



Lighthouse
project

PHARMACY LIAISON PILOT

A Partnership Approach to Improve Harm Reduction Services for Injecting Drug Users in Liverpool

March 2009
Lighthouse Project
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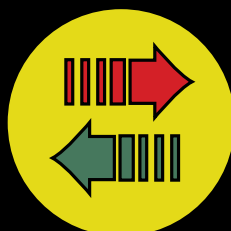


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1. Executive Summary

Data from Liverpool DAAT and John Moores University indicates that a significant number of problematic drug users (PDU's) are not in any form of structured drug treatment. Evidence informs us that this cohort of drug users regularly present to the pharmacy Syringe Exchange Programme (SEP) for clean injecting paraphernalia; quite often pharmacy staff are the only health professionals this group of PDU's have contact or engage with. Data from the Inter-Agency Database (IAD) at Liverpool John Moores University (LJMU) suggests that 1704 IDUs presenting to pharmacy syringe exchange programmes in Liverpool are not in structured treatment.

Furthermore, the Glasgow Study data suggests that there are 3780 treatment naive PDUs in Liverpool. It is this data which led us to develop a pilot study with a city centre central pharmacy syringe exchange programme in Liverpool.

In order to find out more about this treatment naive group and try to engage them with treatment services, Lighthouse Project (LHP) and Lloyds Pharmacy decided to embark on a 3 month pilot project in order to achieve the following:

1. To identify those injecting drug users (IDUs) presenting to the pharmacy SEP for injecting paraphernalia that are not in structured treatment, and to refer on appropriately.
2. To provide on-site joint training for both LHP and pharmacy staff in providing a holistic harm reduction service to IDUs.
3. To ensure that pharmacy staff have up to date information and literature regarding appropriate referral destinations for IDUs within Liverpool.
4. To identify ways in which building and pharmacy based SEP's can work more effectively together.

In order for both organisations to gain maximum benefit from the pilot, staff from both agencies shadowed each other at the pharmacy or agency based exchange on alternate weeks for a minimum of half a day per week during the pilot.

In total 52 IDUs were seen at Prospect Point pharmacy over a 7 week period (3.5 days in total). Of the 52 IDUs seen, 46 reported to be in structured treatment. Of the remaining 6, 4 were referred to structure treatment programmes and 2 declined any intervention.

The pilot allowed us to examine the level of harm reduction knowledge and interventions provided at the pharmacy and to provide a minimum level of training for the pharmacy staff on basic key harm reduction messages. This report details recommendations benchmarked against NICE guidance as to how harm reduction interventions can be improved for IDUs within pharmacies and across agencies in Liverpool.

2. Introduction

Harm Reduction

Syringe exchange programmes emerged in England in the early to mid 80s in response to the concern about the potential for a blood borne virus (BBV) epidemic amongst (IDUs). Since then they have been widely acknowledged for their significant role in the containment and reduction of BBV's among IDUs. Recent epidemiological data from the Health Protection Agency suggests that despite these notable successes, the rate of BBV infections among IDUs remains persistently high¹. In England & Wales (outside of London), HIV in IDU's has risen from 1 in 400 in 2002, to 1 in 150 in 2007. In Scotland it has fallen to 1 in 350².

HIV, hepatitis B and C are continuing to occur among IDUs in the UK. Overall, approximately 1 in 90 is now infected with HIV, around 1 in 6 have been exposed to hepatitis B, and almost half of IDUs have been infected with hepatitis C. In addition, having an abscess, open wound or sore at injection sites during the last year are reported by around 1 in 3 IDUs. Though the level of needles and syringe sharing has declined in recent years, it remains higher than in the middle of the 1990's, with around a quarter of IDUs reporting direct sharing during the previous month in 2007. The sharing of other injecting-related equipment, particularly mixing containers and filters, is even more common³.

IDUs are clearly the most at risk group in terms of hepatitis C. Data from throughout the UK consistently shows that

more than 90% of all newly diagnosed infection occurs in IDUs⁴. Compared to other regions, the North West has one of the greatest burdens of infection⁵. For example:

- The North West has had the highest number of hepatitis C cases reported to laboratories in England since 1999; numbers in 2005 (2019) were 73% higher than the next highest region (Yorkshire and Humber, 1161).
- The prevalence of hepatitis C among IDUs is higher in the North West (58%) than any other region, based on IDUs in contact with drug services for 2004 and 2005 combined.

