The Evidence to Scale Up Safer Inhalation Resources

Andrée Germain MSW

Harm Reduction Research Manager,

HIV & HCV Prevention Research Team,

University of Ottawa

Harm Reduction Overview

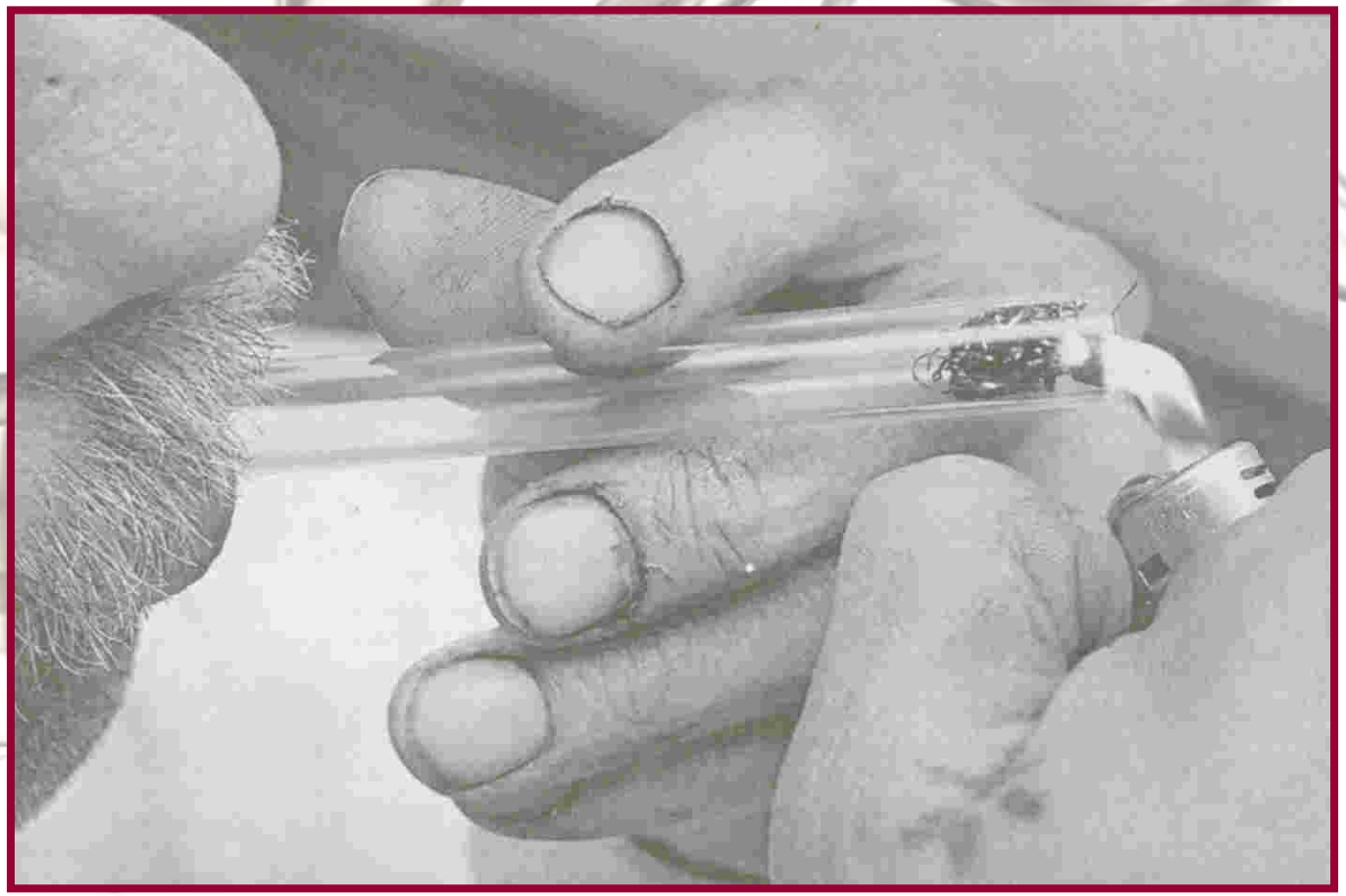
- 82 countries provide some access to NSP
  - 70 offer opioid substitution therapy
- 8 countries (60 cities) operate drug consumption sites
- 4 countries (Germany, Spain, Netherlands & Switzerland) have safer inhalation rooms
- Difficult to know how many counties/cities distribute safer inhalation supplies

