NHS

National Treatment Agency
for Substance Misuse

The NTA's 2005 survey of needle exchanges in England

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April 2007

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The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

Document purpose	To provide the findings of a national study of needle exchanges, in response to the Department of Health's Hepatitis C action plan for England (2004).
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Circulation list	Commissioners of treatment services, coordinators and chairs of local partnerships (e.g. drug action teams and crime and disorder partnerships), regional government department leads on drugs, central government leads on drugs.
Description	This document aims to investigate the extent and nature of provision of needle exchanges and other harm reduction measures and to investigate issues relating to their delivery, commissioning and planning. It also aims to assess the levels and quality of data collection.
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Glossary

Drug action team (DAT) or DAT partnership will be used in this report as shorthand for all strategic partnerships.

Needle exchange will be used to refer to all types of distribution of sterile syringes and needles free of charge.

Specialist needle exchange will be used to refer to needle exchange provided by a specialist drug treatment services (Tier 2 and Tier 3 treatment).

Outlets and facilities will be used interchangeably to refer to all type of settings for needle exchange.

Pharmacy needle exchange co-ordinator will be used to refer to those have responsibility for co-ordinating pharmacy needle exchange schemes.

Region will be used as shorthand to refer to NTA regions that are co-terminus with Government Office regions.

1 National survey of needle exchange facilities

1.1 Introduction

This document reports the findings of a survey of needle exchange provision in England and other measures to reduce drug-related harm, specifically blood-borne infections. The survey falls within the Department of Health (DH) programme of work on blood-borne viruses and was initiated in response to the Hepatitis C Action Plan for England (DH, 2004). It was supported by the Department of Health.

The project was informed by a multidisciplinary advisory group of relevant stakeholders (including DH, The Royal Pharmaceutical Society of Great Britain, National Needle Exchange Forum, UK Harm Reduction Alliance and service users).

Linked surveys were carried out in Scotland, in partnership with the Scottish Executive Interventions Unit (EIU), in Wales, in partnership with the Welsh Substance Misuse Policy Development Team and in Northern Ireland, with the Department of Health, Social Services and Public Safety (DHSSPSNI). Cross-country comparisons will be included in a later publication when all data is collated and analysed.

This study was carried out between 1 November 2004 and 30 September 2005.

Gateway clearance was obtained from the NHS Review of Central Returns/Gateway (ROCR/05/003).

Three separate studies were conducted. This document reports on the findings of the quantitative arm of the study and the survey of DAT partnership joint commissioners or their equivalents, the survey of specialist needle exchange services and the survey of pharmacy needle exchange schemes. The findings of the two additional qualitative pieces of work that were conducted may be published separately.

1.2 Aims and objectives

Overall, the aims of the survey were:

- To investigate the extent and nature of provision of needle exchange and wider interventions to reduce drug-related harm, including blood-borne viruses (BBVs) in England
- To assess data reporting systems
- To investigate issues relating to the delivery, commissioning and planning of needle exchange and harm reduction services.

In order to achieve this, it was agreed to undertake the following tasks:

- Identifying the number, range and coverage of services that provide needle exchange and harm reduction services
- Gathering data on needle exchange activity, clients and distribution of sterile injecting equipment and other paraphernalia, as well as data on the return of used injecting equipment
- Examining aspects of the management, commissioning and planning of needle exchange and harm reduction interventions
- Investigating aspects of service delivery practice, policy and procedures
- Examining service users' views of the service provided and barriers to its use, and the perceptions of stakeholders (commissioners, providers and pharmacy needle exchange co-ordinators) on a range of issues related to needle exchange and harm reduction provision.

This document reports on the national and regional pictures. It investigates the assumption of large variability in needle exchange provision in terms of the planning and commissioning of interventions, as well as service delivery and data collection and management. It also looks at the strengths and weaknesses of needle exchange in this country and issues relating to practice (commissioning and service delivery). This work will contribute to the development of a better understanding of what a good needle exchange system should look like. The report will focus on the provision of needle exchange to adult populations but will look briefly at issues pertaining to young people.

1.3 Policy context and background

1.3.1 Policy context

It is estimated that there were 287,670 problem drug users (PDU) in the UK in 2001 and that 161,200 of them were presumed to be injectors (EMCDDA, Annual Report 2004). Injecting drug users have higher mortality rates than the general gender and age-matched population, with studies estimating that the risk of death among injectors to be over 13 times higher (Hulse *et al.*, 1999).

With the increasing prevalence and high incidence of hepatitis C infection among this group and in recognition of the public health importance of hepatitis C infection and its prevention, a separate Government strategy for England was published iby the Department of Health (DH, 2002). This report suggested how prevention, diagnosis and treatment should be improved.

The main proposals in the hepatitis C strategy included the following:

- Improving public awareness of hepatitis C by general and targeted health promotion campaigns on avoiding hepatitis C infection and seeking testing, where appropriate

- Efforts to prevent new cases of hepatitis C infection, particularly in relation to injecting drug users, with the continuation and improvement of harm reduction services, including needle exchange
- Diagnosing people at current or past risk of infection by raising awareness of hepatitis C and promoting testing for those at risk of infection in a range of clinical settings
- Managed clinical networks to provide accessible specialist assessment and treatment, where necessary, to people who have hepatitis C infection
- Improving the evidence base through epidemiological surveillance and research so that, for example, trends in hepatitis C infection in the population and the effectiveness of prevention measures can be monitored more closely and the future disease burden estimated.

The Hepatitis C Action Plan for England was subsequently published in 2004 (DH, 2004). It was based on good practice and served as a broad framework for the implementation of the strategy. The plan reflected existing work that should be sustained and intensified, and identified a number of new areas for action. The following set of four actions to be taken was identified:

- Improved surveillance and research in order to monitor trends and the effectiveness of prevention measures
- Increased awareness and reduction of undiagnosed infections
- High-quality health and social care services
- Intensified prevention efforts to reduce the spread of infection among at-risk populations.

The Hepatitis C Action Plan for England instructed the National Treatment Agency (NTA) to undertake this national survey of needle exchange services, including an assessment of throughput of needles and syringes across the country. The NTA was also requested to develop a national monitoring system and to monitor the offer and uptake of hepatitis C testing to all those attending drug treatment services.

From 1 April 2005, the NTA have been collecting, through partnership treatment plans:

- National information on the date of clients' last hepatitis C tests
- Data on whether a client was:
  - Offered hepatitis B vaccination and accepted
  - Offered and refused
  - Not offered
  - Already immunised.

Information is also collected on those who accepted the offer of immunisation on how many vaccinations they have received. Information gleaned to date is still patchy and does not reflect all of the treatment population, as data is collected on new clients coming into treatment since 1 April 2005.

Through Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006), the NTA is advocating a far greater emphasis on the reduction of drug-related harm, with particular emphasis on reducing the risk of immediate death due to overdose and risks of morbidity and mortality due to blood-borne viruses (BBVs) and other infections. The document advocates the commissioning and provision of a wide range of interventions to reduce the adverse effects of drug misuse. This may include responses at a commissioning and strategic planning level, and expansion and improvement in the provision of interventions to reduce drug-related harm.

Models of Care: Update 2006 recommends that harm reduction interventions may include increasing the availability of clean injecting equipment, interventions to encourage drug injectors not to share injecting equipment, encouraging ingestion methods as an alternative to injecting and attracting drug users into oral substitute treatment, where appropriate. Blanket vaccination of drug users at risk of hepatitis B infection is advocated and those already infected with BBVs should be encouraged to take action to improve their health, to reduce the risks of transmission of BBV to others and to link into appropriate medical services. It is noted that initiatives involving empowering services users or ex-users in initiatives to reduce the risks of BBV infection and overdose, through peer support or peer-led interventions, are generally welcomed by service users (NTA, 2006).

The Audit Commission report Drug Misuse 2004 (Audit Commission, 2004) introduced the concept of the "treatment journey", and one of the core recommendations of the report is that local partnerships monitor the "efficiency and effectiveness of the overall local service package" (Audit Commission, 2004, p55). The recommendation is based on the concept of drug treatment systems developed and structured to support drug users across their treatment journey, and this will include needle exchange services which have a central role in reducing harms, but also in providing services to those not in contact with structured treatment.

1.3.2 Surveillance of blood-borne infections

The seriousness of the spread of hepatitis C infection has also resulted in the publication of an annual report by the Heath Protection Agency (HPA) and its partner organisations to monitor blood-borne infections among drug misusers in the UK. Shooting Up: Infections Among Injecting Drug Users in the United Kingdom (HPA, 2005) aims to increase understanding of the distribution of infections and the types of behaviour which increase the risks of exposure to them.

Shooting Up reported that, in 2004, more than two in five injecting drug users had been infected with hepatitis C. In

England and Wales, transmission of hepatitis C was high, with one in six of those who have started to inject since the beginning of 2002 having become infected. This was higher in Scotland, with one in two who have been injecting for less than two years in 2004 being infected with hepatitis C. High estimated incidence among injectors with short injecting careers suggests that transmission may have increased recently (HPA, 2005). Overall, the high incidences and increasing prevalence suggest a deteriorating situation.

Up to the end of 2004, there were 46,349 cases of hepatitis C infection reported by laboratories in England, the majority of which would have been acquired through injecting. Research has suggested marked regional differences in the prevalence of hepatitis C. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey in 2004 (HPA, 2005) found that 42 per cent of injectors who took part in the study had antibodies for hepatitis C, with 20 per cent in the North East, compared with 55 per cent in London and 59 per cent in the North West (HPA, 2005: p15). In 2004, approximately half of the injectors with hepatitis C in the UAPMP survey were not aware of this fact, despite an increase in the uptake of testing; this is however an improvement on the 60 per cent who did not know whether they carried infections in 2000 (HPA, 2005).

The transmission of hepatitis B (and A) has also continued among this group although effective vaccines are available and uptake has increased markedly in recent years. In 2004, 21 per cent of IDUs who took part in the UAPMP survey had antibody to hepatitis B core antigen (HPA, 2005). There has also been, in recent years, a growing problem with injection site infections associated with methicillin-resistant *Staphylococcus aureus* (MRSA) and severe group A streptococcal infection, as well as continued occurrence of wound botulism (HPA, 2005).

HIV infection remains rare among injectors in the UK, but there is, nonetheless, some evidence of ongoing and possibly increased prevalence and incidence. Surveillance data from the voluntary unlinked anonymous cross-sectional surveys in England and Wales showed that HIV prevalence among IDUs declined from 5.9 per cent in 1990 to 0.6 per cent in 1996 and then remained stable until 1999. However, rates have risen again to 1.4 per cent in 2003 and prevalence among short-term injectors has increased, suggesting a situation very different from between 1994 and 1999, where very few new HIV infections were detected among this group. HIV among injectors in London has remained substantially higher than in the rest of the country, including among new injectors, with around one in 25 IDUs in London HIV-positive (Hope *et al*, 2005).

Research also suggests an increase in risk behaviour. In the late 1990s, the reported levels of direct sharing during the previous month increased from earlier in the decade and this higher level of sharing has been sustained. The sharing of needles and syringes was reported by 28 per cent of the participants in UAPMP survey in 2004. The sharing of paraphernalia was at even higher levels, with 50 per cent of current injectors reporting, in the UAPMP agency survey, the sharing of items such as filters, spoons and flushing water and this remains at high levels in England (HPA, 2005).

The apparent increase of crack injecting reflects evolving patterns of drug use and risk, and provokes questions on appropriate services responses. There is evidence that crack injectors engage in higher levels of risk behaviours and there is emerging evidence of higher rates of hepatitis C infection and HIV infection. Crack injecting currently appears to be focused in particular areas of the UK, but there is evidence to suggest that both the use and injection of crack cocaine are becoming more widespread (HPA, 2005).

1.3.3 Needle exchange interventions

The idea of distributing sterile injecting equipment to drug users was first advanced by a pharmacist in Edinburgh, following an epidemic of hepatitis B and C between 1982 and 1984, and in Amsterdam in 1983 after an outbreak of hepatitis B. In both cases this was initially overruled by the authorities, but the advent of HIV gave momentum to this work. In 1987, 15 pilot schemes were established in England and Scotland and by 1989/90, a survey estimated that there were approximately 120 outlets in England, distributing in the region of four million syringes (Donoghoe, Stimson & Dolan, 1992). By 1997, there were over 2,000 outlets in the UK operating from specialist services and community pharmacies, distributing an estimated 27 million syringes (Parsons *et al.*, 2002). Today, needle exchange facilities in the UK are well-established cornerstones of harm reduction strategies not only in this country, but also in more than 40 countries worldwide.

The effectiveness of needle exchange programmes in the prevention of HIV is now well established, although a few North American studies have shown a negative or neutral effect of these programmes. Overall, a World Health Organization international evaluation of the effectiveness of needle exchange for the prevention of HIV at a global level, and in different contexts and settings, concluded there is compelling evidence that increasing the availability and utilisation of injecting equipment by IDUs (injecting drug users) reduces HIV infection substantially. It also showed that these programmes are cost-effective, have additional and worthwhile benefits in addition to reducing HIV infection and that there is a lack of convincing evidence of any major unintended negative consequences. However, the review also showed that needle exchange programmes are not enough on their own to control HIV infection, but must be considered as part of a wider system, which includes a range of other complementary measures (WHO, 2004).

Hepatitis C, however, posed a challenge to the evidence on the efficacy of needle exchange programmes in prevention of all blood-borne viruses. Although it can be assumed that without these measures the spread of infection would have been worse, it has been noted that preventing hepatitis C requires much more ambitious strategies that aim to eliminate even occasional high-risk behaviours, including not only the sharing of needles and syringes, but also of any other injecting paraphernalia. In his review of the literature, Ashton (2004a) concluded that, in the UK, the supply of injecting equipment falls short of demand and that trickle-feed or limited needle exchange does not work, or at least not well enough. Ideally, a sterile needle and syringe should be available for each incidence of injecting, making it at least as easy to use a new needle as a previously used one. Moreover, clean equipment and paraphernalia are not sufficient on their own and enhanced and comprehensive risk reduction strategies have been called for (Ashton, 2004b).

Shooting Up (HPA, 2005) makes a number of similar recommendations for the commissioning of treatment services for drug users. Priorities for commissioning include the development of high-quality needle exchange services with sufficient coverage to prevent sharing. Such services should also provide:

a Information and advice on safer injecting practices, on avoiding injecting site infections, on the prevention of BBVs and on the safe disposal of used equipment

b Injecting-related equipment or paraphernalia in addition to sterile needles and syringes

c Easy access to other on-site services such as immunisation, health checks and diagnostic tests. It is noted that these services are more likely to be effective if provided through specialist services staffed by trained drug workers and nurses rather than in pharmacies.

