



Injecting drug users and HIV

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Executive summary

- Injection-driven HIV epidemics are amongst the fastest growing in the world:
 - 1 in 10 new HIV infections worldwide occurs in an injecting drug user (IDU)
 - Three million IDUs are living with HIV worldwide – one in five of the estimated total number of IDUs
 - In some countries IDUs account for between 30% and 80% of all reported HIV infections.
- HIV in IDUs in the UK is relatively uncommon due to harm reduction measures introduced over 20 years ago:
 - IDUs account for around two percent of all people living with diagnosed HIV in the UK
 - Around 1 in 73 IDUs in the UK is living with HIV, but in London the proportion is 1 in 20.
- 70% of IDUs living with HIV in the UK are men and 30% are women. 85% of IDUs seen for HIV care are of white ethnicity. The majority of IDUs diagnosed with HIV are aged 25 to 34.
- Around a third of the UK's IDUs living with HIV were diagnosed late, and a third are unaware of their infection. Almost 80% of people whose probable route of HIV infection was injecting drug use are on antiretroviral therapy (ART), which is comparable with other communities affected by HIV.
- In the UK there is only limited information available about the sexual orientation of IDUs living with HIV, their adherence to ART, and levels of Hepatitis C co-infection. More information is needed.
- Harm reduction services such as needle and syringe exchanges have been shown to reduce HIV infections and risk behaviour, without contributing to increased drug use. The UK is one of 77 countries with needle exchange facilities. However, areas for improvement have been identified (for example, extending the availability of blood borne virus testing and immunisations in needle exchange settings and extending the provision of out-of-hours needle exchange).
- 45% of men and 65% of women arrive at prison drug dependent, and 40% of these report injecting drug use within the previous month. Injecting equipment is prohibited in prisons, so prisoners who inject drugs are highly likely to share injecting equipment.
- Prisons have a range of harm minimisation and drug treatment services for IDUs, but needle and syringe exchange is not available in prisons in the UK. Attempts to establish a trial of needle exchange facilities in the Scottish Prison Service should be encouraged and the outcomes of any such trial monitored.
- HIV prevalence in IDUs should remain below five percent to avoid risk of a very rapid spread of HIV. Harm reduction measures should be safeguarded from public spending cuts in order to protect the health of IDUs and public health.

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Section one: Epidemiology

An overview of the data available for IDUs living with HIV in the UK

HIV is relatively uncommon among IDUs in the UK, with IDUs accounting for around two percent of all people living with diagnosed HIV in this country. 1 in 73 IDUs are living with HIV. Higher levels of HIV infection among IDUs have been reported in London however, and surveillance data for the Health Protection Agency suggests that there have been raised levels of HIV transmission among IDUs in recent years.ⁱ

Context: IDUs living with HIV worldwide

One in ten new HIV infections worldwide results from the use of contaminated injecting equipment by IDUs, with this figure rising to just under a third outside sub-Saharan Africa.¹ Injection-driven epidemics are amongst the fastest growing in the world:² in many countries in Europe, Asia, the Middle East and Latin America, the use of non-sterile injecting equipment by IDUs has accounted for between 30% and 80% of all reported HIV infections.³

Latest estimates from a study of worldwide prevalence of injecting drug use and of HIV in IDUs are that there could be 15.9 million IDUs across the world, with three million IDUs – just under one in five - living with HIV.⁴ The study, in which the authors were able to make prevalence estimates for 77% of the world's population aged 15 to 64, found that HIV in IDUs represents a substantial global health challenge. It also highlighted the inadequacy of surveillance data. The largest numbers of IDUs were found to be in China, the USA and Russia (which together account for around 40% of the global IDU population).⁵ HIV prevalence amongst IDUs in these countries was 12%, 16% and 37% respectively. Mid-range estimates for the number of IDUs living with HIV across the world's regions were as follows:⁶

Eastern Europe	940,000
East and South East Asia	661,000
Latin America	580,500
Canada and the USA	347,000
Sub-Saharan Africa	221,000
Western Europe	114,000
South Asia	74,500
Central Asia	29,000
Caribbean	24,000
Middle East and North Africa	3,500
Australia and New Zealand	2,500
Pacific Island States and Territories	500

In the Eastern Europe and Central Asia region, injecting drug use accounts for a very significant share of HIV prevalence in the following countries: Ukraine (64.1% of the country's total HIV cases), Kazakhstan (74%), Kyrgyzstan (75%), and Russia (83% of total HIV cases). In East and South-East Asia it accounts for 44% of all infections, 52% in Vietnam, 54% in Indonesia and 72% in Malaysia.⁷

Worldwide coverage of HIV prevention, treatment, and care services in IDU populations is very low. There is an urgent need to improve coverage of these services in this at-risk population.⁸ One study has recently called for 20% of international donor funding for HIV prevention to be targeted at harm reduction amongst people who inject drugs.⁹

IDUs in the UK

The injecting drug use population is a 'hard to reach' group, which presents challenges in ascertaining a definitive number of IDUs in the UK.¹⁰ Estimates as to how many people are experiencing drug problems have to be drawn from different sources, using different ways of measuring.¹¹

The UK Focal Point on Drugs is based at the Department of Health in London, with support from the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University. It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the Centre on the drug situation in England, Northern Ireland, Scotland and Wales.¹²

The UK Focal Point estimated in 2009 that there are 147,900 IDUs in the UK, a rate of 3.69 per 1,000 people aged 15 to 64. This includes 116,809 IDUs in England (3.47 per 1,000), 23,933 in Scotland (6.99 per 1,000), 6,662 in Wales (3.47 per 1,000) and 496 in Northern Ireland (0.45 per 1,000).¹³

A three year study of the use of opiates and/or crack cocaine (defined as 'problem drug use') in England up to 2007 found that there was a decrease in the number of IDUs from 137,141 in 2004-05 to 129,977 in 2005-06 and to 116,809 in 2006-07.¹⁴ The report showed marked variation in prevalence of problem drug use in different regions of England. Yorkshire and the Humber was found to have the highest estimated rates of injecting, and the East of England had the lowest estimates for opiate use and injecting use.¹⁵

The Health Protection Agency states that the extent of injecting drug use in the UK remains uncertain. It acknowledges the figures mentioned above, but also notes that other studies have suggested the number of IDUs in England may be higher, such as a 2009 report estimating the number of IDUs in England and Wales at up to 217,000.¹⁶

IDUs living with HIV in the UK

Harm reduction measures - including free needles and syringes, promoting the safe disposal of used equipment, and information campaigns on safer injecting – that were introduced as part of the public health approach to containing HIV transmission are regarded as having been successful amongst IDUs.¹⁷ Apart from a particular outbreak in Edinburgh in the 1980s, HIV in IDUs in the UK has remained relatively uncommon.¹⁸

In the UK in 2008 there were 2,350 people living with HIV, both diagnosed and undiagnosed, whose probable route of HIV infection was injecting drug use.¹⁹ According to the Health Protection Agency's (HPA) SOPHID data (Survey of Prevalent HIV Infections Diagnosed), there were 1,489 people living with HIV seen for care that year whose probable route of HIV infection was injecting drug use.²⁰ These individuals will be referred to as IDUs throughout this paper, but it should be noted that they may not necessarily still be continuing to inject drugs.

Of these 1,489 individuals, 1,076 were seen for care in England, 29 in Wales, seven in Northern Ireland and 362 in Scotland. The total includes two IDUs living with HIV of no fixed abode, 12 whose area of residence was not reported and one who was living abroad.²¹ Statistics for those IDUs seen for care in England were broken down into regions as follows: 505 in London, 110 in the North West, 82 in the South West, 81 in the East of England, 77 in the East Midlands, 66 in the South East Coast region, 49 in both the South Central region and in Yorkshire and the Humber, 34 in the West Midlands and 23 in the North East.²²

The HPA also collects information on the prevalence of HIV in IDUs. This is done through voluntary unlinked anonymous saliva samples and self-reported behavioural data collected from IDUs in contact with over 50 specialist agencies throughout England, Wales and Northern Ireland. The agencies provide a range of services from medical treatment to needle exchange and outreach work. HPA data shows that HIV prevalence amongst people in the UK whose probable route of HIV transmission was injecting drug use has increased since 2002. In England (the regions outside London) and Wales, HIV prevalence in IDUs rose from around one in 400 in 2002 to around 1 in 91 in 2008. London has a higher rate but has remained relatively unchanged since the year 2000, with around 1 in 20 IDUs living with HIV. In Northern Ireland, HIV prevalence in IDUs was around 1 in 45 in 2008 and in Scotland, around 1 in 200. For the UK as a whole, around 1 in 73 IDUs are living with HIV.²³

Uptake of HIV testing

In 2008, 28% of IDUs (863 of 3,087) reported never having had a voluntary confidential test for HIV, the lowest level ever recorded in the UAPMP (unlinked anonymous prevalence monitoring programme) survey. This reflects an increase in the uptake of testing: before 2003, uptake had changed little since 1990, with 42% (1,126 of 2,651) reporting never having had a test in 2002.²⁴

By comparison, the proportion of all individuals receiving an HIV test at a GUM clinic increased more than threefold between 1999 and 2008, from 29% (18,980 out of 65,613) to 93% (97,444 out of 104,370).²⁵

Infections acquired abroad

In 2009, approximately 49% of IDUs who were newly diagnosed with HIV were estimated to have contracted HIV in the UK. Around 35% of HIV infections in IDUs were acquired in other European countries, 13% in Africa, one percent in Asia and two percent in the rest of the world.²⁶

