NHS

National Treatment Agency
for Substance Misuse

Harm reduction findings from the NTA's 2006 survey of user satisfaction in England

August 2007

Contents

Acknowledgements

We would like to thank all service users who took time to respond to the survey very much. Your contribution is greatly appreciated.

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Executive summary

Introduction and background

This report investigates the harm reduction support received by the users of drug services, as well as pharmacy-based needle exchange services.[1] Data was collected as part of The NTA's 2006 Survey of User Satisfaction in England (NTA, 2007), [2] which included a section on harm reduction.

Self-completion questionnaires were distributed in August 2006 to the clients of Tier 3 and 4 drug treatment services in England, as well as the users of Tier 2 drug services. In addition, a shorter questionnaire – consisting of the harm reduction questions only – was distributed in October 2006 to the clients of pharmacy-based needle exchange services.[3]

This document reports on data on harm reduction from 10,070 respondents to the combined questionnaires.

Findings and implications

- The population surveyed was mostly in treatment. The majority of respondents to the two surveys had a care plan (64.7%) and were in structured treatment
- Respondents to the pharmacy and user surveys had similar levels of contact with drug treatment:
  - Approximately two-thirds of respondents to The 2006 user survey (65.7%) had a care plan. Seventy per cent were in opioid substitute prescribing treatment and/or had a care plan
  - Approximately 60 per cent of respondents contacted via the pharmacy survey also had a care plan and data suggests that overall, 70 per cent of respondents to the surveys had care plans, were on an opioid substitute treatment regimes, or both
  - Data from only 50 respondents from the pharmacy survey suggests that pharmacies may be their only contact with drug services. They formed approximately four per cent of respondents of the pharmacy survey
  - Respondents of the combined surveys used a range of substances which included heroin (55%), crack (44.6%), benzodiazepines (32.3%) and amphetamines (16.6%)
- Polydrug and alcohol use were common among this group – approximately a third of respondents to The 2006 user survey reported using both heroin and crack (32.5%), as did 70.75 per cent of those responding to the pharmacy survey. Overall, there was a link between current injecting (in past four weeks) and the use of both heroin and crack
- The majority of respondents had a history of injecting (approximately 70%), but only just over a third (36.9%) reported they had injected in past four weeks. Respondents to the pharmacy survey were significantly (and predictably) more likely than others to be current injectors, hence their attendance at needle exchange facilities
- The desire for change of behaviour was widespread. The majority, approximately 80 per cent, of current injectors reported wanting to stop injecting, particularly if they were in substitute prescribing treatment. Young people under the age of 30 years were also more likely to have reported wanting to stop injecting than their older peers
- A range of needle exchange facilities were used by injectors to obtain needles and syringes. Approximately two-thirds (68.6%) of current injectors (had injected in previous four weeks) used drug services and needle exchanges to obtain sterile injecting equipment and paraphernalia, and 57.4 per cent used pharmacy-based needle exchange facilities. Approximately 30 per cent of current injectors received free clean needles and syringes from drug services, needle exchange services and pharmacy needle exchanges. A small number also obtained sterile needles and syringes from other injectors (6.7%) or dealers (1.7%)

[1] For the sake of convenience they will be referred to as the harm reduction system.
[2] Will be referred to for convenience as the 2006 user survey
[3] Will be referred to for convenience as the pharmacy survey

- The survey suggested that high-risk drug-using behaviours may have continued to take place among some groups, despite contact with drug treatment services. Injecting, polydrug use, illicit drug use on top of a prescribing regime and problem alcohol use were common
- Harm reduction goals were included in most, but not all, care plans. Approximately 60 per cent of current injectors with a care plan reported that this included goals to reduce the risks of the spread of BBVs and 60 per cent of this group reported goals of reducing the risks of overdose in their care plans
- The reduction of alcohol-related harm was less likely to be identified as a goal in care plans. Approximately 30 per cent of all respondents with a care plan reported goals relating to the reduction of alcohol-related harm. The reduction of alcohol-related harm was also not always a care plan goal where it may have been needed: approximately one-third of respondents who had requested help over alcohol-related issues and had a care plan reported that this care plan did not have a goal to reduce alcohol-related harm
- Care plans reviewed in the past three months were more likely to have harm reduction goals than those reviewed more than three months ago
- Respondents to The 2006 user survey reported that their use of illicit drug use had reduced as a result of treatment (almost 90 per cent agreed or strongly agreed that this was the case). Substantial percentages also reported that they wanted to stop completely their use of substances including heroin (77%) and crack (73%). Almost half of methadone users (49.2%) reported wanting to stop using methadone completely
- Nonetheless, many respondents on an opioid substitute treatment regime did report using illicit substances in addition to the substances prescribed. Fewer than 30 per cent of respondents who were on an opioid substitute treatment regime reported never using on top of prescriptions. The majority did so, but at different frequencies (“sometimes”, “often” or “always”). Most of those (just over half) reporting doing so ”sometimes”. Respondents to the pharmacy survey were significantly more likely to use on top of prescriptions and did so at a higher frequency than respondents to The 2006 user survey
- Illicit substances used on top of prescriptions (or in addition to) prescribed through a treatment regime included the following:
  - In the 2006 user survey, the following percentages of respondents who reported using on top of prescriptions used these substances: heroin (81.6%) crack (approximately 60%), cannabis (57%) benzodiazepines (43%) and amphetamines (18.7%). The use of both heroin and crack on top of a prescribed substance was reported by 55 per cent of respondents
  - In the pharmacy survey, the following percentages of respondents who reported using on top of prescriptions – heroin (95%), crack (76%), amphetamines (27%) and benzodiazepines (58%). The use of both heroin and crack on top of a prescribed substance was reported by 75 per cent of respondents
  - Overall in both surveys, the majority (58%) of those who used on top of prescriptions used both heroin and crack
- The following groups were more likely to use on top of prescriptions and do so more frequently:
  - Current injectors (in past four weeks)
  - Service users with a methadone rather than buprenorphine prescription
  - Users of both heroin and crack.
- The surveys have provided a systematic overview of the harm reduction advice and interventions that service users received in the three months before the survey. This data provides concrete evidence to support national policy drives aimed at reinvigorating harm reduction interventions: overall, many service users received the range of advice, but most did not
- Current injectors (in past four weeks) were significantly more likely to have received the advice and interventions than others in the past three months, but not all did. For example, more than 60 per cent of current injectors received advice on the risks of sharing needles and syringes, filters and injecting water, and approximately 60 per cent received advice on the increased

risks of overdose from injecting. Respondents were more likely to have received advice on the risks of sharing needles and paraphernalia than other harm reduction advice

- Service users were significantly more likely to have received harm reduction advice and interventions in the past three months if:
  - They were current injectors
  - They had a care plan and particularly if the care plan was reviewed in the past three months
  - They were in an opioid substitute prescribing programme
  - They had a keyworker
  - They were men
- Substantial numbers of respondents believed that the range of harm reduction advice and interventions were relevant to them, but they had not received them. This suggests un-met needs among many respondents
- Although injectors may have been more likely than others to have received harm reduction advice and interventions, they were also more likely than others to say that this was relevant to them, but that they had not received them. In particular, almost 33 per cent of current injectors believed that overdose prevention training was relevant to them but they had not received it. Almost 30 per cent reported the relevance of a general health check and one-quarter identified the need for having their injecting sites checked. One in five current injectors believed that hepatitis B immunisation was relevant to them but they had not received it
- The survey clearly indicates the need to enhance harm reduction across of the whole of the treatment system and in all treatment tiers, with targeted interventions for those most at risk and those who have been less likely to be reached by harm reduction advice and interventions.

1 Introduction

This report investigates the harm reduction support received by the users of all drug treatment services, as well as pharmacy-based needle and syringe exchange services in England.[4] Data was collected as part of The 2006 user survey, which included a section on harm reduction.

The NTA and other government agencies are concerned over reports of the increase of sharing of injecting equipment and the growing risk of transmission of blood-borne viruses (BBVs) and infections (HPA: 2006a; HPA: 2006b). Similarly, it is acknowledged that drug-related deaths (DRDs) must be reduced further as the government strategy to reduce these deaths (DH, 2001) from a baseline of 1,480 in 1999 by 20 per cent by 2004 was not met.

Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006) advocates a far greater emphasis on harm reduction at all points in the treatment journey, before, during and after all structured treatment. It also specifically mentions the need to reinvigorate harm reduction in all treatment tiers and the requirement for an immediate response by commissioners and providers in order to stem the increase in BBVs and drug-related deaths. This will be carried out through the following:

1 Joint NTA and 2006/07 Healthcare Commission Improvement Reviews, which focused in 2006 on harm reduction

2 Baseline data to inform a variety of programmes of improvement as part of the new Reducing Drug-Related Harm: An Action Plan (DH, 2007)

This survey will feed into a wider piece of work that will gauge whether local drug treatment systems in England meet the recommendations identified by Models of Care: Update 2006 (NTA, 2006).

This document is part of a series of national users survey reports. It complements The NTA's 2006 Survey of User Satisfaction in England (NTA, 2007) and A Comparison of the NTA's Survey of User Satisfaction 2005 and 2006 (NTA, forthcoming) and should also be read in conjunction with the report of the pharmacy survey (NTA, forthcoming).

2 Project design and respondents to the questionnaire

2.1 Project design and methods

Questionnaires were distributed to the clients of all Tier 2, 3 and 4 drug services in England. In addition, a shorter questionnaire – consisting of the harm reduction questions only – was distributed to the clients of pharmacy-based needle exchange services.[5]

A total of 1,014 drug services and 1,658 needle exchange pharmacies in England were asked to distribute self-completion confidential questionnaires to their service users. Questionnaires were returned by respondents in pre-paid sealed envelopes directly to the NTA.[6]

This document will report on the findings of the two surveys together. It will specifically look at the questions relevant to harm reduction. A total of 10,070 responses to the two sets of questionnaires were analysed (8,765 from the 2006 user survey and 1,305 for the pharmacy survey). Assuming that all questionnaires were distributed, the response rate to the 2006 user survey was just over 12 per cent and the response rate to the pharmacy survey was approximately 3.5 per cent.

[4] For the sake of convenience they will be referred to as the harm reduction system.
[5] Will be referred to for convenience as the pharmacy survey
[6] A detailed description of survey design and methodology can be found in the wider report on the NTA's Second Annual User Satisfaction Survey (NTA, forthcoming) and the report on the report on the pharmacy survey (NTA, forthcoming).

2.2 The survey tool

The primary objectives of the harm reduction elements of the questionnaire were to:

- Ascertain the level of harm reduction support received by service users. Gather baseline information that could be used for measuring change over time
- Establish the extent to which drug treatment services are operating in line with Models of Care and other guidance to inform the joint NTA and Healthcare Commission 2006/07 Improvement Reviews on harm reduction

In particular, the questionnaire collected information on the following:

1 Did respondents have a history of injecting and were they injecting at the time of the survey? Which types of needle exchange facilities did they use and did they receive injecting paraphernalia?

2 Did the care plans include harm reduction goals? This included goals around the reduction of the risks of overdose, the reduction of the risks of blood-borne infections, the reduction of alcohol-related harm and general health improvements.

3 Did they use illicit substances in addition to the substances prescribed to them (use on top of prescriptions) and how frequently they did so? What was the treatment services' response to this?

4 Have service users received advice and interventions in the past three months from professionals in the treatment system on the following issues?

   - Advice on BBV prevention
   - Advice on risks of sharing needles and syringes and other injecting paraphernalia
   - Advice on safer injecting techniques; checking of injecting sites
   - Advice on risks of overdose (as a result injecting, mixing substances or when tolerance was low). Overdose prevention training
   - Advice on preventing crack-related harm (heart and respiratory problems)
   - Advice on reducing the risks of alcohol
   - Hepatitis B immunisation, hepatitis C and HIV testing, HIV and hepatitis C treatment
   - Advice on safer sex and contraception, and advice on safe storage of medicines and general health checks.

2.3 A population mostly in treatment

The respondents of the two surveys (the 2006 user survey and the pharmacy survey) represented a population in contact with specialist drug services (Tiers 2–4). The majority were receiving structured drug treatment and 64.7 per cent had care plans.

It is also important to note that the majority of respondents contacted via the Pharmacy Survey also reported being in structured care. Specifically, just under 60 per cent of respondents to the survey reported having a care plan. Data suggests that around 70 per cent of respondents had care plans, were in opioid substitute prescribing treatment or both.

Thirty per cent of respondents contacted via the pharmacy survey were not in structured treatment (did not have a care plan or were not on a substitute prescribing regime). Data from only 50 respondents from the pharmacy survey suggested that pharmacies may be their only contact with drug services. They form approximately four per cent of respondents.

The high percentage of pharmacy needle exchange clients who were also in structured drug treatment raises a number of questions about how representative the sample is. It is not possible to determine why this was the case but the following factors should be considered:

- Design and methodology bias of the survey. Pharmacy clients not in touch with other drug treatment services (including Tier 2 services and needle exchange services) may have been less willing to complete the questionnaire.
- Good treatment penetration among injectors. It is also possible that the cohort of respondents to the pharmacy needle exchange survey were representative and that drug users on structured treatment programmes represented the majority of the users of pharmacy-based needle exchanges. This may reflect a good treatment penetration into injecting populations.