Other priorities identified by the 2005 update of Shooting Up are easy access to hepatitis B immunisation and strategies for completion of vaccination courses, to consider incorporating hepatitis A immunisation and tetanus vaccine booster, and improvement of access to diagnostic testing for hepatitis C. Shooting Up also identified, as a priority, easy access to the range of treatment and support services for all those who wish to cease injecting, or to reduce their drug use. It called for the development of BBV prevention mechanisms, such as needle exchanges, which can respond in a timely fashion to evolving patterns of drug use and risk, such as crack injecting. The report also recommended that consideration should be given for the establishment of a UK-wide system for monitoring the form and extent of needle exchange provision, a recommendation also made by the Hepatitis C Action Plan for England, and which is being developed for implementation by the NTA. Other research has also noted that it is critical that harm reduction measures are invigorated and evolved in response to changes in drug use risk behaviours and policy (Hope *et al.*, 2005).

This survey will contribute to the process by gauging if and how current needle exchange and harm reduction interventions in England meet the recommendations identified by the evidence. The survey will also identify what additional work is required at local and national levels to ensure there is a system in place that can tackle the issues of the reduction of blood-borne viruses and harm reduction effectively.

1.4 Design and methods

1.4.1 Multi-method study

This study was designed to elicit local information from people working at the strategic level (commissioning level) as well as the two operational levels of service provision (specialist needle exchange services and pharmacy schemes). Some work was also carried out with users.

A multi-method approach was adopted by this study as both quantitative and qualitative research methods were used:

1 The quantitative element consisted of three postal questionnaire surveys:

- A survey of DAT partnership joint commissioning managers or their equivalent (referred to as the DAT partnership questionnaire)
- A survey of specialist needle exchange services (referred to as the services questionnaire)
- A survey of pharmacy needle exchange co-ordinators (referred to as the pharmacy co-ordinator questionnaire)

2 The qualitative element consisted of:

- Focus groups with the following:
  - DAT partnerships and joint commissioning managers, where appropriate
  - Service providers
  - Pharmacy needle exchange co-ordinators
- An in-depth exploration of service users' perceptions as well as those of providers (community pharmacists and specialist services).

Through the three components, the study gathered data from all 149 English DATs or equivalent partnerships. This therefore provided a comprehensive national picture and allowed for the investigation of the variations that existed between local DAT partnerships and wider regions.

An identical exercise was also carried out in all of Scotland, Wales and, to some extent, Northern Ireland. Data from all these studies will be combined to form a wider national picture as well as

differences that may exist between all home countries. The findings of the UK survey will be published at a later stage.

This document reports on the findings of the qualitative arm of the study only. Reports of the findings of these two studies will be published separately.

1.4.2 Compiling a list of needle exchanges

A survey of needle exchange facilities was dependent on the existence of a list of such facilities. However, a comprehensive list did not exist and one was compiled for this study, which included pharmacies involved in needle exchange schemes as well as specialist services. It took three months to develop a list to identify the number, range and coverage of all needle exchange outlets.

The pharmacy database was compiled by accessing and crosschecking existing databases, for example, the nhs.uk website (http://www.nhs.uk/England/Pharmacies/Default.aspx) and the Prescription Prescribing Authority. A short survey of all local pharmaceutical committees (LPCs) was conducted by the Pharmaceutical Society Negotiating Committee. The services database was compiled by requesting from DrugScope a list of all Tier 2 and Tier 3 specialist drug services, then telephoning each in turn to establish whether or not they provided a needle exchange service. A final check for accuracy of both databases involved sending all (149) joint commissioning managers a list of all needle exchange pharmacies and services in their area and asking them to update this list if necessary.

1.4.3 Strength and weakness of data

The quantitative component of the study looked at the two levels of commissioning and service delivery through three separate survey tools or questionnaires. Overall, there were satisfactory response rates. A total of 328 questionnaires were returned and analysed from across the 149 DATs, thus giving a comprehensive picture of the situation in England. Together, the three sets of questionnaires showed broadly similar trends and patterns. Overall, the triangulation of data suggests that confidence can be had in the trends and patterns shown by the survey, but specific calculations on throughput must be treated as indicative.

The study provides information on activity and distribution based on available information and data already collected at DAT partnership and provider levels. This affected the quality of the survey results in the following ways:

- Findings were often based on a limited number of responses to the relevant questions, particularly but not exclusively in the DAT questionnaire. Overall, service providers and pharmacy co-ordinators were more likely to provide data on their facilities and data provided by the services questionnaire and the pharmacy co-ordinators questionnaire was more complete. However, even in these cases, the response rate for some questions was poor
- Findings were based on information which could be unreliable or incomplete
- Different methods of data collection were utilised by the different DAT partnerships or providers. This has limited in particular, questions relating to age group.

1.4.4 Analysis of data

The data from the survey results was analysed using the computer programme Statistics Package for Social Sciences. Analysis has demonstrated the very high variability between DATs and providers. In order to illustrate this variability, the range of values will be provided. Data on needle exchange throughput and activity was also highly positively skewed, which means that a small number of DATs or of providers reported very high activity throughout. In order to account for that, emphasis should be placed on median values rather than the averages or means.

This document will not provide any national estimates on activity and throughput based on these data. This will require complex statistical analysis and will be carried out at a later stage.

All data in this report and specifically data on needle exchange throughput and activity relates to the period April 2004 to March 2005.

2 Results of the joint commissioners (DAT) questionnaire

2.1 Response rate and identification of the sample of respondents

Questionnaires were sent to joint commissioning managers, or their equivalents, in all 149 English DATs or other strategic partnerships. The overall response rate was 74 per cent.

The questionnaire was aimed at DAT joint commissioners or their equivalents. However, less than 60 per cent of questionnaires were returned by commissioners or others working within a joint commissioning group or DAT. The questionnaires were often passed on to other professionals; usually (but not exclusively) needle exchange service providers or needle exchange co-ordinators. Even those questionnaires that had been returned by commissioners had very often been filled in by providers or co-ordinators. This is particularly the case for questions on activity and distribution numbers.

This is, in itself, a significant finding of the audit. It suggests that in many DATs comprehensive information on the provision of needle exchange was not held centrally by the commissioning group or equivalent body and there was no central data management on needle exchange to inform planning and commissioning. The aim of the DAT questionnaire was to investigate issues at a strategic level. What the audit suggests is that, in many areas, work on needle exchange at this strategic level is absent or limited. This finding was compounded by the particularly poor response rate by DAT respondents to questions relating to needle exchange throughput and activity, even where a questionnaire was returned. The paucity of data collection and management on needle exchange activity will be discussed further in section 2.5.

Responses were received from DATs in all Government regions, with a better response rate from some regions than others (for a full list of response rate by region, see Appendix).[1]

DATs surveyed were located in the range of settings, from the most urban to the most rural, based on categories developed by the DfES for PCTs and adapted to DATs by the NTA – ranging from one (most urban) to six (most rural). However, DATs in category one formed 40 per cent of all respondents (for a full list of number of DATs by setting, see Appendix).

2.2 Co-ordination of needle exchange services at a DAT level

In 71 per cent of DATs responding (n=78), there were individuals with responsibility for the co-ordination of needle exchange facilities.

A larger percentage of DATs had individuals with responsibility for co-ordinating the pharmacy exchange scheme (81 per cent; n=89). In 13 per cent of cases, this was the same individual who co-ordinated needle exchange facilities as a whole.

There were significant differences by region ($p<0.001$) in the availability of a DAT-wide needle exchange co-ordinator. DATs in the Yorkshire and Humber region were least likely to have such a post and those in the East of England and South West regions were most likely to do so (for more detail see Appendix). No regional differences were found in availability of pharmacy co-ordinators.

There was no consistency in the type of organisation that employed a needle exchange or a pharmacy exchange co-ordinator, as can be seen in table 1. Nonetheless, needle exchange co-ordinators were most likely to be employed by provider organisations (71 per cent) and less likely to be employed directly by the DAT or the commissioning group (19.4 per cent). Other types of organisations (including PCTs, community pharmacists, public health departments, hospital trust pharmacy departments and local authorities) were the employers of needle exchange co-ordinators in eight per cent of cases, and in 1.5 per cent these were joint appointments.

Just over half of pharmacy co-ordinators were employed by provider organisations, but a significant number were also employed by PCTs, the DAT or by other organisations such as hospital trust pharmacy departments, community pharmacies and trusts.

There was also no consistency in the type of professional employed for the co-ordination of needle exchange facilities in

	5-25% (WTE)	26-50% (WTE)	51-75% (WTE)	76-100% (WTE)	Don't know
DAT needle exchange co-ordinator	29.3%	24.1%	10.3%	34.5%	1.7%
Pharmacy scheme co-ordinator	23.6%	40%	1.8%	21.8%	12.7%

Table 1: Time allocated to co-ordination of needle exchange and of pharmacy scheme by percentage of DATs

[1] Because of the very small number of responses from the East Midlands, data on this region will be combined with those of the West Midlands in the analysis of regional differences

a DAT, or the needle exchange schemes. A very wide range of job titles for co-ordinators was provided. This included but was not limited to the following: pharmacy or needle exchange co-ordinator, health promotion nurse, clinical manager, joint commissioning manager, outreach worker, community pharmacist, pharmaceutical advisor, head of medicines management, drug worker, primary care liaison worker, practice development manager, shared care scheme officer, receptionist and administrator. This implies that the role of the co-ordinator was often merged with other tasks and that people of very different types of expertise and levels of seniority were employed.

There was also no consistency in the time allocated by people in post for the co-ordination of a DAT's needle exchange scheme or a pharmacy exchange scheme. In both cases, this varied and ranged from five per cent to full time (100 per cent). Like the data on the type of professional employed, data on the time allocated to the co-ordination of needle exchange suggested that the role of the co-ordinator was often merged with other tasks.

2.3 Range and number of needle exchange services

Data from the DAT questionnaires suggests that needle exchange outlets were available in all DATs surveyed (either specialist services or pharmacy-based needle exchange or both).

It is not possible to identify clearly the number of facilities that existed in all DATs surveyed, as not all respondents provided information on the number of services and pharmacies involved in needle exchange in the DAT.

Only 108 respondents provided information about facilities providing needle exchange. These were divided along the following types:

- Specialist needle exchange services: (n=261)
- Pharmacies: (n=1,048)
- Other (n=116).[2]

The overwhelming majority of these were outreach or mobile services (n=99) and were generally managed and run from fixed based needle exchanges. In addition this number of includes needle exchange facilities in 14 custody suites and three A&E departments.

Therefore, the 108 respondents reported a total of 1,425 facilities, although as mentioned in the paragraph above, most "other" facilities (n=116) were part of wider needle exchange facilities. These were therefore not counted separately from specialist services. This gave a total of 1,326 reported facilities – 1,309 pharmacies and specialist services and 17 facilities in custody suites and A&E departments.

What is significant about these figures is that they suggest that approximately 80 per cent of needle exchange facilities operate from pharmacies and that 20 per cent were provided by non-pharmacy services. If all outreach services were included as separate services from the agencies that ran them, the proportion of pharmacies would be approximately 74 per cent of all facilities.

Further information about the "mixed economy" of facilities is also provided by the DAT questionnaire and clearly shows that there was great variability between DATs in the number of specialist services and needle exchange pharmacies they had. To illustrate this variability, the range of the number of facilities is listed below as well as the average number.

In particular, the DAT survey suggests that specialist needle exchange services were available in all but two of the DATs surveyed (one DAT did not provide any information).[3] The number of specialist services offering needle exchange in each DAT ranged from one to ten services per DAT, with a mean of 2.4 services per DAT (median = 2.0).

Data also suggests that pharmacy exchanges were available in all DATs. The number of pharmacies offering needle exchange within a DAT ranged from one to 58 pharmacies per DAT, with a mean of 11 pharmacies and median of eight pharmacies per DAT. This average number of pharmacies per DAT was corroborated by the survey of pharmacy co-ordinators, which also showed an average of 11 pharmacies participating in each scheme in each DAT (median = 8.0).

Twenty-three DATs reported providing needle exchange from other settings, in some cases more than one such service (outreach services, mobile services, home delivery custody suites, A&E departments and "other").

2.4 Needle exchange coverage

There is an assumption that needle exchanges must be within five miles of all residents, if they are to be accessible. This figure must, however, be treated with caution. It can be meaningless in a large urban setting such as London where five miles could be a different DAT area and may be meaningless in a rural setting where any type of amenity (such as shops and post offices) could be well beyond this distance.

With this limitation in mind, the DAT questionnaire shows that in 54.5 per cent of DATs, all residents have access to specialist needle exchange services within five miles of their place of residence. In 67.3 per cent of DATs, all residents have access within five miles of their place of residence to a pharmacy that exchanges syringes. Thirty DATs (27.3 per cent) reported having other types of needle exchange services within five miles

[2] Some DATs have more than one such service whilst others have none; the overwhelming majority are managed by and run from fixed base NeX services

[3] Both DATs who had not identified a specialist service have a low prevalence injecting rate (based on Frischer, Heatlie and Hickman, 2004 estimates); both have pharmacies involved in a needle exchange scheme.

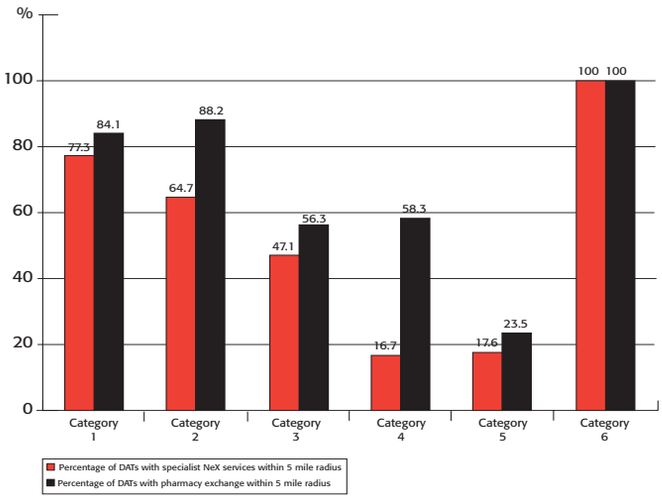

Figure 1: Percentage of DATs access to a specialist needle exchange and to a pharmacy exchange within five miles of residence by urban/rural variation[4] (1 = most urban; 6 = most rural)

(e.g. outreach services, home delivery, custody suites, mobile services, health centres).

It is perhaps not surprising that there were also significant differences based on rural versus urban variations ($p<0.001$) as shown in figure 1.[4]

Figure 1 shows that, in general, urban areas were more likely to have a specialist needle exchange and a pharmacy within a five-mile radius for all injectors. The exception was services in category six although the very small number of DATs involved (n=2) makes it difficult to generalise. Nonetheless, data suggests that rurality does not have to imply lack of access and that these DATs provide models of good practice.