In England & Wales the overall hepatitis C prevalence has increased since the beginning of the current decade. There is evidence indicating that ongoing transmission has been elevated in recent years, with the prevalence among recent initiates having increased from around 1 in 10 in the late 1990's to around 1 in 5 in 2007⁶. While it is recognised that IDUs are the most at risk group with reference to hepatitis C, one must not forget the risks for powder cocaine users. Between September and December 2008, the harm reduction service at Lighthouse Project conducted blood borne virus screening for a number of drug users, 3 powder cocaine service users who had never injected test positive for hepatitis C.

Treatment

The prevalence of opiate &/or crack cocaine users in Liverpool is estimated at 6,631 with 1,445 estimated to be injectors. ⁷According to the Citysafe partnership plan for Liverpool (07/08), 43% of problematic drug users were in treatment the previous year (05/06) compared with 55% in 04/05. Subsequently one of the partnership's key priorities is to improve the penetration rate by ensuring that access to treatment is 'easy' for high risk groups not engaging with service providers. In addition to this, the partnership is committed to ensuring that tier 3/4 providers are fully compliant with NDTMS reporting and have IT systems which are fit for purpose. ⁸Local intelligence informs us that a number of PDUs are treated within primary care services, however, one could not be certain that this is accurately represented within the NDTMS.

Syringe Exchange Programmes (SEPs)

Liverpool John Moores University collect SEP data from 31 pharmacies across Liverpool. In total, between October 2007 and September 2008, 6200 service users presented at pharmacy SEPs for clean paraphernalia (these figures include steroid users). During this time Lighthouse Project had 1557 service users present across 2 agency SEPs.

Syringe Exchange Service	No. Clients	%
Croxteth (LHP)	264	17.0
Hope St (LHP)	1293	83.0
Total	1557	100.0
Lloyds Prospect Point	719	11.6
Total of all Pharmacy SES programmes	6200	100.0

¹ Health protection Agency, Shooting Up (2007). Infections among injecting drug users in the United Kingdom 2006. An update 2007.

² Hope, V (2008) Presentation at National Conference on Injecting Drug Use.

³ Health Protection Agency, Shooting Up, infections among injecting drug users in the UK 2007: An update October 2008.

⁴ Hepatitis C in the UK. The HPA Annual Report 2008.

⁵ HPA (2006). Shooting Up. Infections among injecting drug users in the United Kingdom. An Update: October 2006. London: Health Protection Agency.

⁶ Health Protection Agency, Shooting Up, infections among injecting drug users in the UK 2007: An update October 2008.

⁷ Hay, G et al (2006/7), Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, North West Region. The Centre for Drug Misuse Research, University of Glasgow.

⁸ Liverpool Citysafe (CDRP/DAAT), Adult treatment Plan 2007/8. Published by NTA October 2006.

Breakdown of Service users by gender at all 3 SES programmes.

SES Programme	Male	%	Female	%	Total
Lloyds Prospect Point	592	82.3	127	17.7	719
Croxteth (LHP)	214	81.1	50	18.9	264
Hope St (LHP)	1178	91.1	115	8.9	1293
Total across 3 sites					2276

According to the IAD quarter 2 report (July – September 2008)⁹ 3,885 service users were registered as being in treatment via NDTMS, 258 service users accessed the agency syringe exchange during this period, with 186 classified as being in treatment (thus included in the 3,885 figure). Thus 72 individuals accessed an agency based programme that were not in treatment.

During the same reporting period, pharmacy based exchanges saw 2,216 individuals; 512 were identified as being in treatment which indicates that 1704 were not.

Using the Glasgow Study data one can assume that there are 3780 treatment naive PDUs in Liverpool. It is this data which led us to develop a pilot study with a city centre central pharmacy syringe exchange programme in Liverpool.

Rationale

Data from Liverpool DAAT and John Moores University indicates that a significant number of problematic drug users (PDU's) are not in any form of structured drug treatment. Evidence informs us that this cohort of drug users regularly present to the pharmacy SEP for clean injecting paraphernalia, quite often pharmacy staff are the only health professionals this group of IDU's have contact or engage with.