Because of the similarities of the two groups in terms of their contact with the drug treatment system, this document looks at data from the combined questionnaires together (the 2006 user survey and the pharmacy survey). This is because the majority of both sets of respondents were in structured treatment, and thus should have been exposed to an equivalent level of harm reduction support.

Where there were differences in the questionnaire questions, data from each is discussed separately.

2.4 Characteristics of the survey population

Respondents of the combined questionnaires were characterised as follows: 70 per cent male and 30 per cent female; the average age was 34 years. The majority (89%) described themselves as "white British" (3.5% "mixed race", 1% "Indian", 1.3% "Pakistani", 0.7% "Bangladeshi", 0.5% "Other Asian", 1.6% "Black Caribbean", 0.5% "Black African", 0.7% "Black Other", 0.1% "Chinese" and 1.1% "other ethnic group").

The respondents from the two questionnaires were similar in many respects and there were no differences in the mean age of respondents, nor in their gender. pharmacy survey respondents were predictably much more likely to be current injectors. There were also differences by ethnicity, with a smaller percentage of respondents from minority ethnic groups in the pharmacy survey than in the 2006 user survey.

The population surveyed was, on average, slightly older than the population in treatment as identified by NDTMS for 2005/06, which had an average age of 30 years. White respondents were over-represented in the pharmacy survey, where they constituted 93.5 per cent in comparison to NDTMS, where they accounted for 88 per cent. This may be sample bias, but probably also reflects the lower prevalence of injecting among black and minority ethnic respondents than white respondents discussed in Section 3.

	User Satisfaction Survey	pharmacy survey
White British	85.5%	93.5%
Mixed	3.6%	2.9%
Indian	1.1%	0.3%
Pakistani	1.1%	1%
Bangladeshi	0.8%	0.1%
Other Asian	0.6%	0.2%
Black Caribbean	1.7%	0.8%
Black African	0.6%	0.2%
Black Other	0.7%	0.4%
Chinese	0.1%	0%
Other ethnic group	1.2%	0.5%

Table 1: Response rate by questionnaire and by ethnicity

3 Drugs used by respondents

3.1 Drugs used and injected

The most commonly reported substance used was methadone, reflecting the fact that the survey was conducted mainly with a population in treatment and will be discussed in further detail below.

Respondents of the combined surveys used a range of substances which included heroin (55% of respondents), crack (44.6%), benzodiazepines (32.3%) and amphetamines (16.6%). There were differences between the two surveys, partially explained by the fact that respondents to the pharmacy survey were more likely to be current injectors (injected in the past four weeks) and were more likely to be active users of illicit substances and more likely to use illicit substances in addition to those prescribed by a treatment regime.

Drug used	Respondents to Annual user satisfaction survey (% of respondents)	Respondents to pharmacy survey (% of respondents)	All respondents (% of respondents)
Heroin	49.4%	89.6%	55%
Crack	41.1%	72.6%	44.6%
Amphetamine	14.7%	34.4%	16.6%
Benzodiazepines	29.7%	54.8%	32.3%

Table 2: Drug used by questionnaire

3.2 Polydrug use

Data suggests that polydrug and alcohol use was common, including the use of both heroin and crack, which is of particular interest to harm reduction. Overall and among respondents of the two surveys, 37 per cent reported using both heroin and crack.

In the 2006 user survey, 32.5 per cent of all respondents (2,147 out of 6,610) reported using both heroin and crack. Of the total respondents who used heroin (3,086), 70 per cent of this group also reported using crack.

A much larger percentage (71%) of all respondents of the pharmacy survey used both these substances (600 out of 848). Of the total respondents who used heroin (743), 80 per cent of this group also reported using crack.

The survey also confirmed that problematic alcohol use was common in this population. Approximately 24 per cent of respondents to the 2006 user satisfaction survey reported requesting alcohol advice; a similar percentage were referred to alcohol addiction services.

4 Injecting status and aspirations for change

4.1 Injecting behaviour

The majority of respondents of the combined questionnaires (69.3%) had previous or current experience of injecting drug use. Respondents were divided in the following broad categories:

- 36.9 per cent were “current” injectors (injected in the past four weeks)
- 32.4 per cent had previously injected (but not in the past four weeks)

- 30.7 per cent had never injected.

In comparison to the data on the population in treatment identified by the National Drug Treatment Monitoring System (NDTMS) for the 2004/05 period, respondents of the two surveys were more likely to be current injectors (30% in NDTMS), to have injected in the past (22% in NDTMS) and less likely to have never injected (49% in NDTMS).

However, the survey data is biased by the data from respondents to the pharmacy survey, who were overwhelmingly current injectors. This is not surprising as respondents to this survey were approached to take part in the survey at a time when they were obtaining sterile injecting equipment. In contrast, 28.8 per cent of respondents to the 2006 Annual User Satisfaction Survey were current injectors.

There were significant differences in injecting status by gender ($p<0.001$). Men were significantly more likely to have been current injectors; they were also significantly less likely to have never injected. This is shown in Table 3.

	Male	**Female**
Injected in past four weeks	39%	31.8%
Previously injected (but not in past four weeks)	32.4%	32.7%
Never injected	28.5%	35.5%

Table 3: Injecting status by gender

There were significant differences by ethnicity, with respondents who described themselves as white significantly less likely than other groups to have never injected ($p<0.001$).

It is worth noting that respondents from across the whole of the treatment system reported current injecting. More than one-third of respondents (34.1%) in a prescribing programme reported current injecting (in the past four weeks); 42 per cent previously injected and 23.9 per cent reported never having done so.

4.2 Desire for change of behaviour

The majority of current injectors (had injected in previous four weeks) reported wanting to stop injecting (81.7%); the remainder were divided between those who did not want to stop injecting (8.8%) and those who did not know (9.44%).

There were significant differences by age group ($p<0.001$), with those over the age of 40 least likely to want to stop injecting and those under 30 most likely.

Respondents on a substitute opioid regime were also more likely to want to stop injecting than those who were not receiving one ($p<0.001$).

5 Use of needle exchange facilities

5.1 Types of outlets (or facilities) used

Respondents who injected at the time of the survey used a range of facilities to obtain sterile injecting equipment, as can be seen in Figure 1 (they could use more than one facility).

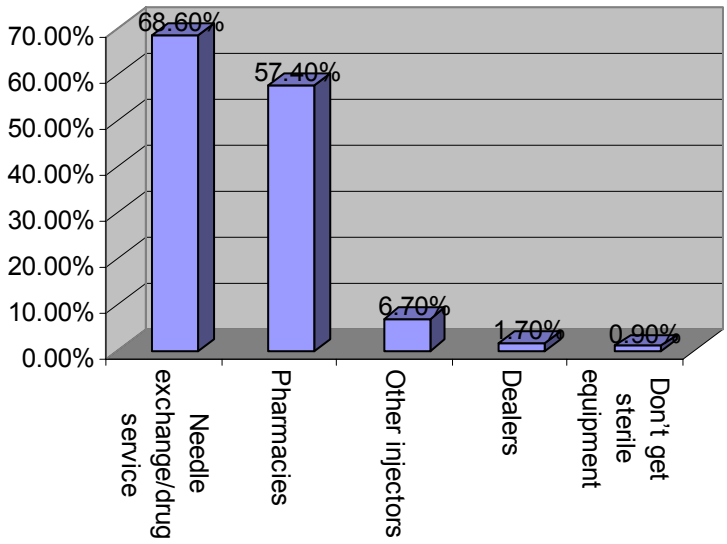

Figure 1: Needle exchange facilities used by percentage of respondents

Figure 1 shows that needle exchanges and drug services were the most commonly used type of facility to obtain sterile injecting equipment. This was followed by needle exchange pharmacies. It also shows a certain level of secondary distribution (distribution through peers); 6.7 per cent of respondents obtained needles and syringes from other injectors; 1.7 per cent from their dealers.

Figure 2 looks at respondents' use of the mixed economy of needle exchange facilities. It shows that more than a quarter of respondents used more than one type of facility to obtain clean needles and syringes. The majority, however, did not do so, and only used either pharmacies or drug service needle exchanges.

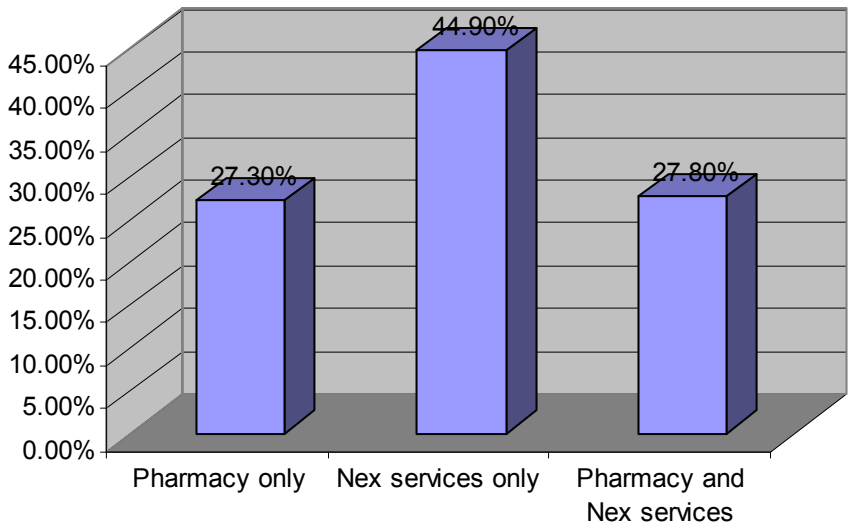

Figure 2: Needle exchange facility utilisation

Data suggests that women were significantly more likely than men to use both types of facilities ($p=0.03$). It also indicated that young people under 21 years were more likely than older age groups to use both types of facilities. Those over the age of 40 years were most likely to use pharmacies only to obtain sterile injecting equipment.

5.2 Access to injecting paraphernalia

In addition to sterile needles and syringes, injectors received a range of injecting paraphernalia and other items, as can be seen in Figure 3.

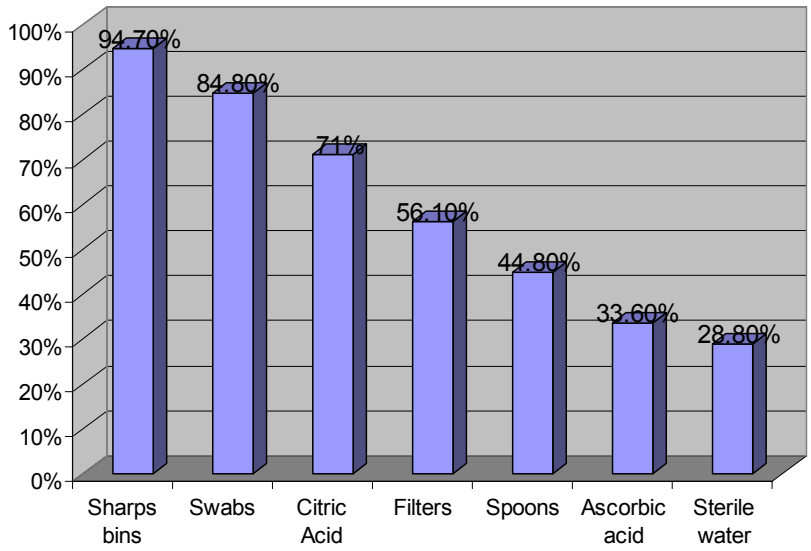

Figure 3: Percentage of respondents receiving paraphernalia and other items

There were variations in the number and range of paraphernalia and other items injectors received. Fewer than ten per cent received one item only, usually sharps bins. Three-quarters received three or more items and 12.3 per cent received all seven listed items.

Respondents reported receiving all of these items of paraphernalia from all needle exchange facilities (pharmacies and non-pharmacies). Nonetheless, the survey suggests that respondents who used pharmacies only to obtain sterile injecting equipment were significantly less likely than others to obtain the range of paraphernalia listed ($p<0.001$).

6 Harm reduction goals in care plans

The majority of respondents of the combined questionnaires said that they had a care plan (64.7%), as did the majority in the individual surveys (65.7% of respondents to the 2006 Annual User Satisfaction Survey and 58.7% of those of the pharmacy survey).

These figures are lower than national targets of 91 per cent of people new to treatment to have an identifiable care plan for 2006/07 and the average of 88 per cent identified by NDTMS. This is partially because some respondents to this survey were in Tier 2 services and not in structured treatment. The majority of those with a care plan (84.4%) responding to the 2006 Annual User Satisfaction Survey said that their care plans were reviewed in the past three months. (For more information see The NTA's 2006 Survey of User Satisfaction in England (NTA, 2007).)

The survey investigated whether clients believed their care plans included harm reduction goals or aims (as listed in the questionnaire). Figure 4 focuses on current injectors with a care plan and shows that almost 60 per cent reported having goals in their care plan around the reduction of the risks of overdose and slightly fewer had goals relating to the reduction of the risks of BBV infection.

