SMMGP Policy Update - March 2009

The primary prevention of hepatitis C (HCV) among injecting drug users (IDU) – Advisory Council on the Misuse of Drugs (ACMD) - February 2009

ACMD prevention of HIV reports published in 1988 and 1993 were highly influential by emphasising the importance of harm reduction and explaining the importance of investing in a range of harm reduction services. Many of the findings in those early reports parallel this inquiry regarding HCV prevention. This report focuses on primary prevention of HCV in IDU. It acknowledges the vital nature of expansion of treatment services (secondary prevention) but does not cover those areas, although the potential of HCV treatment as a component of prevention and the importance of HCV testing to promote prevention and improve epidemiological evidence is discussed. The report also summarises the effectiveness of interventions to prevent HCV and what actions will reduce the risk of HCV infection.

The ACMD's report on hepatitis C states that it is a significant public health issue. In the UK, HCV infection is one of the commonest viral infections, and it is likely that in England and Wales between 120,000–300,000 people are infected and 50,000 in Scotland. It is estimated that between 85%-90% of current HCV infections are acquired through injecting drug use and that around 50% of IDU in the UK may be infected with HCV and approximately half of the drug using population who are infected may be unaware that they are HCV positive.

Preliminary analysis of HCV surveillance data suggest that it is likely that the overall prevalence of HCV among IDUs has increased in recent years and HCV infection among recently initiated injectors has almost doubled between 1998 and 2007 (HPA 2008a). The public health challenge is to increase action and effective prevention in order to stem the upward rise in HCV prevalence.

The ACMD recognises the importance of a combination of interventions to help tackle the spread of hepatitis C and has made a total of 12 recommendations including:

- that service planners review local needle and syringe programmes (NSP) in order to increase access to injecting equipment and increase the proportion of injectors who receive 100 per cent coverage of sterile injecting equipment.
- provision of better interventions so that services offering methadone also provide sterile injecting equipment and that needle and syringe distribution services facilitate entry into drug treatment.
- increasing the frequency of hepatitis C diagnostic testing amongst injecting drug users.
- ensuring that staff are competent and confident in providing HCV and BBV antibody testing.
- studies to strengthen the evidence of the impact of interventions on hepatitis C incidence.

In reviewing the evidence the ACMD concluded that a single intervention may not, alone, be sufficient to prevent the spread of HCV. The evidence suggests that the most effective way of reducing HCV incidence among active IDU is through a combination of opiate substitution therapy and the provision of NSP.

The ACMD report on the primary prevention of hepatitis C was published alongside and is complementary to public health guidance from the National Institute for Health and Clinical Excellence (NICE) on *Needle and Syringe Programmes: providing people who inject drugs with injecting equipment* http://www.nice.org.uk/guidance/index.jsp?action=download&o=43302

For the full hepatitis C report, which is definitely worth reading go to:

http://drugs.homeoffice.gov.uk/publication-search/acmd/acmdhepcreport2

Needle and Syringe Programmes: providing people who inject drugs with injecting equipment. NICE PH18 – February 2009

The public health guidance makes evidence-based recommendations on the optimal provision of needle and syringe programmes (NSP). A key aim is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment.

In 2005/6 one report estimated that there were around 130,000 – 200,000 injecting opiate and/or crack cocaine users in England, although the true extent of injecting drug use is difficult to estimate and prevalence varies across regions. The risk of death among people who inject drugs is high, at over 1% per year, and over ten times higher than for the general population.

The majority of NSP are currently run by pharmacies and drug services and work by providing injecting drug users with sterile injecting equipment. Some services may also offer advice on safer injecting practices, advice on how to avoid an overdose and information about appropriate injecting equipment disposal techniques. NSP can also act as an effective conduit through which healthcare professionals are able to have direct contact with people that traditionally have not accessed treatment services including women, users of anabolic steroids (and other performance and image enhancing drugs), cocaine and speedball users, young people, homeless people and prison populations. These groups may also require special consideration when planning services such as flexible locations and opening times and novel methods of service delivery. The direct contact would allow NSP staff to explain the many dangers of drug misuse and the possible treatment pathways open to them, including access to services to help them stop injecting drugs, such as those offering opioid substitution therapy (OST).

The guidance recommends partnership working, joint planning, needs assessment and community engagement to ensure that a mix of generic and targeted (services for special groups) services are available to meet local need in terms of for example opening times and locations.