What the data also suggests is that variations between rural and urban areas alone do not necessarily determine accessibility. Differences existed within DATs of each category, showing that an urban setting did not guarantee access and that a rural setting did not necessarily imply lack of access. This shows that variability exists between services and that there often was no rationale for this variability.

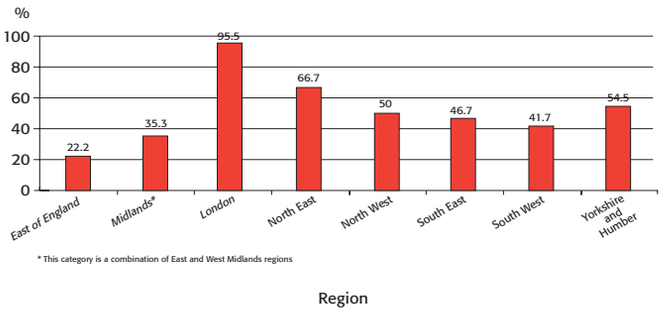

Figure 2: Percentage of DATs in each region with access to needle exchange service within five miles

There may also have been significant differences in access to both specialist services and to pharmacies based on government region ($p<0.001$ and $p<0.001$ respectively). This can be partially, but not exclusively, explained by variations in population density and settings. Figure 2 looks at access to a specialist needle exchange within a five mile radius by region. It shows not only variation between regions, but also the fact that the accessibility of specialist services in terms of proximity is generally poor. Figure 2 highlights particularly poor coverage by specialist needle exchange services in the East of England region.

2.5 Data management

With some notable exceptions, the collection or central holding of data by DATs was poor. As can be seen in section 2.5, only a minority of respondents were able to provide figures and this limits the quality of the data.

Data on activity was also affected by the variability between DATs, and this is illustrated below by the range of the values. Data was also highly positively skewed (which means that a very small number of DATs had very high levels of activity). In order to account for this, emphasis must be place on the median (midpoint) rather than mean or average values.

2.5.1 Activity monitoring

The majority of respondents (89 per cent) said that needle exchange activity was monitored by contact (visits and transactions) and 64.5 per cent said they monitored the numbers of clients. More than half of all DATs surveyed (61 per cent; n=67) said that information is collected by both contact and client.

However, only a much smaller number of DATs provided actual numbers for the period of April 2004 to March 2005, as requested. A small number of those who failed to do so reported that data collection systems have only been recently introduced and figures for that period were unavailable. Others stated that data was not kept electronically and was therefore difficult to retrieve.

2.5.1.1 Contacts

All contacts: Only 36 respondents (33.3 per cent) provided figures for the total number of contacts (visits and transactions) for all needle exchange facilities in their DAT for April 2004 to March 2005. The total recorded number of contacts was 389,183 across the 36 DATs. Contacts ranged from 104 in one DAT to 36,768 contacts in another, with a median of 8,089 visits (mean = 10,810). In all but one case, the number of contacts exceeded 1,000.

[4] DEFRA categories are as follows: 1= Urban Less Sparse (most urban), 2 = Urban Sparse, 3 = Rural Less Sparse Town & Fringe, 4 = Rural Sparse Town & Fringe, 5 = Rural Less Sparse Village & Dispersed, 6 = Rural Sparse Village & Dispersed (most rural)

Contacts with specialist services: A larger number of DATs (n=44) provided data on the number of contacts by specialist services for the same period. The total number of contacts reported was 139,548 in the 44 DATs. These ranged from 16 in one DAT to 11,964 contacts in another, with all but two having more than 144 contacts in that period. The median number of contacts with all specialist services in a DAT was 2,031 contacts (mean = 3,207).

Contacts with pharmacies: Thirty-one DATs (28 per cent) provided information on contact with pharmacies within the same timeframe. The total number of contacts reported was 229,806 across 31 DAT areas. Contacts ranged from 104 to 28,500 contacts per DAT, with a median of 4,292 per DAT (mean = 7,413).

Contact with other (e.g. outreach and A&E): A small number of DATs (n=9) provided data on contacts in other settings. These ranged from 14 to 9,950.

There were no significant differences by region.

2.5.1.2 Clients

Data on clients was particularly poor and here too, focus should be placed on mean values.

All clients: Only 21 DATs provided actual figures for the total number of clients seen by all needle exchange facilities in the period March 2004 to April 2005.

Numbers of clients per DAT: This ranged from 104 to 15,907 clients,[5] with a median of 698 per DAT (mean = 2,007 clients).

Clients of specialist services: A larger number of DATs (n=36) provided data on clients of specialist services. The total number of clients was 21,784.

Number of clients of needle exchange services per DAT: This ranged from nine to 4,185 clients, with a median of 305 clients per DAT (mean = 605 clients).

Clients by pharmacies: Twenty-one DATs provided data on pharmacy clients. The total number of clients reported was 15,360.

Numbers per DAT: This ranged from 60 to 15,279,[6] with a median of 560 clients per DAT (mean = 1,170).[7]

2.5.1.3 Number of contacts per client (per year)

Data on number of contacts per client per year is limited by the very poor response rate to the relevant questions (April 2004 to March 2005). Nonetheless, the data suggests the following:

- Total contacts (specialist services and pharmacies) range from one to 28 contacts per client annually (overall average = 5.9 visits)
- Contacts with specialist service per client per year range from 1.16 to 27.2 annually (overall average = 4.6 visits)
- Contact with pharmacies range from one to 28 (overall average = 5.2 visits).

2.5.1.4 Monitoring client demographics

Data suggests that needle exchange clients were most likely to be adult males. The limited data available shows no significant differences by region but large variations by DAT in the gender ratio by contacts as can be seen below. Women injectors in some DATs were much more likely to use needle exchange services than in other DATs.

- Contact with all needle exchanges outlets by gender: Male to female ratio 3.6:1 (ranged from 2.23:1 to 9.67:1)
- Clients of all needle exchanges outlets by gender: Male to female ratio is 4.1:1 (ranged from 1.63:1 to 16.5:1).

Services in 75.5 per cent of DATs reported that they monitor gender, 64 per cent monitor age, 88 per cent monitor ethnicity and 55.6 per cent record information on main drug injected. Again, only a small number of DATs provided actual figures, making any analysis meaningless.

2.6 Distribution of injecting equipment

Information provided on the amount of injecting equipment distributed and returned also suffered from a poor response rate to the relevant questions.

Although the majority said that they collected the relevant information, only a small number of services were able to provide figures on the number of syringes distributed by all outlets (36 DATs), by services (41 DATs), by pharmacies (43 DATs) and by other outlets (ten DATs). The total number of syringes distributed in these responding DATs is 9,936,746 (numbers distributed by services, pharmacies and other outlets).

Overall, pharmacy exchange schemes distributed a similar number of syringes and needles as specialist services:

- Total number distributed by services: 4,822,475 syringes
- Total number distributed by pharmacies: 4,846,253 syringes
- The total number of syringes distributed by all facilities in DATs ranged from 3,171 to 1,200,000 (median = 149,950 syringes and mean = 276,031)
- The number of syringes distributed by specialist needle exchange services in each DAT ranged from 209 to 807,300,

[5] This very large number must be treated with caution, however, it was provided by a central London DAT which attracts a very high number of injectors. These may be using local services, but not necessarily living in the DAT.

[6] This very large number must be treated with caution, however, it was provided by a central London DAT which attracts a very high number of transient injectors. These may be using local services, but not necessarily living in the DAT. The area also has a large homeless population

[7] The high mean was affected by the DAT mentioned above.

with a median number of 40,100 syringes per DAT (mean = 117,621)

- The number of syringes distributed by pharmacies in DATs ranged from 2,500 to 547,340 syringes, with a median of 85,000 syringes (mean = 112,703).

2.6.1 Syringes per contact and per client

The calculation of the number of syringes distributed per contact (or visit) is also limited by the poor response rate to questions on numbers of contacts and clients and questions on amount of equipment distributed. With these limitations in mind, the data suggests that:

- Numbers distributed by services per contact ranged from one syringe to 173 syringes (overall 27.5 per contact)
- Numbers distributed by pharmacies per contact ranged from one to 55 syringes (overall 16.2 per contact).

The calculation of the number of syringes per client (for the April 2004 to March 2005 period) is limited by an even smaller number of responses to the relevant questions. Nonetheless, data showed the following:

- Numbers of syringes distributed by services to individual clients annually ranged from 1.6 to 921 syringes (average = 196 syringes)
- Numbers of syringes distributed by pharmacies per year to individual clients per year ranged from 27 to 372 (average = 67.5 syringes).

2.6.2 Conclusions of data of syringe distribution

Overall, data suggests that although pharmacies and services distribute similar amounts of injecting equipment per year, numbers of contacts (or visits) to pharmacies are higher. However, specialist services provided more injecting equipment annually by contact and by client.

Data also suggests that in very many DATs, the numbers of syringes given to clients fall short of the ideal of ensuring that injectors have access to a new piece of equipment for each injection. This is particularly the case for crack injectors. There are some DATs where numbers appear to be more adequate, but inferences here are restricted by data limitations and marked by variability across respondents where data is available.

2.7 Return of injecting equipment

Data on the number of returns of used injecting equipment is also limited by a very poor response rate to relevant questions. Although a large percentage of DATs stated that they did collect this information, only a few were able to provide actual figures for the March 2004 to April 2005 period (22 DATs reported number returned to all facilities, 29 DATs reported numbers returned to specialist services and 19 DATs reported numbers returned to pharmacies).

The total number of returns reported was 4,042,452 syringes, which indicates a ratio of 1.9 distributed for one returned.

Only a small number of DATs provided data on the number of syringes returned to drug services (2,976,100 syringes). This ranged from 158 to 622,464 returns, with a median of 39,822 returns (mean 102,624).

- Ratio of 1.2 distributed to one returned.

Only a small number of DATs provided information about returns to pharmacies (864,846 syringes), ranging from 1,000 to 148,693 (median 20,000, mean 45,518).

- Ratio of 2.6 distributed to one returned.

An even smaller number of DATs provided data on returns to other services (201,506 syringes)

- Ratio of 1.6 distributed to one returned.

Because of the very small numbers involved, it was not possible to look at regional differences, although these would suggest higher return rates to specialist services than to pharmacies.

2.8 Service provision and range of harm reduction interventions

In addition to sterile needles and syringes, a range of other harm reduction interventions and services are provided by needle exchange services. Table 2 shows the percentage of DATs

Intervention or service provided by specialist needle exchange services	% of DATS with at least one service that provides intervention
Paraphernalia	90%
Face-to-face harm reduction advice	97.3%
Referral to structured treatment	97.3%
On-site hepatitis B immunisation	60%
On-site hepatitis B testing	54.5%
On-site hepatitis C testing	51%
On-site HIV testing	39%
On-site pre and post-counselling for testing of BBVs	55.5%
Other psychosocial interventions	72.7%

Table 2: Services and interventions provided by specialist needle exchange services

Intervention or service provided by pharmacies	% of DATs
Face-to-face harm reduction advice	44.5%
Referral to structured treatment	45.5%
Injecting paraphernalia	65.5%

Table 3: Percentage of DATs with pharmacy schemes offering interventions

with at least one needle exchange service that provides particular interventions.

There were no regional differences in the provision of injecting paraphernalia, in the provision of face-to-face harm reduction advice or referral to structured treatment.

There were, however, significant differences by region in the provision of on-site hepatitis B immunisation by services ($p<0.001$), the provision of hepatitis B testing on-site ($p<0.001$) and the provision of hepatitis C testing on-site ($p<0.001$). In particular, services in the South West region were least likely to provide these interventions on-site and significantly less likely to have done so than DATs in the North West region in particular (for more detail, see Appendix). A similar finding was noted for hepatitis B on-site testing, with all DATs in the North West region having at least one specialist needle exchange service that provided hepatitis B testing on-site, with services in the South West region in particular least likely to do so (for more detail see Appendix).

2.8.1 Data conclusion

Overall, data suggests that DATs in the South West and the West Midlands regions were least likely to have services that provide BBV-related interventions on site. DATs in the North West region, on the other hand, provided injectors were most likely to have services that provide them on site.

2.9 Differences in access by setting

There were also significant differences by setting (urban versus rural) in injectors' access to hepatitis B immunisation ($p<0.007$) and testing ($p<0.003$). No significant differences were found in other factors, as can be seen in figure 3.

Figure 3 shows that injectors in urban areas were generally more likely to have access to services that provide hepatitis B immunisation and testing on-site, and that rural areas may have been poorly served in that respect. It is interesting to note that this was particularly so for categories four and five and less so for the most rural areas, a finding that will be replicated elsewhere. However, the data also shows that an urban setting did not

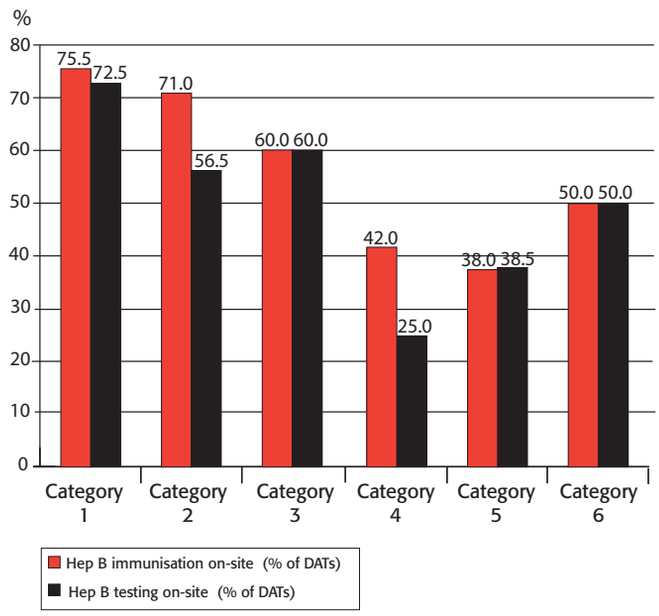

Figure 3: Percentage of DATs with at least one service providing hepatitis B immunisation and testing by rural/urban variaton. 1 = Urban Less Sparse (most urban), 2 = Urban Sparse, 3 = Rural Less Sparse Town & Fringe, 4 = Rural Sparse Town & Fringe, 5 = Rural Less Sparse Village & Dispersed, 6 = Rural Sparse Village & Dispersed (most rural).(DEFRA categories)

guarantee the presence of these interventions, but that variations exist between services, including those in similar settings.

Pharmacy schemes provided a much more limited range of interventions than services as expected. Table 3 shows the percentage of DATs with pharmacies schemes that provide particular interventions.