In order to find out more about this treatment naive group and try to engage them with treatment services LHP and Lloyds pharmacy decided to embark on a 3 month pilot project in order to achieve the following:

1. To identify those IDUs presenting to the pharmacy SEP for injecting paraphernalia that are not in structured treatment, and to refer on appropriately.
2. To provide on-site joint training for both LHP and pharmacy staff in providing a holistic harm reduction service to IDUs.
3. To ensure that pharmacy staff have up to date information and literature regarding appropriate referral destinations for IDUs within Liverpool.
4. To identify ways in which building and pharmacy based SEP's can work more effectively together.

Timescale

The pilot commenced on Thursday 7th August 2008 and was due to finish on Wednesday 5th November. However, due to staff absence, it was extended to 21st November 2008 (see Appendix 1). Locations for the pilot were the agency-based SEP at Hope St and Prospect Point pharmacy, both in Liverpool city centre.

3. Methodology

In order for both organisations to gain maximum benefit from the pilot, it was agreed that staff from both agencies would shadow each other either at the pharmacy or building based exchange on alternate weeks for a minimum of half a day per week (see appendix 1).

Prior to the pilot beginning, both agencies met on 2 separate occasions to set aims and objectives, discuss roles and responsibilities, address any potential concerns and to ensure that everyone was comfortable with the process. Lighthouse Project staff were asked to complete a template for all the service users they saw at the pharmacy (see appendix 2). These data sheets formed the basis of the findings described on page 8.

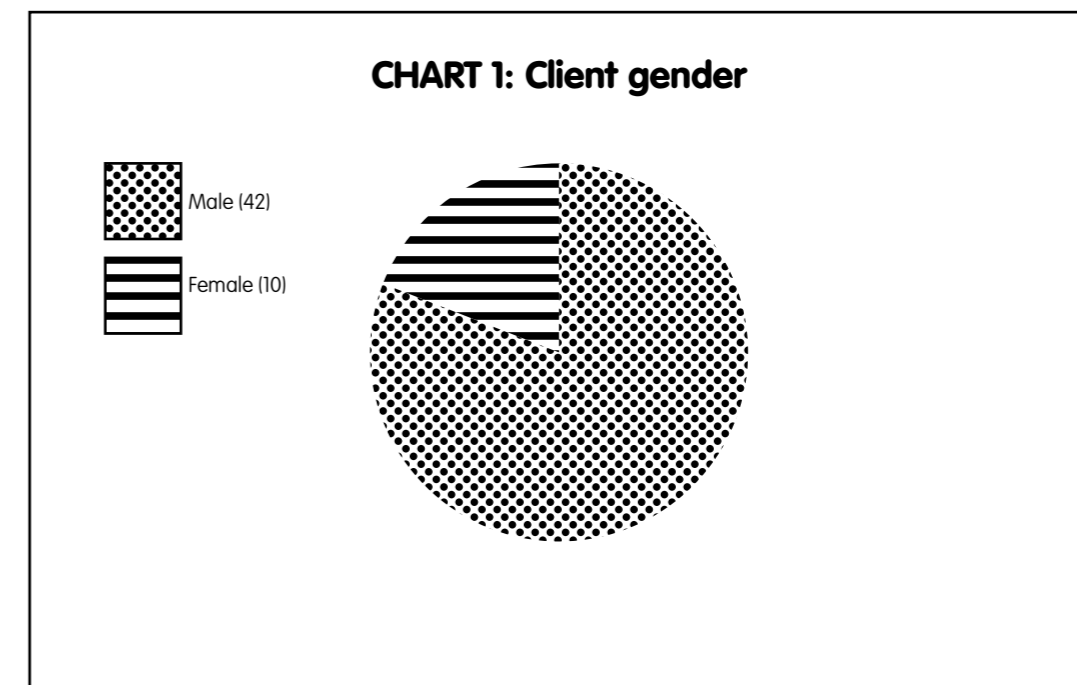
While at the pharmacy, LHP staff were introduced to service users who presented for SEP services and both members of staff endeavoured to engage the service user and conduct a brief assessment of their presenting needs and to gather basic information regarding their substance misuse and treatment history. Pharmacy staff shadowing agency-based exchange workers acted as passive observers, although they were introduced to service users who presented for injecting paraphernalia.

After each session Lighthouse Project staff completed the template with a brief narrative of the learning experience. The pharmacy staff were also asked to note their experiences for discussion at the mid-way review and the end of the pilot.