Other recommendations include:

- encouraging people who inject drugs to use services which aim to reduce the harms associated with injecting drug use; encouraging them to stop using drugs or to switch to non-injecting methods (for example OST); and address their other health needs.

- making available guidance on the provision of needles, syringes and other injecting equipment to people who inject drugs.

- advising local strategic partnerships on how to develop plans to ensure NSP meet local need and offer integrated care pathways for people who inject drugs.

- helping NSP providers develop plans for needle and syringe disposal, in line with "Tackling drug-related litter" (*Department for Environment, Food and Rural Affairs 2005*).

- ensuring people who use NSP are provided with 'sharps bins' and advice on how to dispose of needles and syringes safely.

- ensuring that staff receive training appropriate for the level of service provided.

Comments from SMMGP

It is helpful that these two reports have come out together on this vitally important issue. With the HCV prevalence figures that we have in people who inject drugs it is essential that this problem is addressed adequately and we hope that government strategies to expand substitution therapy and NSP continue.

Due to concerns about HCV from yourselves, SMMGP along with RCGP SMU and SDHIV Task Group have developed a business case for a certificate course called '*RCGP Certificate in the Detection, Diagnosis and Management of Hepatitis B and C in Primary Care'.* We have just heard funding has been agreed but how this is going to move forward is yet a little unknown so watch this space!!

Cannabis: Classification and public health: Advisory Council on the Misuse of Drugs (ACMD)

In 2007, Gordon Brown asked the ACMD to carry out a review into the classification of cannabis, which had been downgraded to a Class C drug in 2004 to reflect more accurately its relative level of harm. Concerns had been raised about the stronger cannabis strain known as *skunk*, and whether it had a connection to mental illness and therefore warranted a return to Class B. Looking closely at the evidence the Council found there should be a wait of two more years to establish further scientific basis of the link and recommended that cannabis should remain as a Class C drug. The government ignored this recommendation with the Home Secretary, Jacqui Smith, saying there was a compelling case to act now. Cannabis was therefore reclassified as a Class B drug in January 2009.

The ACMD report did confirm that cannabis could produce immediate and longer-term harm to physical and mental health. The report also confirmed that cannabis poses a real threat to the health of those who use it because:

- most of the cannabis around today is much stronger

- some young people may 'binge smoke' strong cannabis

- cannabis can worsen the symptoms of schizophrenia and lead to relapse

- as well as its short-term psychological effects, there is a probable, though weak causal link between cannabis use and the later development of psychotic illness.

The Association of Chief Police Officers (ACPO) and the Home Office jointly developed the three steps of warning, fine and arrest as a way to strengthen the enforcement approach to cannabis possession for repeat adult offenders.

Adults in possession of cannabis:

If caught in possession of cannabis, as well as considering arrest and confiscating the drug, police are likely to:

- give a cannabis warning for a first offence of possession
- give a Penalty Notice for Disorder - this is an on-the-spot fine of £80 for a second offence
- make an arrest if it is the third offence of having been caught with cannabis - this could lead to conviction and a criminal record

Penalties for possession: The maximum penalty increases from two years to five years imprisonment.

Penalties for supply, dealing, production and trafficking: The maximum penalty is 14 years imprisonment.

Young people in possession of cannabis: A young person found to be in possession of cannabis will be arrested and taken to a police station where they can receive a reprimand, final warning or charge depending on the seriousness of the offence.

Following one reprimand, any further offence will lead to a final warning or charge. Any further offence following a warning will normally result in criminal charges. After a final warning, the young offender must be referred to a Youth Offending Team to arrange a rehabilitation programme.

Comments from SMMGP

It is important to remember that classification is basically about punishment and not about health effects of drugs. SMMGP feel the classification of drugs system is fundamentally flawed and it is based upon the false assumptions underlying historical prohibition of specific drugs, rather than upon evidence of the efficacy of the classification system for reducing drug harms. There are many reasons why we feel it is flawed which include: the system is based on the un-evidenced assumption that criminal penalties are an effective deterrent and that stronger penalties are a stronger deterrent, criminal law is supposed to prevent crime, not 'send out' public health messages; alcohol and tobacco - our most harmful drugs - are not included in the classification system; drug harms are mediated by the nature of the user, the dose of drug consumed and the method of consumption – making a system based upon broad-sweep single classifications for each drug fundamentally unscientific and meaningless in most practical terms; and to translate generalisations about harms/risks to an entire population into penalties for individuals is both unscientific and unjust. (Adapted from Transform - for more on these arguments see: www.tdpf.org.uk)