In approximately two-thirds of DATs, pharmacies provided some injecting paraphernalia. In just under half of DATs, pharmacies provide face-to-face harm reduction advice and referral to structured treatment.

However, caution must be used in interpreting these results: harm reduction advice can be a quick informal chat to accompany a leaflet and not structured work. Similarly, referral varies from giving the address of a service to writing a referral letter or telephone. Even in the best-case scenario, the clients of pharmacies did not receive comprehensive harm reduction support, which includes but is not limited to, limiting the harms of injecting by checking injecting sites and hygiene.

2.10 Drug litter and public health

Just over half of all DATs (54.6 per cent) reported recording reports of discarded used sharps in public spaces. Ten DATs provided figures on number of reports ranging from three to 4,118. Eighteen DATs reported recording reports of needle stick injuries. Less than

Target population	% of DATs
Homeless injectors	46%
Young injectors	45%
Sex workers	41%
Stimulant injectors	37%
Women injectors	34.6%
Steroid injectors	33.6%
Rural injectors	23.4%
Black and minority ethnic populations	17%

Table 4: Percentage of DATs that target specific populations

half of all respondents (41.2 per cent) were aware which organisations at local levels were responsible for drug litter.

2.11 Commissioning and funding

In the testing of knowledge of prevalence and needs, less than half of respondents (40 per cent) reported that they had an estimate of the prevalence of injectors in the DAT area in 2005. Figures were provided by 41 respondents (37.3 per cent). Estimates of the number of injectors in a DAT area ranged from 116 injectors to 4,500 injectors (mean = 1,636; median = 1,700).

Figures were derived from the following sources:

- Estimated (52.3 per cent of responses)
- Derived from locally commissioned research (13.6 per cent)
- Derived from national research (13.6 per cent)
- Derived from Frischer & Hickman (1999) study (20.5 per cent).

2.11.1 Sources of funding

Funding for needle exchanges in the majority of DATs (93 per cent) was reported to come from the pooled treatment budget, at least partially. PCTs also fund this intervention in 41 per cent of DATs, also generally in conjunction with funding from another source. In 41 DATs (37.2 per cent of all responses), funding is made available from both these sources.

Needle exchanges in five DATs are also funded by monies from other sources. This includes funding from social services departments (in four DATs) and funding from the DIP (in one DAT) and from the police (one DAT).

Problem	% of DATs
Budget shortfalls	46%
Planning permission	45%
Pharmacy withdrawal from scheme	41%
Obtaining insurance	37%

Table 5: Percentage of DAT partnerships identifying specific problems

2.11.2 Commissioning organisations

Although in the majority of cases (94.5 per cent of cases) the DAT joint commissioning group or manager is responsible for commissioning needle exchange facilities, they are also commissioned by other organisations – mainly the PCT (30 per cent) – and are in some cases jointly managed by more than one organisation. There were cases of needle exchange facilities been commissioned by social services (4.5 per cent) and other organisations (1.8 per cent).

2.12 Reaching diverse populations

Table 4 shows the percentage of DATs that had targeted particular population groups.

Respondents were requested to provide information on how this targeting was carried out, but only a few provided this information. Interventions identified included specialist workers (for example outreach homeless workers or Black and minority ethnic workers), targeted sessions or outreach (for example for the homeless or for working women), specific interventions (for example access of homeless users to showers, laundry and telephones in the needle exchange service). Other interventions aimed at specific groups included leaflets in community languages.

2.13 Problems affecting the provision of needle exchanges

Table 5 shows the percentage of DAT partnerships that identified specific problems. Only a small number of respondents gave actual details regarding the problems faced, despite being asked to provide the information.

Budget shortfall problems included no dedicated funding for paraphernalia and no dedicated funding for needle exchange workers or sterile equipment. Reported planning permission problems included difficulty in identifying suitable accommodation for a service and planning permission with restrictions on numbers of clients. Pharmacy-related problems included high turnover of pharmacists, inability to recruit new pharmacies and pharmacies

withdrawing from the scheme. Problems around insurance included increasing costs of insurance.

2.14 Conclusion

The DAT partnership questionnaire has shown a mixed economy of pharmacies and specialist needle exchange services, with the overwhelming majority of DATs having both types of facilities, albeit in different proportions and offering different levels of coverage. In general, specialist services provided a more extensive range of harm reduction interventions, suggesting that pharmacy needle exchanges should be developed as complementary to specialist services and not alternative models, if injectors were to receive comprehensive harm reduction support.

The survey has also shown large variations between DAT joint commissioning groups in their commissioning practice and in what is commissioned at local levels. Only in a minority of DATs do joint commissioners collect central information on the throughput of services and pharmacies. Similarly, interventions available to injectors in a DAT varied, with those in some DATs receiving a more comprehensive range than those in others.

3 Results of the services questionnaire

3.1 Response rate

A total of 263 questionnaires were sent to drug services providing needle exchange facilities. Information on 145 services was received, a response rate of 55 per cent. Responses were received from specialist needle exchange services in all Government regions, with a better response rate from some regions than others (for a full list of numbers of services by region, see the Appendix)

3.1.1 Ranges of setting

Needle exchanges operate in a range of settings, reflecting the geographic diversity of the country. These were scored between one and six, from metropolitan areas (one) to the most rural (six). There were more responses from services in category one settings (30 per cent of responses), closely followed, however, by services in category five (26 per cent). For a full list of response rates by setting see the Appendix. Additional information requested shows that specialist needle exchange services often served populations in more than one setting, for example in a small town and the surrounding rural areas.

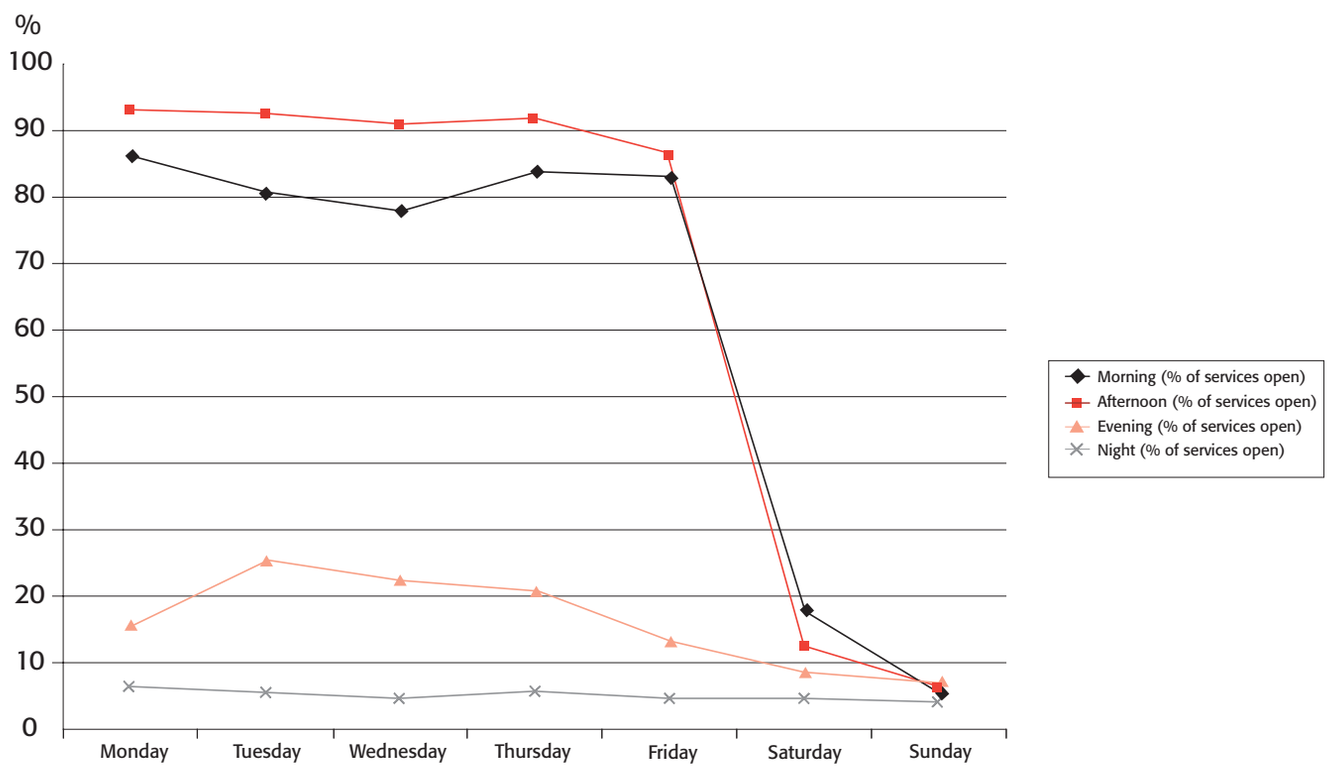

Figure 4: Service opening times

3.2 Types of needle exchange services

The services questionnaire shows that only ten per cent (n=13) of specialist needle exchange services were dedicated or standalone needle exchange services. The overwhelming majority were attached to a wider drug treatment service that provided other interventions (82 per cent).

Both types of specialist needle exchange services often provided needle exchange in more than one way, or in more than one setting. In 60 per cent of cases, needle exchange was carried out mainly in the agency itself, but also through outreach and mobile services or through peripatetic outreach in non-drug treatment settings. Specifically, these services surveyed offered 20 mobile facilities including home delivery, 29 outreach facilities and 16 exchange facilities in other outlets (e.g. constabulary hostels, A&E and health centres). It is also significant to note that 35 specialist services surveyed (24 per cent) were also managed or co-ordinated by the pharmacy needle exchange scheme of the DAT area.

There were ten (7.5 per cent) needle exchange services that were exclusively outreach, mobile or other types of services (the latter were usually located in Tier 1). This included two exclusively mobile facilities, two exclusively outreach facilities, one service that provided outreach and mobile facilities and five services that provided services from other types of facilities (Tier 1, including hostels, primary care clinic and A&E).

3.2.1 Treatment tiers

Needle exchanges located within wider treatment services were located in services across treatment Tiers 1 to 3. Specifically, they were located in services described in table 6.

Needle exchange services were therefore located in a variety of treatment services, ranging from Tier 2 drop-in advice and information services to Tier 3 community drug services or prescribing services. It is also interesting to note that a small number of services had established joint needle exchange outlets with Tier 1 services (non-specialist drug services such as primary healthcare centres, A&E or constabularies).

3.2.1.1 Accessibility – opening times

Opening times is a partial measure of accessibility of needle exchanges.

Weekday opening: The majority of services offered needle exchange in the mornings and particularly in the afternoons on Mondays to Fridays. A minority were open in the evenings (ranging from 12.5 per cent to 25 per cent of services depending on the weekday). Only a handful of services were available at night (ranging from five to seven services, depending on the night).

Service tier	
1 & 2	1%
2	27.7%
1, 2 & 3	2%
2 & 3	35.6%
3	29.7%
Young people's services	4%

Table 6: Locations of needle exchange services within other services

Weekend opening: A much smaller number of services are available at weekends. This suggested generally poor availability of needle exchanges outside office hours.

There were significant differences by service tier. Needle exchanges in Tier 2 services were more likely to be open on some weekday evenings and nights than those in Tier 3 services or combined Tier 2 and Tier 3 services ($p<0.009$), although the number of services operating at these times was small.

3.3 Activity and client data

3.3.1 Data collection

A considerable number of specialist needle exchange services collected some activity and other data, reflecting a situation quite different from that observed in DATs. Services generally provided more information on throughput than DATs.

Nonetheless, response rates to questions on activity and data collection was poorer than it was for other questions. Response rates for some questions were particularly low. Caution must be exercised in interpreting the figures in this section.

Here too, the data shows the very wide variability between services, and the range of values will be listed to illustrate this variability. Moreover, and like DAT-wide data, this data was highly positively skewed (that is, a small number of services had very high activity) and it is therefore important to focus on median values rather than mean averages.

3.3.2 Contact with needle exchanges

Data on the number of contacts (visits and transactions) was provided by 100 services. Some of those who did not provide data stated this was because services were either very new or that data was collected manually.

The number of contacts ranged from one contact (in this case a young person's service) to 33,287 for the period of April 2004 to March 2005. Excluding non-specialist drug services (those in Tier 1) and young people's services, all but one service had more than 50 contacts in this period.

The total reported number of contacts: 378,835, with a median number of 1,245 contacts per service (the average of 3,750 contacts).

A comparison number of contacts provided by the DAT questionnaire and the services questionnaire shows that the two questionnaires suggest a broadly similar median number of contacts, taking into account the fact that there was a median of two specialist needle exchange services per DAT.

3.3.3 Data by client

The number of clients of individual needle exchange services from April 2004 to March 2005 ranged from one to 4,988, with a total of 39,178 clients. Services with a small number of clients were also non-specialist drug services or young people's services.

Overall, the median number of clients of a service was 250 clients (and the mean was 493 clients). Numbers here too are smaller than those uncovered by the DAT questionnaire and result from the fact that DATs have in general a median of two specialist needle exchange services and average of 2.5.

3.3.4 Contact per client.

The average number of contacts per client with a needle exchange for the period from April 2004 to March 2005 ranged between 1 to 56.25 contacts. The overall average per client was 7.1 contacts for this period.

This rate of contact is higher than the one provided by the DAT questionnaire of (4.6 visits per year). This was calculated from a much smaller number of responses.

3.3.5 Client demographics

3.3.5.1 Gender

There was a great variation between services in the male:female ratio of their clients and their contacts. One of the services surveyed was a women-only service, but overall, males constituted the majority of clients of the majority of services.

- Gender ratio (contacts): ranges from 0 males to one female to 35:1
- Gender ratio (clients): ranges from 0:1 to 26:1
- Overall, the average gender ratio of contacts was: 3.9 males to one female
- Overall, the average gender ratio for clients was: 4.4 males to one female, suggesting that male injectors may have attended needle exchange services more often.

The DAT questionnaire showed slightly better female utilisation of needle exchanges, with a lower male to female ratio (3.6:1 for contacts and 4.1:1 for clients). Ratio calculations made in the DAT questionnaire however, refer to clients of all needle exchange facilities, whereas the present ones refer to those of specialist services only.

3.3.5.2 Young people

Although all but four services surveyed were adult services, more than a third (36 per cent) exchanged syringes for young people under 16 years old and 52 per cent to young people between 16 and 17 years old.

Approximately 60 per cent of all services said they had a written policy on needle exchange for young people (including 91 per cent of those who work with under-16 year olds and 84 per cent of those who work with 16-17 years old). In total, 28.6 per cent said that this policy has been shared with the area child protection committee (ACPC). This includes 70 per cent of those who work with those under 16 years old and 84 per cent of those who work with 16-17 year olds.