Mid-way through the pilot a meeting was arranged with operational & managerial staff, including the lead pharmacist for Prospect Point to discuss progress and to overcome any perceived barriers to the success of the pilot. A further meeting was arranged at the end to summarise, discuss the findings and recommendations for future practice.

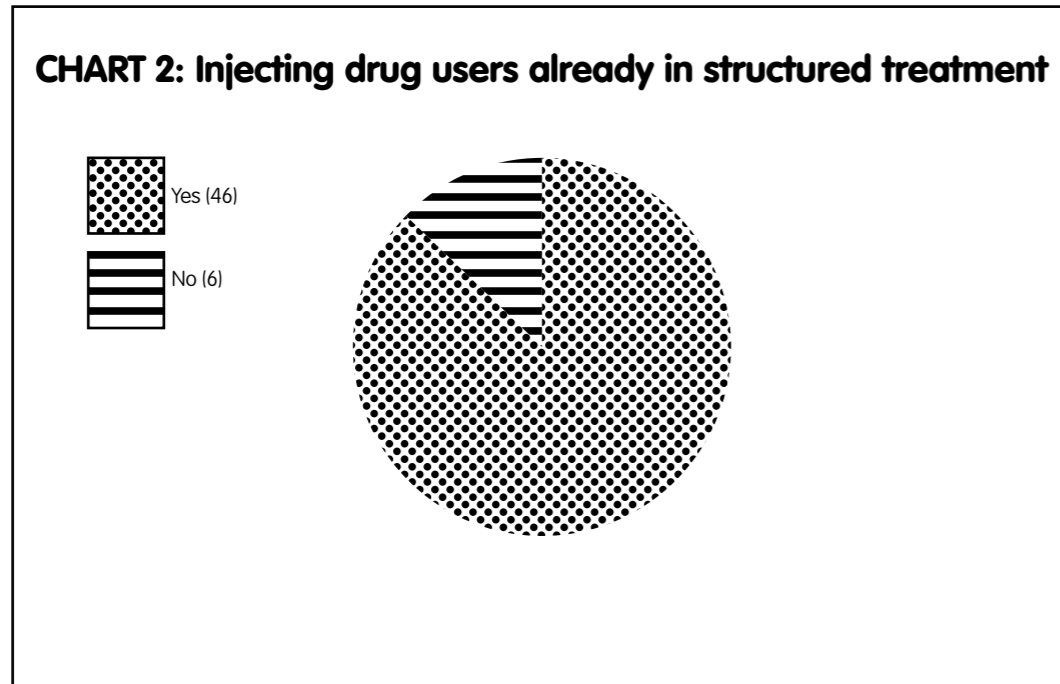
4. Results

In total 52 IDUs were seen at Prospect Point pharmacy over a 7 week period (3.5 days in total). As Chart 1 below illustrates 42 were male and 10 female.



⁹ Baron, L, et al Merseyside Inter Agency Drug Misuse Database, Quarter 2 July – September 2008. LJMU Centre for Public Health.

Of the 52 attenders 46 were already in structured treatment, 6 were not known to treatment services, chart 2.



The 6 service users who were not in treatment were referred on to appropriate services based on presenting need as indicated in chart 4.