Risks Associated with Smoking Crack

HCV transmission via non-injection drug use may be a common, yet under-appreciated, public health problem

- Exposure to HCV RNA in biological fluids
  - HCV RNA detected in saliva among 52% with chronic HCV infection
- Direct interaction between the virus and the host's blood
  - Oral injuries, ulcerations, burns

Harms Associated with Smoking Crack



OHRDP 2011 – "The Point of It"

HIV HEPATITIS C PREVENTION RESEARCH TEAM

Transmission of HCV

Epidemiological role of shared crack inhalation devices in HCV infection examined in a number of studies

- History of sharing oral or intranasal devices associated with doubling of risk of HCV infection *(Tortu et al., 2004)*
- Sharing crack pipes and sharing when blood present associated with higher prevalence of HCV *(Howe et al., 2005)*
- Sharing crack inhalation equipment independently associated with HCV prevalence among 182 Spanish non-IDUs, elevating risk three fold (AOR=3.6; CI 1.3, 9.8) *(Macias 2008)*

Evidence of HIV and HCV Risks

- Documented HCV transmission from infected host onto paraphernalia as a precondition to host-to-host transmission via shared crack paraphernalia use possible (Fischer et al. 2008)

- Smoking crack found to be independently associated with HIV seroconversion, especially among women. (DeBeck et al. 2008)

Safer Inhalation in Canada

- 2007 – Anti-Drug Strategy
  - Elimination of harm reduction pillar
  - Shift from public-health oriented drug policy to criminal justice inspired initiatives
- Safer inhalation programs in operation in several Canadian cities
  - Many are run outside of public health

Ottawa Safer Inhalation Prog.

- Personal structured interviews with 550 street-recruited active IDUs who reported smoking crack in previous 6 months.
- Interviewed at four time points

6 months	PRE	112 crack-smokers
1 month	POST	114 crack-smokers
6 months	POST	157 crack-smokers
12 months	POST	167 crack-smokers

- Provided saliva samples for HIV and HCV testing.
- Compensated $10 CA.
- Extraction NEP program data.

Results: Program Uptake

Immediate, high and sustained

Direct users

80 %	1 month	POST
80 %	6 months	POST
87 %	12 months	POST

Direct and indirect users

81 %	1 month	POST	
86 %	6 months	POST	
94 %	12 months	POST	*p=.003*

Results: Sharing Smoking Devices

Decline in sharing crack-smoking equipment

85 %	6 months	PRE
85 %	1 month	POST
80 %	6 months	POST
80 %	12 months	POST

Among "sharers", significant decline in sharing every time

37 %	6 months	PRE	
31 %	1 month	POST	
12 %	6 months	POST	
13 %	12 months	POST	*p=0.001*

Results: Transitioning

Significant increase in smoking crack

Smoked crack in six months prior to interview

77 %	6 months	PRE	
86 %	1 month	POST	
89 %	6 months	POST	
97%	12 months	POST	$p \leq 0.001$

Frequency of smoking crack since availability of crack-smoking equipment

26 % "more"	6 months	POST
29 % "more"	12 months	POST

Results: Transitioning

Significant decrease in injecting drugs

Injected drugs in month prior to interview

96 %	6 months	PRE	
84 %	1 month	POST	
78 %	6 months	POST	
78 %	12 months	POST	$p \leq 0.001$

