All interviewed partnerships had services that provided some advice, information and referral to people held in custody for drug-related offences. This included talking to clients about issues such as blood-borne viruses, safer injection and making them aware of services in the community. A small number of areas had a needle exchange in the policy custody suite.

Other examples of harm reduction services in non-drug treatment settings included:

- Harm reduction workers in magistrates' courts
- Providing harm reduction training to housing staff
- Training community wardens in harm reduction
- A hospital pharmacy running a needle exchange
- Needle exchange in a hospital A&E
- Needle exchange in hostels.

# 5 Conclusion

The NTA and Healthcare Commission harm reduction improvement service review found evidence of good practice in harm reduction services, but also that many improvements can still be made, even for these scoring highly overall. This overall finding was reflected in the areas selected for interview.

The interviews revealed that even in the partnerships that are performing well, there are still a few areas for improvement. A number of these were highlighted in most interviews and included harm reduction for stimulant users, testing for blood-borne viruses, and particularly treatment pathways for hepatitis C.

However, although it was a necessarily limited interview sample, there was plenty evidence of good, innovative practice and robust strategic service development. The harm reduction practices of these areas are therefore worth considering and have been set out in the report with the aim of providing useful pointers for other areas. Partnerships that also performed well on harm reduction may not find anything particularly new in this report but it is the NTA's experience, in this and past reviews, that partnerships that scored less highly will usually have a something to learn from the areas that are performing well. The practice highlighted by the interviewed partnerships provides a basis for building good-quality harm reduction services.

## 5.1 Acknowledgements

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# 7 Appendix 1: Key documents and guidance

## 7.1 Models of Care: Update 2006

Models of Care for the treatment of adult drug misusers is the national framework for the commissioning and provision of drug treatment services in England. Although the NTA had already stressed the importance of harm reduction in the original Models of Care for the treatment of adult drug users (NTA, 2002), the 2006 update of Models of Care (NTA, 2006a) had a specific aim of a greater emphasis in harm reduction as a core component of all structured treatment interventions (Tiers 1–4). One of the main reasons for this was the reported rises in blood-borne viruses and site infections among injecting drug users and an increase in drug-related deaths.

## 7.2 Clinical guidelines

Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH *et al.*, 2007) is the national clinical guidelines for clinicians providing pharmacological interventions for drug misusers as a component of drug misuse treatment. It was fully updated and published in September 2007 and this update fully replaces the original 1999 clinical guidelines.

The 2007 clinical guidelines provide guidance on the treatment of drug misuse in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances.

The updated clinical guidelines cover harm reduction in chapter six. There are extensive sections on both blood-borne infections – covering prevention and testing, responding to exposure to infection, and a range of viral infections and bacterial infections – and preventing drug-relating deaths, covering causes of drug-related deaths, how clinicians can reduce these deaths in their patients and how to deal with overdose.

## 7.3 Reducing Drug-Related Harm: An Action Plan

This plan was published by the Department of Health in May 2007 to set out the broad streams of action to be taken in England to enhance harm reduction activities within drug treatment services. The aim of the plan is to limit to number of drug misusers dying from drug-related causes or contracting blood-borne virus infections.

The action plan builds on previous work on reducing drug-related harm and reflects lessons drawn from an expert group. It sets out all the activities to be undertaken within the each of the three strands, which are:

- Campaigns
- Improving delivery
- Increased surveillance.

## 7.4 Hepatitis C Action Plan

The growing importance of hepatitis C as a public health issue was highlighted in 2002 with the publication of the Government's Hepatitis C Strategy for England. It brought together existing initiatives to tackle hepatitis C and suggested how prevention, diagnosis and treatment could be improved. The Hepatitis C Action Plan, published by the Department of Health in 2004, is based on best practice, serves as a broad framework for implementation of the Hepatitis C Strategy for England. It reflects ongoing work that needs to be sustained and intensified and also identifies new areas for action.