Mother to child transmission

The impact of maternal drug use on unborn children is well known, as is the fact that babies are affected by withdrawal from maternal drug use. In the United Kingdom, there is little evidence of HIV transmission to babies through maternal infection specifically associated with drugs.²⁷

Trends in new diagnoses since data collection began

The HPA reports that up to the end of 2009, 5,244 HIV and AIDS diagnoses have been made amongst people who were probably infected through injecting drug use.²⁸

There have consistently been more diagnoses in men than in women (see below). The majority of those diagnosed have been in the 25 to 29 age group, which has had 1,326 IDUs contracting HIV, followed by those aged 30 to 34 (1,258 diagnoses). Lowest numbers of diagnoses occurred in IDUs aged over 50.²⁹

Of the 5,244 HIV diagnoses in IDUs in the UK, 3,813 were made in Strategic Health Authorities in England. The vast majority of those (2,088) were in London, followed by the North West (286) and the East of England (244), with the lowest number of diagnoses in the

North East (70). 55 diagnoses were made in Wales, 1,346 in Scotland, 16 in Northern Ireland and 14 in the Channel Islands and the Isle of Man.³⁰

One third of the UK's IDUs living with HIV remain unaware of their infection.³¹

Ethnicity, gender and sexuality of IDUs living with HIV

The ethnicity of those diagnosed with HIV has been collected since 1995. Of a total of 2,405 diagnoses of IDUs made from then until December 2009, 1,941 individuals were white, followed by 198 classified as 'other/mixed'. 76 were black African, 36 were black Caribbean and the ethnicity of a further 154 individuals was not reported.³²

The HPA has identified that in 2008, 71% of IDUs seen for HIV care were male (788 of 1,112) and 85% (941 of 1,105) were white.³³ Of the total number of IDUs living with HIV (2,350), 70% (1650) are men and 30% (700) are women.

In line with this, around 70% of all HIV diagnoses amongst IDUs in the UK have been in men, and 30% in women: 3,663 male IDUs have been diagnosed with HIV compared to 1,581 female IDUs. There have been 1,009 first AIDS diagnoses amongst male IDUs (72.4%) and 385 first AIDS diagnoses amongst female IDUs (27.6%) up to 2009. As might be expected, the majority of AIDS diagnoses occurred earlier in the HIV epidemic, before the advent of treatment.³⁴

Neither the HIV reporting section of the HPA or the unlinked anonymous survey collects information on the sexuality of IDUs.³⁵

Late diagnosis

In 2008, an estimated 32% (2,310/7,218) of all adults aged over 15 years were diagnosed with HIV with a CD4 cell count lower than 200 per mm³ within three months of diagnosis. Fifty five percent (3,970/7,218) were diagnosed with CD4 cell counts lower than 350 per mm³ (the threshold at which treatment should be considered according to 2008 British HIV Association guidelines).

The figures for IDUs being diagnosed late were slightly lower than the average, with around 30% diagnosed with a CD4 count less than 200 and around 52% diagnosed with a CD4 count of less than 350.³⁶

Life expectancy of IDUs living with HIV

Whilst AIDS-related mortality has decreased significantly since the advent of HIV treatment, in general the overall benefit from antiretroviral therapy (ART) has been lower in IDUs living with HIV than in other groups of people living with HIV.³⁷ Poorer outcomes in IDUs living with HIV are related to a variety of factors. These include increased rates of non-HIV related deaths, Hepatitis C, delayed access to effective treatment, lower adherence to care and treatment regimens, continuation of illicit drug use, depression and negative life events.

However, more positive reports have also been published. A 2007 Spanish study found that survival is improving amongst IDUs with HIV.³⁸ It looked at survival durations for HIV infected and HIV uninfected IDUs for the period 1987 to 2004, and found that the survival durations for IDUs living with HIV in the latter period of the study (from 1997 to 2004, the era of HAART and established methadone programmes) were virtually the same as for those without HIV.

Information about the life expectancy of IDUs living with HIV in the UK is not readily available. However a British HIV Association (BHIVA) HIV mortality audit published in 2006 found that nine percent (of 387 patients studied) had a history of injecting drug use but stopped prior to their final illness, and five percent of patients continued injecting drug use until the onset of their final illness.³⁹ This compares with the fact that two to three percent of all heroin users die each year, and death rates amongst opiate users are 20 times the norm for their age and gender.⁴⁰

Accessing anti-retroviral therapy

Of the 1,489 IDUs living with HIV seen for care in 2008, 79% (1182 individuals) were reported to be on antiretroviral therapy (ART). 20% (302 individuals) were not on treatment (of whom 33 had a CD4 count below 200 and 49 had a CD4 count of 201 to 350).⁴¹

By comparison, around 76% (19,422 of 25,569) of men who have sex with men (MSM) living with HIV who were seen for care in 2008 were on ART therapy,⁴² and around 77% of black African people living with HIV in the UK seen for care that year were on ART therapy (17,090 of 22,282).⁴³

Adherence to treatment

Adherence is a key issue for the success of HIV treatment, particularly in the months soon after initiating therapy. Ongoing injecting drug use (as well as alcohol consumption and cocaine use) is associated with non-adherence and adherence failure.⁴⁴ A 2000 study in France found that poor adherence to treatment was associated with younger age, alcohol use, negative life events in the last six months and current drug use.⁴⁵

More recently, research has found that IDUs co-infected with HIV and hepatitis C taking ART who enrolled in opioid substitution programmes saw reduced heroine use, improved treatment adherence and better health outcomes.⁴⁶ Other research has shown that IDUs taking part in opioid substitution programmes have an increased chance of their HIV treatment working. The longer a patient remained in the opioid substitution programme, the greater their chances of achieving long-term HIV suppression, even if adherence of less than 100% was taken into consideration.⁴⁷

Co-infection with Hepatitis C

Information about the numbers of IDUs co-infected with HIV and Hepatitis C (HCV) in the UK is not readily available, but approximately 40% of the UK's IDUs have HCV.⁴⁸ Around five percent of all people living with HIV in the UK are co-infected with HCV: approximately 3,000 people. This compares well with other European countries: about one in three people in Europe living with HIV are estimated to have HCV⁴⁹ and Spain and Italy have co-infection rates of almost 50%. Worldwide, between four and five million people have both HIV and HCV. For IDUs living with HIV who contracted HCV through drug use, it is likely that they became infected with HCV before HIV, as HCV is more infectious in blood which makes it easier to catch.⁵⁰

A 2009 UK study of HIV-HCV co-infection in a cohort of 1,622 people living with HIV noted that rates of infection due to shared drug equipment have fallen, but found that co-infected people, compared with consistently HCV negative individuals, were more likely to be women (26% compared to seven percent) and IDUs (62% compared to one percent). Co-infected individuals in the study also spent more time off antiretroviral therapy, which was again more

noticeable amongst IDUs compared with non-IDUs.⁵¹ This mirrors a 2006 Canadian study which also concluded that HCV co-infected individuals are less likely to adhere to their treatment.⁵²

An earlier study noted that there is limited information on the prevalence of HCV in people living with HIV in the UK but, in a cohort of 1,017 people living with HIV in London, found that current or previous injecting drug use accounted for 7% of HIV transmissions. The overall prevalence of HCV co-infection was 9% (90/1017), with 82% amongst the individuals who had a history of injecting drug use.⁵³

More than 45% of HIV-negative people, and up to 20% of HIV-positive people clear HCV without treatment within the first few months of infection. However, in general, co-infection with HIV and HCV complicates each condition.⁵⁴

Route of HIV transmissions

IDUs are vulnerable to HIV through the sharing of injecting equipment, as well as through sexual transmission. The HPA collects data on individuals “probably infected [with HIV] through injecting drug use”. One report has provided evidence that the incidence of HIV was higher amongst people who reported injecting crack cocaine than IDUs overall. This was borne out by the HPA reporting that individuals injecting crack cocaine report more equipment sharing.⁵⁵ Individuals under the influence of crack cocaine are known to take more risks: for instance, a UK study found that crack/cocaine use was seen as more likely to lead to risky or extreme behaviour than other drugs, including heroin.⁵⁶

It is widely recognised that other high risk behaviour can accompany injecting drug use. A presentation at the International AIDS Conference in 2008 gave the example of some IDUs with high rates of HIV risk behaviours: 90% were sexually active in the previous year, 20% reported having sex with over five partners, and there were low rates of condom use (between nine percent and 34%).⁵⁷

Risk of transmission from sharing injecting equipment

According to the WHO and UNAIDS, sharing of injection equipment is a much more efficient mode of HIV transmission than sexually transmitted HIV - drug-related HIV epidemics therefore spread more rapidly.⁵⁸

Sharing needles and paraphernalia such as syringes, spoons, filters and blood-contaminated water is thought to be three times more likely to transmit HIV than sexual intercourse. Disinfecting equipment with bleach between each use can reduce the chance of transmission, but does not eliminate it entirely.⁵⁹ Whilst laboratory studies show that bleach disinfection is effective in deactivating HIV, evidence suggests that IDUs’ practices in cleaning their syringes are too inconsistent to represent an effective stand-alone intervention.⁶⁰ The probability of becoming infected with HIV after using an infected syringe ranges from 0.34% to 1.4%. By comparison, the risk for Hepatitis C ranges from 1.5% to five percent.⁶¹

A recent study acknowledges that the reasons HIV spreads more in some places than others are not really known, but suggests that the type of syringe used to inject drugs may affect HIV epidemics amongst IDUs. Syringes can be either low dead space syringes (LDSS) with permanently attached needles, or high dead space syringes (HDSS) with detachable needles. Laboratory experiments demonstrated that HDSS may retain over 1,000 times more blood than LDSS. Observational studies found an association between use of HDSS

and prevalent HIV infection. Preliminary results of an ongoing literature review suggest an association between syringe type and HIV prevalence amongst IDUs.⁶²

Gaps in UK data

There is a gap in UK data concerning sexual orientation of IDUs living with HIV. The HPA does not collect information about the sexuality of people whose probable route of HIV infection is injecting drug use. One HIV organisation contacted for this paper made the point that if an IDU is a gay man, he would be classed in the 'men who have sex with men' (MSM) category of UK HIV statistics, even though it is possible he contracted HIV through sharing injecting equipment.