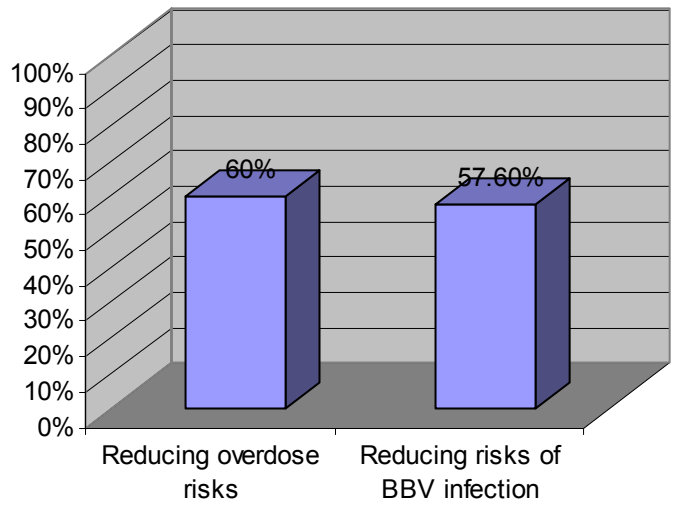

Figure 4: Percentage of current injectors with a care plan with overdose and BBV reduction goals.

Figure 5 looks at all respondents with a care plan and shows the percentage who reported having goals relating to the reduction of the harm of alcohol and goals on general health improvements.

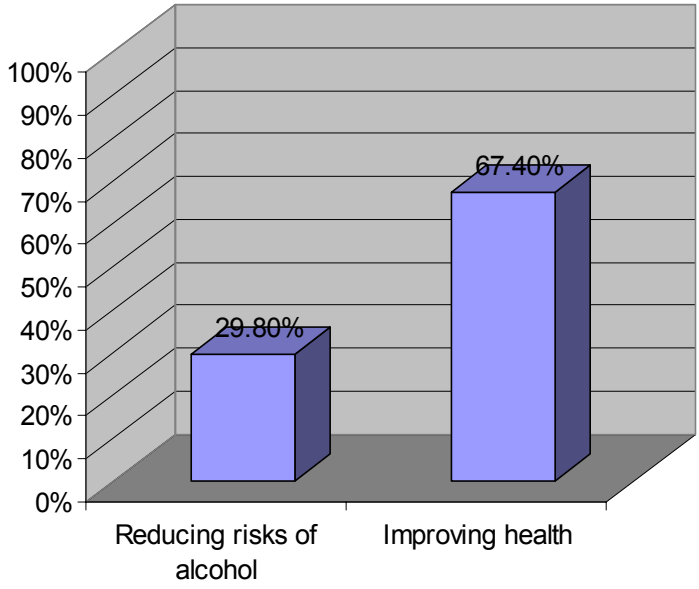

Figure 5: Percentage of respondents with a care plan that has harm reduction goals listed

As can be seen in Figure 5, respondents overall were most likely to have reported a care plan goal of generally improved health. The reduction of alcohol-related harm was not frequently identified as a care plan goal.

Among respondents to the user satisfaction survey, the data suggests that respondents whose care plans had been reviewed in the past three months were significantly more likely to have had harm reduction goals included in their care plan than those whose care plan was reviewed longer than three months ago. Figure 6 focuses on current injectors with a care plan and shows these differences.

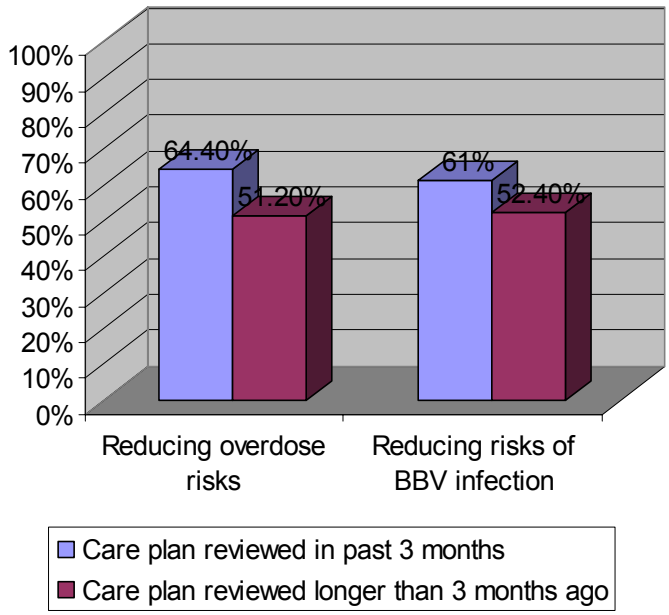

Figure 6: Harm reduction goal in care pan by frequency of review (percentage of current injectors)

7 Use of illicit substances in addition to substitute opioid prescriptions

7.1 Respondents not on substitute opioid treatment programmes and wanting such treatment

Data from the 2006 user survey strongly suggests that respondents reduced their illicit drug use as a result of treatment (almost 90% agreed or strongly agreed that this was the case). Substantial percentages also reported that they wanted to stop completely their use of substances including heroin (77% of heroin users) and crack (73%). Almost half of all methadone users (49.2%) reported wanting to stop using this substance completely. (For more information see the NTA's Second Annual User Satisfaction Survey (NTA, 2007).

Overall, more than 30 per cent of respondents from the combined questionnaires, who were not on a substitute treatment programme at the time of the survey, reported their desire for this form of treatment.

7.2 Using on top of prescriptions

A minority of respondents (29.7% of those who reported having a prescription) said that they never used illicit drugs on top of prescriptions. Illicit substances used are discussed in section 7.2.1.

The majority of those who received a prescription did use on top of prescriptions, but did so at different frequencies, suggesting different patterns of use and different causes for this. The different frequencies are shown in Figure 7.

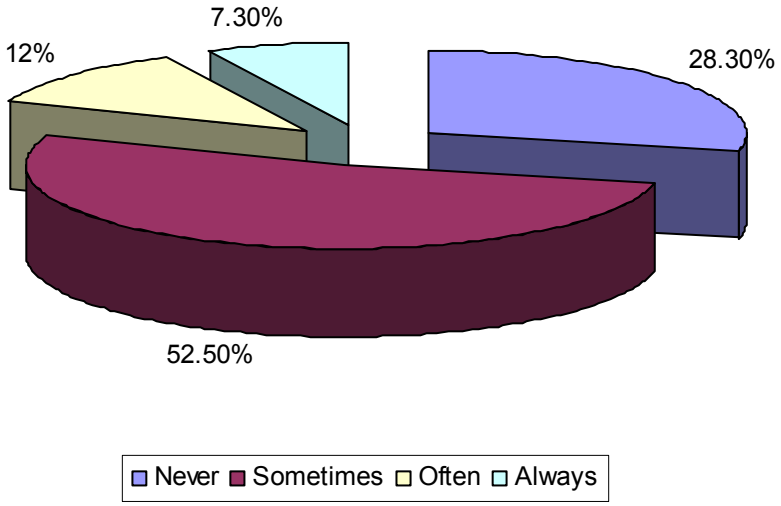

Figure 7: Percentage of respondents by frequency who use on top of prescriptions

7.2.1 Which illicit substances are used on top of prescriptions?

Respondents from the 2006 Annual User Satisfaction Survey, who reported using on top of prescriptions, reported using the following substances: heroin 81.6%; crack 58.6%; amphetamines 18.7%; cannabis 56.9% and benzodiazepines 42.8%. More than half (55%) of respondents who reported using on top of a prescribed substance used both heroin and crack.

Respondents from the pharmacy survey who reported using on top of prescriptions reported using the following substances: heroin 95%; crack 76%; amphetamines 27.3% and benzodiazepines 57.6%. Three-quarters of those who used on top of prescriptions (75%) used both heroin and crack.

Data also suggests a possible link between the use of both heroin and crack and frequency of use on top of prescriptions. For example, the analysis of responses from the 2006 Annual User Satisfaction Survey shows that those who used the two substances in addition to a prescribed substance did so at the following frequencies: 70.9% “sometimes”, 18.6% “often” and 10.5% “always”.

From respondents to the pharmacy survey, it can be seen that those who used both substances used on top of prescriptions, and did so at the following frequencies: 56.1% “sometimes”, 25.1% “often” and 18.8% “always”.

7.2.2 Injecting status and use on top of presciptions

The higher prevalence of respondents who always used on top of prescriptions among the pharmacy survey has to be looked at, at least partially, in relation to injecting. Overall data suggests a strong link between use on top of prescriptions, frequency of use on top of prescriptions and injecting status. Respondents who never used on top of prescriptions were significantly less likely to be current injectors (had injected in past four weeks) than those who injected in the past (had not injected in the past four weeks) and those who had never injected.

Conversely, respondents who used on top of prescriptions often or always were significantly more likely to be current injectors than those who did so less frequently (injected in past four weeks) ($p<0.001$). Under half (47.5%) of those who used on top of prescriptions sometimes, injected in the past four weeks. This is in comparison to 68.2 per cent of those who used on top of prescriptions often and 72.6 per cent of those who reported always using on top of a prescription.

It is also not surprising that the respondents to the pharmacy survey, who were by definition injectors, used on top of prescriptions “always” ($p<0.001$). This was shown in the difference in the

frequency of use on top of prescriptions between respondents of the two questionnaires. For example, almost 17 per cent of respondents to the pharmacy survey who reported using on top of prescriptions always used on top (they were by definition injectors). In contrast, 8.6 per cent of respondents to 2006 Annual User Satisfaction Survey did so.

7.2.3 Opioid substitute prescribed and use on top of prescriptions

A link may exist between use on top of prescriptions and the substance prescribed. Respondents were significantly more likely to never use on top of prescriptions if they received a buprenorphine prescription rather than one for methadone (47.4% of buprenorphine clients and 26.2% of methadone clients never used on top of prescriptions). Conversely, methadone clients were significantly more likely than buprenorphine clients to use on top of prescriptions often or always ($p<0.001$). This may be due in part to buprenorphine being a part-agonist, part-antagonist.

7.2.4 Dose of prescribed drug and use on top of prescriptions

The use of illicit substances in addition to those prescribed has often been linked to prescription of sub-optimal doses, but the survey shows this may not always be the case. The 2006 user survey suggested that respondents who reported always using on top of prescriptions were on average prescribed a significantly higher dose of methadone than those who never did so, or only used on top of prescriptions sometimes. This is shown in Figure 8.

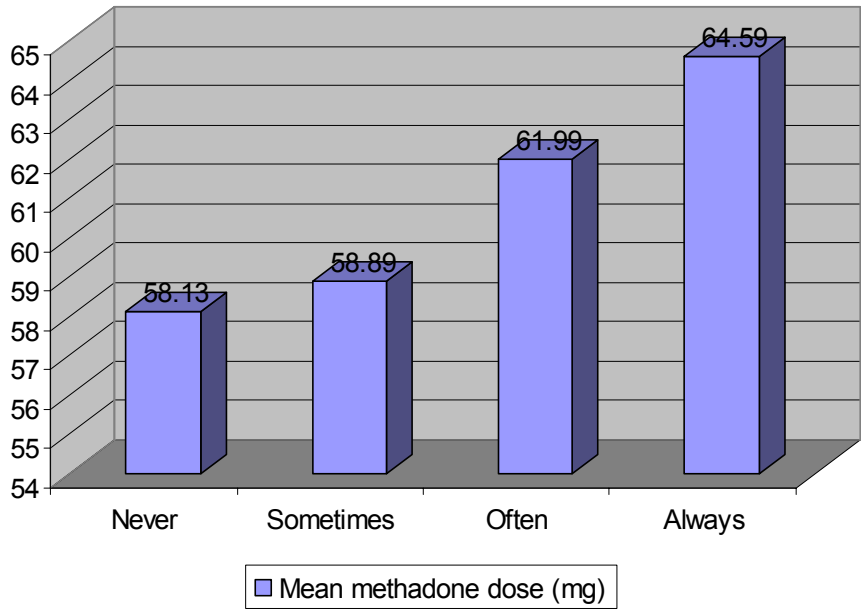

Figure 8: Average dose of methadone by frequency of use on top of prescriptions

Other survey data shows that people on doses of methadone of 60mg and over were significantly more likely to be current injectors (in past four weeks) than those prescribed less than 60mg of methadone daily ($p<0.001$). This will be discussed in greater detail in section 12, and suggests that there is a small cohort of respondents who will continue to use and inject illicit substances regardless of oral methadone dose. As discussed above, respondents who used on top of prescriptions frequently were more likely to be injectors and to use heroin and crack.

7.3 Service responses to use on top of prescriptions

Respondents were provided with a list of statements and asked to identify which ones best described the reactions of the services that were providing substitute drug treatment, if they were using on top of prescriptions.

The responses of those who were receiving a prescription at the time of the survey are shown in Table 4 (respondents could tick more than one box).

Service reaction to use on top of prescriptions (respondents were able to tick more than one option)	Percentage of responses who agreed with statement
I discussed my use on top of prescriptions with the service and agreed in the care plan what I want to achieve	60.5%
My daily dose of methadone was increased	40.8%
I have not discussed my use on top of prescriptions with the service as I am worried about their reaction	11.1%
I was given clean needles and syringes or sent to a needle exchange	11.2%
I was given help to stop injecting	12.5%
My daily dose of methadone was decreased	11.1%
My methadone/buprenorphine script was stopped	4.6%
I was told that I could not use the service/programme anymore	2%

Table 4: Service reaction to use on top of prescriptions

Although it is not possible to comment on the therapeutic or non-therapeutic rationale of the services, data suggests that some services may be implementing good practice, while others may not be meeting the recommendations of current clinical guidelines. These suggest that in principle, if a patient is not succeeding in treatment, clinicians should consider optimising treatment by increasing the intensity of the treatment programme rather than reducing it. Optimising treatment may include ensuring medication is provided within evidence-based optimal levels, changing to another substitute medication, increasing keyworking or psychosocial interventions and increasing supervised consumption.