Since the publication of this action plan, the Health Protection Agency has subsequently published yearly updates describing progress on the plan. There have been three Hepatitis C Strategy for England reports to date.

### 7.5 NICE guidance on needle exchange and syringe programmes

NICE is currently in the process of developing public health intervention guidance on the optimal provision of needle exchange schemes among injecting drug users. This guidance will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. The scope of this guidance has been consulted on and the final scope was published in January 2008. Consultation on this guidance will take place throughout 2008, with the final guidance expected in February 2009.

### 7.6 Shooting Up reports

The Health Protection Agency has been producing Shooting Up, a yearly update focusing solely on infections among injecting drug users in the United Kingdom, since 2002. The reports focus on the current prevalence of the main viral infections (hepatitis A, B, C and HIV) and bacterial infections (staphylococcus aureus infections, group A streptococcal infections and clostridial infections) as well as making recommendations.

The key findings of the latest Shooting Up report (2007) include:

- Injecting into the groin and the injection of crack cocaine, which are both associated with higher levels of infection and injecting risk, have become more common
- Overall hepatitis C infection among injecting drug users has increased in recent years, with almost half now infected.
- The level of HIV infection in England and Wales among injecting drug users has increased since the start of the decade to one in 75.
- There has been a marked increase in the number of injecting drug users receiving the hepatitis B vaccine, with two-thirds now reporting vaccination.

### 7.7 The Safer Injecting Briefing

The Safer Injecting Briefing (DrugScope, 1999) is produced as a guide to promoting safer injecting. The guidance covers areas such as the evidence base for promoting safer injecting, routes of administration, vein damage, transmission of blood-borne viruses and providing comprehensive services to tackle unsafe injecting practices.

### 7.8 NICE hepatitis C guidance

The National Institute for Health and Clinical Excellence (NICE) has produced a number of guidance reports on hepatitis C. The guidance most currently relevant is the 2004 technology appraisal (TA) 75 Interferon alfa (pegylated and non-pegylated) and ribavirin for the treatment of chronic hepatitis C. This guidance notes that although current injecting drug users can have high rates of discontinuation of hepatitis C treatment in trials, there is evidence that where adherence is achieved, success rates are not significantly different. The rate of discontinuation of hepatitis C treatment by injecting drug users in trials would not be so great as to prevent the treatment being cost effective.

Technology appraisal guidance 106 Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C was published in August 2006, as an extension of the guidance given in TA75.

## 8 Appendix 2: Partnerships involved and rationale

### 8.1 Partnerships interviewed

The following partnerships were interviewed about their harm reduction practice: Nottinghamshire, Kirklees, Bradford, Harrow, Stockton-on-Tees, Tameside, Knowsley, Calderdale, Wigan, Brent, Kensington & Chelsea, Cheshire

### 8.2 Rationale for selection

The partnerships highlighted above were selected by an iterative process to specifically identify those partnerships which scored highly on harm reduction. The rationale was that a partnership might be particularly good at either harm reduction or commissioning but less good at the other. Therefore rather than merely select the partnerships with the highest overall score, a number of checks were applied to the review data.

The selection process looked at the scores for each criterion within commissioning and harm reduction, and the scores for the questions which made up the criteria. We noted the partnerships that scored consistently well across a range of criteria, those that scored well across the questions within particular criteria and those that scored badly for any particular criteria.

These criteria were looked at individually. The partnerships which scored the highest possible score (14-16) for harm reduction were identified in tables.

The three highest-scoring partnerships (scoring 16) were immediately selected for interview. Since there was not enough time or resources to interview all partnerships which scored 14–16, an iterative process was used to determine which partnerships to interview. This involved looking in more detail at their scores for individual criteria and questions which make up the criteria.