Whilst some data is available about life expectancy of IDUs and their adherence to treatment, information relating to the treatment adherence of IDUs living with HIV in the UK is limited. This is also the case for IDUs co-infected with HIV and Hepatitis C.

Section two: Support services in the UK

Extensive research is available about support services for IDUs, however, less information is available about specific support for IDUs who are living with HIV. However, some issues are relevant for both groups of individuals. This section provides an overview of the services available in the UK.

Prevention services

The importance of treating drug addiction for HIV prevention is widely recognised – the special session on IDUs at the 2009 International AIDS Society Conference identified treatment for drug addiction as “the best strategy” for HIV prevention in drug using populations.⁶³ More than half of the estimated number of problem drug users in the UK are in contact with structured treatment. Harm reduction measures such as needle exchanges and methadone programmes for IDUs appear to have successfully prevented a major HIV epidemic amongst IDUs in the UK compared to other countries.⁶⁴

Drug addiction treatment and harm reduction programmes offered by drug services include a number of different elements. Opiate substitution therapy, such as methadone maintenance treatment (MMT), is designed to enable IDUs to stabilise and reduce their drug use through methadone’s effect of relieving narcotic craving, suppressing the side effects of withdrawal and blocking the euphoric effects associated with opiates.⁶⁵ Treatment has to be supported by a programme of psychological and social support. Drug services therefore offer services such as group work, individual counselling, drop-in sessions and motivational interviewing.⁶⁶

In addition to dispensing methadone, drug services focus on preventing blood contact during injection and promoting use of sterile equipment when injecting. Needle and syringe programmes (NSPs) are therefore a key strategy for preventing transmission of HIV. NSPs were established in the UK in 1985, and they normally distribute syringes for free as well as provide a safe place for disposing of used drug equipment. They are based across a range of services including specialist drug services, pharmacies, outreach or mobile services, custody suites and hospital Accident and Emergency departments. Around seventy percent of needle exchange services in the UK are provided by pharmacies.⁶⁷

Following changes to the Misuse of Drugs Act since 2003, NSPs have been able to provide drug paraphernalia other than syringes and needles. They can now supply items such as swabs, sharps bins, filters, utensils for drug preparation like sterile cups and spoons, ampoules of sterile water, tourniquets and acidifiers such as citrate. Most heroin is sold in poorly soluble base form and IDUs will use an acidifier (such as citric, ascorbic or lactic acids) to chemically convert it into a soluble, injectable form. Whilst these acids are readily available in the form of lemon juice, vinegar and other household products, injecting such substances have reportedly resulted not only in wound infections, but also infections such as endocarditis (infection of the heart valves) and endophthalmitis (the eyes).⁶⁸ Acidifiers from NSPs are a safer alternative.

Many drug services run outreach and mobile services for particularly vulnerable or hard to reach people, such as rough sleepers and sex workers. In many settings, NSPs also provide condoms, education about minimising risk and referrals to drug treatment centres.⁶⁹

Recent research has shown that a combined approach to HIV prevention has the greatest effect on reducing HIV transmission in IDUs. A study completed in 2010 found that HIV infection amongst IDUs in an environment of “self-initiated risk reduction, methadone, education/outreach and HIV testing” but without access to a needle exchange were three

and a half times higher than those injecting within the same environment but with large scale syringe exchange.⁷⁰

Testing

The British HIV Association's UK National Guidelines for HIV Testing recommend that clinicians should routinely offer and recommend a test for HIV to all patients reporting a history of injecting drug use. The guidelines also recommend universal HIV testing in drug dependency programmes.⁷¹

According to the HPA, of the 5,244 IDUs diagnosed with HIV up to the end of 2009, the majority (1,704) were tested at GUM clinics. Of the remainder, 115 were tested in locations classified as 'other', which includes facilities such as drug dependency units and haemophilia services; 1,345 were tested in Scotland (Scotland does not provide test facility data); for 1,305 the testing location was unknown; 254 were tested as inpatients; 163 by a GP; 115 in prison; 109 as outpatients; 57 in infectious disease units; 34 in antenatal settings; 31 at A&E; and 12 in blood transfusion services.⁷²

Blood borne virus testing offered to IDUs through local drug services is outlined below.

Harm reduction

A lack of knowledge still exists amongst IDUs about infectious disease transmission and the risks associated with sharing equipment, particularly items other than needles and syringes. However, it should also be noted that when a drug user is desperate, their need to inject can take priority over thoughts about equipment sharing.

There is also a question of perception: for example, one Glasgow-based study found that women did not tend to see sharing injecting equipment with sexual partners as a risk activity, but as a reciprocal act no different from any other form of sharing which takes place in a close relationship.⁷³

A review of the effectiveness of needle and syringe programmes has noted that the distribution of sterile needles and syringes alone is not sufficient to reduce the transmission of BBVs amongst IDUs.⁷⁴ Harm reduction advice should accompany the distribution of clean needles and syringes.

Specific support for IDUs living with HIV in the UK

There appears to be limited tailored support provided for groups of IDUs living with HIV in the UK. This is in contrast to the way that other communities affected by HIV – such as African women or men who have sex with men – can access peer support or specific programmes designed for their community. However, that is not to say that IDUs living with HIV do not receive support from either drug services or HIV organisations.⁷⁵

Due to the relatively small numbers of IDUs living with HIV in the UK compared with other affected communities, most HIV organisations have only a small proportion of clients who are or have been IDUs. However, organisations are not necessarily aware of how clients contracted HIV, and are not always aware whether someone is a current or former injecting drug users.

Peer group support within HIV organisations for IDUs living with HIV is limited. Whilst such groups may have existed in the past, it is not seen as good practice to mix current drug users with people who are trying to stop. Other than peer group support, IDUs living with HIV are able to access the same services that other people living with HIV use at HIV organisations, ranging from advice sessions to counselling, and information workshops to complementary therapies.

Some HIV organisations do run 'open' group support sessions which IDUs can attend, in addition to specific peer support groups. Some reported that their women's peer support groups are mixed IDU/non-IDU. In addition, whilst organisations generally do not single out IDUs as a particular client group, they have run sessions that could be of interest to IDU clients, for example workshops on safer injecting.

Some services supporting people living with HIV mentioned that whilst recovering IDUs living with HIV might choose to access support from HIV organisations, those still injecting are more likely to lead "chaotic" lives and to make contact with more flexible drug services. Flexibility relates not only to appointment times and opening hours, but also to policies of drug use on premises.

It is clear that 'signposting' exists between local HIV organisations and drug organisations, and the two sectors work together on particular individual cases. For instance, some HIV organisations reported drug caseworkers arranging or accompanying clients to courses they run for people newly diagnosed with HIV. In another case, an HIV organisation noticed a spike in the number of newly diagnosed IDUs in their region. They liaised with the drug service who were better able to target HIV prevention work with this group. Subsequent new infections returned to previous levels.

Support from drug organisations

IDUs living with HIV are able to access the same community drug team services as other clients who do not have HIV. This includes advice and information and harm reduction services such as needle exchange, information about safer sex and sexual health, and condom provision, as well as referral to treatment services. These services are relevant to IDUs living with HIV in relation to onward HIV transmission and leading a healthier lifestyle.

Drug services offer community prescribing services: medically supervised opioid substitutes (usually oral methadone) in conjunction with measures to address IDUs' physical, emotional, social and legal problems. This can be through structured psychosocial counselling, which is separate to other forms of support that are available such as drop-in sessions and informal key-working. Psychosocial counselling includes assessments, clearly defined treatment plans, treatment goals and regular reviews. Drug services also offer 'aftercare' for clients nearing the end of treatment programmes to support them with achieving drug abstinence, as well as structured day programmes, residential rehabilitation for those no longer using drugs and, where relevant, services related to the criminal justice system.⁷⁶

Drug services encourage clients to be tested for blood borne viruses (BBVs) including HIV, as well as Hepatitis B and Hepatitis C. This may be in the form of open access testing at drug centres, where pre-test discussion and post-test counselling should also be available. Some drug services offer incentives for HIV testing: clients receive one £5 supermarket voucher for taking a test, and a further £5 voucher to encourage them to return to the service for the result. Organisations use their links with other agencies to try to set clients with HIV on the pathway of care, including accessing information and support from HIV organisations.

