Nursing Practice

Innovation

Harm reduction services

A harm reduction service for users of intravenous drugs run by mental health nurses developed into wider healthcare services for this vulnerable group.

From needle exchange to sexual health and beyond

In this article...

- How the harm reduction clinic was set up
- Health issues associated with intravenous drug use
- Benefits for patients and the health service

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Harm reduction services for users of intravenous drugs can do more than simply providing clean injecting equipment. This article examines one nurse-led harm reduction service in Scotland that grew in response to the needs and requests from people using it, and now includes bloodborne virus testing and prevention, wound care and sexual health services. The service has led to a decrease in the transmission of hepatitis B and complications from injection site injuries. It has also led to an increase in women attending for smear tests, as well as contraceptive advice and supplies. The service has been rated “high” for attendee satisfaction and participation.

Needle exchange schemes for intravenous drug users (IVDUs) officially began in 1985. Until then it was difficult for those who injected to obtain clean syringes and needles, so these were often reused or shared with others, leading to high transmission levels of bacterial and viral infections. The main driver behind the introduction of needle exchange services was the increase in the number of IVDUs who were becoming infected with the HIV virus. Services in Scotland started in 1987 in Edinburgh, which had a high rate of HIV diagnosis, and were subsequently developed across urban and rural areas.

Needle exchange in the Inverclyde area, on the west coast of Scotland, started in 1994 and, in line with services at the time, offered basic exchange of syringes, needles, injecting swabs and disposal bins. A range of staff from drug treatment clinics, district nursing services and social work drug programmes provided the services at this time. After an outbreak of hepatitis B among local IVDUs in 1998 (Scottish Executive, 1999), the local health board employed a specialist nurse to develop vaccination services, with a long-term goal of expanding general health services.

initial set-up

Emploving a specialist nurse to coordinate the new service ensured continuity across the clinics and provided a figurehead to develop them. Although my training is in mental health – and physical healthcare is not always seen as a traditional role for mental health nurses – I took on the position as I was keen to develop the skills required to offer a range of services.

A management group – comprising nursing, medical, social work, police and health service managers – oversaw the service, and had responsibility for authorising service development and budgetary considerations, and monitoring overall effectiveness.

Having a dedicated management group meant decisions could be made quickly, and funding could be secured and authorised in a timely manner. I also formed close working relationships with primary care services and the local bloodborne virus (BBV) treatment service.

Specialist nurse’s responsibilities

Managing the service involved:

- Day-to-day clinical staffing across a number of sites;
- 5 key points

1 In the UK, needle exchange schemes for intravenous drug users (IVDUs) officially began in 1985.
2 At the end of 2013 there were 35,474 people living with hepatitis C virus (HCV) in Scotland. Of those with a known risk factor, 97% had contracted the virus through drug use.
3 Injection site injuries can become infected and lead to both septicaemia and necrotising fascitis.
4 Conservative estimates of the annual healthcare costs associated with injection site infection range from £15.5m to £47m per year.
5 Intravenous drug users tend to have poor reproductive health.

Hepatitis C is prevalent among drug users.
Developing patient group directions (PGDs) in partnership with a multidisciplinary team;
» Coordinating training for nurses across various sites in established needle exchange and methadone treatment clinics;
» Supervising data collection and service audits.

Clean needles and more
One of the first steps in building the new service was to ensure the right types of equipment and supplies were offered. This led to the service ultimately being:
» A wide range of sizes of both syringes and needles;
» Cleansing swabs;
» Filters;
» Acidifiers (for heroin preparation);
» Disposable spoons;
» Silver foil;
» Advice on injection technique;
» Advice on how to reduce harm from frequent injecting.

Harm reduction, however, is not just about providing clean injection equipment. The National Treatment Agency for Substance Misuse (2009) defines harm reduction as:

“A set of policies, programmes, services and actions [that] work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs”.

So it is recommended that harm reduction services address harm from the:
» Spread of BBVs;
» Overdose or unintentional injury;
» Risk of comorbid health problems (mental health or alcohol);
» Septicaemia, wound infections and other infections resulting from injecting.

Taking a broader view
After establishing the needle exchange, the next step was to introduce further health assessment and care services. This was phased over eight years and included:
» Vaccination against hepatitis A and B;
» Testing for BBVs;
» Wound care;
» Sexual/reproductive healthcare.

To encourage attendance, we offered most services on an anonymous basis and obtained consent from clients before any treatment or referral to external services.

Hepatitis vaccination
Hepatitis A and B are often transmitted among IVDUs and the UK guidelines on the clinical management of drug users recommend vaccination against both (Department of Health, 2007). Working with medical and pharmaceutical staff, we prepared a PGD (Royal College of Nursing, 2004) so nursing staff could administer the vaccination using an accelerated schedule to aid rapid immunity. Having a PGD allowed nursing staff to give vaccinations to those who met the inclusion criteria without having to first obtain an individual prescription. Nursing staff were given additional training on vaccine administration and anaphylaxis, which was updated on a yearly basis.

There were challenges in the final implementation of the scheme because of the need to install vaccine fridges and resuscitation equipment at all sites. However, with the support of the management group, problems were quickly overcome.

BBV testing
At the end of 2013 there were 35,474 people living with hepatitis C virus (HCV) in Scotland alone. Of those with a known risk factor, 97% had contracted it through drug use (McLeod et al, 2014). Transmission rates remained high despite the availability of clean injecting equipment so we decided to develop professional and peer-to-peer education in the clinics.