The four harm reduction criteria were looked at individually. The partnerships which had the highest overall score for each of the criteria were identified. A number of other factors were also considered for each partnership. These were:

- The number of times where individual partnerships achieved the maximum score across for all the criteria
- The criteria for which the partnership scored the highest aggregate score (if any). This is based on the tables in appendix 1
- The total and overall improvement review scores – this shows if the partnership was in among the top scoring partnerships across the whole improvement review. Only partnerships scoring four overall are considered here

Applying these factors helped to narrow down a smaller number of partnerships to prioritise for contacting. The partnerships that were selected are those that have achieved the maximum score for individual criteria consistently, have scored well on all the questions within particular criteria, or have scored highly overall in the service review.

# 9 Appendix 3: Themes from the National Conference on Injecting Drug Use

To augment the interviews of partnerships that scored highly on harm reduction in the 2006/07 NTA/Healthcare Commission improvement review, some informal consultation was carried out at the National Conference on Injecting Drug Use in Glasgow (NCIDU) on 15 and 16 October 2007. This consultation consisted mainly of discussions that took place in a room set aside during the conference breaks and at a meeting of the National Needle Exchange Forum on 15 October.

Given that the NTA was in the process of interviewing local drug partnerships which were scored as being good at harm reduction, the consultation question asked to participants was: "What are the five key elements that you would expect to see in an area that is good at harm reduction?"

The responses covered the following themes.

## 9.1 Diversity of service provision

- "More than just needles"
- Harm reduction provided in as many different ways as possible. (specialist services, pharmacy, outreach, mobile needle exchanges etc)
- Full range of injecting equipment available in needle exchanges
- Give out injecting equipment in large volumes.
- Good service provision for steroid users
- Ability of reach black and minority ethnic groups with harm reduction services

## 9.2 Good access to harm reduction services

- Comprehensive coverage of harm reduction services in local areas
- Good out-of-hours access, including the use of 100-hour pharmacies
- Wider availability of needle exchange through pharmacies
- Outreach services actively finding people and targeting hard to reach groups.
- More home delivery services
- Clear referral routes in place between pharmacy and specialist services, with awareness that some clients may only attend pharmacy service, and who may need to be encouraged into other services

## 9.3 Good quality blood-borne virus interventions

- Screening and anonymous testing of blood-borne viruses (hepatitis B and C and HIV) as widely as possible
- Providing as hepatitis B vaccinations to all service users
- Clear routes into treatment for hepatitis C, to make it easier for clients to access treatment

## 9.4 Good access to harm reduction nurses

- More nurses in needle exchange service to carry out healthcare interventions
- More nurse-led harm reduction drop-in clinics
- Nurses providing general healthcare assessments to clients.

## 9.5 Good links with structured drug treatment

There would be good links between drug treatment and harm reduction services. Examples given of what these links might look like included:

- Shared skills and experience between Tier 2 and 3 services
- Harm reduction through treatment services.

## 9.6 User involvement

- Good user consultation and participation in harm reduction service
- Overdose training provided for users and concerned others
- Availability of peer-based harm reduction workshops, including peer training on overdose.

## 9.7 Staff competence

- Staff trained in blood-borne viruses and able to raise sexual health issues

- Good quality staff training on harm reduction, which ideally would involve users
- Ideally, harm reduction training would be mandatory for everyone involved in working with drug users, including pharmacy shop and counter staff
- Training including pre and post-hepatitis test discussions
- Good signposting between pharmacy needle exchange, specialist needle exchange and other services.

### 9.8 Strategic

- Partnerships and services need to have a good understanding of the needs of the client group
- Good "partnership buy-in" enabling the harm reduction system to work properly
- Good co-ordination of harm reduction services done by a competent professional
- Having good links between the partnership, health promotion and public health.