Gaps in service provision

Harm reduction/needle exchanges

There is a clear correlation between availability of clean injecting equipment and levels of sharing. Whilst the UK is one of 77 countries worldwide that has needle exchange facilities,⁷⁷ recent studies have outlined areas that could be improved. For instance, a 2006 Scottish study found that less than a third of needle exchange services in Scotland offered Hepatitis B testing or immunisation, HIV testing or Hepatitis A immunisation.⁷⁸

Pharmacy-based needle exchange schemes offer a much smaller range of interventions to injectors than non-pharmacy services. However, less than half of non-pharmacy services in the Scottish study provided key working, structured counselling, care for minor infections or complementary therapies. Fewer still provided services such as overdose prevention training for clients, housing, social welfare or legal advice, nutritional advice, primary care sessions or well woman clinics. The study also noted that injectors in rural areas were often reported to be reluctant to use the local pharmacy exchange due to reasons of confidentiality.⁷⁹

Gaps in harm reduction service provision were also identified in a 2008 service review in England. This showed that harm reduction interventions were not provided broadly enough across the treatment system. Almost a quarter (22%) of local drug partnerships did not have a needle exchange service within their drug treatment services, with most being located in open access services. Open access does not relate specifically to a location, but simply means that anyone can walk in and use the service – for instance in a pharmacy - without having to register or make an appointment beforehand.⁸⁰ Just over a third (37%) of local drug partnerships did not have HIV testing with access to pre and post-test counselling integrated with their inpatient drug treatment services. 36% of partnerships did not have Hepatitis C testing integrated into their open access services.

Whilst some local drug services have mobile out-of-hours needle exchange services to target hard-to-reach clients, the review found a national shortfall in the provision of out-of-hours needle exchange. Forty four percent of local drug partnerships were assessed as 'weak' in this aspect of the study: only 21% of partnerships opened most of their needle exchange services on Saturdays and only two percent opened them on Sundays.⁸¹

Provision of silver foil

In terms of harm reduction, smoking heroin - where a drug user heats heroin on foil and inhales the vapours - instead of injecting it reduces the risk of contracting HIV and other blood borne viruses. Article 9A of the Misuse of Drugs Act governs paraphernalia used in the consumption of illicit substances. The article does not include foil, thereby making it illegal to provide free foil as part of drug services' harm reduction methods. Around 100 drug services do currently provide foil, and some police forces have indicated that they are unlikely to pursue prosecutions on this issue. The Advisory Council on the Misuse of Drugs (who advise the Home Office) is examining whether the law should be changed to allow IDUs to receive foil as a way of protecting their health.⁸²

Supervised injectable heroin

There have recently been calls for supervised injectable heroin to be provided for the five to 10% of heroin addicts who do not respond to other sorts of treatment such as injectable or oral methadone (whether they are untreatable or just difficult to treat is unknown). A new

trial reported in May 2010 that this leads to significantly lower consumption of street heroin in chronic heroin addicts – previously unresponsive patients have significantly reduced their use of street heroin in six weeks.⁸³ Rolling out the prescription of injectable heroin to clients who do not respond to other forms of treatment was outlined in the previous Government's 2008 Drug Strategy subject to the results of the trial.

Drug consumption rooms

Drug consumption rooms (also known as injection rooms or safer injecting sites) are a controversial harm reduction intervention. They are safe spaces for injection of illegal drugs (“legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use”).⁸⁴ Medical personnel are on hand to provide first aid in the event of an overdose. They are not permitted under UK law, but have been established in countries including Australia, Canada, Germany, the Netherlands, Spain and Switzerland.⁸⁵

Evaluation of such services is limited, but evidence suggests that drug consumption rooms reduce the risk of harm to drug users, and by reducing injection on the street they also reduce the risk to the general population. In 2002 the Home Affairs Select Committee recommended the establishment of a pilot programme of safe injecting houses for heroin users in the UK, but this was rejected by the Home Secretary.⁸⁶

IDUs in prisons

Prisons are a high-risk setting and the rate of infection with Hepatitis B, Hepatitis C and HIV amongst the prison population in the UK is significantly higher than similar populations in the community.⁸⁷ Since 2006, commissioning for healthcare in prisons in England has been the responsibility of local Primary Care Trusts, delivered in partnership with the prison itself. There is no overall body or individual holding overall responsibility and accountability for the treatment of drug users in prisons.⁸⁸ Treatment programmes vary widely.⁸⁹

Imprisonment is common amongst IDUs.⁹⁰ Problem drug users are much more likely to be found within the criminal justice system than within the wider population. At least one in eight people arrested (equivalent to about 125,000 people in England and Wales) are estimated to be problem heroin and/or crack users, compared with about 1 in 100 of the general population.⁹¹ 45% of men and 65% of women arrive at prison drug-dependent, and 40% of these report injecting drug use within the previous 28 days.⁹² As the possession of injecting equipment is strictly prohibited in prisons, prisoners who inject are likely to share any such items that they manage to acquire.⁹³ A UK study of prisoners and HIV published in 2000 found that 75% of adult male prisoners and 69% of adult female prisoners who had injected drugs inside prison had shared needles or syringes.⁹⁴

The importance of addressing the needs of IDUs in prison is illustrated by the fact that a prisoner who is drug-dependent is twice as likely to commit suicide in the first week of imprisonment than a non-dependent prisoner.⁹⁵ In the two weeks following release from prison, drug-using male prisoners are 29 times more likely to die of a drug overdose than other drug users, due to diminished opioid tolerance – women prisoners are 69 times more likely to do so.⁹⁶ Drug users often see prison as an opportunity to detoxify and contemplate their drug use.⁹⁷ One prison drugs project found that although 70% of those entering the prison had a drug misuse problem, 80% of these had never had any contact with drug treatment services.⁹⁸

A 2007 study of IDUs' experiences of prison in England found that issues that affect levels of drug use and prisoners' receipt of care, support and treatment included: prescribing policies, illicit drug availability and prison staff and doctor attitudes. Whilst negative experiences of prison and drug treatment prevailed, users identified that recent policy and practice changes had positively influenced healthcare provision for drug users in prison, particularly the provision of opiate maintenance therapy.⁹⁹

HIV prevention services in prisons

Needle exchange

Whilst needle and syringe programmes (NSPs) have been available in community settings for over twenty years, needle exchange is not currently available in UK prisons. Evaluations of prison-based NSPs in other countries have been "highly favourable". Outcomes include a substantial reduction in needle sharing, no new cases of HIV amongst prisoners participating in an NSP; and a reduction in overdose incidents and deaths. Negative consequences of NSPs originally anticipated by prison officials and staff were not observed. There have not been any incidents in which needles or syringes from NSPs were used as weapons and NSPs have not led to increased drug use or injecting amongst prisoners.¹⁰⁰

There are no plans to introduce needle exchange in UK prisons at present. The Scottish Prison Service has been attempting to begin a trial of needle exchange in an Aberdeen prison but this has yet to be implemented. The prison service in England and Wales are awaiting the outcome of the Scottish experience to judge any change in current policy. An evaluation of policies relating to blood borne virus prevention and control in prison is being conducted by the Department of Health (Offender Health) in partnership with the University of Stirling and a report is due by the end of 2010.¹⁰¹

Disinfecting equipment

Disinfecting tablets were first made available in prisons in England and Wales in 1995, but were withdrawn a year later following concerns about their safe use in a custodial setting, connected to risk of fire and of poisoning through ingestion. Following several reviews, they were reintroduced from October 2007 (they have been available in Scottish prisons since 1993). The tablets are marketed in prison for general cleaning purposes of personal items as well as being able to be used for decontamination of injecting equipment and other associated paraphernalia.

A Canadian HIV/AIDS Legal Network review of disinfecting equipment (bleach) concluded that bleach programmes should be available in prisons where authorities continue to oppose the introduction of needle and syringe exchange programmes, but because of bleach's limited effectiveness, such programmes "can only be regarded as second-line strategy to NSPs".¹⁰² The review noted that the efficacy of using bleach to eliminate HIV has been "well established" in laboratory studies, but that field studies have "cast considerable doubt on the likelihood that bleach or other disinfectants could ever be effective in real life conditions". Studies have demonstrated that half or more IDUs did not know, could not remember after being taught or did not consistently practice the proper method of using bleach to decontaminate syringes.¹⁰³

Condoms and dental dams

Condoms are available for prisoners from prison healthcare services. Messages about using condoms (and disinfecting tablets) both feature in the latest information leaflets

produced for prisoners ('Get out of jail BBV-free!')¹⁰⁴ The Department of Health and HM Prison Service have issued a guidance note to prison governors and healthcare managers stating that condoms, dental dams and water-based lubricants must be made available to any prisoner who requests them "if, in their clinical judgement, there is a risk of the transmission of HIV or any other sexually transmitted disease".¹⁰⁵

Blood borne virus information and testing

Prisoners are provided with information about blood borne viruses in a variety of ways - for instance leaflets (provided in easy to understand vernacular language), and through DVDs and music (such as Music4Messages rap CD with a health protection message around Hepatitis C). Recent innovations include distributing playing cards with health messages to prisoners. Prison is the most common place for IDUs to be vaccinated against Hepatitis B¹⁰⁶ (Hepatitis B vaccine coverage came into effect as a Key Performance Indicator for Prison Health in November 2007)¹⁰⁷ and the most recent leaflets produced for prisoners contain messages about where they can be tested for Hepatitis B and Hepatitis C and HIV.¹⁰⁸

Next steps and recommendations

UNAIDS has noted that prevention efforts should keep HIV prevalence in IDUs below five percent, or risk a very rapid spread of HIV.¹⁰⁹

In the light of this, any changes in policy from the UK Government (particularly in the context of proposed public spending cuts), should be scrutinised to ensure that harm reduction measures continue to protect the health of IDUs and that of the wider community.

