Title

Improving access to primary healthcare among injecting drug users in Redfern: A project in reorienting resources to expand the services of the needle syringe program.

Abstract

Injecting drug users (IDU) experience a number of health-related problems including those related to their injecting drug use. Access to primary healthcare is often limited for this marginalised population. This project illustrates the processes of how a community-based needle and syringe program (NSP) improved access to primary healthcare and addressed the unmet health needs of IDUs in respect to blood borne viruses (BBV) and drug related health, by reorienting existing resources. It addresses national and international policy frameworks by improving the health of people living with and at risk of contracting BBVs. Data shows a significant uptake of extended services since the introduction of the comprehensive model. Each service represents an intervention, which would not have occurred within the traditional NSP model, demonstrating how NSPs can play a larger role in primary healthcare delivery to IDUs.

Aim

Improve accessibility and utility of primary healthcare for IDU, by providing a comprehensive model of BBV management at the community level through an existing NSP service.

Nature of the Problem

IDUs have a number of unmet health needs and experience a range of health-related problems including those related to injecting drug use and this marginalised population experience limited primary healthcare access. (Day et al, 2003; Abouyanni et al, 2000). In over 20 years of NSP delivery in Australia, the favoured model included the provision of sterile injecting equipment, education and referral. While this model has averted an HIV epidemic among IDUs, it has been less successful in addressing hepatitis C (HCV) and related physical and mental health problems. Many of these problems are preventable, should appropriate and timely healthcare be provided. Inadequate attention to these issues results in compounding health problems.

Extent of the problem

IDU is a leading cause of transmission of HIV and HCV infection globally. Of the estimated 260,000 people living in Australia with HCV, 90% are related to IDU and the majority of these are undiagnosed. One percent of people living with HCV utilise treatment, of which IDU are underrepresented. Co-infection

with hepatitis B (HBV), poor physical and mental health and psychosocial problems compound BBV health problems.

A needs assessment of 100 clients of the NSP in Redfern found:

- 50% reported barriers to utilising local GPs;
- 40% reported never being vaccinated against HBV;
- 50% reported as not being screened for BBV between 1-2 years;
- 30% reported as having injecting related health complaints
- 70% reported some mental instability.
- 90% advised that the NSP would be value-added by introducing BBV screening and vaccinations; sexual health; treatment for injecting related injuries and organised access to drug treatment.

These are consistent with the literature on IDUs' healthcare needs (Day et al 2007; Darke et al, 2005), showing a clear need for basic onsite delivery of healthcare.

Strategic importance

The goals of the Commonwealth's Strategies in HIV/AIDS and HCV are to reduce transmission and improve the health of people living with such infections (Commonwealth, 2005[a]; 2005[b]). Accessibility and appropriateness of healthcare are principles extolled in these policy frameworks. The World Health Organisation [6] and Joint United Nations Program on HIV/AIDS [7] policy frameworks for HIV/AIDS prevention among IDU endorse a primary healthcare model of service provision.

This project addresses these policy frameworks by applying these principles to the former NSP service model, resulting in improved access to healthcare through expanded onsite services. The adaptability of this model means that this project will provide new directions for policy in NSW and elsewhere.

Planning and implementing solutions

The goal of the traditional NSP model is to prevent HIV and HCV transmission by reducing the shared use of needles/syringes, whereas the goal of the comprehensive model is to expand the definition of HIV and HCV prevention to include a more holistic approach to BBV prevention (Table 1).

Table 1: Traditional vs comprehensive NSP model

Traditional Model	**Comprehensive Model**
• **Resource provision** (needle/syringes, education, referral)	• **Resource provision** (needle/syringes, education, referral) • **BBV healthcare** (screening; HBV vaccination, counselling, assessment for treatment, monitoring) • **Sexual healthcare** (screening, assessment, referral)

	• **Drug healthcare** (assessment for treatment, counselling) • **Mental healthcare** (assessment and referral to community-based services) • **Women's Health** (domestic violence screening, sexual assault support, reproductive health and referral) • **Acute care** (referral for emergency accommodation, crisis intervention) • **Case management** (coordinated treatment plans) • **General healthcare** (primary care of injecting related infections, assessment, referral and check-ups) • **Visiting Specialist Services** in BBV, Sexual Health and Mental Health.