## 10 Appendix 4: Service review partnership rankings

The tables on the following pages show the partnerships ranked by their overall harm reduction score from the service review, and the scores from the four harm reduction criteria. There is further data from the review on the NTA website www.nta.nhs.uk

## Service review partnership rankings

| Partnership | Criterion 7 | Criterion 8 | Criterion 9 | Criterion 10 | Overall harm reduction score |
|---|---|---|---|---|---|
| Bradford | 4 | 4 | 4 | 4 | 16 |
| Brent | 4 | 4 | 4 | 4 | 16 |
| Stockton-on-Tees | 4 | 4 | 4 | 4 | 16 |
| Bolton | 4 | 3 | 4 | 4 | 15 |
| City of London | 4 | 3 | 4 | 4 | 15 |
| Darlington | 4 | 3 | 4 | 4 | 15 |
| Ealing | 4 | 3 | 4 | 4 | 15 |
| Kensington and Chelsea | 4 | 4 | 4 | 3 | 15 |
| Knowsley | 4 | 3 | 4 | 4 | 15 |
| Liverpool | 4 | 3 | 4 | 4 | 15 |
| Oldham | 4 | 3 | 4 | 4 | 15 |
| Solihull | 4 | 4 | 4 | 3 | 15 |
| Southend-on-Sea | 4 | 3 | 4 | 4 | 15 |
| Southwark | 4 | 3 | 4 | 4 | 15 |
| Thurrock | 4 | 3 | 4 | 4 | 15 |
| Wigan | 4 | 3 | 4 | 4 | 15 |
| Cheshire | 4 | 3 | 4 | 3 | 14 |
| Croydon | 4 | 3 | 4 | 3 | 14 |
| Hammersmith and Fulham | 4 | 3 | 4 | 3 | 14 |
| Harrow | 3 | 3 | 4 | 4 | 14 |
| Kirklees | 4 | 3 | 4 | 3 | 14 |
| Lancashire | 4 | 3 | 4 | 3 | 14 |
| Middlesbrough | 4 | 3 | 4 | 3 | 14 |
| Newcastle upon Tyne | 3 | 3 | 4 | 4 | 14 |
| North East Lincolnshire | 4 | 3 | 4 | 3 | 14 |
| Nottinghamshire | 4 | 3 | 4 | 3 | 14 |
| Oxfordshire | 4 | 3 | 4 | 3 | 14 |
| Southampton | 3 | 4 | 4 | 3 | 14 |
| Tameside | 3 | 3 | 4 | 4 | 14 |
| Torbay | 3 | 4 | 4 | 3 | 14 |
| Tower Hamlets | 3 | 3 | 4 | 4 | 14 |
| Walsall | 4 | 3 | 4 | 3 | 14 |
| Wirral | 4 | 3 | 4 | 3 | 14 |
| Blackpool | 4 | 2 | 4 | 4 | 14 |
| Calderdale | 4 | 2 | 4 | 4 | 14 |
| County Durham | 4 | 2 | 4 | 4 | 14 |
| Manchester | 4 | 4 | 4 | 2 | 14 |
| West Berkshire | 4 | 2 | 4 | 4 | 14 |
| Birmingham | 3 | 3 | 4 | 3 | 13 |
| Bournemouth | 3 | 3 | 4 | 3 | 13 |
| Dorset | 3 | 3 | 4 | 3 | 13 |
| Islington | 4 | 3 | 3 | 3 | 13 |
| Kingston Upon Hull | 3 | 3 | 4 | 3 | 13 |
| Lambeth | 3 | 3 | 4 | 3 | 13 |
| Leeds | 3 | 3 | 4 | 3 | 13 |