To meet the HIV-related needs of IDUs in the UK, NAT recommends the following activities as priority:

- At a minimum, the new Government should commit to maintaining existing harm reduction measures that are available to IDUs in the UK.
- For harm reduction purposes, free foil should be added to the list of items available from needle exchange programmes under Article 9A of the Misuse of Drugs Act.
- Steps should be taken to extend the availability of out-of-hours needle exchange facilities, and increase the availability of blood borne virus testing and immunisation in needle exchange settings.
- In light of the successful introduction of needle exchange in prisons in other countries, attempts to establish a trial of needle exchange facilities in the Scottish Prison Service should be encouraged and the outcomes of any such trial monitored.
- Further research into the sexual orientation of IDUs living with HIV in the UK, their adherence to treatment and levels of Hepatitis C co-infection is needed to inform IDU prevention and treatment programmes.

NAT
August 2010

Appendix B: Government policies and standards featuring HIV and the health needs of IDUs

Research for this paper found that the HIV and the health needs of IDUs feature in the following range of Government policies and standards on drug use:

The Government's 2008 Drug Strategy

The 2008 drug strategy *Drugs: protecting families and communities* makes two references to HIV, in terms of prevention. It covers drug related harms, which include “drug-related crime, community perceptions of drug problems and the various health consequences that arise from illicit drug use (e.g. HIV, overdoses and death)” and a section entitled ‘What works in drug treatment’ makes reference to methadone maintenance being effective in reducing “illicit opiate use, criminal behaviour, injecting and sharing behaviours, HIV infection rates, and mortality”.¹¹⁰

The Drug Strategy is a cross-government initiative involving a variety of departments and agencies including the Department of Health and the Department of Children, Schools and Families. The Home Office has overall responsibility for delivery of the strategy. The devolved administrations of Scotland, Wales and Northern Ireland have put in place drug and substance misuse strategies which both mirror and complement the UK drug strategy, but which are tailored to the particular circumstances of each country.¹¹¹

Northern Ireland

Northern Ireland's *New Strategic Direction for Alcohol and Drugs, 2006-2011*¹¹² makes no mention of HIV, though does include references to ‘Hepatitis C and other blood borne viruses’. The document established a set of key indicators to measure reductions in alcohol and drug-related harm, one of which relates to blood-borne viruses amongst IDUs.

Scotland

The Scottish Government's *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*,¹¹³ published in May 2008, makes three references to HIV. It appears in the introduction and a background section about the 1980s, and also with reference to harm reduction services they expect to be available in each part of Scotland “to reduce blood-borne viruses such as HIV and Hepatitis C”. This section also has a reference to the prescribing of “substitute drugs, such as methadone and buprenorphine, to reduce high-risk poly-drug use and injecting behaviour”.

Wales

The Welsh Assembly Government's *Working Together to Reduce Harm - The Substance Misuse Strategy for Wales 2008-2018*¹¹⁴ makes numerous references to IDUs and to HIV. For instance, it acknowledges increases in the levels of blood-borne viruses amongst IDUs in Wales and states that “if we are to reduce the harm caused by the transmission of Hepatitis B, Hepatitis C and HIV there will need to be an expansion in harm reduction services for drug misusers”.

The Strategy goes on to acknowledge that “current UK Government legislation and UN conventions mean that drug consumption rooms (DCR) or safer injecting facilities, where illegal drugs are used, are not lawful. Nonetheless, we recognise that there is a need to improve the range of alternative programmes that can reduce the harms associated with injecting illegal drugs and steroids, particularly for those who are homeless.”

Furthermore, its section on legal drugs notes that “injecting is the predominant route of administration of anabolic steroids (80 per cent in one study), and so users are at risk of contracting bloodborne viruses including Hepatitis B and C and HIV. Needle and syringe

exchange services for opiate users have reported increasing numbers of steroid users amongst their clients”.

The National Treatment Agency for Substance Misuse (NTA)

National Treatment Agency for Substance Misuse (NTA) was created by the Government in 2001 and is a special health authority whose purpose is to improve the availability, capacity and effectiveness of treatment for drug misuse in England. The NTA works with local partnerships and health commissioners “to deliver high-quality, effective drug misuse treatment that improves individuals’ physical and mental health and wellbeing. In turn, this improves public health, reduces crime and helps make communities safer”. The NTA was given the target of doubling the number of people in structured treatment programmes between 1998 and 2008 – it achieved its target two years early and now concentrates “on the quality agenda, improving services for people in treatment and improving outcomes for those who leave”.¹¹⁵

NTA: Commissioning for recovery - Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships (2010)

The document states that it is “designed to be used throughout the commissioning cycle when undertaking needs assessment, developing strategy, planning, agreeing contractual arrangements and managing the market, performance management and evaluation”. HIV is not mentioned, however there is a reference to drug treatment: “Drug treatment has been proven to reduce drug misuse, reduce crime, improve health, and protect against blood-borne viruses and overdose.”¹¹⁶

NTA: Clinical governance in drug treatment - A good practice guide for providers and commissioners (2009)

This document makes reference to the importance of partnership working with other organisations in relation to particular client groups, including “those with physical health problems requiring specialist treatment, including Hepatitis and HIV”.¹¹⁷

NTA: Drug Misuse and Dependence: UK guidelines on clinical management (2007)

This document contains a reference to material incentives (such as shopping vouchers up to the value of £10) that should be considered to encourage harm reduction, in particular for testing for HIV and other blood borne viruses for people at risk of physical health problems resulting from their drug misuse.¹¹⁸

IDUs are also acknowledged in the following key HIV policies and guidance from the Government and other agencies:

Review of the National Strategy for Sexual Health and HIV, 2008

Progress and priorities – working together for high-quality sexual health is a review of the National Strategy for Sexual Health and HIV, was produced in July 2008 for the Independent Advisory Group on Sexual Health and HIV by the Medical Foundation for AIDS and Sexual Health (MedFASH). The report outlines what has been achieved and addresses the key barriers which have impeded implementation to the 2001 National Strategy for Sexual Health and HIV. It also recommended actions to be taken at national, regional and local level. It makes reference to the health of IDUs, and warns, in relation to Hepatitis B, Hepatitis C and HIV, of the potential for an ‘explosive epidemic’ if harm reduction measures are not maintained. The review highlights the importance of recommending HIV testing for IDUs and of needle exchange programmes, and summarises Government delivery on actions for young IDUs and needle exchanges.¹¹⁹

The following year, the Department of Health published a response to this Review, entitled *Moving forward: Progress and priorities – working together for high-quality sexual health*,

*Government's response to the Independent Advisory Group's review of the National Strategy for Sexual Health and HIV.*¹²⁰ It made no reference to IDUs.

Hepatitis C Strategy for England

There are several references to HIV in this strategy which was published in 2002.¹²¹ References include experience gained from HIV prevention about the importance of outreach, peer education, mobile services and other measures to help change drug users' injecting behaviour. The strategy makes reference to mother to child transmission of Hepatitis C (which may be more likely when a pregnant woman is also living with HIV) and to prisoners having access to clinical investigation, NHS treatment and care for Hepatitis B and C as well as HIV. It covers exposure to blood borne viruses in the workplace, and hepatology units' care pathways for "special" groups of patients including those with HIV co-infection, children with Hepatitis C, prisoners, patients on renal dialysis and IDUs.

BHIVA Guidelines

Testing: The UK National Guidelines for HIV Testing 2008 prepared by the British HIV Society (BHIVA), the British Association of Sexual Health and HIV (BASHH) and the British Infections Society (BIS) include drug dependency programmes as the fourth of five settings in which universal HIV testing is recommended.¹²² The guidelines also state that HIV testing should be also routinely offered and recommended to all patients reporting a history of injecting drug use – IDUs are listed sixth of eight categories in this section.¹²³ They are also third in a list of four groups to whom repeat testing should be provided: it should be provided to IDUs annually, or more frequently if clinical symptoms are suggestive of seroconversion.¹²⁴

HIV clinical care: BHIVA Guidelines for HIV clinical care contains three references to HIV and IDUs, in relation to HIV affecting minority groups, how it can be transmitted and in a recommendation for commissioning.¹²⁵

The Independent Advisory Group on Sexual Health and HIV

The Independent Advisory Group on Sexual Health and HIV (IAG) was established in 2003 to monitor the progress of and provide advice to the Government on its Sexual Health and HIV Strategy for England. The 2009 document *Building on Progress: Enhancing the Response to HIV in England* makes several references to HIV and IDUs, with reference to behavioural surveillance and trends in new diagnoses, but also makes reference to stigma and discrimination that may be encountered by this community.¹²⁶