8 Harm reduction

Respondents were asked to record if they were given harm reduction interventions from a number of sources in the past three months, on a range of issues listed in the questionnaire (they could select more than one source). In addition, there were also the options of “I did not receive this advice, but it is still relevant to me” or “this advice is not relevant to me”

Table 5 summarises data considered in greater detail in the appendix. It focuses on advice and interventions received in the last three months from at least one professional in the drug treatment or harm reduction system (drugs keyworker, needle exchange or pharmacist).

Overall, respondents reported that harm reduction advice, and interventions provided by drug treatment and harm reduction professionals was limited: substantial percentages of respondents did not receive this advice in the past three months and advice on certain issues was more likely to have been provided. Table 5 shows the percentage of all respondents who reported having received the advice or interventions in the past three months. It shows that service users were most likely to have received general advice on BBV prevention, but that only 51.5 per cent had done so. (Please note that the Table 5 and subsequent graphs in the appendix have excluded respondents who stated that this was not relevant to them.)

	Percentage of respondents
Advice on BBVs	51.5%
Advice on storing medicines safely	48.1%
Advice on risk of sharing cookers	48.1%
Advice on risks of overdose when tolerance is low	47.8%
Advice on risks of overdose from mixing substances	46.2%
Advice on risks of sharing needles and syringes	45.3%
Advice on risks of sharing filters	43.5%
Advice on risks of sharing water	43.2%
Advice on increased risk of overdose from injecting	43.1%
Advice on alcohol-related harm	42.6%
Safer injecting techniques	41.5%
Daily alcohol intake discussed	40.2%
Advice on safer sex	39.9%
Advice on risk of heart problems from crack	38.1%
Advice on problems from smoking crack	38.0%
Advice on harm of alcohol for HCV+ people	37.4%
General health assessment	36.7%
Hepatitis C testing	36.1%
HBV immunisation	34.9%
Checking injecting sites	31.9%
HIV testing	31.5%
Training in dealing with overdose	22.8%
Wound and abscess dressing	18.6%

Table 5: Percentage of overall respondents who have received advice or interventions in past three months from at least one drugs professional – drug keyworker, needle exchange staff or pharmacist (excluding respondents who reported that this was not relevant to them)[7]

The appendix looks in greater detail at the advice and interventions received by the type of issue addressed and listed in the graph. In particular, it shows the percentage of respondents that have received this advice or interventions from each of the relevant group of professionals: drug keyworker, needle exchange worker or pharmacist.

Table 6 focuses on the responses of current injectors (in past four weeks). A detailed examination of the data shows that current injectors were significantly more likely to have received harm reduction support and interventions than non-injectors, or those who had a history of injecting but did not do so at the time of the survey. Nonetheless, very many appear to be missing out.

Table 6 shows that injectors were most likely to have received information on the risks of sharing needles, syringes and other injecting paraphernalia.

[7] A small number received advice from more than one professional. They have been counted once only.

	Percentage of respondents
Advice on risks of sharing needles and syringes	67.3%
Advice on risks of sharing filters	65.4%
Advice on risks of sharing water	65%
Advice on increased risk of overdose from injecting	64.6%
Advice on BBvs	63.4%
Safer injecting techniques	63.4%
Advice on risks of overdose from mixing substances	59.3%
Advice on risks of overdose when tolerance is low	59%
Advice on risk of sharing cookers	57.5%
Advice on storing medicines safely	52.1%
Checking injecting sites	51.2%
Advice on safer sex	45.5%
Hepatitis C testing	44.7%
Advice on harm of alcohol for HCV+ people	44.2%
HBV immunisation	44%
Advice on problems from smoking crack	43.7%
Advice on risk of heart problems from crack	42.1%
Advice on alcohol-related harm	40.9%
HIV testing	40.2%
General health assessment	37.7%
Daily alcohol intake discussed	37.2%
Training in dealing with overdose	34.6%
Wound and abscess dressing	26.4%

Table 6: Percentage of current injectors who have received advice or interventions in past three months from at least one drug treatment professional – drug keyworker, needle exchange or pharmacist (excluding respondents who reported that this was not relevant to them)

9 Who provided harm reduction and were some service users missing out?

9.1 Did respondents believe they were missing out?

The survey showed that the harm reduction needs of substantial percentages of respondents were not being addressed by the treatment system; substantial percentages of respondents reported that this advice or these interventions were relevant to them, but that they had not received them.

Table 7 shows the percentage of respondents who reported not having received interventions that they felt were relevant to them.

Have not received this but it is still relevant to you	Percentage of respondents
General health assessment	18.5%
Overdose prevention training	18.4%
Heart problems from crack	13.7%
Received hepatitis B immunisation	13.1%
Advice on storing medicines safely	12.5%
Problems due to smoking crack	12.2%
Tested for HIV	11.7%
Injecting sites checked	11.7%
Tested for hepatitis C	11.1%
Advice on safer sex and contraception	10.8%
Risks of alcohol for HCV+ people	9.4%
Advice on BBVs	9.0%
Alcohol-related harm	8.7%
Risks of sharing spoons	8.5%
Safer injecting techniques	8.3%
Abscesses dressed	8.0%
Overdose risk of mixing drugs	7.8%
Overdose risk of low tolerance	7.5%
Overdose risk of injecting	7.3%
Risks of injecting water	7.1%
Risks of sharing filters	6.6%
Risks of sharing needles and syringes	6.0%
Daily alcohol intake discussed	5.8%

Table 7: Percentage of respondents who reported interventions relevant to them that they did not receive.

A focus on the responses of current injectors (in the past four weeks) shows an even greater demand for services and a greater level of un-met needs identified by respondents. Although current injectors may have been more likely to have received harm reduction advice and information than others, their needs also appear to be greater. The fact that almost one-third of all current injectors have identified overdose training as an un-met need is very significant. Similarly, over a quarter have identified their needs for general health assessment, with primary care implications both within specialist drug treatment services and general practice. This is shown in Table 8.

Have not received it but still relevant to you	Percentage of respondents
Training in dealing with overdose	32.2%
General health assessment	27.8%
Checking injecting sites	24.8%
Advice on storing medicines safely	20.9%
HBV immunisation	21%
Advice on risk of heart problems from crack	21%
HIV testing	18.6%
Advice on problems from smoking crack	19.2%
Hepatitis C testing	17.8%
Safer injecting techniques	16.9%
Wound and abscess dressing	17.1%
Advice on safer sex	17.3%
Advice on increased risk of overdose from injecting	14.4%
Advice on harm of alcohol for HCV+ people	14.4%
Advice on BBvs	14.3%
Advice on risks of sharing water	13.2%
Advice on risk of sharing cookers	16%
Advice on risks of overdose from mixing substances	12.9%
Advice on risks of overdose when tolerance is low	12.7%
Advice on alcohol-related harm	13.2%
Advice on risks of sharing filters	12.4%
Advice on risks of sharing needles and syringes	11.1%
Daily alcohol intake discussed	8.2%

Table 8: Percentage of current injectors who reported interventions relevant to them that they did not receive

9.2 Which professionals were most likely to provide harm reduction advice or interventions?

Data shows that drug keyworkers were the main source of harm reduction advice or interventions for this sample. This is not surprising, as the majority of respondents were in structured treatment. Keyworkers appear to be crucial to the delivery of harm reduction interventions. The need to enhance the role of non-pharmacy needle exchange services in providing harm reduction advice and interventions has also been shown – respondents who had a keyworker and also used a needle exchange service were more likely to have received this advice by the keyworker rather than needle exchange staff. What is of concern, is that those relying solely on pharmacy-based needle exchanges may not be receiving adequate harm reduction interventions to enable changes in behaviour, although good practice was noted in some areas.

9.3 Advice or interventions from professionals outside the drug treatment system

A sizable percentage of respondents reported having received hepatitis B immunisation or HCV or HIV testing from sources identified as ”other sources”. Although the questionnaire did not investigate what this other source was, other research evidence suggests that this will involve a range of organisations, including the prison services and primary care for immunisation, and genitor-urinary clinics for testing.

A similar comment can be made about respondents reporting a general health assessment in the past three months, with GPs being a likely source.

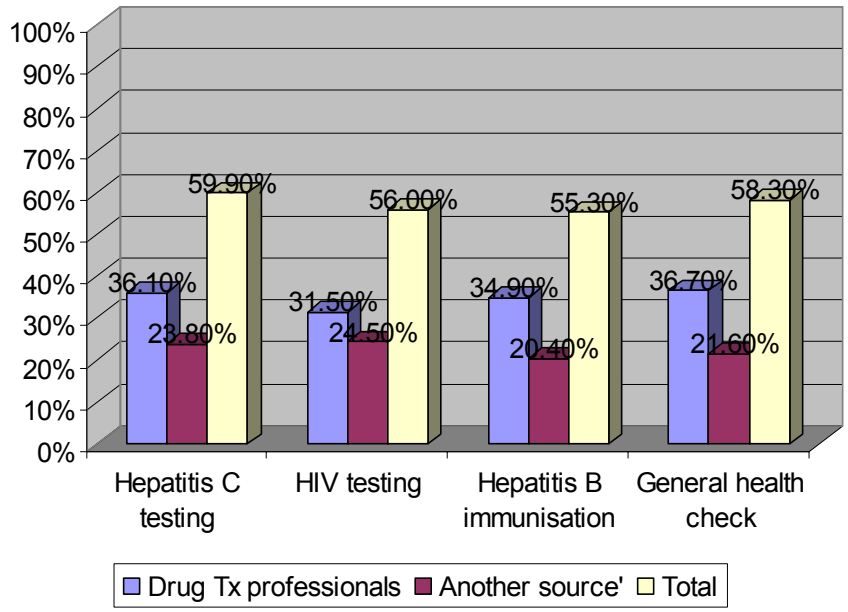

Figure 9: Intervention by source in past three months

Figure 10 shows that a similar pattern true for just the injecting population, although injectors are generally more likely to receive these types of intervention.

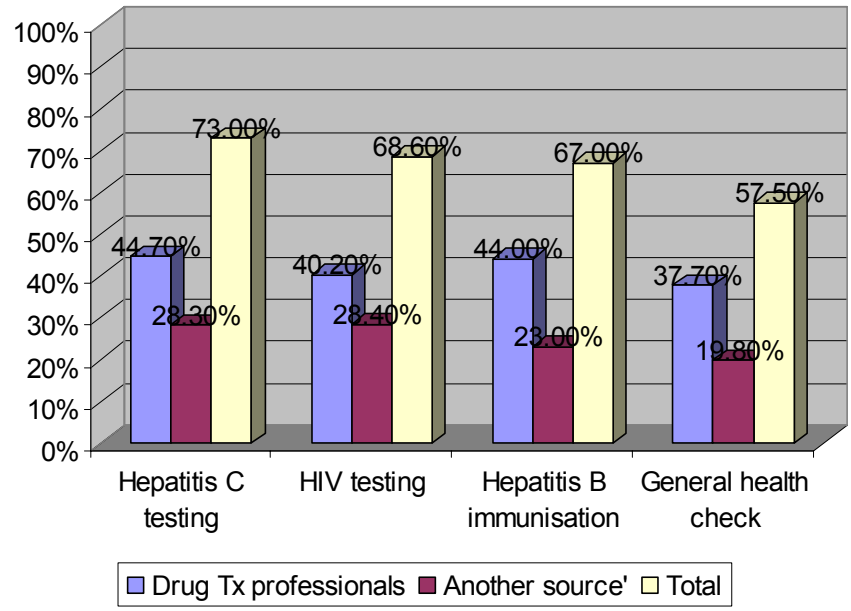

Figure 10: Intervention by source (injectors only)

10 Factors that encourage and discourage harm reduction advice and interventions

10.1 Injecting and harm reduction

The survey has shown that current injectors (had injected in the past four weeks) were more likely to have received the range of harm reduction advice and interventions than others. This is not

surprising, as most harm reduction advice and interventions are aimed at injectors and the prevention of the spread of blood-borne viruses. Significantly, the survey has also shown that injectors have a greater level of un-met needs and demands.

10.2 Care planning and harm reduction

The survey shows a link between the presence (or absence) of a care plan and whether or not respondents had received advice on harm reduction or interventions in the past three months. Respondents with a care plan were significantly more likely to have received the advice or intervention. Those without a care plan were significantly more likely to say that they did not receive this intervention, but it was relevant to them.

Statistical analysis[8] also shows a stronger link between the presence of a care plan and respondents obtaining harm reduction advice in the past three months; more so than any other factor.

10.3 Frequency of care planning review and harm reduction

Survey responses show a link between the frequency of review of care plans and the respondents' access to harm reduction advice or interventions. Respondents whose care plans were reviewed within the past three months were significantly more likely to have received harm reduction advice or interventions than those whose care plans were reviewed more than three months ago.[9]

10.4 Prescribing and harm reduction

There was also a relationship between respondents receiving harm reduction advice or interventions in addition to substitute opiate treatment. Those receiving substitute opioid prescriptions were significantly more likely than others to have received harm reduction interventions in the past three months. Those not receiving substitute opioid treatment were significantly more likely to say that they did not receive this intervention, but felt it was still relevant to them.