Staff attended training from agencies such as the Hepatitis C Liver Trust and Mersey Drugs Training and Information Centre, and worked with peer support workers to assess the suitability of leaflets to educate drug users on safe injecting. Requests for tests increased and anonymous hepatitis and HIV infection testing was introduced across the sites.

Initially all testing was undertaken using venous samples. Hepatitis testing included both antibody and polymerase chain reaction, which gave accurate information on infection status. Before this service was introduced patients had to go to their GP or local sexual health clinic, which discouraged many from testing as they perceived staff there to be prejudiced against them. The Hepatitis C Action Plan for Scotland (Scottish Executive, 2006) recommended that testing for HCV be offered in a range of facilities for high-risk groups – a needle exchange clinic is an ideal place.

The specialist nurse’s role in supporting the HCV treatment clinic offers an ideal chance to encourage those who test positive to access treatment services and make a referral for assessment. Those attending for hepatitis treatment were often prescribed methadone and staff in the harm reduction service could liaise with both services to support the patient and treatment staff.

Offering testing also increased dialogue with attendees about the risk factors for transmission, and offered opportunities to discuss safe injecting techniques and methadone substitution therapy. There was also an increase in those requesting vaccination against hepatitis A and B, which could be attributed to improved knowledge of BBV among service users.

Wound care
Injection site injuries are a common complication of reusing and sharing injecting equipment. Wounds can become infected, leading to septicaemia and necrotising fasciitis (Powell, 2011). Conservative estimates of the annual healthcare costs associated with injection site infection range from £15.5m to £47m a year, most of which relates to hospital admissions associated with severe infections (Hope et al, 2008).

Initially, nursing staff offered advice on reducing injection site injuries and infections, and undertook basic wound cleaning and dressing. Wounds were most commonly dressed using hydrogels, alginates and foam dressings. If they could not attend the clinic regularly, clients were taught how to clean and change their dressings.

As the service became more widely known in the area, we found users disclosing more severe wounds that would ultimately require antibiotic therapy. In response, we established a working group of medical, microbiology, pharmaceutical and nursing staff, to develop a PGD that would allow for the dispensing of a range of antibiotics, as appropriate.

Three separate PGDs were developed to allow the nurses to dispense flucloxacillin, co-amoxiclav and clarithromycin. A consultation in microbiology gave further training on the use of these drugs and the indications for each, with yearly updates.

District nursing staff provided training...
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It has been reported that IVDUs have very poor use of contraceptives (Gutierres and Barr, 2003). Female opiate users commonly experience an absence of menstruation caused by disruptions in the endocrine system after chronic use (Vuong et al, 2010). As a result, many of the women who attended the clinic believed they could no longer become pregnant.

IVDUs often have chaotic lifestyles and the need to take regular tablets dissuades many from accessing contraceptive services. It is also known that low numbers of IVDUs attend for regular cervical smears (McKnight et al, 2006).

To address these shortfalls, I undertook training with the charity Marie Curie to perform cervical smears and obtained a qualification in sexual and reproductive health. This allowed me to introduce sexual health services into the clinics, offering condoms and a range of contraceptives such as long-acting progesterone implants.

As the female attendees became more aware of the new reproductive health services being offered, uptake of cervical smear tests increased. An audit in 2011 of the uptake showed that all of those attending for a smear were either late for their routine recall or had never had the screening offered previously (Fig 1). Those who had not received a previous invitation for screening frequently reported either not being registered with a GP or having unstable living conditions where written invitations were not received. It was also common for women to report fear of having this screening test undertaken, or having a poor relationship with their primary care provider, and the trusting relationship they developed with the staff within service allowed this important screening to be undertaken. Any abnormalities picked up were quickly referred for further investigation to the local hospital; patients could be helped to attend appointments for investigation or treatment.

Both female and male patients could access basic sexual health screening and treatment for simple infections such as chlamydia, bacterial vaginosis and trichomoniasis. Those requiring contact tracing would be referred to a health adviser at the local sexual health clinic with whom the service had developed strong links. Attendees who visited the sexual health clinic appreciated these links, as the process was demystified for them. The assurance that they would meet a named individual encouraged their attendance.

Patient satisfaction

All of the services, apart from vaccination, were developed in response to patient requests. The management group were aware that IVDUs often do not access mainstream services, either because of accessibility or a reluctance to disclose their drug use. Having established trust with the staff at the needle exchange, users of the service reported being more comfortable discussing sensitive issues such as BBV and sexual health with staff they already knew.

Annual anonymous audits of user satisfaction ensured services were still meeting the needs of those attending. The users of the services reported having felt involved in the development of the service and discussed how they appreciated this in their responses.

Conclusion

Community-based harm reduction clinics enable specialist nursing staff to reach out to a marginalised group who do not always access mainstream services. Initially those attending may only be seeking clean injecting equipment but having a range of services available on one site encourages the uptake of further healthcare. The development of a trusting relationship with attendees allowed staff to promote external services and make referrals for BBV or substitute prescribing services.

Health problems such as wound infections, if untreated, can require expensive hospitalisation. Having the opportunity to treat infections at an early stage is both beneficial to the patient and cost effective.

Despite some reservations from senior management about whether it was the role of mental health nurses to undertake specialist physical healthcare tasks, after training, staff proved to be both competent and enthusiastic about the new services. As their skills and the service developed, they were keen to share their expertise with others in the field of harm reduction and improve the health of drug users who may not access other services. NT

References


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- Bit.ly/NTExtendingHIVtests