## Service review partnership rankings

| Partnership | Criterion 7 | Criterion 8 | Criterion 9 | Criterion 10 | Overall harm reduction score |
|---|---|---|---|---|---|
| Rotherham | 3 | 3 | 4 | 3 | 13 |
| Salford | 3 | 3 | 3 | 4 | 13 |
| Sunderland | 3 | 3 | 4 | 3 | 13 |
| Westminster | 3 | 3 | 4 | 3 | 13 |
| Bristol | 4 | 3 | 4 | 2 | 13 |
| Buckinghamshire | 4 | 2 | 4 | 3 | 13 |
| Bury | 4 | 2 | 4 | 3 | 13 |
| Devon | 4 | 3 | 4 | 2 | 13 |
| Essex | 4 | 2 | 4 | 3 | 13 |
| Gateshead | 4 | 3 | 4 | 2 | 13 |
| Haringey | 4 | 2 | 3 | 4 | 13 |
| Luton | 4 | 2 | 4 | 3 | 13 |
| Northumberland | 4 | 3 | 4 | 2 | 13 |
| Poole | 4 | 3 | 4 | 2 | 13 |
| Reading | 4 | 2 | 4 | 3 | 13 |
| Sefton | 4 | 2 | 4 | 3 | 13 |
| Sheffield | 3 | 4 | 4 | 2 | 13 |
| Trafford | 3 | 2 | 4 | 4 | 13 |
| Wandsworth | 4 | 2 | 4 | 3 | 13 |
| Norfolk | 3 | 3 | 3 | 3 | 12 |
| Barnet | 4 | 2 | 3 | 3 | 12 |
| Bexley | 2 | 3 | 4 | 3 | 12 |
| Cornwall & Isles of Scilly | 2 | 3 | 4 | 3 | 12 |
| Doncaster | 4 | 2 | 3 | 3 | 12 |
| Gloucestershire | 2 | 4 | 3 | 3 | 12 |
| Greenwich | 3 | 3 | 2 | 4 | 12 |
| Leicester | 3 | 3 | 4 | 2 | 12 |
| Lewisham | 3 | 2 | 4 | 3 | 12 |
| Lincolnshire | 3 | 3 | 4 | 2 | 12 |
| North Lincolnshire | 3 | 3 | 4 | 2 | 12 |
| Rutland | 3 | 2 | 4 | 3 | 12 |
| Somerset | 3 | 2 | 4 | 3 | 12 |
| Stockport | 3 | 2 | 4 | 3 | 12 |
| Waltham Forest | 3 | 3 | 4 | 2 | 12 |
| Warwickshire | 3 | 2 | 4 | 3 | 12 |
| Wolverhampton | 3 | 2 | 4 | 3 | 12 |
| South Gloucestershire | 4 | 2 | 4 | 2 | 12 |
| Barking and Dagenham | 3 | 3 | 3 | 2 | 11 |
| Brighton and Hove | 3 | 2 | 3 | 3 | 11 |
| Hillingdon | 2 | 3 | 3 | 3 | 11 |
| Newham | 3 | 3 | 2 | 3 | 11 |
| North Tyneside | 2 | 3 | 3 | 3 | 11 |
| Sandwell | 3 | 2 | 3 | 3 | 11 |
| Swindon | 3 | 3 | 2 | 3 | 11 |
| Blackburn with Darwen | 2 | 2 | 4 | 3 | 11 |