The exception to this rule is that access to substitute opioid treatment did not increase the chance of receiving advice relating to alcohol or safer sex. Anecdotal evidence suggests that these issues are often missed by drug treatment providers.

10.5 Gender and differential impact of harm reduction

There were also statistically significant differences by gender in respondents who received some harm reduction advice or interventions in the past three months (see Table 9). Women who injected at the time of the survey were less likely to have received them than their male counterparts. It is also important to note that female current injectors were also more likely than men to have reported that this advice or these interventions were relevant to them, but that they had not received them.

[8] Logistic regressions (binary regressions)
[9] Logistic regressions

	Received in past three months (% of males)	Received in past three months (females)	Did not receive still relevant to you (males)	Did not receive still relevant to you (females)
Hepatitis B immunisation	44.8%	42.2%	18.9%	24.9%
Sharing cookers/spoons	59.4%	51.8%	12.2%	18%
Safer injecting techniques	63.6%	62.3%	15.3%	19.8%
Overdose risk as a result of mixing substances	60%	56.4%	11.3%	16.1%
Advice about problems due to smoking crack	44.3%	40.9%	16.6%	24.3%
Advice on harm caused by alcohol to people who have hepatitis C	45%	40.7%	12.9%	17.2%
Advice on risks of heart problems from cocaine or crack use	43.9%	36.3%	18.3%	26.1%
General health assessment	39.2%	33%	26.3%	30.8%
Injecting sites checked	51.5%	50.7%	23.3%	27.6%
Training in dealing with overdose	35.9%	31.6%	30.2%	41.1%

Table 9: Percentage of respondents who received in the last three months and did not receive (though still relevant) harm reduction advice and interventions by gender

10.6 Regional differences in access to harm reduction

There were differences between the various regions (by government region) in the percentage of respondents who were injectors – this is shown in Table 10. Of course percentages reflect the population surveyed and are not prevalence data of injecting in these regions (these can be found on the NTA's website, www.nta.nhs.uk).

Region	Current injector (in past four weeks)	Previously injected (not in past four weeks)	Never injected
North East	42.6%	34.3%	23.2%
South East	40.6%	31.4%	28.1%
South West	40.1%	33%	26.8%
Yorkshire and Humber	38.9%	38.9%	22.1%
East Midlands	37.7%	35.9%	26.3%
North West	36.8%	34.4%	28.8%
Eastern	32.9%	30.7%	36.4%
London	32.9%	25.1%	41.9%
West Midlands	32.5%	31.6%	35.8%

Table 10: Percentage of respondents by region

Tables 11–19 show the percentage of respondents who have received the advice or interventions in the past three months and those who reported not having received them although it was relevant to them. (People who reported that the advice or interventions were not relevant to them are not included.)

10.6.1 HCV testing

There were regional differences in respondents' reported access to hepatitis C testing in the past three months from drug treatment professionals or from another source such as a genitor-urinary clinic (see Table 11). Differences by region also emerged in respondents reporting not having had a test, but feeling they were relevant to them ($p<0.001$). As can be seen in Table 11, respondents were most likely to have been tested in Yorkshire and Humber region and in the North East, and least likely to have been in the Eastern region and the West Midlands.

	Had HCV testing is past three months	Did not get tested, but still relevant to me
Yorkshire and Humber	67.1%	9.5%
North East	65.8%	8.6%
North West	62.3%	9%
East Midlands	62.6%	10.8%
London	61.6%	10.6%
South West	60%	13.8%
South East	57.5%	12.5%
West Midlands	53.8%	13.7%
Eastern	51.4%	10.7%

Table 11: Percentage of respondents by region

10.6.2 Hepatitis B immunisation

There were also regional differences in reported access to hepatitis B immunisation in the past three months from drug treatment professionals or from another source (for example prisons or primary care). Differences by region also existed in respondents reporting not having immunisation, but feeling it was relevant to them ($p=<0.001$). Table 12 shows that differences existed in particular between Yorkshire and Humber, where high levels of immunisation were reported, and the Eastern region, where significantly lower levels were reported.

	Had HBV immunisation is past three months	Did not get immunisation, but still relevant to me
Yorkshire and Humber	69.2%	8.4%
North East	65.4%	8.3%
North West	59.4%	10.8%
East Midlands	55.7%	11.9%
London	55.2%	13.3%
West Midlands	50.5%	14.3%
South East	49%	17.5%
South West	48.4%	18.9%
Eastern	44.4%	14.4%

Table 12: Percentage of respondents by region

10.6.3 Advice and risks of alcohol to people who are HCV+

There was also differential access to advice on risks of alcohol for people who are positive for hepatitis C ($p<0.001$). As Table 13 shows, significant differences existed between London and Yorkshire and Humber on the one hand, and the Eastern region on the other.

	Had advice on risks of alcohol for HCV+ people is past three months	Did not get advice, but still relevant to me
Yorkshire and Humber	50.1%	7.5%
London	50.2%	9.9%
North East	49.8%	5.3%
North West	48.8%	8.8%
South East	45.6%	11.7%
East Midlands	43.1%	9.6%
South West	42.4%	11.4%
West Midlands	40.8%	8.8%
Eastern	38.4%	8.8%

Table 13: Percentage of respondents by region

10.6.4 Having injecting sites checked

Respondents in some regions were significantly more likely than those in other regions to have had their injecting sites checked ($p<0.001$). Table 14 shows that differences exist in particular between the North East and the Eastern regions.

	Injecting sites checked is past three months	Did not get tested, but still relevant to me
North East	51.9%	6.8%
Yorkshire and Humber	46.7%	10.5%
East Midlands	40.4%	13%
North West	39.3%	10.4%
South West	39.1%	15.8%
West Midlands	36%	10.9%
London	35.6%	10.8%
South East	35.6%	15%
Eastern	32.6%	11.2%

Table 14: Percentage of respondents by region

10.6.5 Advice on problems due to smoking crack

The survey also shows that respondents were significantly more likely to have reported having received advice on the risks of smoking crack in London and in Yorkshire and Humber than those in the South West ($p<0.001$). (See Table 15.)

	Received advice on problems caused by smoking crack is past three months	Did not get advice, but still relevant to me
London	51.6%	12.9%
Yorkshire and Humber	51%	10.6%
North East	48.2%	6.3%
South East	47.5%	14.5%
North West	45.8%	11%
West Midlands	43%	12.7%
Eastern	42.6%	11.8%
East Midlands	42.1%	8.9%
South West	33.5%	15.9%

Table 15: Percentage of respondents by region

10.6.6 Advice on risks of heart problems resulting from crack

Differences by region were also noted in respondents' access to advice on risks of heart problems resulting from crack use ($p<0.001$). Again, significant differences in access to this advice were noted in particular between London and the South West (see Table 16).

	Advice on risks of heart problems from crack use three months	Did not get advice, but still relevant to me
London	53.6%	15.3%
Yorkshire and Humber	49.5%	11.6%
North East	47.8%	7.3%
North West	46.9%	12.8%
South East	45.9%	16.3%
West Midlands	44.5%	13.7%
Eastern	42.2%	12.8%
East Midlands	41.5%	12.1%
South West	34.9%	16.4%

Table 16: Percentage of respondents by region

10.6.7 Advice on safer sex

Advice on safer sex was also significantly more likely to have been provided in services in some regions than in others ($p<0.001$). As Table 17 shows, services in the North East were significantly more likely to have provided this advice than those in the South West and the West Midlands.

	Advice on safer sex in past three months	Did not get advice, but still relevant to me
North East	59.7%	5.6%
Yorkshire and Humber	57.6%	8.6%
North West	53.2%	10.2%
London	51.7%	12.3%
East Midlands	50%	12.2%
Eastern	47.8%	9%
South East	46.9%	13.2%
South West	46.4%	11.4%
West Midlands	46.4%	11.7%

Table 17: Percentage of respondents by region

10.6.8 Advice on storing medicines safely

Differences by region were also noted in the percentage of respondents who received advice on storing medicine safely ($p<0.001$). In particular, significant differences exist between the North East where this advice was most likely to be provided and the Eastern region where was least likely to be given. This is shown in Table 18.

	Advice on storing medicines is past three months	Did not get advice, but still relevant to me
North East	67.5%	6.3%
Yorkshire and Humber	65.9%	10%
North West	60%	11.8%
West Midlands	58%	14.1%
East Midlands	55.3%	11.2%
London	49.9%	12.1%
South East	47.6%	16.9%
South West	47.2%	15.1%
Eastern	44.7%	13.2%

Table 18: Percentage of respondents by region

10.6.9 Consistent patterns across regions

The tables looking at regional trends have shown that there are consistent pattern across regions. Respondents from the South East and South West were more likely than others to have reported that the interventions were relevant to them but that they had not received them.

Conversely, respondents from Yorkshire and Humber, the North East and the North West were more likely than others to have received BBV-related advice and interventions (HCV testing, hepatitis B immunisation and advice on risks of alcohol for people who are hepatitis C positive) as well as advice on safer sex and advice on storing medicine safely. Respondents in the Yorkshire and Humber and North East regions were also more likely than others to have had their injecting sites checked.

Advice on crack-related problems was more likely to be provided by services in London and Yorkshire and Humber.

11 Discussion and concluding remarks

This document reports the findings of two questionnaire surveys conducted among users of drugs services from Tier 2 interventions (including pharmacy needle exchange facilities) to Tier 4

residential services. Respondents, therefore, represented the range of service users before entering structured treatment and at all points in the treatment journey. Nonetheless, the majority had a care plan and were in structured treatment, including the majority of those contacted via the pharmacy survey.

The survey showed that for some users, high-risk drug-using behaviours continue to take place, even when drug users were in contact with drug treatment services (including structured care and substitute opioid prescribing). This may to be expected as few drug injectors are able to cease injecting immediately upon receiving drug treatment. However, this may indicate that some drug users in treatment may be at risk of drug-related illness and death through blood-borne viruses if they continued to share injecting equipment. This may also indicate risk through overdose as drug injectors were more likely to overdose (Gossop *et al.* 1996).

Nonetheless, the survey shows that changes in behaviour can and do take place among the users of drug treatment services. Approximately half of those with experience of injecting (46.7%) reported that they did not inject at the time of the survey (had not injected in the four weeks before the survey).

Data from current injectors (who had injected in the previous four weeks) suggests that a two-pronged approach may be required to tackle injecting-related harm in particular. On the one hand, interventions are required with this group to motivate and encourage changes in behaviour away from injecting drug use. Target groups for these interventions include those who were more likely than others to have reported their wish to cease injecting, namely young injectors under the age of 30 and injectors on opiate prescribing regimes. There is a need to target those whose drug use is less entrenched and those who are motivated to change behaviour and already involved in treatment that facilitate this change of behaviour (for example prescribing regimes). Contingency management is an approach that could potentially improve these outcomes.

On the other hand, needle exchange facilities and harm reduction support must be available and signposted to all drug users, regardless of treatment status or opioid substitution treatment. Indeed, more than 35 per cent of respondents on a prescribing regime were injecting at the time of the survey. For some, injecting appears to have been an entrenched form of behaviour that must be addressed at a number of levels. Among other things, data strongly suggests that the reduction of injecting-related harm must be addressed in the care plans of substantial numbers of users of treatment services.

Polydrug use (and particularly the combined use of heroin and crack), as well as the use of these substances in addition to, or on top of, a prescribed substance were linked to injecting. This strongly suggests the need for treatment to address this form of polydrug use and to target those most at risk.

11.1 Were service users receiving an appropriate level of harm reduction support?

The surveys have provided a systematic overview of the harm reduction advice and interventions that service users received in the three months before the survey. They show a mixed picture and provide concrete evidence to support national policy drives aimed at reinvigorating harm reduction interventions – overall, many service users received the range of advice, but most did not.

A number of factors were linked to better access to harm reduction advice and interventions. Injecting was a factor that was perhaps not surprising, as harm reduction support available was generally injecting and opiate-focused. Current injectors (those injecting in the past four weeks) were significantly more likely than others to have received advice and interventions in the past three months. In particular, they received advice on the reduction of injecting-related harm, such as advice on the risks of sharing injecting equipment and paraphernalia. Yet substantial percentages of current injectors did not, and it is recommended that this be improved to ensure that all injectors receive up to date advice on a regular basis. The survey also suggests the need to enhance other harm reduction and advice which are not directly related to injecting and not only aimed at injectors. This includes, but is not limited to, advice on alcohol use and advice on the risks of using crack, both of which were common.

The survey also showed that specialist drug services were providing interventions aimed at the prevention of the spread of BBVs, particularly hepatitis B immunisation and HCV and HIV antibody testing. However, these interventions were identified as un-met needs by substantial number of injectors and it is therefore recommended they be enhanced at local levels. Moreover, data shows that this was also often carried out by organisations outside the drug treatment system, such as prisons, GUM clinics and in general practice. Whereas this maximises access to these interventions, recommendations from the Health Protection Agency report Shooting Up (HPA, 2006a) state that on-site hepatitis B vaccinations in particular should be available in needle exchange services and other services working with injecting drug users.

It is also important to note that although current injectors were more likely to have received harm reduction advice and interventions, they also reported the highest levels of un-met needs. Training in dealing with overdose was identified as a particularly important area for service development, as approximately one-third of injectors identified this as relevant to them but had not received it. Similarly, the need to enhance the availability of general health checks was identified by approximately one-third of injectors and points to the need to find solutions within drug treatment services or within other healthcare provision such as general practice.