References

- i Health Protection Agency. *HIV data: Injecting Drug Users 2009*
<http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1202115502904> and 2% figure from HPA, *Numbers accessing HIV care: National Overview*
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203064766492
- ¹ UNAIDS (11 May 2007), '[Injecting drug use: focused HIV prevention works](http://www.avert.org/injecting.htm)', from www.avert.org/injecting.htm
- ² Centre for Strategic and International Studies, Fiellin D.A. et al (2008) *Combating the Twin Epidemics of HIV/AIDS and Addiction: Opportunities for Progress and Gaps in Scale*, page 33
http://csis.org/files/media/csis/pubs/080129_fiellincombatinghiv.pdf
- ³ World Health Organisation, United Nations Office on Drugs and Crime (UNODC) 2004 - *Advocacy guide: HIV/AIDS prevention among injecting drug users*
<http://www.unodc.org/documents/hiv-aids/advocacy%20guide%20on%20prev%20for%20IDU.pdf>
- ⁴ Mathers, B.M et al (2008) *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review* The Lancet, Volume 372, Issue 9651, Pages 1733 - 1745, 15 November 2008
<http://www.thelancet.com/journals/lancet/article/PIIS0140673608613112/abstract>
- ⁵ Mathers, B.M. et al (2008), *HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage*, The Lancet, Volume 375, Issue 9719, pages 1014 – 1028, 20 March 2010. <http://www.idurefgroup.unsw.edu.au/idurgweb.nsf/page/Publications>
- ⁶ Regional and global estimates of the number of people who inject drugs, and the number who may be HIV positive, 2007, table 7 from Mathers et al 2008, accessed at
<http://www.idurefgroup.unsw.edu.au/idurgweb.nsf/page/Publications>
- ⁷ International Harm Reduction Development Program, Open Society Institute (2008, March) *Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics*. Figures: Eastern Europe and Central Asia as of 2007 (Russia: 2006); Indonesia and Malaysia: 2006; China and Vietnam: 2005.
http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/developments_20080304
- ⁸ Mathers, B.M. et al (2008), *HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage*, The Lancet, Volume 375, Issue 9719, pages 1014 – 1028, 20 March 2010. <http://www.idurefgroup.unsw.edu.au/idurgweb.nsf/page/Publications>
- ⁹ Stimson, G et al: *Three cents a day is not enough: resourcing HIV harm reduction on a global basis*. Paper ID 252, Harm Reduction 2010: International Harm Reduction Association (IHRA)'s 21st international conference, April 2010 <http://www.ihra.net/Assets/2502/1/HarmReduction2010Abstracts.pdf>
- ¹⁰ Sweeting M.J. et al, *Estimating the prevalence of ex-injecting drug use in the population*, Statistical Methods in Medical Research, August 2009; 18: 381 – 395 <http://smm.sagepub.com/cgi/content/abstract/18/4/381>
- ¹¹ Drugscope: Resources *How many people are addicted? Addiction or problematic use are a difficult concept to measure* <http://www.drugscope.org.uk/resources/faqs/faqpages/how-many-people-are-addicted>
- ¹² UK Focal Point on Drugs Annual Report to the EMCDDA: *United Kingdom Drug Situation*, 2009 edition.
<http://www.nwph.net/ukfocalpoint/showupload.aspx?categoryid=pub&id=8be41fb1-3503-4916-86ce-0963e2ad2b73>
- ¹³ UK Focal Point on Drugs Annual Report to the EMCDDA: *United Kingdom Drug Situation*, 2009 edition.
<http://www.nwph.net/ukfocalpoint/showupload.aspx?categoryid=pub&id=8be41fb1-3503-4916-86ce-0963e2ad2b73> The 147,900 figure is based on estimates of injecting of opiates and/or crack cocaine in England for 2006/07, opiate and/or problem cocaine use in Northern Ireland for 2004 and injecting of opiates and/or benzodiazepines in Scotland, 2006. Estimates for Wales are extrapolated from England. Injecting estimates for Northern Ireland assume the same proportion of injecting as England. Source: The Centre for Drug Misuse Research 2006; Hay et al. 2008; Hay et al. 2009a
- ¹⁴ Home Office Research Report 9, 2008 *National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/07: a summary of key findings*, Hay G et al
<http://rds.homeoffice.gov.uk/rds/pdfs08/horr09.pdf>

¹⁵ Home Office Research Report 9, 2008 *National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/07: a summary of key findings*, Hay G et al
<http://rds.homeoffice.gov.uk/rds/pdfs08/horr09.pdf>

¹⁶ Health Protection Agency *Shooting Up – Infections among injecting drug users in the United Kingdom 2008, An update: October 2009*, page 6 http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1254510653792 Source of 217,000 figure is De Angelis D et al, *An evidence synthesis approach to estimating Hepatitis C Prevalence in England and Wales*. *Statistical Methods in Medical Research* 2009; 18:361-379

¹⁷ UK Focal Point on Drugs Annual Report to the EMCDDA *United Kingdom Drug Situation, 2009 edition*.
<http://www.nwph.net/ukfocalpoint/showupload.aspx?categoryid=pub&id=8be41fb1-3503-4916-86ce-0963e2ad2b73>

¹⁸ HPA, *Shooting Up*, page 7 – as per note 16.

¹⁹ Health Protection Agency, *HIV in the United Kingdom: 2009 report*, Figure 1: Estimated number of adults (15 to 59 years) living with HIV (both diagnosed and undiagnosed) in the UK: 2008. Figure 1,
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259151891830

²⁰ Health Protection Agency, Numbers of persons accessing HIV-related care: Survey of Prevalent HIV Infections Diagnosed (SOPHID), Injecting drug users (IDU) data tables. SOPHID Table SHAIDU: Diagnosed HIV-infected IDUs seen for care by area of residence, United Kingdom: 1999-2008.
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1221482346358

²¹ HPA, *Shooting Up* - as per note 16

²² HPA, *Shooting Up* - as per note 16

²³ HPA, *Shooting Up*, page 20, as per note 16.

²⁴ HPA, *Shooting Up*, page 8 - as per note 16

²⁵ HPA, *Unlinked Anonymous Survey of Genitourinary Medicine Clinic Attendees (GUM Anon Survey)*, 2008
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1202115496235

²⁶ HPA, *New HIV diagnoses in the UK by prevention group and estimated world region of infection:2009*
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1252660014023

²⁷ UK Focal Point on Drugs Annual Report to the EMCDDA *United Kingdom Drug Situation, 2009 edition*.
<http://www.nwph.net/ukfocalpoint/showupload.aspx?categoryid=pub&id=8be41fb1-3503-4916-86ce-0963e2ad2b73>

²⁸ HPA, *Injecting Drug Users: United Kingdom New HIV Diagnoses to end of December 2009*. Table 1: *New HIV & AIDS diagnoses & deaths by year of diagnosis or death and sex among individuals probably infected through injecting drug use* http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1219735626104

²⁹ In relation to age groups, studies have been conducted about drug use and ageing – for instance the number of people in Europe aged 65 and over needing treatment for substance abuse will double between 2001 and 2020 (see Beynon, C et al *Drug use and ageing: setting the scene*, Paper ID 83, Harm Reduction 2010: International Harm Reduction Association's 21st international conference, April 2010). Adults who are 45 or over comprise the fastest growing age group of drug users as well as new AIDS cases in the USA (see Boeri, M et al. *A contextual analysis of risk behaviours among older adult drug users and harm reduction in suburban versus inner-city social environments*, Paper ID 900, Harm Reduction 2010: International Harm Reduction Association's 21st international conference, April 2010). Whilst these particular studies do not deal specifically with HIV, the issue may be worth considering when looking at the issue of HIV and IDUs.

³⁰ HPA, *Injecting Drug Users: United Kingdom New HIV Diagnoses to end of December 2009*. Table 2: *New HIV diagnoses in the United Kingdom by year, country and Strategic Health Authority (SHA) of diagnosis among individuals probably infected through injecting drug use*
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1219735626104

-
- ³¹ HPA, *Shooting Up*, page 4 - as per note 16.
- ³² HPA, Injecting Drug Users: United Kingdom New HIV Diagnoses to end of December 2009. Table 4: *New HIV diagnoses in the United Kingdom by year of diagnosis and ethnic group among individuals probably infected through injecting drug use* http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1219735626104
- ³³ HPA, *Shooting Up* - as per note 16
- ³⁴ HPA, Injecting Drug Users: United Kingdom New HIV Diagnoses to end of December 2009. Table 1: *New HIV & AIDS diagnoses & deaths by year of diagnosis or death and sex among individuals probably infected through injecting drug use* http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1219735626104
- ³⁵ Personal communication with the HPA, June 2010
- ³⁶ Health Protection Agency, *HIV in the United Kingdom: 2009 report*, Figure 3: Estimated late diagnosis of HIV infection by prevention group among adults aged ≥15 years, UK: 2008 http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259151891830
- ³⁷ Lert, F and Kazatchkine, M.D. *Antiretroviral HIV treatment and care for injecting drug users: an evidence-based overview International Journal of Drug Policy*, August 2007 Volume 18, Issue 4, Pages 255-261, abstract <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020510/>
- ³⁸ Legge A, *Survival improving among injecting drug users with HIV; ARTs not the only factor*, AIDSmap 16 July 2007, reference Muga R et al, *Survival of HIV-infected injection drug users (IDUs) in the highly active antiretroviral therapy era, relative to sex- and age-specific survival of HIV-uninfected IDUs*. *Clinical Infectious Diseases* 45 :370-376, 2007
- ³⁹ Mortality Audit, British HIV Association Audit and Standards Sub-Committee. 2005-06 Full results of mortality audit , accessed at <http://www.bhiva.org/NationalAuditReports.aspx> and AIDSmap, *BHIVA: One-in-three UK HIV deaths 'not directly related to HIV'*, 18 October 2006, <http://www.aidsmap.com/en/news/8DB0098A-5707-4F4C-84FA-AE9C854865F6.asp>
- ⁴⁰ Morris, D National Needle Exchange Forum presentation, March 2010 (quoting the International Centre for Drug Policy, *Drug related deaths in the UK Annual report 2008*, St George's University of London)
- ⁴¹ SOPHID Table ARTIDU: Diagnosed HIV-infected IDUs seen for care by level antiretroviral therapy and CD4 count, United Kingdom: 2000-2008. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1221482346358
- ⁴² SOPHID Table ARTMSM: Diagnosed HIV-infected MSM seen for care by level of antiretroviral therapy and CD4 cell count, United Kingdom: 2000-2008. http://www.hpa.nhs.uk/web/HPAwebFile/HPAweb_C/1221482345551
- ⁴³ SOPHID Table ARTBA: Diagnosed HIV-infected black-African individuals seen for care by level of antiretroviral therapy, and CD4 count, United Kingdom: 2000-2008. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1221482345789
- ⁴⁴ Lert, F and Kazatchkine, M.D. *Antiretroviral HIV treatment and care for injecting drug users: an evidence-based overview International Journal of Drug Policy*, August 2007 Volume 18, Issue 4, Pages 255-261, abstract <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020510/>
- ⁴⁵ Moatti J.P. et al, *Adherence to HAART in French HIV-infected injecting drug users: the contribution of buprenorphine drug maintenance treatment*, *AIDS* 2000, January 28; 14(2):151-5 <http://www.ncbi.nlm.nih.gov/pubmed/10708285>
- ⁴⁶ Palepu A et al, *Antiretroviral adherence and HIV treatment outcomes among HIV/HCV co-infected injection drug users: the role of methadone maintenance therapy* [Drug Alcohol Depend.](http://www.drugalcohol.org) 2006 Sep 15;84(2):188-94. Epub 2006 Mar 20