3.4 Distribution of injecting equipment

3.4.1 Syringes distributed

The majority of services provided a range of syringes of different sizes, particularly 1ml insulin (or microfine), 2ml and 5ml syringes. There were no significant regional differences, with the exception of the distribution of 10ml syringes, which were most likely to be given out in London.

Data on the number of syringes distributed was provided by less than 50 per cent of respondents. Figures provided show that 6,850,881 syringes have been distributed in the period between April 2004 and March 2005. This figure does not represent the total number of syringes distributed by all services surveyed, but only of those who have provided the information.

The median number of syringes provided was 43,587 per service (mean = 109,348).

The most widely distributed syringes are the "all-in-one" insulin or microfine needles and syringes, followed by other 1ml, 2ml, 5ml, 10ml and 20ml syringes (see figure 5).

Data shows that just under half of all syringes distributed (44 per cent) were all-in-one 1ml insulin syringes and needles. They also show that this and other forms of 1ml syringes formed the overwhelming majority of needles distributed. Only a very small number of large-size syringes (10ml and 20ml syringes) were distributed.

3.4.2 Needles distributed

In addition to the range of syringes distributed, a range of needles were also given out (mainly short orange or 0.5x16mm, green or 0.8x40mm, long blue or 0.6x30mm, short blue or 0.6x25mm, long orange or 0.5x25mm and brown or 0.45x10mm by order of magnitude). The total reported number of needles distributed was 3,102,350, but this figure is based on low response rate to this question. This figure provided for the total number of needles is smaller than that provided for syringes, probably because the numbers of all-in-one syringes and needles were not included in information provided.

A broadly similar number of needles of the various types were distributed, with the exception of brown needles, which were given out much less often, as can be expected because of their large size.

3.4.3 Syringes per client and per contact

The number of syringes distributed per contact (visit):

- Range: from one to 93 syringes per contact
- Overall average number of syringes distributed per contact: 25.5 syringes per contact

The number of syringes distributed per client per year (April 2004 to March 2005)

- Range: from nine to 713 syringes per client
- Overall average number of syringes distributed per client: 172 syringes per client per year. This average number is slightly smaller than the one identified by the DAT questionnaire.

3.5 Distribution of paraphernalia

The majority of services surveyed provided sharps bins, citric acid, swabs and condoms. A range of other items were distributed in other services, showing variation between services in the distribution of paraphernalia (see table 7).

There were significant regional differences in the provision of all items of paraphernalia, with the exception of condoms and sharps bins. Significant differences by region arose in the distribution of citric acid, despite legislation on this issue. Services in the East and West Midlands regions were less likely than others to provide citric acid; all those surveyed in the South West and

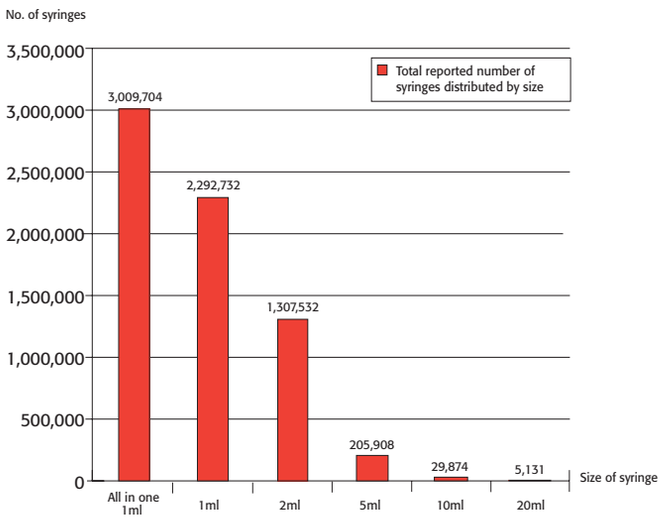

Figure 5: Distribution of syringes by size of syringe

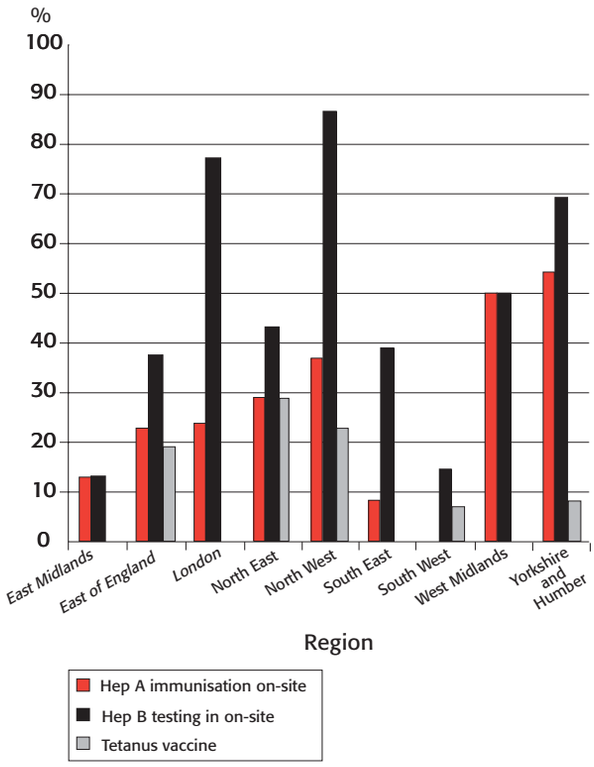

Figure 6: Percentage of services that provide immunisation on-site by region

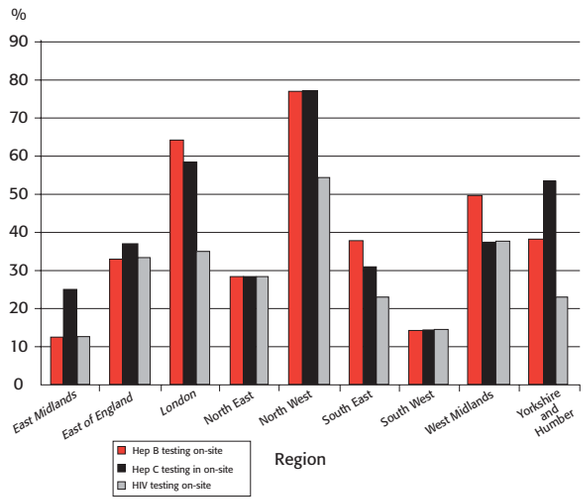

Figure 7: Percentage of services that provide BBV testing on-site by region

Yorkshire and Humber regions distributed it ($p<0.004$) (for more information by region, see the appendix)

There were also significant differences by region in the distribution of the following items; services in London and the North East were most likely to provide vitamin C ($p<0.018$); services in London and the North East were most likely to provide spoons ($p<0.004$).

There were also significant differences by service tier, as can be seen in table 7.

Tier 3 services were significantly less likely than Tier 2 and combined Tier 2 and 3 services to provide citric acid ($p<0.001$); they were also less likely to provide vitamin C and less likely to give spoons ($p<0.007$).

3.6 BBV prevention interventions

Testing for hepatitis C or B or HIV, as well as hepatitis B immunisation, were only carried out on-site in less than half the specialist needle exchange services surveyed (see table 8).

There were significant differences by region as shown in the figures below. Services in the South West and in the East Midlands regions were least likely to provide these interventions on-site, a fact also shown in the DAT questionnaire (see figure 7).

There were significant differences between regions in the immunisation of hepatitis A ($p<0.002$), hepatitis B immunisation ($p<0.001$) and tetanus. Figure 6 shows that the West Midlands and Yorkshire and Humber services were most likely to provide hepatitis A immunisation on-site. Services in the East Midlands and South West regions were least likely to provide hepatitis B immunisation on-site. Only a small number of services provided tetanus vaccines on-site and that this was not provided by services in the East Midlands, London, South East and South West regions.

Figure 7 shows that hepatitis B testing and hepatitis C testing and HIV testing on-site were least likely to be provided by services in the East Midlands and the South West – they were most likely to be provided in the North West, but the national picture is highly inconsistent. Data also shows that pre and post-test counselling for hepatitis and HIV was least likely to be carried out on-site in South West region services.

3.7 Other harm reduction interventions

There were variations between services in the types of harm reduction and interventions they provided.

Table 9 shows that a significant number of services did not provide the full range of interventions, including overdose prevention training and care for minor infections.

There were significant differences by region in the percentage of services that provided face-to-face harm reduction advice ($p<0.002$), keyworking ($p<0.002$), care for minor wounds and infections ($p<0.001$) and complementary therapies ($p<0.001$). Services in the North East were least likely to have keyworker systems. Services in London were also significantly more likely than all others to provide care for minor infections and wound dressing. Complementary therapies were found in all regions, with the exception of Yorkshire and Humber, where 25 per cent did not have them.

Item	% of services distributing item
Sharps bins	96.2%
Condoms	92.5%
Wipes and swabs	85%
Citric acid	80.5%
Filters	52%
Spoons	49%
Vitamin C	38.3%
Sterile water	26.3%
Tourniquets	18%

Table 7: Percentage of services that distribute paraphernalia items

Intervention	% of services offering intervention
Hepatitis B immunisation on-site	49.6
Hepatitis C pre and post-test counselling on-site	48.1
Hepatitis C testing on-site	43
Hepatitis B testing on-site	42.1
HIV pre and post-test counselling on-site	34.6
HIV testing on-site	31
Hepatitis A immunisation on-site	25
Tetanus vaccine and booster on-site	10.5

Table 8: Percentage of services that provide BBV prevention measures

Intervention	% of services providing intervention on-site
Motivational interview	95.5
Leaflets on needle exchange in DAT	83.5
Housing, welfare, legal advice	74.4
Face-to-face hard reduction advice	70.7
Counselling	70.7
Keyworking	62.4
Complementary therapies[8]	58.6
Referral to structured treatment	54.9
Care for minor infections, dressings	46.6
Overdose prevention training for clients	33.1
Well-women clinic	33.1
Primary care or GP sessions	27.1
Nutrition advice	15
Other[9]	18.8
Well-women clinic	8.2
Steroid injectors clinic	6.8

Table 9: Percentage of services that provide harm reduction interventions

There were significant differences by treatment tier in as much as needle exchange facilities located in Tier 3 services were least likely to provide motivational interviewing or interventions ($p<0.003$). They were also least likely to provide leaflets detailing all needle exchange facilities in the DAT ($p<0.001$).

3.8 Assessment and review of clients' needs

There appeared to be no uniformity in whether services carried out an initial assessment of new needle exchange clients.

Table 10 shows that, although a majority of services discussed with the client the issues listed during the initial assessment, very many do not. It can be noted for example that more than 40 per cent did not discuss testing for BBVs and hepatitis B immunisation, and a quarter did not discuss the risk of overdose. The majority did not discuss contact with primary healthcare.

There were no differences by region or by treatment tier. There were, however, some differences based on geographic setting categories, ranging from one (most urban) to six (most rural). There were differences in the percentage of services that discussed the assessment of the risks of sharing equipment ($p<0.001$), with those in rural areas in category five least likely to do so. Differences were also noted in the discussion of the risks of sharing paraphernalia ($p<0.003$), with those in category five also least likely to do so. Services in urban areas (categories one and two) were more likely to discuss testing for BBVs ($p<0.002$), and current involvement in treatment ($p<0.001$).

Similar findings were found regarding the discussion of BBV testing and of a client's current involvement in treatment.

Issues discussed in initial assessment of needle exchange clients	% of services
Sharing needles and syringes	84.2%
Sharing paraphernalia	81.2%
Disposal of used equipment	78.2%
Overdose risk	75.2%
Safer injecting techniques	70%
Injecting hygiene	64.7%
Vein care	63.2%
Sexual risk	63.2%
Alternatives to injecting	61%
Testing for BBVs	56.4%
Hepatitis B immunisation	56.4%
Referral to structured treatment	56.4%
Current involvement in treatment	56.4%
Health status	56.4%
GP registration	39%

Table 10: Percentage of services that discussion harm reduction issues as part of assessment

[8] Acupuncture, shiatsu, reflexology, yoga, person centred counselling, aromatherapy; electro-stimulation therapy, detox and 'sleepy tea', Reki, Indian head massage, NLP, hypnosis, life coaching, 'black box', Chinese herbal medicine.

[9] Including CBT, family/friends support group, neo-natal nurse, sexual health support, domestic violence support, relapse prevention, diversionary activities, 'rent and board' schemes, stimulants, relaxation techniques.

Another difference between urban and rural areas was whether services discussed with clients testing for BBVs ($p<0.002$) and their involvement in drug treatment ($p<0.005$). In particular, services in category five in particular were least likely to discuss these important harm reduction issues. Only a very small number of services were in category six, making generalisation meaningless. Services in rural areas with a five rating were less likely to discuss with clients in assessment the risks of sharing needles and sharing paraphernalia. They also show differences in the discussion of BBV testing and involvement in drug treatment.

Combined, the data shows that services in rural areas may be less likely to discuss a range of important harm reduction issues as part of a client's assessment. However, they also show that even if this more likely to be the case in urban areas, it is not always necessarily so, as sizeable minorities of services also did not address these issues.

There was also no uniformity in whether the needs of clients were reviewed. Services described their practices as follows:

- Reviews not systematically undertaken: 36.6 per cent
- Reviews are encouraged but are not a condition to continue accessing the service: 55 per cent
- Care planned reviews are a condition of continued access to injecting equipment: 4.6 per cent
- Other: 3.8 per cent.

3.9 Service policies

3.9.1 Maximum number of needles given out

There were differences between services in whether they distributed a maximum number of syringes at any one contact (exchange).

- Maximum number: six per cent of services had a pre-determined maximum number to be given out at each exchange
- No maximum number: 31.5 per cent had no pre-determined maximum number
- Variable: 42.5 per cent of services said that numbers given out varied.

There was no consistency in the maximum number of needles given out in one contact with service users. Reported numbers ranged from ten to 300. However, even when respondents said that there was a maximum number, other information in the questionnaire suggested that the number was often dependent on a number of issues, usually whether returns of used equipment have been made, for example, "100 if returns, five if no returns".

"Variable" numbers of syringes distributed depended on a variety of factors and often had an identified upper limit (in one case 600 syringes). Factors identified by respondents included the following:

- Whether returns have been made (for example: "100 syringes when returns were made but only five if no returns" or "if (client) is good at returning, will give in excess of 100")
- Numbers of returns (for example "can double number of returns" or "match clients returns")
- New clients versus known clients (for example "ten initially then 20")
- Location and accessibility (for example "30 per day for town residents; up to 100 to those who live outside town" or "if the service user does not live locally then we provide more")
- Type of drug injected and frequency of use (for example "steroid users often get more due to course of steroids they are on")
- Depends on "whether a person (is) running a small exchange service from their flat", "if taking syringes for squats and partners" (secondary distribution)
- Stock level
- Level of engagement with service
- Depending on "needs and health of client"
- Depending on client "history" and characteristics (e.g. "chaotic clients are encouraged to return to the service more often by providing them with minimal number of syringes").