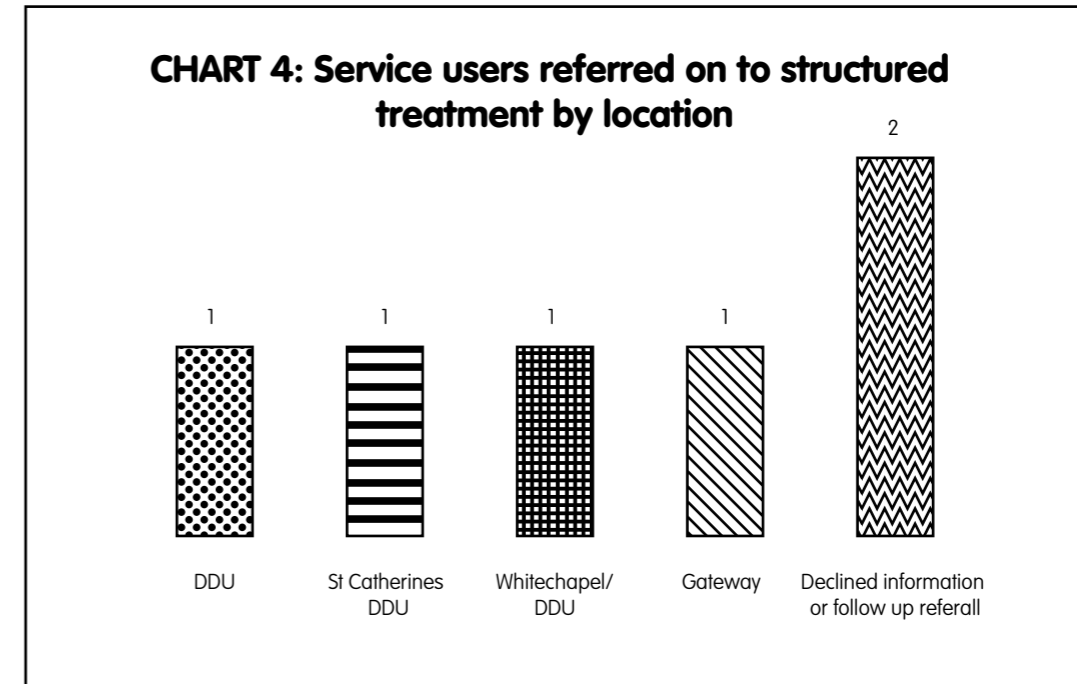
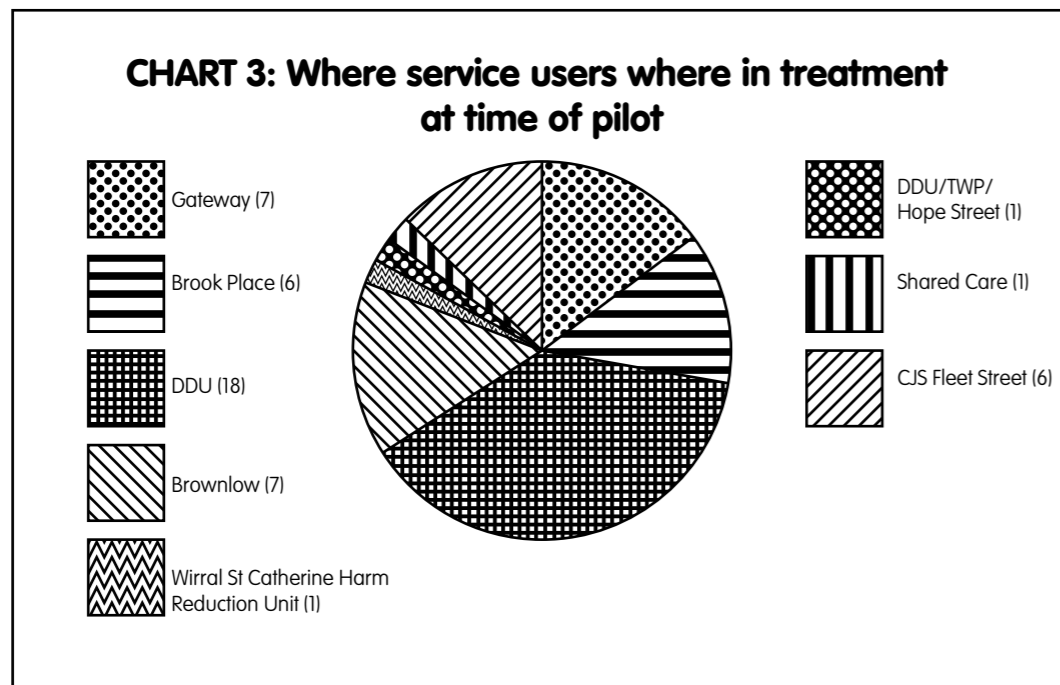
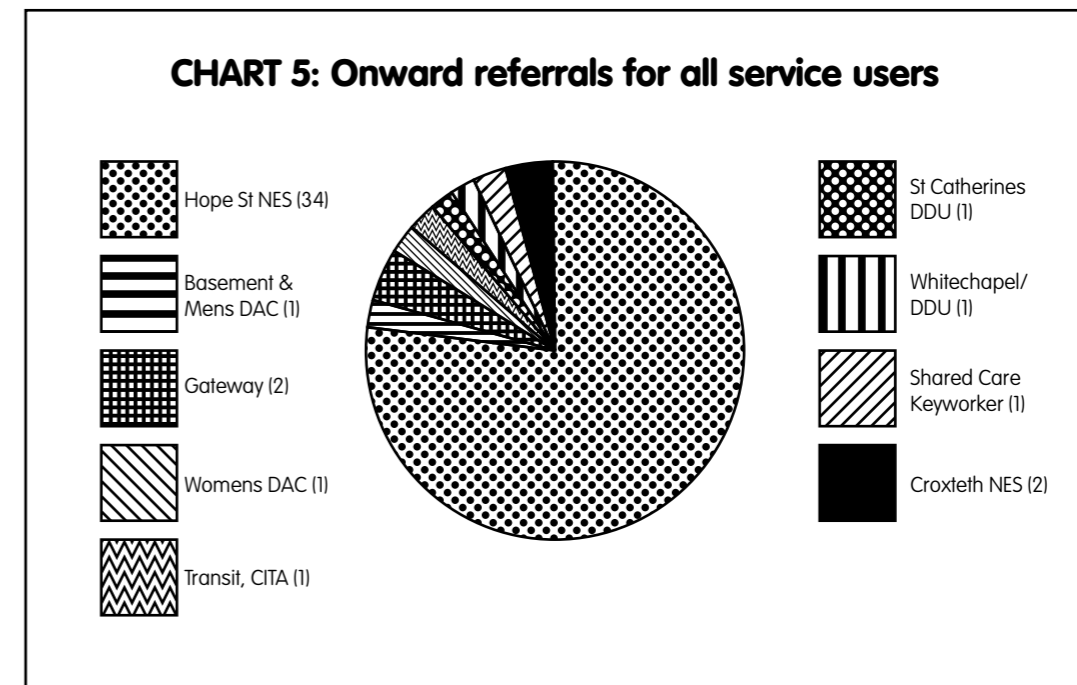