-
- ⁴⁷ AIDSmap, *Retention in opioid replacement programmes improves chances of HIV treatment working for drug users* Michael Carter, 29 October 2010, reporting on Roux P et al, *Retention in opioid substitution treatment: a major predictor of long-term virological success of HIV-infected injection drug users receiving antiretroviral therapy* Clin Infect Dis 49: 1433-40, 2009
- ⁴⁸ *A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users*, Liverpool John Moores University Centre for Public Health, Page 2, <http://www.nice.org.uk/nicemedia/pdf/NSPRevieweffectivenesscosteffectExecsummaryJune08.pdf>
- ⁴⁹ Mainliners, *Hep C and HIV co-infection*, <http://www.mainliners.org.uk/pages/hep-c-hiv-co-infection.html>
- ⁵⁰ All points apart from 1 in 3 statistic from *Hepatitis C for people living with HIV*, i-Base guide March 2009, <http://i-base.info/guides/hepc/first-questions>
- ⁵¹ Highleyman L, *British Study Finds HIV-HCV Co-infected Patients Do Not Have Impaired CD4 Cell Recovery after Starting HAART*, Coverage of the 16th Conference on Retroviruses and Opportunistic Infections (CROI 2009), reference to F Ewing et al, *HIV-infected Individuals Co-infected with HCV Appear to Have Faster CD4 Decline in the Absence of ART but Similar Response Once Combination ART Is Initiated*. 16th Conference on Retroviruses and Opportunistic Infections (CROI 2009). Montreal, Canada. February 8-11, 2009. Abstract 851. http://www.hivandHepatitis.com/2009icr/croi/docs/030309_e.html (Conference poster available at <http://retroconference.org/2009/PDFs/851.pdf>)
- ⁵² Braitstein P et al, *Hepatitis C co-infection is independently associated with decreased adherence to antiretroviral therapy in a population-based HIV cohort*. AIDS 2006 Feb 14:20(3):323-31 <http://www.ncbi.nlm.nih.gov/pubmed/16439865>
- ⁵³ Mohsen A. H. et al, *Prevalence of Hepatitis C in an ethnically diverse HIV-1-infected cohort in south London*. HIV Medicine 2005 May;6(3):206-15
- ⁵⁴ *Hepatitis C for people living with HIV*, i-Base guide March 2009, <http://i-base.info/guides/hepc/first-questions>
- ⁵⁵ HPA, *Shooting Up* (as per note 16 above) – reference to Judd A et al, *Incidence of Hepatitis C virus and HIV among new injecting drug users in London - prospective cohort study*. British Medical Journal 2005;330:24-25
- ⁵⁶ Vivancos, R et al (2006) *Crack/cocaine use in a rural county of England*, Oxford Journal of Public Health 2006, volume 28, number 2, pages 96-103, <http://jpubhealth.oxfordjournals.org/cgi/content/full/28/2/96>
- ⁵⁷ HIV i-Base, International AIDS Conference report December 2008, *Injection drug users and HIV: evidence based review of clinical treatment considerations*, <http://i-base.info/idu/244>
- ⁵⁸ World Health Organisation, United Nations Office on Drugs and Crime (UNODC) 2004 - Advocacy guide: HIV/AIDS prevention among injecting drug users <http://www.unodc.org/documents/hiv-aids/advocacy%20guide%20on%20prev%20for%20IDU.pdf>
- ⁵⁹ Avert: Injecting drugs, drug users, HIV and AIDS, accessed at <http://www.avert.org/injecting.htm>
- ⁶⁰ *The primary prevention of Hepatitis C among injecting drug users*, Home Office Advisory Council on the Misuse of Drugs, February 2009 (citing Palmateer et al 2008 and Tilson et al 2007), accessed at <http://www.hepctrust.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=a50a1f8cd13244b89e36cfd9bc7b354a&mode=link&guid=fd3b10eb79d64f1c9c4c157706c22995>
- ⁶¹ *The primary prevention of Hepatitis C among injecting drug users*, Home Office Advisory Council on the Misuse of Drugs, citing Vickerman et al, accessed at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/acmdhepreport2.pdf>
- ⁶² Zule, W et al, *Syringe type and HIV risk: current knowledge and future directions* Paper ID 209, Harm Reduction 2010: International Harm Reduction Association (IHRA)'s 21st international conference, April 2010 <http://www.ihra.net/Assets/2502/1/HarmReduction2010Abstracts.pdf>

- ⁶³ *Drug and alcohol dependence: new advances and ongoing challenges in HIV treatment and prevention*, HIV i-Base, ART4IDUs, Volume 2 number 1, October 2009, <http://i-base.info/idu/files/2010/02/ART4IDUOct09.pdf>
- ⁶⁴ UK Drug Policy Commission, *An Analysis of UK Drug Policy*, 2007, Page 9. <http://www.ukdpc.org.uk/docs/UKDPC%20drug%20policy%20review.pdf>
- ⁶⁵ Joseph H. Et al, *Methadone maintenance treatment (MMT): a review of historical and clinical issues*, *Mt Sinai J Med.* 2000 Oct-Nov;67(5-6):347-64, <http://www.ncbi.nlm.nih.gov/pubmed/11064485>
- ⁶⁶ Examples from Mersey Care NHS Trust Drug Misuse Services and Manchester Drug Network.
- ⁶⁷ *A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users*, Liverpool John Moores University Centre for Public Health, Page 2 <http://www.nice.org.uk/nicemedia/pdf/NSPRevieweffectivenesscosteffectExecsummaryJune08.pdf> and Scottish Government Needle Exchange Provision in Scotland – a report of the national needle exchange survey 2006, <http://www.scotland.gov.uk/resource/doc/130349/0031220.pdf>
- ⁶⁸ Beynon C.M. et al, *The impact of citrate introduction at UK syringe exchange programmes: a retrospective cohort study in Cheshire and Merseyside, UK* *Harm Reduction Journal* 2007, 4:21doi:10.1186/1477-7517-4-21
- ⁶⁹ MacDonald M et al, *Effectiveness of needle and syringe programmes for preventing HIV transmission* *International Journal of Drug Policy* 14 (2003), 353-357, <http://www.ihra.net/Assets/20/1/HIVAdditionalPapers83a.pdf>
- ⁷⁰ Des Jarlais, D.C. et al, *HIV infection during limited versus combined HIV prevention programs for IDUs in New York City: The importance of transmission behaviours*, *Drug and Alcohol Dependence*, accessed via http://www.aidsportal.org/Article_Details.aspx?ID=12665
- ⁷¹ *UK National Guidelines for HIV Testing 2008*, prepared jointly by the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and the British Infection Society <http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>
- ⁷² Health Protection Agency, personal communication, July 2010
- ⁷³ Aidsmap, *Equipment sharing among IDUs* <http://www.aidsmap.com/cms1324135.aspx>
- ⁷⁴ *A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users*, Liverpool John Moores University Centre for Public Health, Page 13, <http://www.nice.org.uk/nicemedia/pdf/NSPRevieweffectivenesscosteffectExecsummaryJune08.pdf>
- ⁷⁵ All information in this section from personal communication with HIV and drug organisations, unless otherwise specified.
- ⁷⁶ Drugscope website, <http://www.drugscope.org.uk/resources/databases/typesoftreatment.htm>
- ⁷⁷ <http://www.avert.org/needle-exchange.htm>
- ⁷⁸ *Scottish Government Needle Exchange Provision – a report of the national needle exchange survey*, <http://www.scotland.gov.uk/resource/doc/130349/0031220.pdf>
- ⁷⁹ *Scottish Government Needle Exchange Provision – a report of the national needle exchange survey*, <http://www.scotland.gov.uk/resource/doc/130349/0031220.pdf>
- ⁸⁰ Personal communication, Drugscope, August 2010
- ⁸¹ All statistics from Service Review: Healthcare Commission and National Treatment Agency for Substance Misuse, *Improving services for substance misuse, Commissioning drug treatment and harm reduction services* Page 7, http://www.nta.nhs.uk/uploads/nta_improving_services_substance_misuse.pdf
- ⁸² The Observer, 20 September 2009, *UK addicts may be given free foil for 'safer' heroin smoking* by Denis Campbell
- ⁸³ *Supervised Administration of Injectable 'Medical' Heroin Leads to Larger Reductions in Street Heroin Use Than Injectable or Oral Methadone (RIOTT Trial)*, 28 May 2010 http://www.actiononaddiction.org.uk/news_and_campaigns/news/187_supervised-administration-of-injectable-medical-heroin-leads-to-larger-reductions-in-street-heroin-use-than-injectable-or-oral-methadone-riott-trial
- ⁸⁴ Wright, NMJ and Tompkins, CNE (2004) *Supervised injecting centres*, *British Medical Journal*, *BMJ* 2004;328:100-102, <http://www.bmj.com/cgi/content/full/328/7431/100#REF5> quoting Consumption Rooms as a Professional Service in Addictions Health: International Conference for the development of guidelines. *Guidelines for the operation and use of consumption rooms*, 1999.
- ⁸⁵ GNP+ and ICW Position Statement, *Injecting Drug Users and Access to HIV Treatment* October 2005, page 8 <http://www.icw.org/files/IDUEN.pdf> and Wright et al as above.