Other factors that were linked to better access to harm reduction advice and interventions include the presence of a care plan and how recently this had been reviewed, a prescribing programme or regime, a keyworker and the utilisation of drug services and needle exchanges (as well as pharmacies) rather than solely pharmacies, to obtain sterile injecting equipment.

The fact that people with care plans, those on opioid prescribing regimes and clients who had keyworkers were likely to have received harm reduction advice and these interventions is positive and suggests that harm reduction was integrated within the wider treatment of respondents. However, not all respondents who met these criteria necessarily had access to harm reduction advice and many were missing out. The survey suggests that structured drug treatment services in general should enhance the support provided to service users to reduce the whole range of drug-related harms and to look beyond injecting alone.

The combined questionnaires also strongly suggest the need to enhance the harm reduction support provided to respondents outside the structured drug treatment system. There are examples of good practice among Tier 2 drug services and, in some areas, the users of these services were receiving adequate support. However, the surveys provided evidence that overall this must be better developed. What is of concern is that those relying solely on pharmacy based needle exchanges may not be receiving adequate harm reduction support to enable changes in behaviour.

11.2 Conclusions on harm reduction

This survey of more than 10,000 service users has shown that adequate harm reduction support for drug users can and has been provided. However, this was not always the case and the survey shows that this must be enhanced.

The development of harm reduction approaches throughout the drug treatment system is an NTA and a Department of Health priority. Measures are now in place to support this process. The Department of Health launched Reducing Drug-Related Harm: An Action Plan (DH, 2007) in May 2007 with new monies to support a variety of measures, including increasing surveillance and monitoring, improving the delivery of harm reduction interventions and public health campaigns targeting those most at risk.

The joing NTA and Healthcare Commission 2006/07 Improvement Reviews on harm reduction will provide an impetus for all local areas to improve – especially those performing most poorly – and provide comparisons against which they can measure themselves

Tools to support services and DAT partnerships to develop strategic harm reduction approaches are also under development by the NTA, including a national campaign in 2008. These include ensuring that harm reduction is embedded in all Tier 2–4 services, workforce competencies,

minimum standards for needle exchanges and the closer monitoring of needle exchange activity through NDTMS.

What local services must also address is the importance attributed to harm reduction in terms of commissioning, resource allocation and priorities of service providers, commissioners and strategic partnerships. Harm reduction should not be conceptualised as an add-on intervention, but an integral part of any structured treatment or Tier 2 interventions.

12 References

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13 Appendix 1

13.1 Detailed analysis of harm reduction support by topic. How much support was provided and by whom?

The graphs in this appendix show in greater detail the advice and interventions received by the type of issue addressed.

13.1.1 Prevention of blood-borne viruses (BBVs)

Figures 11 and 12 show respondent's access to harm reduction interventions relating to the prevention of the spread of BBVs. Figure 11 shows these results for all respondents, whereas Figure 12 focuses on respondents who are current injectors (those who have injected in the past four weeks).

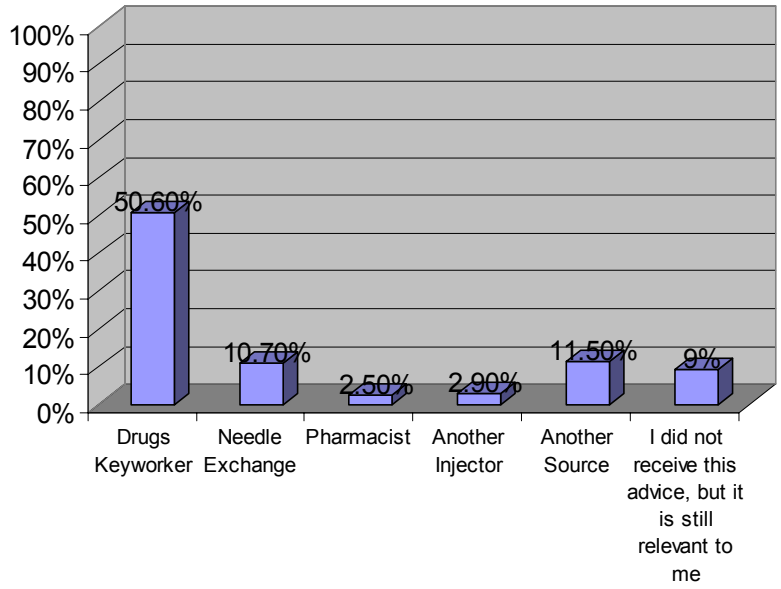

Figure 11: Advice on blood-borne viruses

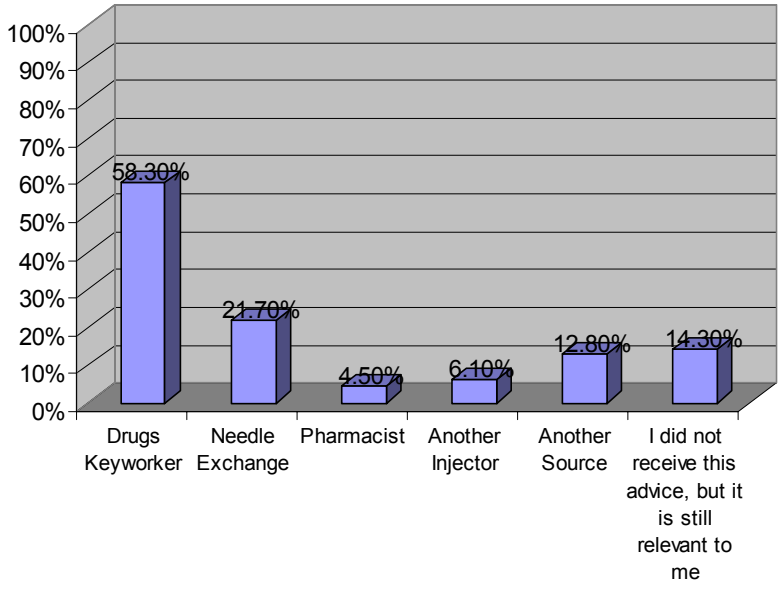

Figure 12: Advice on blood-borne viruses (injectors only)

Figures 13 and 14 show respondent's access to hepatitis B immunisation, hepatitis C testing and HIV testing. Figure 13 shows these results for all respondents and Figure 14 focuses on respondents who are current injectors (those who had injected in the previous four weeks).

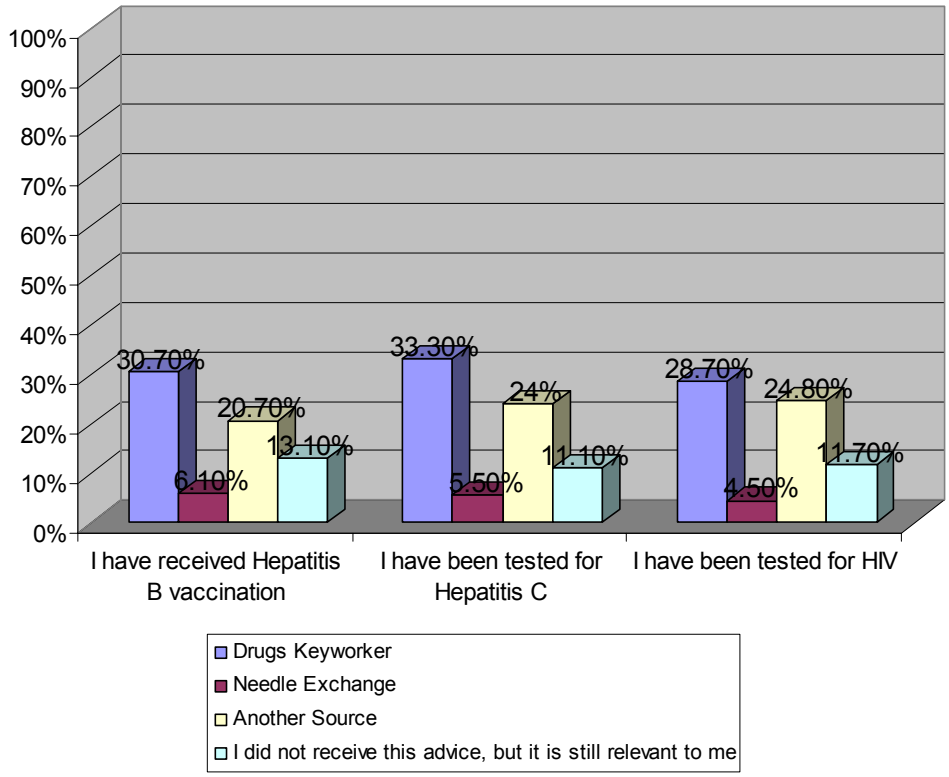

Figure 13: Hepatitis B immunisation, hepatitis C testing and HIV testing

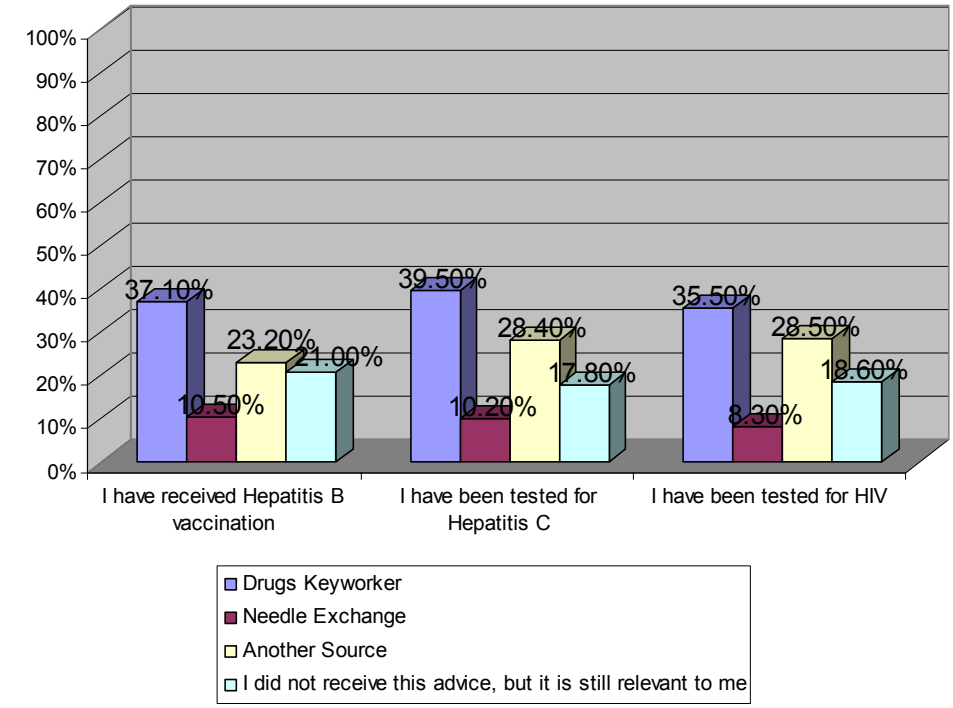

Figure 14: Hepatitis B immunisation, hepatitis C testing and HIV testing (current injectors only)

13.1.2 Prevention of high-risk injecting behaviours:

Figures 15 shows respondents' access to advice on risks sharing injecting equipment (needles and syringes, injecting water, spoons or cookers, and filters). Figure 16 shows the same information, but for current injectors only.