It is therefore significant to note that in some services, the number of syringes distributed to individuals depended on a subjective decision made by the worker. The wisdom of this logic can be questionable, especially where the workers were not very experienced. One service stated that this decision was not taken by an individual worker but "through initial discussion with line manager and social worker and not an isolated decision by a needle exchange worker." This practice means that the decision was not taken by an individual and it could be too cumbersome.

3.10 Returning used injecting equipment

3.10.1 Policies on returns

In the majority of services, service users were encouraged to return used needles and syringes, but this was not a condition for accessing sterile injecting equipment. There were no significant regional differences. Specifically, the practice of services was described as follows:

- Strict one-to-one exchange: 0.8 per cent (one service)
- Returns always required: 3.1 per cent
- Service encourages returns but not a condition for accessing sterile injecting equipment: 93.8 per cent
- Other: 2.3 per cent.

However, and as discussed earlier, the number of needles given out was in general dependent on whether a service user had returned any used equipment. It appears that, formally or informally, services' policies on distribution and return of equipment were linked. In the majority of services, any injector that turned up was given some equipment but quantities depended on returns.

3.10.2 Drug litter – disposal of used equipment

There were also variations in the equipment and interventions provided to help secure a safe disposal of used injecting equipment and other drug litter. The majority of services still mainly depended on the distribution of sharps bins and through discussion with clients.

- Sharps bins: 98.3 per cent
- Written information: 45.7 per cent
- Discussion: 77.6 per cent
- Bins in hostels: 34.5 per cent
- Bins in public places: 15.5 per cent
- Bins in public lavatories: 11.2 per cent
- Other: 14 per cent.

This included:

- Large metallic bin outside agency to use when the agency is closed
- Local gym for steroid users
- Outreach training sessions in hostels, probation, alcohol and drug services on safer disposal issues
- Regular displays on safe disposal, needle finds and needle stick injuries in the community
- Bins in police custody suites
- Various incentives to encourage returns
- Night shelters.

There were some significant differences by service tier. Tier 2 services were significantly more likely than others to encourage safe disposal through discussion with clients ($p<0.001$): only 60 per cent of Tier 3 services, as opposed to 93 per cent or 84 per cent of combined Tier 2 and 3 services.

3.10.3 Secondary distribution

There was no consistency regarding services' attitude towards secondary distribution (i.e. service users distributing sterile needles and syringes to their networks).

- The majority (64.5 per cent) reported that they neither encouraged not discouraged it
- 15.5 per cent said they encouraged secondary distribution
- 20 per cent reported they discouraged secondary distribution.

There were no significant regional differences, and no differences based on rural versus urban variations. Twelve services (n=12), or 10.3 per cent of services, had a written policy on secondary distribution.

3.11 Funding

Needle exchanges were funded by a number of sources, in many cases at the same time (co-funding). The most common source of funding for needle exchange services was identified as the DAT (42.3 per cent). This was closely followed by the pooled treatment budget (40.8 per cent) and the PCT (39.2 per cent). Needle exchanges are also funded by social services (5.4 per cent), DIP (0.8 per cent), probation (0.8 per cent). Seven services (5.4 per cent) were funded through other budgets, which include a trust's HIV funds.

There were significant regional differences: needle exchanges were least likely to be funded by the pooled budget in East of England, South East and South West regions. They were least likely to be funded by the DAT in London and the East Midlands.

Respondents' perceptions on changes in budget in real terms over the past three years are shown in figure 8. It is interesting to note that one-third did not know.

Figure 8 shows a less positive picture than that provided by joint commissioners in the DAT partnership questionnaire, where most believed that funding had increased in real terms over the past three years. This is discussed in more detail in the discussion section (chapter five).

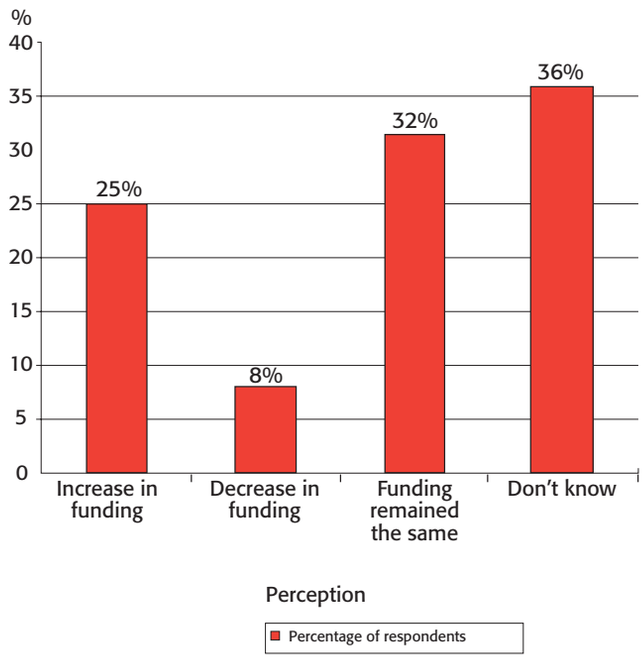

Figure 8: Respondents' knowledge of needle exchange funding

3.12 Staff competence

There were variations between services in the training and competencies of needle exchange staff as well as variations within each service in the training, competency and experience of the various needle exchange staff. There was much variation between services on the range of these competencies. Eight services only employed staff with no formal training in the area.

The following were employed by services:

- General registered nurse: 38.3 per cent of services
- General mental nurse: 30 per cent of services
- NeX staff with no formal training on needle exchange: 61.7 per cent of services
- NeX staff with in-house training only: 64 per cent of services
- NeX staff with academic qualifications: 49 per cent of services
- NeX staff with social work qualifications: 20.3 per cent
- NeX staff with other vocational qualifications: 12.8 per cent
- NeX staff with other training of competencies: 21 per cent (including training by specialist training organisations).

3.13 Assessing client satisfaction

Over 60 per cent of services said they assess client satisfaction. There was, however, much variation in relation to what this meant and how formal the process was.

Thirty-seven respondents (n=37) provided information on how they assessed satisfaction.

Twenty-one (n=21) reported that they gave out evaluation forms or carried out surveys – a small number of cases on an annual or six-monthly basis. A few referred to complaints or satisfaction forms or policies and procedures.

Others referred to informal methods, for example "by verbally asking if they are getting good service and enough clean equipment when they present at the exchange". They also referred to verbal communication with clients, "regular dialogue" or "word of mouth" methods.

A number of services reported assessing client satisfaction through the user representative, the user groups or user involvement meetings. Creative ways included "quizzes used to assess client knowledge and satisfaction".

3.14 Problems faced by services

Only a minority of respondents identified the problems facing services listed in table 11. Other problems identified included:

- Budget shortfalls resulting in limited paraphernalia distribution
- No funding for viral screening
- Staff shortage
- Legislation: e.g. legal position of sterile water
- Lack of funding for a van for rural areas.

3.15 Conclusion

Specialist needle exchange services were overall more likely than DAT joint commissioners to provide information on needle exchange throughput (activity and distribution), although the response rate to the relevant questions in this survey was also poorer than the response rate to other questions.

The survey of specialist needle exchange services has also highlighted the large variations that exist between services. It shows that although specialist needle exchange services may have been most likely to provide a comprehensive range of harm reduction and BBV prevention interventions, the range and comprehensiveness of services provided was in many cases limited.

There were some differences based on the treatment tier as well as by region. Rurality was also identified as sometimes linked with more limited service provision, although this did not imply that needle exchanges in specialist services necessarily provided a comprehensive service.

Problem	% of services facing problems
Budget shortfalls affecting supplies	16%
Complaints from residents or businesses	16%
Insurance problems	6.1%
Inability to recruit or retain staff	8.3%
Planning permission	3.8%

Table 11: Problems facing services, as identified by respondents

4 Results of the pharmacy co-ordinator survey

4.1 Response rate and setting of schemes

Questionnaires were sent to the person with responsibility for co-ordinating the pharmacy exchange scheme in each DAT. A total of 149 questionnaires were distributed and 72 were completed and returned (48 per cent). Each region was represented by at least one respondent. At the time of this study, nine of the 149 DAT partnerships did not have a pharmacy needle exchange co-ordinator or equivalent in the post. Pharmacy co-ordinators who responded to the questionnaires operated schemes that were located in all urban and rural settings (for a list of response rate by region, see Appendix).

Although pharmacy co-ordinators had a variety of titles, for the sake of convenience they will be referred to as pharmacy co-ordinators throughout this chapter.

4.1.1 Employers of pharmacy co-ordinators

Pharmacy co-ordinators were employed by three main organisations: primary care trusts (37.5 per cent), treatment services (20.8 per cent) and mental health trusts (13.9 per cent). These findings are similar to those of the DAT partnership questionnaire with no regional differences evident. Data from services showed that 53.5 per cent were responsible for co-ordinating the DATs pharmacy needle exchange scheme.

4.2 Access and availability of pharmacy needle exchange schemes

There was great variability between pharmacy schemes in the participation of local pharmacies in needle exchange schemes, with some recruiting a considerably larger percentage of pharmacies than others. This was investigated in detail by the pharmacy co-ordinator questionnaire, which looked at the percentage of pharmacies in a DAT that were involved in a needle exchange scheme.

Seventy-three per cent of schemes surveyed (n=53) were able to record the total number of pharmacies in their DAT – the percentage of needle exchange pharmacies ranged from 4.2 to 100 per cent. Fifty per cent of schemes had less than 15 per cent of local pharmacies on board. Overall, the data indicates 22.5 per cent of all pharmacies are involved in needle exchange schemes.

There were differences by region ($p<0.001$) with the North East and Yorkshire and Humber having a significantly smaller percentage of pharmacies participating compared with the East of England (see figures 9, 10 and 11).

4.3 Opening times of pharmacies in needle exchange schemes

Pharmacy co-ordinators were asked to indicate the availability of needle exchange pharmacies for their DAT opening times and responses showed that "all" or "most" pharmacies were operating during weekday mornings and afternoons (until 6pm). During the evening (until 9pm) and night (after 9pm) availability was reduced to predominately "few" or "none" opening during these times. The pattern of weekday opening times was reflected in Saturday opening times as shown in figures 9 and 10.

There was less access to pharmacy needle exchanges on Sundays, as can be seen in figure 11. One London DAT had an A&E that operated a needle exchange service on Sunday night and it was this same A&E that operated a 24-hour service, however the number of clients that visited this service is unknown. These findings suggest there are generally low levels of pharmacy needle exchange schemes opening outside commercial hours.

4.4 Data management

Like other data on activity and throughput, this showed great variability and hence the range of values identified. Similarly, like other data, this is very highly positively skewed – emphasis should therefore be placed on the median rather than mean values to understand the trends and patterns identified. Most schemes required participating pharmacists to record activity by contact, for example visits (87.5 per cent, n=63) with 43.1 per cent (n=31) recording by client.

4.4.1 Contacts

Fifty-five (76.4 per cent) of the 63 schemes that recorded activity by contact were able to provide the number of contacts to their scheme during the period of April 2004 to March 2005. The total number of contacts reported was 449,309 across the 55 schemes. The number of contacts ranged from 95 to 38,941 visits, with a median of 5,542 (mean = 8,169).

4.4.2 Clients

Twenty-three (31.9 per cent) of the 31 schemes went on to give the number of clients for their scheme during April 2004 to March 2005. The total number of clients reported was 15,022 across the 23 schemes. The number of clients ranged from 50 to 1,670, with a median of 590 clients per scheme (mean = 653).

4.4.3 Number of contacts per client (per year)

The average number of contacts of pharmacy needle exchange schemes ranged from 50 to 21,650 with an average of 9.2 visits per year. This is higher than that found in the DAT partnership questionnaire which found an average of 5.2 visits per year. It is impossible to determine which set of data is more representative,

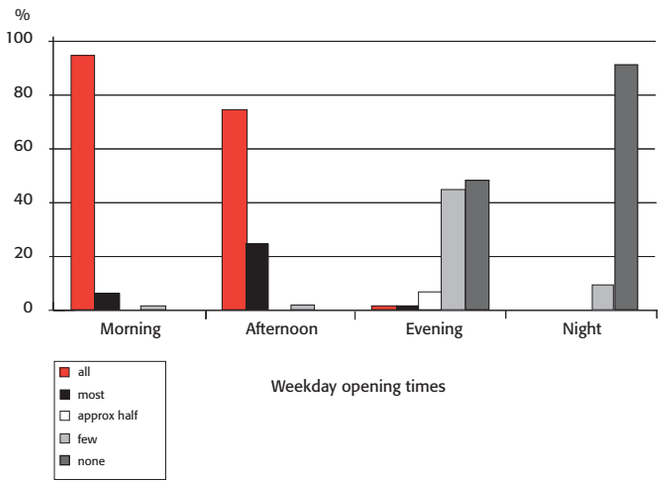

Figure 9: Pharmacy availability by scheme (weekday opening)

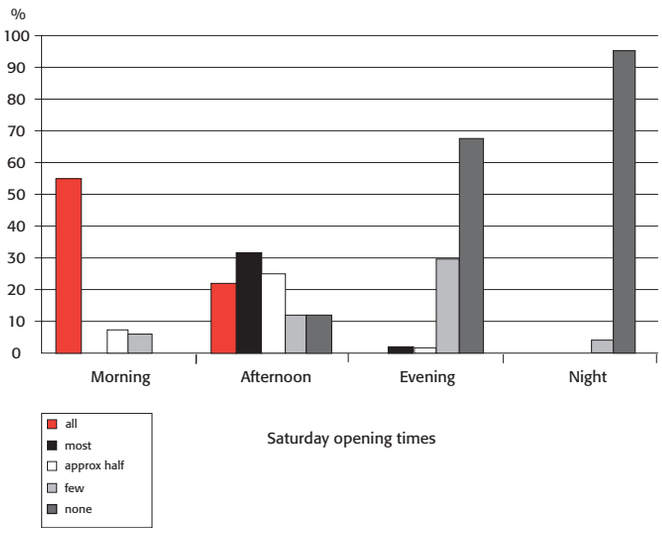

Figure 10: Pharmacy availability by scheme (Saturday morning)

as both suffer from a poor response rate. However, combined data suggest that injectors may have more frequent contact with pharmacies than with specialist drug services.

4.4.4 Information collected from clients

A significant number of schemes required pharmacists participating in the scheme to collect information about their clients. However, the amount and type of information requested varied across schemes. The most frequently asked information is displayed in figure 12.