-
- ⁸⁶ Government reply to the third report from the Home Affairs Committee: The Government's Drugs Policy: Is It Working? Session 2001-2002 HC 318. 2002. London, HMSO, quoted in Wright et al as above.
- ⁸⁷ Offender Health letter to Prison Governors, Healthcare Managers, Doctors and CARAT teams regarding health promotion materials for blood borne viruses, 9 December 2009.
- ⁸⁸ Price Waterhouse Coopers, Report to the Department of Health and Ministry of Justice: *Review of Prison-Based Drug Treatment Funding* published March 2008, <http://www.justice.gov.uk/news/docs/prison-drug-treatment-funding.pdf>
- ⁸⁹ http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/addictionadvice/
- ⁹⁰ Tompkins C.N.E. et al, *Experiences of prison among injecting drug users in England: A qualitative study* International Journal of Prisoner Health, Volume 3, Issue 3 September 2007 , pages 189 – 203
- ⁹¹ UK Drug Policy Commission, *Reducing Drug Use, Reducing Reoffending: Are programmes for problem drug-using offenders in the UK supported by the evidence?* March 2008 www.ukdpc.org.uk/reports.shtml
- ⁹² Speech by Lord Patel at the NTA treatment and reintegration conference: Delivering the Drug Strategy, 11 June 2008 <http://www.pdtsrg.co.uk/sites/default/files/PDTSRSpeechJune08KPfinal.pdf>
- ⁹³ Prison Service Instruction 34/2007, *Re-introduction of disinfecting tablets* http://psi.hmprisonservice.gov.uk/PSI_2007_34_disinfecting_tablets.doc
- ⁹⁴ Weild AR et al (2000) *Prevalence of HIV, Hepatitis B, and Hepatitis C antibodies in prisoners in England and Wales: a national survey*, Communicable Disease and Public Health, Vo. 3, No. 2: 121-126 (summary) accessed via <http://www.aidsmap.com/cms1324135.aspx>
- ⁹⁵ Prison Drug Treatment Strategy Review Group, Speech by Lord Patel to at the National Treatment Agency (NTA) Treatment and Reintegration Conference, June 2008 <http://www.pdtsrg.co.uk/sites/default/files/PDTSRSpeechJune08KPfinal.pdf>
- ⁹⁶ Morris, D National Needle Exchange Forum presentation, March 2010 (quoting Farrell M and Marsden J *Acute risk of drug-related death among newly released prisoners in England and Wales* [Addiction](http://www.addiction.org.uk) Volume 103 Issue 2, Pages 251 – 255)
- ⁹⁷ Tompkins C.N.E. et al, *Experiences of prison among injecting drug users in England: A qualitative study* International Journal of Prisoner Health, Volume 3, Issue 3 September 2007 , pages 189 – 203
- ⁹⁸ Social Exclusion Unit, *Reducing Re-offending by ex-Prisoners* July 2002 http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/reducing_summary.pdf ,
- ⁹⁹ Tompkins C.N.E. et al, *Experiences of prison among injecting drug users in England: A qualitative study* International Journal of Prisoner Health, Volume 3, Issue 3 September 2007 , pages 189 – 203
- ¹⁰⁰ Canadian HIV/AIDS Legal Network *Needle and Syringe Programs and Bleach in Prisons: Reviewing the Evidence* (2008) page 5 <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1291>
- ¹⁰¹ Personal communication (July 2010) with Offender Health, a partnership between the Ministry of Justice and the Department of Health whose remit is to improve the standard of healthcare for offenders. Offender Health homepage available at <http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Offenderhealth/index.htm>
- ¹⁰² Canadian HIV/AIDS Legal Network *Needle and Syringe Programs and Bleach in Prisons: Reviewing the Evidence* (2008) page 5 <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1291>
- ¹⁰³ As per note above
- ¹⁰⁴ *Get out of Jail BBV-Free!* leaflet http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110379.pdf
- ¹⁰⁵ HM Prison Service and Department of Health Clinical Guidance Note – Issuing condoms to prisoners, July 2006.
- ¹⁰⁶ Prison Drug Treatment Strategy Review Group, Speech by Lord Patel to at the National Treatment Agency (NTA) Treatment and Reintegration Conference, June 2008 <http://www.pdtsrg.co.uk/sites/default/files/PDTSRSpeechJune08KPfinal.pdf>
- ¹⁰⁷ HPA Prison Infection Prevention Team, *Infection Inside, the Prison Infectious Disease Quarterly, May 2008* Volume 4, Issue 2 http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1221722409971

-
- ¹⁰⁸ *Get out of Jail BBV-Free!* leaflet
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110379.pdf
- ¹⁰⁹ UNAIDS 2001, quoted in *An Analysis of UK Drug Policy*, UK Drug Policy Commission, Reuter P & Stevens A, 2007 <http://www.ukdpc.org.uk/docs/UKDPC%20drug%20policy%20review%20exec%20summary.pdf>
- ¹¹⁰ UK Government *Drugs: protecting families and communities: the 2008 Drugs Strategy*, pages 51 and 52
<http://webarchive.nationalarchives.gov.uk/20100419081707/http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-20082835.pdf?view=Binary>
- ¹¹¹ Home Office web site, content archived following the May 2010 General Election. Accessed at
<http://webarchive.nationalarchives.gov.uk/20100418065544/http://drugs.homeoffice.gov.uk/drug-strategy/uk-government/?view=Standard>
- ¹¹² Northern Ireland Department of Health, Social Services and Public Safety: New Strategic Direction for Alcohol and Drugs, 2006-2011 <http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf>
- ¹¹³ Scottish Government: *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, May 2008 <http://scotland.gov.uk/Resource/Doc/224480/0060586.pdf>
- ¹¹⁴ Welsh Assembly Government: *Working Together to Reduce Harm - The Substance Misuse Strategy for Wales 2008-2018*, <http://wales.gov.uk/dsjlg/publications/communitysafety/strategy/strategye.pdf?lang=en>
- ¹¹⁵ Health care Commission and National Treatment Agency: *Improving services for substance misuse, Commissioning drug treatment and harm reduction. Service review, 2008. Page 2*
http://www.nta.nhs.uk/uploads/nta_improving_services_substance_misuse.pdf
- ¹¹⁶ NTA: *Commissioning for recovery - Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships*, page 5
http://www.nta.nhs.uk/uploads/commissioning_for_recovery_january_2010.pdf
- ¹¹⁷ NTA: *Clinical governance in drug treatment - A good practice guide for providers and commissioners* page 23
<http://www.nta.nhs.uk/uploads/clinicalgovernance0709.pdf>
- ¹¹⁸ NTA: *Drug Misuse and Dependence: UK guidelines on clinical management 2007*
http://222.nat.nhs.uk/uploads/clinical_guidelines_2007.pdf
- ¹¹⁹ *Progress and priorities – working together for high-quality sexual health, A Review of the National Strategy for Sexual Health and HIV* (2008) by Medical Foundation for AIDS and Sexual Health (MedFASH) for the Independent Advisory Group on Sexual Health and HIV. Pages 19,20, 36 and 71,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/documents/digitalasset/dh_086741.pdf
- ¹²⁰ *Moving forward: Progress and priorities – working together for high-quality sexual health*, Government's response to the Independent Advisory Group's review of the National Strategy for Sexual Health and HIV,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103089.pdf
- ¹²¹ Department of Health, *Hepatitis C Strategy for England* August 2002,
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4059510.pdf
- ¹²² Section 4.2A of the *UK National Guidelines for HIV Testing 2008*, prepared jointly by the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and the British Infection Society
<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>
- ¹²³ Section 4.2C of the *UK National Guidelines for HIV Testing 2008*, prepared jointly by the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and the British Infection Society
<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>
- ¹²⁴ Section 4.3 of the *UK National Guidelines for HIV Testing 2008*, prepared jointly by the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and the British Infection Society, accessed at
<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>

¹²⁵ British HIV Association (BHIVA) Guidelines for HIV clinical care, section 3.1
<http://www.bhiva.org/documents/Guidelines/Standards/StandardsHIVClinicalCare.pdf>

¹²⁶ The Independent Advisory Group on Sexual Health and HIV, *Building on Progress: Enhancing the Response to HIV in England*
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_108981.pdf