Chart 3 illustrates which treatment provider the service user was registered at.



Of all the service users who presented at the pharmacy SEP, 44 were referred onto further services for additional harm reduction support and interventions, chart 5 depicts where they were referred to.



5. Conclusions

It is quite apparent that a high proportion of IDUs are accessing pharmacy SEPs compared to agency based SEPs, with a large cohort who are not presenting for treatment as defined by the NTA. Between July – September 2008, 72 individuals accessed the building based SEP and 1704 accessed the pharmacy SEP who were not registered as being in a treatment programme. This begs a number of questions; are IDUs being referred to treatment, and, if so why don't they make it to services?

Of the 258 service users accessing agency SEPs within the same reporting period, 186 reported they were in treatment, 512 of the 2216 accessing pharmacy SEPs reported as being in treatment. What is apparent is that significant numbers of service users in treatment are continuing to engage in high risk behaviours, for example, one client was prescribed 100mls methadone daily but continued to inject several times a day. The culture of drug treatment nationally, coupled with issues of confidentiality, does not allow service providers to share client information between agencies, and some would argue that this should not happen. However, one would advocate that this could have the potential to improve harm reduction services for IDUs as long as service providers do not use this information to threaten the continuation of treatment, but utilise it to review and improve care plans and treatment goals and to ensure appropriate and targeted harm reduction advice.

Pharmacy Staff Signposting to Other Agencies

Verbal reports from pharmacy staff suggest that they had been issued with a credit card size leaflet with potential referring agencies on it, however, not all were aware of it and on examination it was out of date. Due to the time constraints on pharmacy staff, it is very rare that they can engage with service users in order to provide any meaningful interventions. By way of example, the pharmacy staff were unaware of the prescribing service delivered from the Whitechapel Centre. In addition to this, pharmacy staff felt that they did not have the training or expertise to provide such interventions.

Treatment

One of the main aims of this pilot was to try and engage with treatment naive IDUs and refer to treatment in order to help improve penetration rates in Liverpool. As the data indicates, all but 6 of the 52 service users reported being in treatment, therefore there was little opportunity to achieve this aim. The 6 service users who reported not being in treatment were referred accordingly.