In addition to the information collected (as identified by figure 12), some schemes (34.7 per cent, n=25) would collect information on main drug injected or drug of choice (n=6), information on whether clients had ever shared equipment and if they had shared since joining the scheme (n=1). Information was also collected on BBV status, with advice on where to go for screening and vaccinations (n=3), secondary distribution (n=2), and whether clients were new or regular clients to the scheme (n=4). The figures here are very small but indicate that some schemes were attempting to get a better understanding of the type of clients who access their scheme.

There were a few schemes which collected no information about their clients. These schemes were based in the West Midlands (n=2), the South East (n=2) and London (n=1). However, the scheme in London stated that data would be available from April 2005 and one scheme in the South East was currently reviewing its pharmacy scheme, including developing strategies to record basic data. No such plans were mentioned for the two schemes in the West Midlands.

4.5 Injecting equipment, paraphernalia and harm reduction services provided

4.5.1 Distribution of injecting equipment

Needles and syringes given out by pharmacies were mostly distributed by packs, (64 per cent, n=46) however there were schemes that would opt for a combination of packs and "pick and mix" (25 per cent) or "pick and mix" only (11 per cent).

4.5.2 Different types of packs

Pharmacy schemes provided a number of different types of packs based on the size of needles and syringes in each pack. Eight different types of packs were recorded by one scheme, however most schemes had two or three different types of packs.

Across schemes there were similarities in the size and number of needles and syringes in each pack. This survey found three types of packs that were frequently distributed by schemes. Each will be

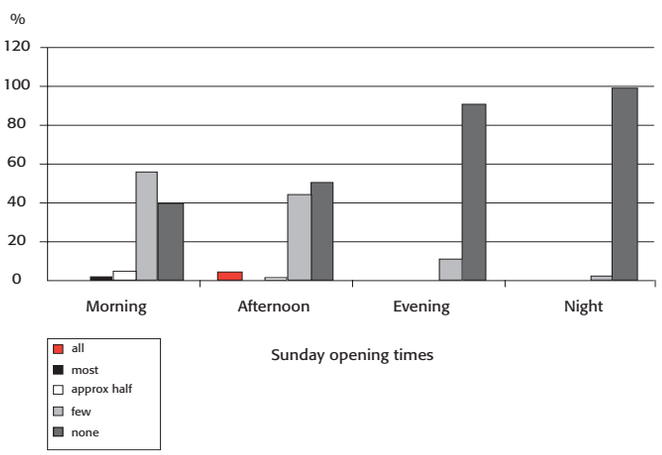

Figure 11: Sunday pharmacy opening times

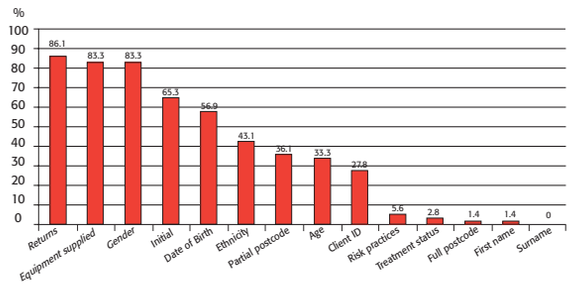

Figure 12: Information collected by pharmacy schemes

described in turn and will be referred to as Pack 1, Pack 2 or Pack 3.

- Pack 1
  - This type of pack would contain 1ml insulin needles and syringes (all-in-one insulin). There were generally ten needles and syringes in this pack, although 15 or 20 needles and syringes would sometimes be provided. The number of this type of pack distributed ranged from 100 to 117,644 (mean = 9,821, median = 5,548). It was the most widely distributed pack between April 2004 and March 2005, as around 451,769 were distributed. This type of pack was distributed by 73.6 per cent of pharmacy schemes.
- Pack 2
  - This type of pack would contain predominately 2ml syringes. Mostly, ten needles and ten syringes were provided but this sometimes varied. The number of this type of pack distributed ranged from 301 to 31,050 (mean = 3,474, median = 1,960). Between April 2004 and March 2005 about 132,017 were distributed. This type of pack was distributed by 21.5 per cent of pharmacy schemes.
- Pack 3
  - This type of pack would contain needles with predominately 5ml syringes. It had the widest variation in the number of needles and syringes provided, as mostly five or ten needles were provided and the number of syringes supplied could be five, ten or 15. The number of this type of pack distributed ranged from ten to 5,676 (mean = 936: median = 409). Between April 2004 and March 2005 the number distributed was 29,971 packs. This type of pack was distributed by 4.8 per cent of pharmacy schemes.

4.5.3 Distribution of packs per contact per year

The calculation of the number of syringes distributed per contact (or visit) is also limited by the poor response rate to questions on number of contacts and clients and questions on amount of equipment distributed.

The number of packs given per user contact was 1.6 packs (16 syringes in general) and the distribution of packs per user per year was about 20 packs (circa 200 syringes).

4.5.4 Distribution of paraphernalia and other items

The most common items supplied by schemes were sharps bins (91.7 per cent), wipes (79.2 per cent) and condoms (55.6 per cent). These and others supplied are listed in figure 13.

There was a significant difference by region in the distribution of sterile water. Schemes in the North East region were most likely to provide sterile water but, with the exception of the East Midlands and Yorkshire and Humber, none of the other regions provided water. None of the schemes in the East of England, the North East, the North West and the South West provided vitamin C.

4.5.5 Information and advice on harm reduction

Leaflets relating to harm reduction were provided by pharmacies in 81.9 per cent of schemes, a list of other needle exchange pharmacies in the DAT was provided by 69.4 per cent of the schemes and 56.9 per cent of schemes provided a list of drug treatment services by DAT area. Some schemes would provide lists of pharmacies or services in neighbouring DATs.

Twenty-five per cent of schemes required pharmacies to provide "formal" referrals to drug treatment services by letter or phone and 52.8 per cent of schemes required its pharmacies to provide face-to-face harm reduction advice. There was no information about what this would range from, for example a few minutes chat to a longer discussion.

4.6 Interventions to prevent blood-borne virus infections

Information on BBVs was sometimes placed in packs for clients and pharmacies would receive handbooks on BBV information and infection control. Two schemes were providing on-site BBV immunisation or testing in pharmacies, these include:

> *"Harm reduction nurses hold clinics within the pharmacy to offer advice and BBV testing and hepatitis B immunisation."*
>
> Pharmacy co-ordinator of a scheme in the North East
>
> *"We have also piloted BBV tests in pharmacies and will be extending this service later this year. It is believed that we are perhaps the first pharmacy to deliver BBV testing in the country."*
>
> Pharmacy co-ordinator of a scheme in the East Midlands

There was also some evidence of schemes collecting and recording information on BBVs, e.g. clients were asked about

their BBV status, with advice on where to go for screening and vaccination.

4.7 Pharmacy staff training

Seventy-two per cent of schemes required pharmacy staff to undertake "specific" training before they could run a needle exchange facility. Ongoing training was offered in over seven per cent of schemes for pharmacists. These training sessions were generally annual and included training on drug awareness, BBVs, harm minimisation and legislation. Over 70 per cent of schemes offered ongoing training to other pharmacy staff, some of the training was similar to that which the pharmacist would receive. An "annual update for counter staff" was also mentioned.

This study revealed that schemes were offering support to participating pharmacies in the following ways:

- 95.8 per cent of schemes offered support and advice over the telephone
- 84.7 per cent of schemes provided written policies and procedures on needle exchange
- 77.8 per cent of schemes visited pharmacies on a regular basis.

Other methods of support included the provision of literature (n=9) e.g. information packs, newsletters and press releases and to a lesser extent more regular visits (n=3) e.g. monthly or weekly. This shows there is some good practice represented here but it is lacking consistency. This study did not look at pharmacists' views or rating of this support and further research is suggested.

4.8 Policies, procedures and commissioning in pharmacy needle exchange schemes

4.8.1 Maximum number of packs

Only 22.2 per cent of schemes had a maximum number of packs that could be given out in any one exchange, this ranged from one to 200 (mean=18, median=4). Forty-two per cent had no maximum limits and in 26.4 per cent of schemes, the number of packs given out varied on whether a client was known or on the number of returns.

Those schemes that distributed by pick and mix were also asked to indicate if there was a maximum number of syringes given out. On these occasions, the trend was reversed as the number of syringes given out was most likely variable, with only one scheme distributing by pick and mix reporting limits on the number of syringes given out.

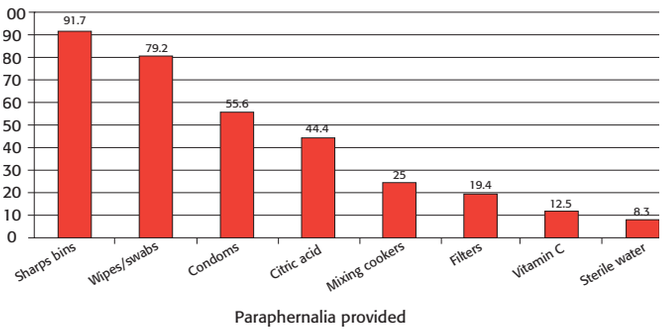

Figure 13: Percentage of schemes providing paraphernalia

4.8.2 Standard operating procedures

This study revealed that 75 per cent of schemes required their pharmacies to have standard operating procedures on needle exchange. No significant regional differences were present.

4.8.3 Formal contracts, service level agreements or other written agreements

Seventy-nine per cent of needle exchange schemes have formal contracts, service level agreements or other written agreements. All schemes in the East of England, London and the West Midlands had service level agreements; the remaining regions had at least one scheme which did not have a service level agreement.

4.9 Financing pharmacy needle exchange schemes

4.9.1 Sources of funding

Funding for schemes came predominately from the DAT (47.2 per cent), the pooled treatment budget (43.1 per cent) and the PCT or health board (31.9 per cent). These findings are fairly consistent with those of the DAT partnership. There were not significant regional differences in funding other than it was notable that no schemes were funded by PCTs in the South West region.

4.9.2 Pharmacy payment structure

There was variation in the way that schemes pay pharmacies. Payment per pack was the most popular method of payment and 54.2 per cent used this method. Payment here ranged from 50p per pack to £1.75 per pack.

Payment per transaction was another method used and 25 per cent of schemes opted for this method. Payment here ranged from £1 to £2 per transaction. Payment per syringe was the least popular and only 5.6 per cent used this method.

Two schemes paid pharmacies quarterly – for example, fees were paid per number of registered clients per quarter. In this instance, £60 would be paid for six to 12 clients, £120 for 13 to 50 clients and £180 for 51 clients and above. Quarterly payments were also

made by packs, in this instance pharmacies would be paid £104 quarterly if 100 packs or less were supplied, £208 quarterly if more than 100 packs were supplied and £312 if over 200 packs had been supplied.

Seventy-two per cent of schemes provided pharmacists with an annual retainer as well as through other methods of payments. This ranged from £50 to just over £3,000. A number of schemes would also make additional payments for returns, some examples of prices include, 25p, 75p, £1.25 and £1.50 per return. This incentive was provided by eight pharmacy schemes in the London region, one pharmacy scheme in the South East and one pharmacy scheme in the East Midlands operated a bonus payment based upon achieving seven per cent return rates.

4.10 Problems experienced by pharmacy needle exchange schemes

Pharmacy needle exchange co-ordinators were asked to indicate whether any problems had affected their provision of needle exchanges. Two recurring problems were found:

- Nearly half of all schemes (45.8 per cent) were having difficulty in recruiting new pharmacies. Pharmacy co-ordinators gave the reason for this as lack of money and pharmacists' perceptions of this client group, for example the stigma attached to clientele, or an unwillingness to be thought of as condoning drug use. The former issue is further reiterated by several respondents when asked to describe any particular concerns or impediments to good practice for the provision of needle exchange pharmacy schemes.
- 23.6 per cent of schemes had experienced the problem of attrition: reasons for leaving were centred around adverse incidents with clients, e.g. clients shoplifting, pharmacists reporting that the crime rate had increased and one pharmacist gave the example of an "aggressive client thought to have a gun".

4.11 Assessing satisfaction with pharmacy needle exchange schemes

Client satisfaction: 41.7 per cent of schemes made a point of assessing the satisfaction of clients with their service. Almost half the respondents claimed that their pharmacy scheme assessed client satisfaction. The level of formality varied, although most schemes used some kind of regular survey for this purpose, a large number relied on "comments on data forms", "informal feedback" and "user representation on advisory group".

4.12 Conclusion

This chapter provides an overview of pharmacy scheme provision in England and shows there is little uniformity in the practices of the various schemes.

The pharmacy schemes on the whole tend to provide needles and syringes, sharps bins, wipes, swabs and condoms, and these findings mirror the services as these were the main items they provided. Other paraphernalia was available, but fewer pharmacy schemes provide them. BBV prevention and other harm reduction initiatives were minimal, although two pharmacy schemes were providing on-site testing. Services provided a more encouraging picture, but hepatitis B immunisation, and hepatitis B, C and HIV testing were carried out on-site in less than half the services surveyed.

There was reasonably good access to pharmacy schemes from Monday to Friday between 9am and 6pm, but this service was significantly reduced at evenings and weekends. There were similar findings in the services questionnaire, however pharmacies provided better access on Saturday mornings and afternoons.

Overall visits to pharmacies were higher than those of other services. This was supported by the DAT partnership findings and pharmacies on average were distributing more syringes per client per visit.

5 Discussion and conclusions

5.1 Variability and commissioning "in the dark"

One of the striking, if perhaps not unexpected, findings of the study was the wide variability that existed throughout England in the commissioning and the provision of needle exchange facilities and the wider range of interventions to reduce drug-related harm and BBVs in particular. Indeed, the surveys not only show lack of uniformity in the commissioning and provision of needle exchange, but also no apparent rationale for this diversity. Wide variations have been noted between DATs, between specialist needle exchange services and between pharmacy schemes and in some cases between regions.

There was no single model for commissioning needle exchange and harm reduction interventions, no uniform access to and accessibility of interventions, and no uniformity in what services were offered and in the way they were offered.

This key finding of variability raises a number of important questions concerning the lack of uniformity of both the nature and the adequacy of needle exchange provision in England. Substantial areas and numbers of injectors were denied the range of interventions that are in line with Models of Care guidance (NTA, 2006), Shooting Up (HPA, 2005) and other research and good practice evidence. This does not mean that all commissioning and service delivery was poor – there were some examples of good practice and injectors in some areas received a much more comprehensive service than in others.

The other striking finding of the report was the paucity of information on needle exchange throughput and activity. This was particularly the case with the DAT questionnaire, which raises some very substantive issues about the information DATs had on the extent of needle exchange provision in their areas – most appear to have only limited information on the amount of equipment distributed and where it was distributed from, to how many people and on how many occasions. This is very worrying, as such information on levels of provision is essential to the assessment of the adequacy of provision as well as informing effective purchasing.