The pre-assessment of 74 clients in May 2006 found 55% were suitable and motivated for immediate triaging into the primary healthcare service. The comprehensive model was then set up within the existing framework of the NSP, supported by the Area Health Service. A team of nursing and casework staff were recruited and a steering committee was established, comprising key bodies to oversee the transition and implementation of the model.

Outcomes and Evaluation

Over 1000 clients have received health consultations with over 200 clients registered in the clinic's treatment program. Examples of health measures among clients include:

- 47 vaccinated against HBV
- 54 received blood screening protocol (HIV/AIDS, viral hepatitis)
    - 5 new diagnosis of hepatitis C and syphilis identified
- 120 assessed in drug health; BBV health; mental health
- 52 received general health check-ups (vital signs), results and referral
- 70 managed for psychosocial support
- Over 100 formal referrals made, of which over 50 confirmed as successful admission to treatment for drug and alcohol and BBV management.

Each of these services represents an intervention, which would not have occurred within the traditional NSP model and demonstrates how NSPs can play a larger role in the delivery of primary healthcare to IDUs.

The state-wide targets and performance indicators for BBVs relevant to this project include increased numbers in BBV screening and Hepatitis B vaccination, which is particularly low among IDU [7], referral to drug treatment and targeted education for IDUs. The data presented above has directly contributed to these indicators. The comprehensive model therefore contributes to state-wide targets by providing a local level service in a high risk community that is not otherwise available.

Sustaining change

The primary healthcare service is a low threshold model that currently runs through existing funds and therefore places minimal financial burden on the service. The primary healthcare service is now well established as a part of the clinical network of the Area Drug Health Service.

The development of a database and a regular reporting system has enabled service provision and outcome data to be used for the creation of performance benchmarks and clinical indicators for the program.

Future Scope

The primary healthcare service was set-up under the auspice of the already established NSP utilising existing funds and resources. The model is an expansion and diversification of the service, rather than a change or redirection in service provision. Therefore the project provides scope for easy transferability to other Area Health Services where the need is indicated. The model has already been used to expand and diversify HIV and HCV prevention programs in other communities of the Area Health Service where indicated.

Reference list

Day C, Ross J, Dolan K. (2003). Hepatitis C related discrimination among heroin users in Sydney: Drug user or hepatitis C discrimination? Drug Alcohol Rev 22:316-20.

Abouyanni G, Stevens LJ, Harris MF, Wickes WA, Ramakrishna SS, Ta E, et al. (2000) GP attitudes to managing drug- and alcohol-dependent patients: a reluctant role. Drug Alcohol Rev 19(2):165-70.

Day CA, White B, Thein HH, Doab A, Dore G, J., Bates A, et al (2007). Experience of HIV and hepatitis C testing among injecting drug users in Sydney, Australia. AIDS Care. In press.

Darke S, Ross J, Teesson M, Lynskey M. (2003) Health service utilization and benzodiazepine use among heroin users: Findings from the Australian Treatment Outcome Study (ATOS). Addiction. 98(8):1129-35.

Commonwealth Department of Health and Ageing (2005). National HIV/AIDS Strategy 2005 - 2008, Commonwealth Government of Australia, Canberra.

Commonwealth Department of Health and Ageing (2005), National Hepatitis C Strategy 2005 - 2008, Commonwealth Government of Australia, Canberra.

World Health Organisation (WHO) (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. WHO, Geneva, Switzerland.

Joint United Nations Programme on HIV/IADS (UNAIDS) (2005). Intensifying HIV prevention: UNAIDS Policy Position Paper. UNAIDS, Geneva, Switzerland.

MacDonald V, Dore GJ, Amin J, van Beek I. (2007) Predictors of completion of a hepatitis B vaccination schedule in attendees at a primary sexual health care facility. Sexual Health 3:1-4.