Due to the methodology of the pilot, however, we have not been able to confirm if these IDUs attended or not. Given that 1704 IDUs who are not in treatment are using pharmacy SEPs, it was quite surprising to see low numbers. There may be some explanations for this, firstly the pilot was short in duration, and in total LHP staff attended the pharmacy for 7 half day sessions which did not give an opportunity to see a significant number of the 719 service users registered with Prospect Point. Secondly, it may be plausible to suggest that IDUs attending city centre pharmacies are more likely to be in treatment due to the proximity of services. This is something which LJMU could investigate as this would give us an indication as to which pharmacy SEPs to target for further joint working.

The DAAT have made a commitment to ensure that tier 3 & 4 providers are fully compliant with NDTMS reporting. This suggests that the 43% penetration rate may be inaccurate and higher numbers of people are actually receiving treatment, particularly within primary care services. By way of example, LHP provides RCGP part 1 certificate training to GPs locally; to date over 200 doctors have been trained and not one of them has been aware of NDTMS and the need to report patients they are currently treating. Given this information one would question the accuracy of the estimated penetration rate.

Liverpool DAAT has worked with their main providers to ensure that access to treatment is easy and flexible to meet the needs of service users. There has been an abundance of positive work over the last 12 months and partnerships are much stronger than they have been before. The DAAT should capitalise on this and consider supporting a break out session at the RCGP conference in Liverpool this year for all those practitioners working with substance misusers across the city to advise, promote and dispel any myths of the treatment services which may be overhanging from some time ago.

Referrals on

Thirty six of the fifty two service users were referred onto agency SEPs for a thorough harm reduction assessment, health and BBV screening. Clearly these are services which the pharmacy SEPs do not currently provide. As stated previously, the methodology of the pilot was not sophisticated enough in terms of follow-up of referrals thus this data has not been matched against attendance. Eight service users were referred to other service providers for further support, including to structure treatment programmes and homeless providers.

Harm reduction

The second aim of the pilot was to provide on-site training to both organisations in order to deliver a holistic harm reduction service to IDUs. While this was an aim it was intended to be an informal process and evaluation of this was received via feedback from the staff at the mid and end review meetings.

This element of the pilot was quite significant in terms of highlighting the skills and competencies of staff and their approach to the delivery of key harm reduction messages. The pharmacy staff reported that their knowledge around harm reduction was quite limited, they were not aware of basic information such as which type of needles/barrels should be advised depending on drug used and injection site. They also reported that they did not give harm reduction advice because they were not confident in doing so and lacked the formal training. Agency SEP workers provided informal training on some of the basic key harm reduction messages, how to conduct a brief assessment and advise on how to promote safer injecting and minimisation of possible overdose situations. The pharmacy staff found this useful, however, this should not be considered as a substitute for formal training. It was suggested that they should undertake the 2 day safer injecting course run by HIT.

Feedback from IDUs on the pharmacy SEP was very positive, with a number reporting that it was a quick service, with minimal wait, friendly and non-judgemental staff. One IDU reported that Prospect Point pharmacy was the best he had attended for feeling respected and valued.

It is quite evident that there are significantly more IDUs accessing pharmacy SEPs than agency SEPs. From a service user point of view this creates choice and flexibility, however, this service is only a small element of the pharmacy staffs' role, and it is quite clear that staff don't have the time or the knowledge to provide a thorough harm reduction service or to provide brief interventions which can have a lasting impact on health behaviours. Given the volume of IDUs going to pharmacy SEPs this is a real missed opportunity, particularly as high numbers are not in any form of treatment which means that the pharmacy staff are the only health care professionals they may have contact with. It is paramount, therefore, that IDUs get the basic key harm reduction messages from this source. If key messages are not delivered, this only increases the probability of IDUs becoming infected with hep C and other blood borne viruses. The distribution of sterile needles and syringes alone is not sufficient to reduce the transmission of blood borne viruses amongst IDUs¹⁰. This point of view has been expressed in the 2009 NICE guidance:

“syringes and needles are available in a range of sizes in locations sited across the area covered by the strategic partnership. They should only be provided in venues where safer injecting advice and information is available...”¹¹

¹⁰ Jones, L, et al (2008) A Review of the Effectiveness and Cost Effectiveness of Needle & Syringe Programmes for IDUs. LJMU Centre for Public Health

The guidance makes several recommendations for pharmacy SEPs. It suggests that staff in pharmacies that provide more than needle exchange packs should be trained to provide health promotion advice, in particular how to minimise the harm caused by injecting. Offering injecting packs to clients without brief assessment and key harm reduction messages should only be acceptable as occasional practice. If commissioners cannot support training for pharmacy staff to provide a comprehensive service, then a system should be put in place to ensure that persistent pharmacy attenders who are not in treatment and not registered with a agency SEP have access to a thorough health assessment by an appropriately trained harm reduction nurse. This could be done within the pharmacy, referred and supported to attend an agency, or where appropriate, in the IDU's home or other place of residence. Working alongside Supporting People teams would allow harm reduction services to do this safely and effectively.