## Service review partnership rankings

| Partnership | Criterion 7 | Criterion 8 | Criterion 9 | Criterion 10 | Overall harm reduction score |
|---|---|---|---|---|---|
| Bracknell Forest | 3 | 2 | 4 | 2 | 11 |
| Cambridgeshire | 4 | 2 | 3 | 2 | 11 |
| Coventry | 2 | 3 | 2 | 4 | 11 |
| Cumbria | 2 | 2 | 4 | 3 | 11 |
| Derbyshire | 2 | 2 | 4 | 3 | 11 |
| Dudley | 3 | 2 | 2 | 4 | 11 |
| Hackney | 2 | 2 | 4 | 3 | 11 |
| Halton | 3 | 2 | 4 | 2 | 11 |
| Hartlepool | 2 | 2 | 4 | 3 | 11 |
| Leicestershire | 3 | 2 | 4 | 2 | 11 |
| Plymouth | 2 | 2 | 4 | 3 | 11 |
| Rochdale | 2 | 2 | 4 | 3 | 11 |
| Shropshire | 2 | 3 | 4 | 2 | 11 |
| Stoke-on-Trent | 2 | 3 | 4 | 2 | 11 |
| Windsor and Maidenhead | 2 | 2 | 4 | 3 | 11 |
| Barnsley | 2 | 3 | 3 | 2 | 10 |
| Derby | 2 | 2 | 3 | 3 | 10 |
| East Sussex | 3 | 2 | 2 | 3 | 10 |
| Hampshire | 3 | 2 | 2 | 3 | 10 |
| Hertfordshire | 3 | 2 | 2 | 3 | 10 |
| Kingston upon Thames | 2 | 2 | 3 | 3 | 10 |
| Nottingham | 2 | 3 | 3 | 2 | 10 |
| Portsmouth | 3 | 2 | 3 | 2 | 10 |
| South Tyneside | 3 | 2 | 3 | 2 | 10 |
| St Helens | 2 | 3 | 2 | 3 | 10 |
| Suffolk | 3 | 2 | 3 | 2 | 10 |
| Sutton | 3 | 3 | 2 | 2 | 10 |
| Telford and Wrekin | 2 | 3 | 2 | 3 | 10 |
| Wakefield | 3 | 2 | 3 | 2 | 10 |
| Wokingham | 3 | 2 | 2 | 3 | 10 |
| York | 2 | 2 | 3 | 3 | 10 |
| East Riding of Yorkshire | 2 | 2 | 4 | 2 | 10 |
| Enfield | 2 | 2 | 2 | 4 | 10 |
| Havering | 2 | 2 | 4 | 2 | 10 |
| Isle of Wight | 2 | 2 | 4 | 2 | 10 |
| Slough | 2 | 2 | 4 | 2 | 10 |
| Bath and North East Somerset | 3 | 2 | 2 | 2 | 9 |
| Bedfordshire | 2 | 2 | 2 | 3 | 9 |
| Bromley | 2 | 2 | 3 | 2 | 9 |
| Herefordshire | 2 | 2 | 3 | 2 | 9 |
| Kent | 2 | 2 | 2 | 3 | 9 |
| Merton | 2 | 2 | 2 | 3 | 9 |
| North Somerset | 2 | 2 | 2 | 3 | 9 |
| North Yorkshire | 2 | 2 | 3 | 2 | 9 |
| Northamptonshire | 2 | 2 | 2 | 3 | 9 |

## Service review partnership rankings

| Partnership | Criterion 7 | Criterion 8 | Criterion 9 | Criterion 10 | Overall harm reduction score |
|---|---|---|---|---|---|
| Staffordshire | 3 | 2 | 2 | 2 | 9 |
| Warrington | 2 | 2 | 2 | 3 | 9 |
| Wiltshire | 2 | 2 | 3 | 2 | 9 |
| Hounslow | 2 | 2 | 1 | 4 | 9 |
| Camden | 2 | 2 | 2 | 2 | 8 |
| Medway towns | 2 | 2 | 2 | 2 | 8 |
| Redbridge | 2 | 2 | 2 | 2 | 8 |
| Surrey | 2 | 2 | 2 | 2 | 8 |
| Worcestershire | 2 | 2 | 2 | 2 | 8 |
| Milton Keynes | 2 | 2 | 1 | 3 | 8 |
| Peterborough | 1 | 3 | 2 | 2 | 8 |
| Redcar and Cleveland | 2 | 1 | 3 | 2 | 8 |
| West Sussex | 2 | 2 | 1 | 3 | 8 |
| Richmond upon Thames | 1 | 2 | 2 | 2 | 7 |

**National Treatment Agency for Substance Misuse**

8th floor, Hercules House, Hercules Road, London SE1 7DU

Tel: 020 7261 8801. Fax: 020 7261 8883

Email: nta.enquiries@nta-nhs.org.uk  Website: www.nta.nhs.uk

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