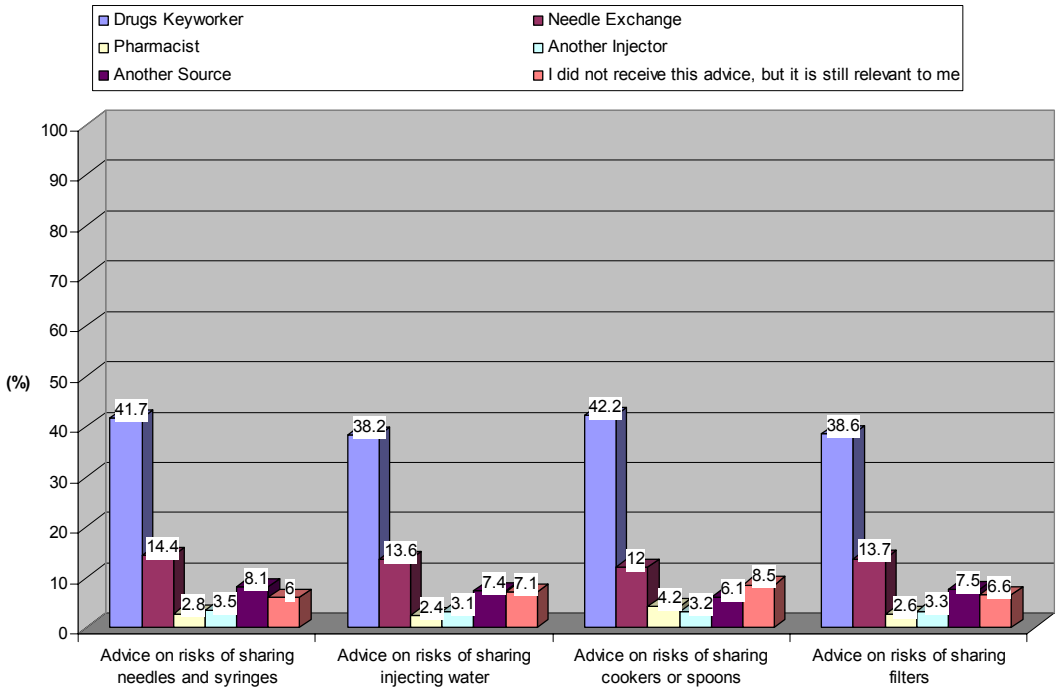

Figure 15: Access to advice on sharing injecting equipment by source

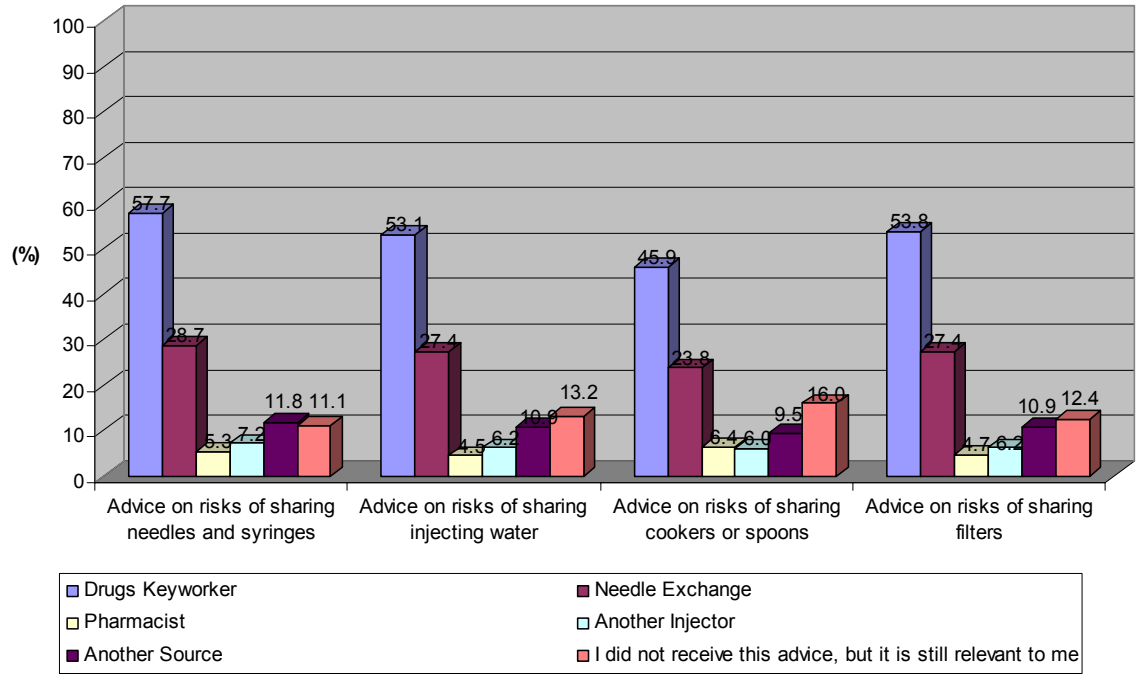

Figure 16: Access to advice on sharing injecting equipment by source (current injectors only)

Figure 17 shows respondents' support around injecting-related problems (advice on safer injecting techniques, having injecting sites checked and having injecting-related wounds or abscesses dressed). Figure 18 shows the same information, but for current injectors only.

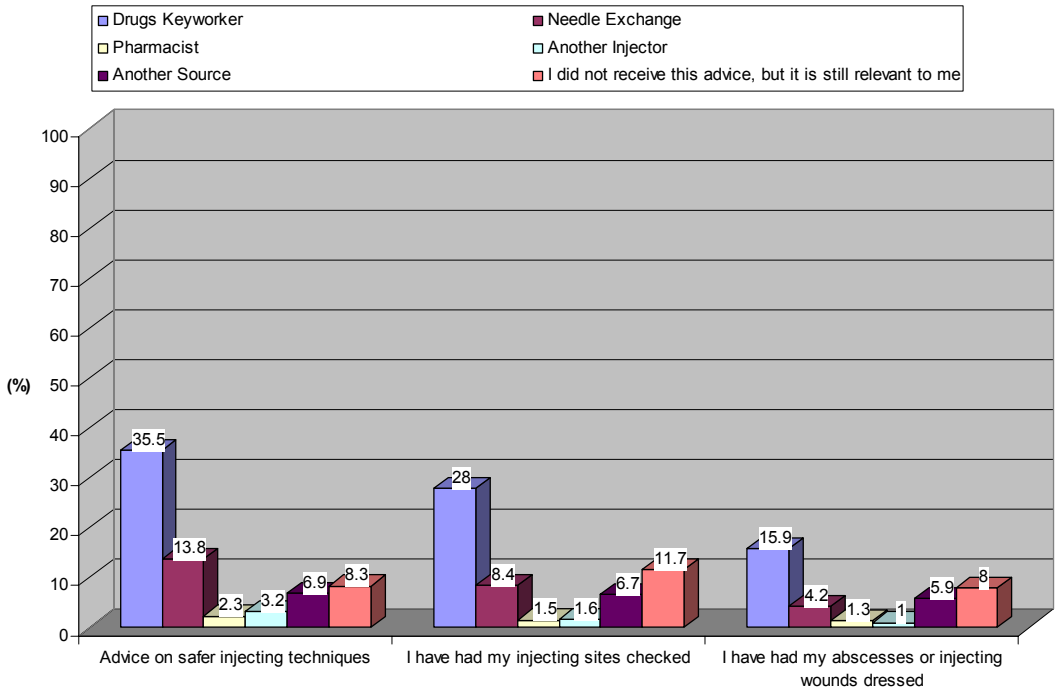

Figure 17: Access to support around injecting-related problems by source

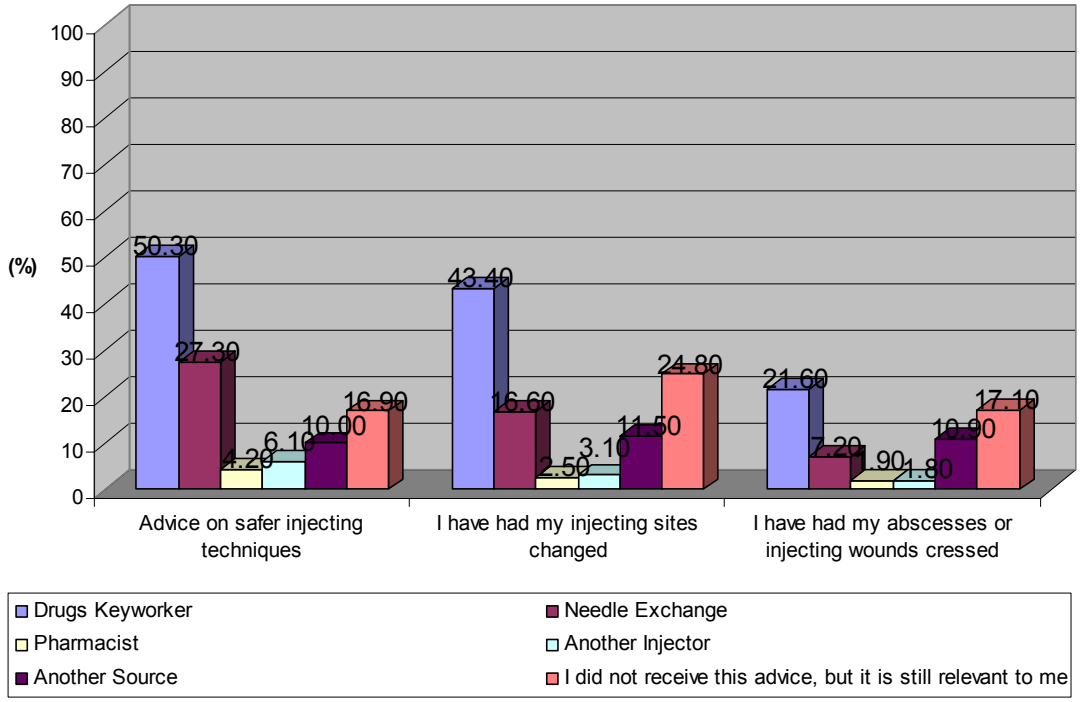

Figure 18: Access to support around injecting-related problems by source (current injectors only)

13.1.3 Overdose prevention advice

Figure 19 shows respondents' access to overdose prevention advice. Figure 20 shows the same information, but for current injectors only.

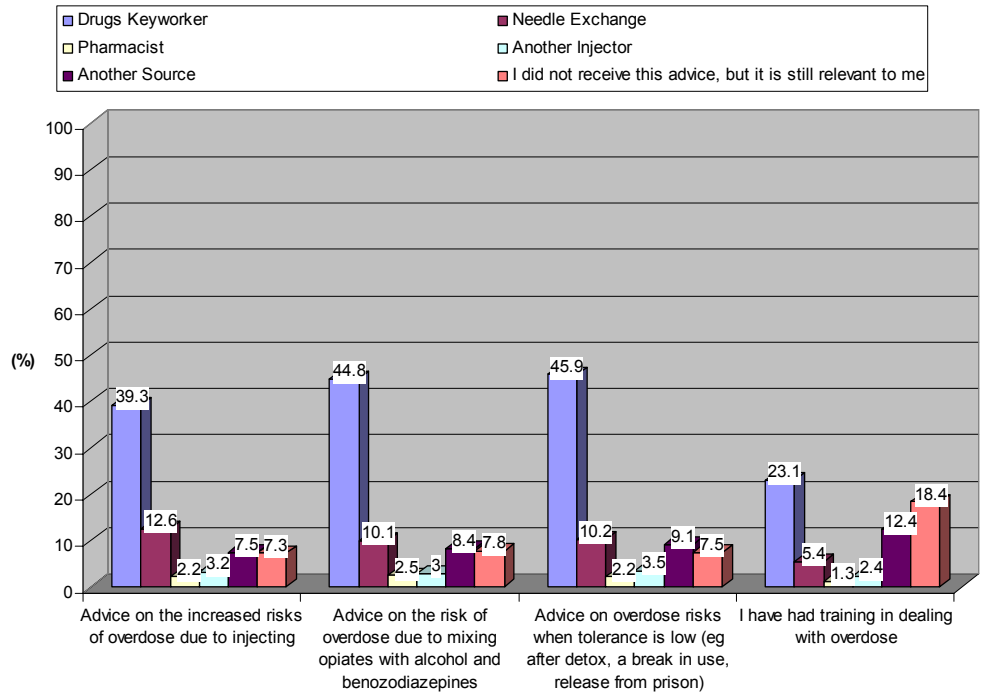

Figure 19: Access to overdose prevention advice by source

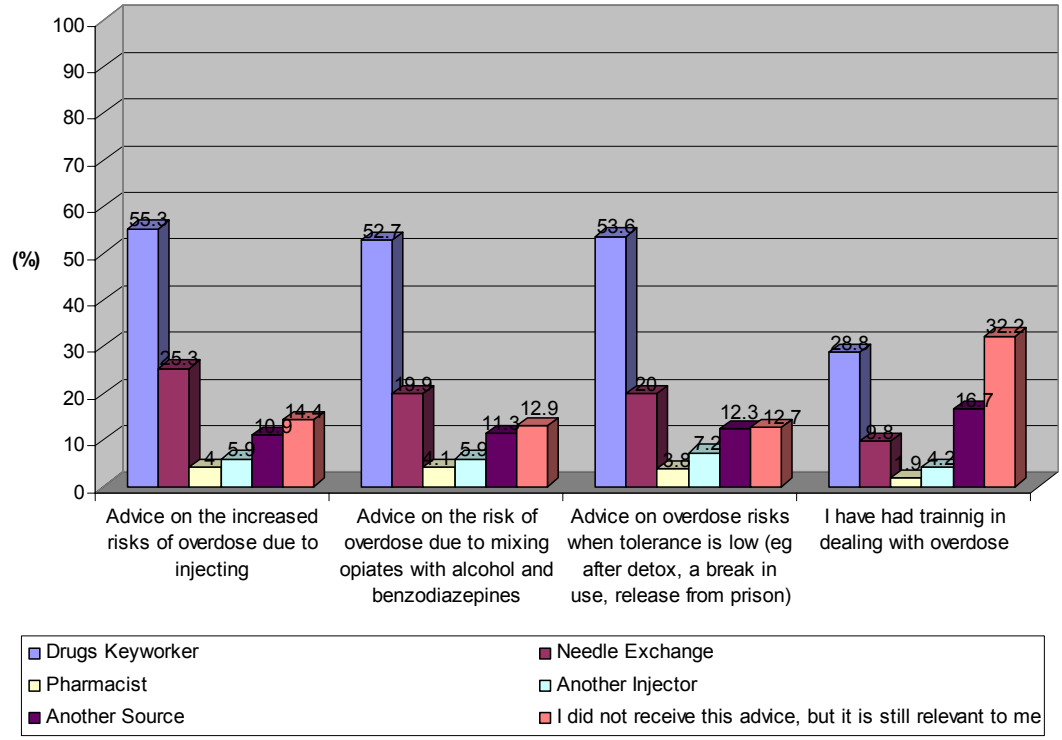

Figure 20: Access to overdose prevention advice by source (current injectors only)

13.1.4 Crack-related harm

Figure 21 shows respondents' access to advice on the prevention of crack-related harm. In particular it looks at advice on preventing respiratory problems resulting from smoking crack and advice on risks of heart problems resulting from cocaine/crack use. Figure 22 shows the same information, but for current injectors only.