Over the last few years, pharmacy SEPs have grown considerably and now make up over 70% of SEPs in England. This has been a growth area which service users and service providers alike have welcomed as they have provided greater coverage geographically, flexibility and choice for IDUs. The concern arises when IDUs only have contact with pharmacist programmes with no other specialist professional advice and support. As the evidence suggests the number of IDUs in Liverpool who fall into this category is alarmingly high, it is more concerning that the key harm reduction messages are not being delivered.

Having an abscess, open wound or sore at injection sites within a 12 month period was reported by 1 in 3 IDUs, and is estimated to cost the NHS £47 million¹². The risk of death for IDUs is estimated 13 times higher than the general population when matched for age and gender¹³. Needle and syringe sharing remains higher than in the 1990's, with around a quarter of IDUs reporting direct sharing in the last 4 weeks. The sharing of other injecting paraphernalia is reported as being even more common. Data such as this can not be ignored, thus it is imperative that evidence-based harm reduction services should be promoted, services should be commissioned to deliver this agenda in a joined up way.

6. Recommendations

1. Services commissioned by the Citysafe partnership should evidence interventions and referral destinations for all service users.
2. Services should share information with treatment providers if they feel IDUs in treatment are involved in risky injecting behaviours.
3. A system should be put in place to ensure that persistent pharmacy attenders who are not in treatment and not registered with an agency SEP have access to a thorough health assessment by an appropriately trained harm reduction nurse.
4. Pharmacies should be equipped with up to date information regarding referral destinations to meet the needs of complex IDUs.
5. All pharmacy staff dealing with IDUs should at a minimum attend a safer injecting course. This could be reflected in their contract akin to that of the local enhanced services for GPs.
6. Agency based harm reduction services should maintain relationships with pharmacy SEPs and, where possible, provide regular on-site sessions in order for IDUs to access healthcare assessments and screening & vaccination for BBVs.
7. Service users clearly appreciate pharmacy SEPs, therefore the partnership should seek to support and enhance this where possible.
8. The partnership should implement recommendations for SEPs as directed by NICE.
9. Services should develop partnerships with Supporting People teams to try and reach those IDUs attending pharmacies that are not in contact with mainstream services.
10. LJMU could provide detailed data to the partnership regarding those pharmacies that have the highest number of IDUs registered and who are not in treatment. This data can then be used in order to inform further partnership working with the aim of accessing people into effective treatment.
11. If the partnership opts for the pick and mix schemes within pharmacies they should first consider the competencies of the staff to provide such a service.

¹¹ NICE (2009) Needle & Syringe Programmes: Providing Injecting Equipment to People who Inject Drugs

¹² Hope, V (2008) Presentation at National Conference on Injecting Drug Use

¹³ NICE (2009) Needle & Syringe Programmes: Providing Injecting Equipment to People who Inject Drugs

Appendix 1: Timetable

Day	Date	Time	Staff member
Thursday	7th August	9.30 - 1 pm	Hope St
Wednesday	13th August	1-5pm	Pharmacy
Thursday	21st August	9.30-1 pm	Hoper St
Wednesday	28th August	1-5pm	Pharmacy
Thursday	4th September	9.30-1 pm	Hope St
Wednesday	10th September	1-5pm	Pharmacy
Thursday	18th September	9.30 - 1 pm	Hope St
Wednesday	24th September	1-5pm	Pharmacy
Thursday	2nd October	9.30-1 pm	Hope St
Wednesday	8th October	1-5pm	Pharmacy
Thursday	16th October	9.30-1 pm	Hope St
Wednesday	22nd October	1-5pm	Pharmacy
Thursday	30th October	9.30-1 pm	Hope St
Wednesday	5th November	1-5pm	Pharmacy