Frequency of injecting since availability of crack-smoking equipment

41 % “less”	6 months	POST
40 % “less”	12 months	POST

Scaling Up Harm Reduction

	6 Months PRE	1 Month POST	6 Months POST	Cumulative 12 Months
IDU ONLY	2,566	723	1,829	4,566
IDU and Smoke Crack	N/A	742	2,040	4,838
Smoke Crack ONLY	N/A	543	1,899	4,469

Conclusions - SIP Evaluation

Significant and sustained community and individual level harm reduction impacts:

- Increased availability and accessibility of resources to reduce the harms associated with smoking crack.
- Decrease in the frequency of engagement in the multi-person use of crack-smoking implements.
- Transitioning to smoking crack – significant predictor of injection cessation.
- Contact with previously un-engaged population at risk of the harms associated with drug use.
- Evaluation findings suggest the urgent utility of replicating this initiative at all NEPs.

Cancellation

- Safer Inhalation Program instituted April 2005
- 2007 July, Ottawa City Council voted 15 to 7 to cancel the Safer Crack Use Initiative – not enough evidence
- 10 community agencies continued program – but Ottawa Public Health 91% of 71,000 safer inhalation resources distributed.
- Currently AIDS Bureau funding program out of a CHC
- Comparison of PRE-cancellation behaviours among participants interviewed in 2006 with POST-cancellation 2008.

Safer Inhalation in Ontario

- 13 of 36 PHU in Ontario are distributing at least some safer inhalation supplies
  - Northwestern, Ottawa, Peterborough, Halton, Haliburton-Kawartha, Middlesex-London, Simcoe Muskoka, Thunder Bay, Toronto, Waterloo, Wellington-Dufferin-Guelph, Kingston and Durham.
- Often operated outside of public health
- Limits program reach

Prevalence of Crack Smoking

- (1,622) 1,643 active IDUs from 26 Public Health Units in Ontario
- (Sept 2006 – Aug 2007)May 2007 – March 2008
- Also *used* non-injection drugs in 6 months prior to interview: **97%**
- Top 3 non-injection drugs used the MOST

  (26%) 23% Crack

  (20%) 23% Marijuana

  (10%) 11% Alcohol

Smoking Crack

- (67%) 62% smoked crack in 6 months prior to interview
  - (64%) 65% at least once a week
  - (26%) 24% daily
- Average number of days smoked crack
  - (14 days) 13 days
  - 1 – 31 days
- Average number of times per day smoked crack
  - (22 times) 24 times
  - 1 – 1,000 times

Devices Used to Smoke Crack

- **Recommended**

(83%)	89%	Glass stems

- **NON Recommended**

(76%)	79%	Metal pipe
(71%)	74%	Pop can
(70%)	69%	Inhalers
(22%)	21%	Car antenna
(13%)	13%	Light bulb

Harms Associated with Smoking Crack

HIV- HCV-Related Practices

Multi-person Use of Smoking Equipment

- Passing on used drug-smoking equipment

  (78%) 78%

  (56%) 54% Every time/Frequently

- Smoking with used drug-smoking equipment

  (80%) 78%

  (48%) 49% Every time/Frequently

Needs of People who Smoke Crack

- 84% sites surveyed in Wave One Process Evaluation stated that safer inhalation equipment should be made available through the OHRDP for women and men who smoke crack.
- 70% sites surveyed in Wave Two Process Evaluation stated that the services provided within their PH region were NOT adequately serving the needs of non-injection drug users in their community.
- Not permitted to distribute or no money for safer inhalation equipment, no service for non-IDUs.

Reasons for Non-Distribution of Safer Inhalation Supplies

55%	Distribution not approved by MOH or Regional Board of Health
23%	No financing available to purchase
22%	Supplies not available for distribution
10%	Not yet sought approval from PHU

Discussion Points

- Barriers to the provision of harm reduction resources go beyond financial considerations.
- Barriers to the provision of harm reduction resources go beyond lack of scientific evidence.
- Ideological and political barriers need to be overcome before people who use drugs can access the supplies needed to protect their health.

Thank you.

Andree Germain – agermai2@uottawa.ca

HIV & HEPATITIS C PREVENTION RESEARCH TEAM

University of Ottawa