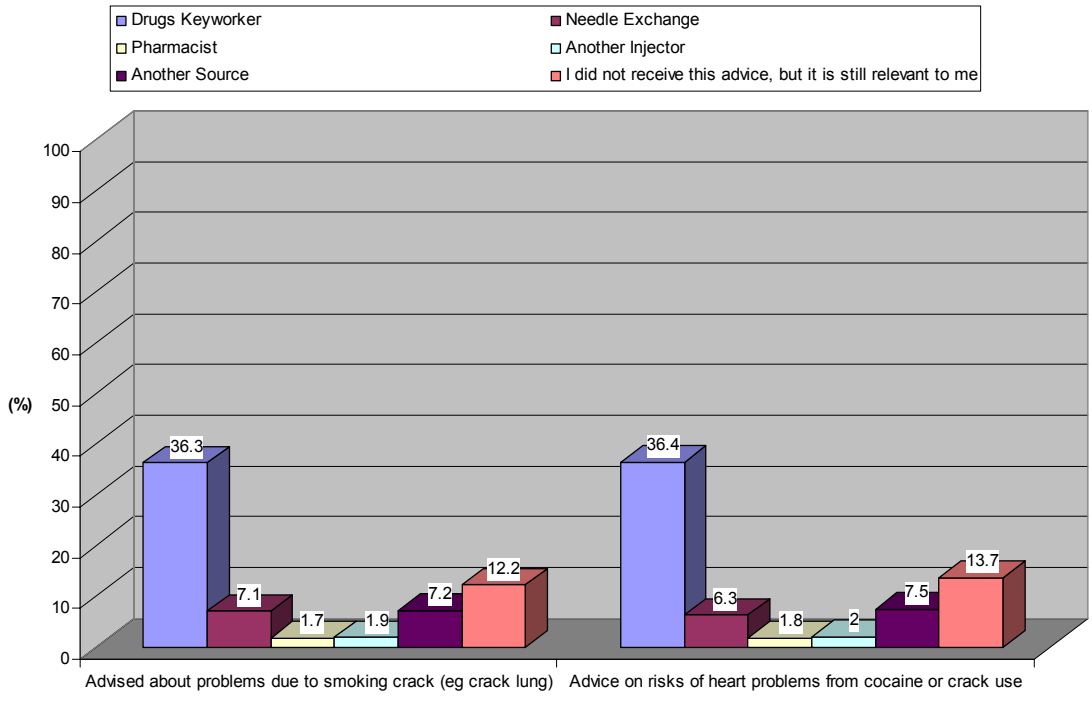

Figure 21: Access to advice on preventing crack-related harm by source

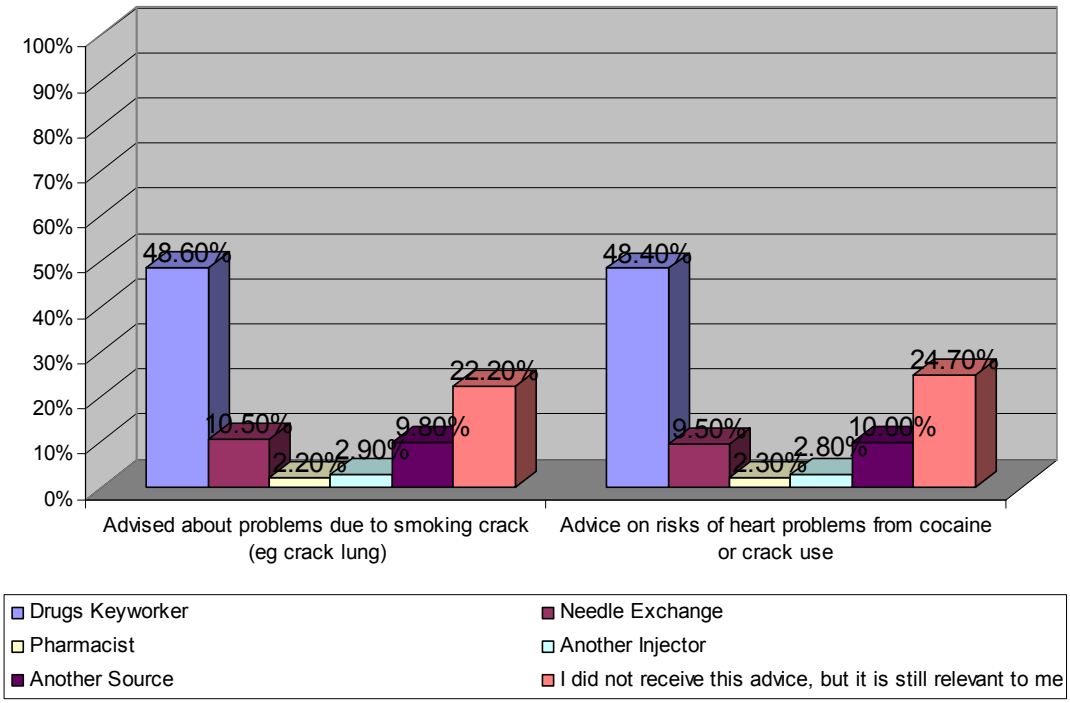

Figure 22: Access to advice on preventing crack-related harm by source (crack users only)

13.1.5 Alcohol-related harm

Figure 23 shows respondents' access to advice on reducing alcohol-related harm. In particular it looks at advice about harms caused by alcohol to people who are HCV+; advice on reducing harm caused by alcohol; and discussed daily alcohol intake.

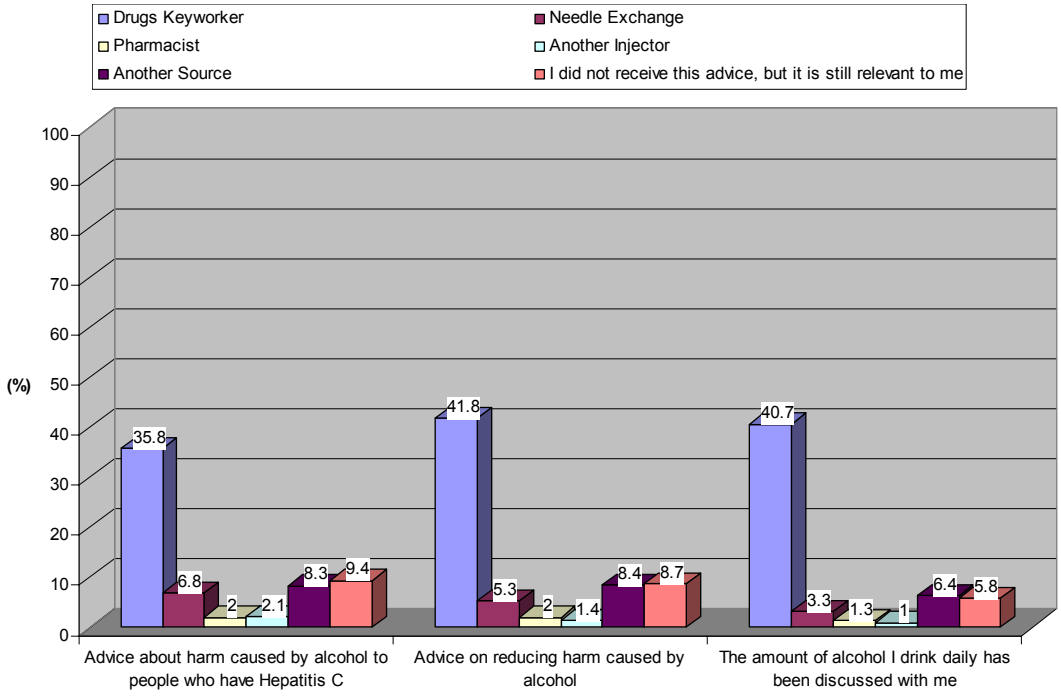

Figure 23: Access to advice on reducing alcohol-related harm by source

13.1.6 Other harm reduction advice

Figure 24 shows respondents' access to advice on how to store medicine safely and safer sex and contraception. Figure 25 shows respondents' access to a general health assessment.

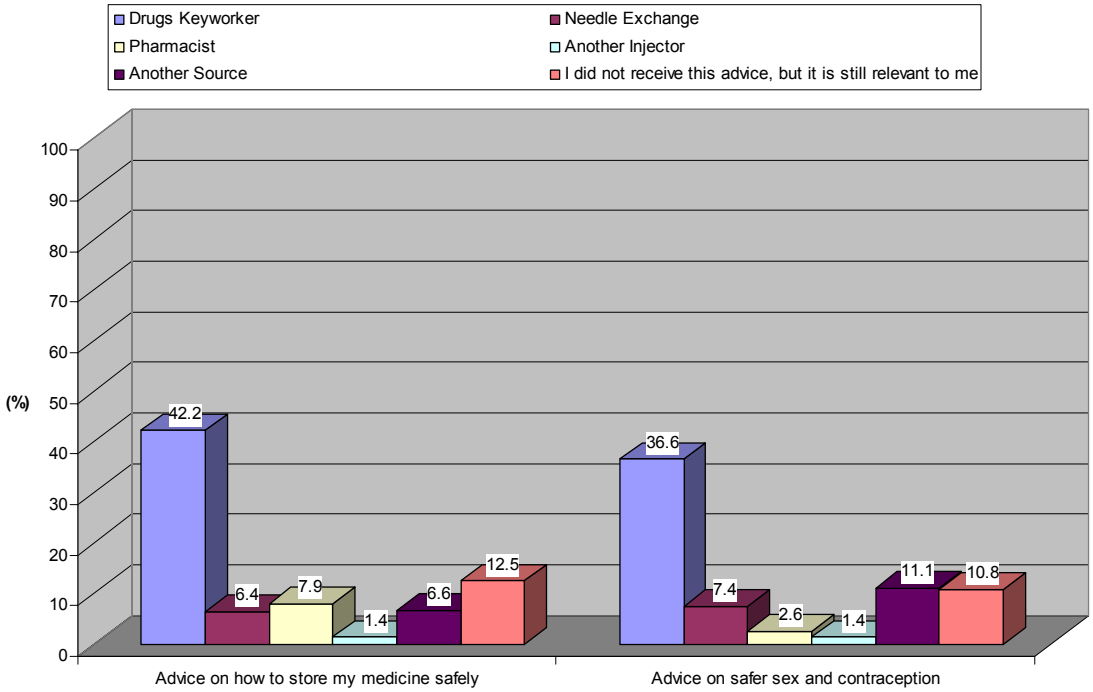

Figure 24: Access to advice on other harm reduction by source

It is interesting to note that women were more likely to have received safer sex advice in the past three months than men and that men were more likely to say that they did not receive this advice but it was still relevant to them.

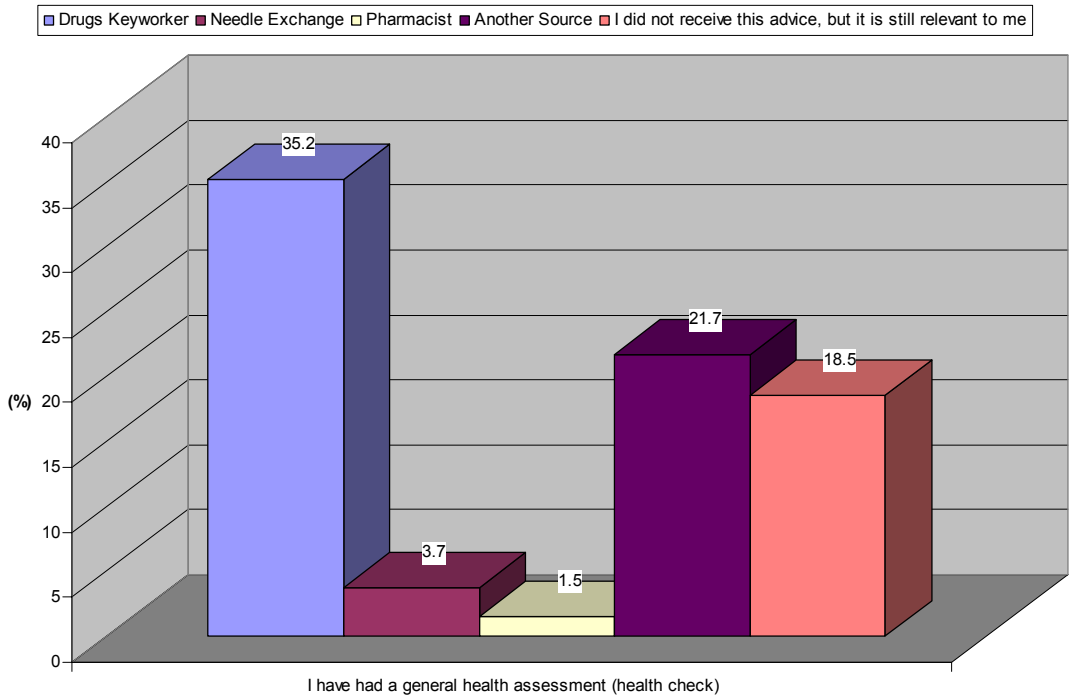

Figure 25: Access to a general health assessment