



Harm reduction initiatives for drug users and the general population: what value to society?

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In the past decade there have seen extensive changes in the services available to drug users in Ireland with the expansion in the Drug Treatment Services in response to the Government Strategy to Prevent Drug Misuse 1991 and The National AIDS Strategy Commission report 1992. In 1998 the Health Services introduced the methadone protocol, one of the most stringent in Europe, to control the prescribing and dispensing of methadone.

At present it is estimated that there are over 13,000 heroin addicts in Dublin. The National Advisory Committee on Drugs Prevalence Survey for 2002/2003 report lifetime prevalence rates for all adults in the Republic of Ireland for the use of heroin as 0.5%, cocaine as 3.1%, other opiates as 3.1%, and any illegal substance as 19%.

Currently there are approximately 7,000 individuals in Ireland receiving methadone treatment. There are over 55 methadone treatment clinics in the Eastern region, and almost one third of individuals are placed with community GPs. There has also been a significant expansion in the availability of needle exchange programmes and at present there are approximately 14 programmes serving the Dublin area. Patients attending these services have access to methadone, clean injecting equipment, counselling, sex education and contraceptive advice, and all have free access to condoms. The implementation of these various harm reduction strategies was primarily a public health response to reduce the spread of HIV and other infectious viruses, to improve health, lifestyle, and to reduce criminal activity associated with illegal drug use.

The National Disease Surveillance Centre (NDSC) in Dublin publishes annual reports on the incidence and prevalence of infectious diseases, including HIV sexually transmitted diseases and infectious hepatitis. Injecting drug users represent approximately 40% of the total cohort of HIV infected individuals in Ireland. The cumulative total of HIV infections in Ireland to the end of December 2002 was 3009. During 2002 there were 364 newly diagnosed cases of HIV infection, an increase of 22% of cases diagnosed in 2001.² It was also reported that the total number of modifiable sexually transmitted diseases, of which there are currently 14,

increased by 9.4% in 2002 compared with those in 2001.

The numbers of infectious hepatitis B notifications continued to increase in 2002 with 458 cases being notified, the number of viral hepatitis type unspecified, were similar in 2002 to 2001, and most of these were due to hepatitis C. Interestingly hepatitis C was not a notifiable disease, however recent public health initiatives have been put in place and from 2004 hepatitis C will become notifiable.

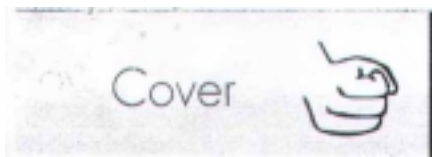
Whilst HIV infection is primarily a sexually transmitted disease, its main mode of transmission among intravenous drug users is through the sharing of contaminated injecting equipment. Much evidence has become available over the past decade to confirm that drug injectors have reduced their sharing of equipment in response to a wide variety of prevention programmes including methadone treatment services and needle exchange programmes.^{3,4} These programmes have been shown to reduce the transmission of infectious viruses, to reduce the incidence of many medical complications associated with the injecting of substances such as deep vein thrombosis, abscesses, septicaemia etc, as well as improving the overall general health and well-being of substance misusers.

Saving the tax payer

Whilst they offer an opportunity to encourage risk reduction and to provide counselling and access to healthcare for all individuals at high risk, they have also been shown to be cost effective. The British NTORS study found that for every £1 spent on treatment there is a return of more than £3 in terms of savings associated with victim costs due to crime. Methadone treatments not only reduce demands upon the criminal justice system, but have also been found to have significant benefits in terms of health savings, therefore benefiting society in general,

High risk sexual behaviour

However, changing sexual risk behaviour has proved to be considerably more difficult. The relationship between sexual behaviour and drug use is complex. Levels of reported condom use in intravenous drug users have been seen to be



comparable to that of the heterosexual population as a whole with approximately 70% never using condoms with primary partners, and 50% never using condoms with casual partners. A study carried out in Dublin in 1997 by the Drug Treatment Centre Board, measured the prevalence of HIV and risk behaviours in 185 Irish intravenous drug users, and concluded that sexual risk behaviour was high, with 50% of males and 63% of females never using condoms with regular sexual partners.

Female intravenous drug users were found to be at greater risk of HIV infection than their male counterparts and they concluded that there was a high potential for sexual spread of HIV into the non-injecting heterosexual population.⁵ The NDSC reports that the majority of newly diagnosed cases of HIV in 2003 were amongst heterosexuals (63.5%), that the number of cases of transmission among heterosexuals increased by 34% between 2001 and 2002. The rates of sexually transmitted diseases are increasing not only in injecting drug users, but also in the population as a whole, therefore it seems more work is needed to promote safer sexual practices, not only among intravenous drug users but the population in general.²

In light of this, further prevention efforts should therefore be focused not only on people who misuse substances themselves but on their partners, those who exchange sex to support an addiction and people who have multiple social, financial and educational problems. It would appear that cities with the most success in averting HTV epidemics have intervention developments that emphasise rapid reorientation towards user-friendly and low threshold services, community based approaches and public policies supportive of such interventions. Practical interventions include outreach, peer and social interventions, sex education, as well as legal access to sterile injecting equipment and low threshold agonist pharmacology in the form of methadone treatment programmes. Indeed, a study conducted in Glasgow in 1996 reported that if multidisciplinary health and social care are provided to street sex workers at a time and place that are convenient to their work, then the benefits are considerable and in their study they report prevalence rates of HIV infection amongst women remaining less than 5%.⁶

Whilst the importance of preventing the sharing of injecting equipment is well established, and considerable data is available to show that needle exchange programmes and methadone treatment programmes are effective in reducing the spread of infectious viruses, they also offer an opportunity for those already diagnosed with such illnesses to engage in and receive treatment.^{7,8} Patients attending these services are routinely offered virology screening, and where appropriate are offered vaccination. Data exists to show that those already infected with HIV have a greater rate of uptake of receiving highly active antiretroviral therapy and adherence to treatment if attending a methadone programme.⁹

There is little doubt of the value to drug users and to society in general that these services provide both in terms

of general health and social well being, as well as the money saved in terms of the criminal justice system and Health Services. Declines in HIV and AIDS incidence in intravenous drug users are indirectly attributable to these services. The increase in HIV antibody positive cases among heterosexuals may reflect a relapse in safe sex behaviour, and we should not only target the substance misusing population but target education programmes aimed at individuals who work closely with young people such as youth workers, teachers, probation officers and juvenile liaison officers, for the benefit of society as a whole.

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