The Audit Commission requirement for local partnerships to provide efficient and effective services to cover clients across the treatment journey, and to demand value for money from service providers (Audit Commission, 2004) provided the foundation for the "systems" approach introduced in the NTA's Treatment Effectiveness strategy (NTA, 2005). This approach includes needle exchange within the overall treatment system and as a core part of effective local provision. In this approach, needle exchange is not seen as a standalone component of treatment evaluated according to different criteria, but as an integral component of a system that has the potential to improve engagement, to initiate, support and assess behaviour change, and to act as a safety net for treatment dropout. As a result, commissioners and providers must be clear about the goals of needle exchange provision in terms of philosophy, activity, audit and evaluation. As such, and as any other part of the treatment system, needle exchanges must establish that they can offer value for money, and that they enable clients to complete their treatment journeys.

5.2 Commissioning and co-ordination

The study suggests variability in system management at DAT commissioning level, including data management systems. Some DATs were able to provide some data on activity and throughput, and in a few cases these appeared to be comprehensive. However, where they existed, monitoring and information systems were diverse, lacked comparability and were often poor. The majority of DAT questionnaires did not have information on needle exchange activity and throughput, let alone information on estimates prevalence rates of injecting. It has been noted that it is important to balance monitoring requirements with the need to maintain a low threshold system. However, the study shows that a case exists for improving monitoring systems and greater standardisation of the information collected.

There was also variability in commissioning practice. In the case of pharmacy schemes for example, there was no uniformity in whether formal contracts or service level agreements were made with pharmacies and no uniformity between schemes in how pharmacies were paid or how much. Only a minority of all pharmacy schemes required pharmacies to have a formal standard operating procedure for needle exchange, which is recommended in the guidelines of the Royal Pharmaceutical Society of Great Britain. There was also no uniformity in the commissioning of specialist needle exchange services, for example what organisation commissioned services, or whether funding for the services was sought from a number of organisations to supplement the pooled treatment budget.

Needle exchange facilities were also co-ordinated in different ways. For example, approximately one in five pharmacy needle exchange schemes did not have a named co-ordinator, although this is regarded as good practice (NTA, 2006). The varying importance attributed to needle exchange at DAT levels was shown in the large variations that existed in the seniority and skills of the co-ordinator, which ranged from an administrator to a senior member of staff. It was also shown in time allocated to the task and this was usually not on a full-time basis, but was often merged with other duties.

5.3 Types of services

Needle exchange facilities were available in all English DATs surveyed. The overwhelming majority of DATs had a mixed economy of facilities or a combination of both specialist drug

service(s) providing needle exchange and a pharmacy scheme; some also had facilities provided from other settings (e.g. outreach).

In the DATs surveyed, specialist needle exchange services constituted approximately 20 per cent of all needle exchange facilities and pharmacies the remaining 80 per cent. This suggests that there has been a slight expansion of pharmacy exchanges involvement from 1997, where pharmacies constituted 77 per cent of all outlets.

5.4 Accessibility

Data on geographical access and proximity must be treated with caution but suggests there was variability between DAT partnerships – and even regions – in the access of residents to a facility within five miles of their place of residence, a distance that is regarded to reflect accessibility. It appears that the residents of a substantial number of DATs did not have this easy access to sterile needles, and even less so to more comprehensive harm reduction support.

Generally speaking, access to facilities was more limited in rural areas than in urban areas. However, geography and population density alone do not explain accessibility. Injectors in urban and other non-rural areas were not necessarily better served and most particularly those who lived in small towns, suburban areas and semi-rural areas. Conversely, injectors in the most rural areas can have very good access to both pharmacies and specialist services as shown by the (small) number of responding DATs from such settings. This suggests that good access to needle exchange was determined by commissioning policy, rather than geography.

The mixed economy of specialist services and pharmacies maximised injectors' access to sterile equipment. Access to specialist needle exchange services was mainly limited to the working week. Only a very small number were available some evenings (usually up to 8pm) across England. Pharmacies extended injectors' access to sterile equipment through Saturday daytime opening and were generally the only type of outlets available on Sundays.

There was little or no distribution from any type of facility at night and on Sundays, although it should be noted that there were a very small number of exceptions among specialist services and pharmacy schemes. This included 24-hour opening in some of the pharmacies in one scheme. The evaluation of these models is encouraged and should inform if and how they should be replicated elsewhere.

5.5 Needle exchange activity and client contact

Overall, a substantially larger number of visits (contacts) were made to pharmacy exchanges than to specialist needle exchanges (approximately 1.7 times as many). Similarly, pharmacy exchange schemes appeared to have more clients than specialist needle exchange services (also approximately 1.7 times as many).

It is not possible to determine accurately whether the level of activity has changed over time and comparisons with data from earlier research must be treated with caution. However, one possible change over time was perhaps the increase in the number of visits made to non-pharmacy exchanges since 1997. There were, on average, 70 visits in April 1997 (Parsons *et al.*, 2002), a figure lower that what is suggested by the yearly median or mean number of contacts per service in 2004/05 (median number = 1,245 contacts per year), but the variance remains very high.

What was very clear was the very wide variation that existed at the time of this survey between DATs, specialist services and pharmacy schemes in the number of needle exchange clients they had and in the number of visits (contacts) by clients. Some DATs and some services and schemes had much larger numbers of clients and more contacts with injectors. This was not necessarily determined by prevalence or population density.

In general, data suggests that pharmacies were visited more often than services. The three sets of questionnaires suggest that the frequency of individual client contact with specialist services was, on average, between every seven weeks and every ten weeks. The frequency of contact with a needle exchange in a community pharmacy was between 1.3 contacts per month and every nine weeks.

The great variability that existed between DATs, services and schemes in the frequency of contact by clients cannot be stressed enough, with some clearly better able to attract injectors more frequently than others. Frequency of contact is significant, not only in terms of accessing sterile injecting equipment, but also in terms of engagement with services and access to interventions.

5.6 Injecting equipment and other items distributed

Overall, the total number of syringes distributed by pharmacies in England in 2004/05 was very similar to the total number distributed than non-pharmacies, a finding similar to that of Parsons *et al.* for 1997 (Parsons *et al.*, 2002: p846). The three sets of questionnaires utilised for this study showed that pharmacies and services gave out broadly similar numbers of injecting equipment per client for the whole of the period of April 2004 to March 2005. Specialist services, however, gave out a slightly larger number of needles and syringes per contact, and in some cases, a much larger number.

Overall, the study suggests that the number of syringes available to injectors was limited. On average, clients of specialist needle exchange services and pharmacy schemes were given the equivalent of approximately one syringe for every two days.

This suggests that the numbers given out were not sufficient to ensure that injectors have a clean syringe and needle for every injection, even where injectors accessed both types of facilities. New drug-using patterns and the injecting of crack and cocaine in particular, also challenge the adequacy of numbers currently distributed.

There were wide variations between specialist services and pharmacy schemes, with a small number of providers giving out a very large number of syringes to clients. However, even in these cases, numbers distributed could not achieve a rate of a sterile syringe for every injection.

Both pharmacies and specialist services provided a range of injecting equipment, with syringes and needles of various sizes. Both distributed mostly 1ml insulin needles and syringes. Specialist services were more likely to provide injectors with larger size equipment and larger size needles, usually reflecting potentially higher risk injecting practice.

Specialist services were more likely than pharmacies to distribute paraphernalia and to distribute a wider range of items. However, there was also much variation between DATs, specialist needle exchanges and pharmacy schemes in what paraphernalia was distributed, with some giving out a much wider range of items than others. There was no uniformity in what injectors received, even where there have been changes in legislation. For example, one in five specialist services did not distribute citric acid, nor did half of all pharmacy schemes, with significant regional differences. What other paraphernalia was received by clients depended on what services or pharmacy schemes they accessed and in which DAT. This data and written comments on the questionnaires suggest the need for national guidance.

5.7 BBV prevention and other harm reduction interventions

There were significant differences between services and between DATs in the provision of BBV prevention interventions on-site in specialist needle exchanges, a practice that could increase uptake. Regional differences in the provision of hepatitis B immunisation and hepatitis C testing on-site were also identified. Overall, the data shows that substantial sections of the population did not have access to such interventions. For example, 40 per cent of DATs did not have a service that provided hepatitis B immunisation on-site; almost half did not have a service that carried out hepatitis C testing on-site

Substantial sections of the population also seem to have had no access to other harm reduction support. Only in a third of services did injectors have access to care for minor infections and only a third of services provided access to primary care or nutrition advice. One in five specialist needle exchange services did not refer their clients to structured treatment.

The majority of specialist needle exchange services carried out an assessment of client needs, based on a written set of questions; however, this was not the case in approximately 15 per cent of services. The content of the assessment depended on which service was undertaking it. It is cause for concern that approximately 40 per cent did not address hepatitis B immunisation and testing for BBVs, and approximately one-third did not discuss injecting hygiene and safer injecting techniques.

5.7.1 Overdose prevention

Overdose prevention, or the lack of it, in many specialist needle exchange services is a matter for concern. Overdose prevention training for clients was only undertaken in half the services surveyed and a quarter of all specialist services did not assess the risk of overdose of new clients. One of the main goals of all harm reduction services, including needle exchanges, is the prevention of drug-related death and the increased risk of overdose through injecting is well documented.

There were examples of good practice and many services did provide a comprehensive range of interventions. These were more likely to be located in more urban settings, however, a few were also available in very rural areas, suggesting that barriers to the development of such services were due to policy and not only population density and rurality. There were also examples of good practice among pharmacy schemes that were increasing the range and levels of interventions provided, such as immunisation for hepatitis B in pharmacies.

Just over half of pharmacy schemes required pharmacies to provide face-to-face harm reduction advice and a quarter were formally required to refer clients to treatment services (by phone or letter rather than informally).

Overall, the three sets of questionnaires suggest that although there were many instances of good practice, the needle exchange interventions offered were often limited to the exchange and return of sterile injecting equipment and some paraphernalia. What appears to be missing is the wider comprehensive range of interventions that can support the effectiveness of the exchange of injecting equipment.

5.8 Return rates and public heath

Data is based on a very low response rate and must be treated with caution. It suggests a better return rate of used injecting equipment to services than to pharmacies. The return rate to services shows a relatively good return, with an average overall ratio of 1.2 taken to one returned; on the other hand, for every 6.1 syringes taken from pharmacies, one was returned. It is important to note, however, that it was noted that equipment taken from pharmacies was often returned to services.

One important mechanism often used by services to encourage returns was linking distribution to returns. Generally, needle

exchange facilities provided some injecting equipment regardless of returns. However, the number of syringes given out to clients was often determined by whether returns were made and sometimes how many and by whom. Therefore, injectors who had not made any returns received a limited number of sterile syringes, while those who did and did so regularly received a larger number. This suggests good practice at two levels – universal access to injecting equipment by those who need them and taking into account issues of public health and drug litter at the level of distribution. A handful of services only issued injecting equipment when used syringes were returned or insisted on one-to-one exchanges. Numbers involved were too small to compare the impact of the different methods on the rate of return.

5.9 Reaching diverse injecting populations

Rural areas. The survey has shown that injectors in rural areas generally received a poorer service than those in more urban areas. Access to needle exchange facilities was more limited, particularly access to specialist needle exchange services. What they received once they accessed these specialist services was also less comprehensive than their peers in urban areas.

However, an urban setting did not necessarily guarantee accessibility or comprehensiveness of interventions. There were variations between the more urban DATs and services within them, with some providing very limited interventions. Rurality was not the only factor to be linked to poorer services, nor was rurality necessarily linked to poorer services. Indeed, the survey has shown examples of very rural DATs and services that provide facilities that are accessible and comprehensive interventions. Therefore, although there is no doubt that a rural setting makes the development of needle exchange facilities more complex, the accessibility and comprehensiveness of interventions is dependent on local commissioning policy and service practice.

Gender: The majority of needle exchange clients were adult males. In this study, the male to female ratio for all needle exchange clients was higher than the 3:1, which generally characterises the gender ratio in drug treatment in general. This poor representation of women suggested by this survey is cause for concern and should be investigated further. However, this male to female ratio obscures the wide differences that exist between services in attracting women, with some services doing a better job than others. It is sometimes suggested that women were more likely to use pharmacy needle exchange facilities, but data from this audit did not permit the investigation of this.

Ethnicity: This audit did not look in any detail at data by ethnic group because of the very poor quality of this data at local levels. Four out of five DATs, 71 per cent of services and just under half of all pharmacy schemes reported they monitored ethnicity. Very little data was provided and this did not allow for any meaningful analysis.

One out of five DATs said that they targeted Black and minority ethnic groups. Only a few, however, provided details. This was done through specialist Black and minority ethnic workers, to liaison workers with community groups, performance monitoring and leaflets in community languages. A specific study of the utilisation of needle exchange services by minority ethnic populations is recommended.

Steroid users: These were identified by focus group discussion as a largely overlooked group. The in-depth study showed that they have different needs and even greater concern over stigma and privacy. Just under half of all DATs surveyed said that they focused on this group.

5.10 Concluding remarks

The survey has shown that a mixed economy of needle exchange facilities was available in 2004 to 2005 in the overwhelming majority of DATs, with possibly some DATs more dependent on pharmacies than others. Both types of facilities have been shown to have a number of roles. Pharmacies have clear benefits – they formed the largest proportion of needle exchange facilities in England and had more clients than specialist services and more contacts with injectors (visits). Pharmacies increased the accessibility of sterile injecting equipment in terms of distance (there was significantly more of them) and opening times (they were open more often). They generally provided sterile equipment, sharps bins and limited paraphernalia, but the wider harm reduction support they provided remained limited. A few pharmacy schemes were developing this aspect of the work, by providing access to hepatitis B immunisation for example.

Specialist needle exchange services were crucial to the provision of a comprehensive system. Injectors were generally more likely to receive a larger amount of sterile injecting equipment from specialist needle exchanges at each contact and each year and a wider range of paraphernalia. Only the clients of specialist needle exchanges were likely to receive a wider package of support and a range of other complementary measures, ranging from support over safer injecting and injecting hygiene to access to risk assessment and support over overdose prevention. Specialist services were more likely to be set up to consider needle exchange as not enough on its own, but as part of a wider system which includes a range of other complementary measures. Injectors who only accessed pharmacies missed out on this wider treatment system.

The study confirms that there are two models of delivery, but that pharmacies have to be seen as complementary to specialist services rather than alternative settings. Both types of facilities must be in place to maximise accessibility and a comprehensive system. International research evidence clearly shows that the distribution of injecting equipment is not enough in itself to control blood-borne infection, but must be considered as part

of a wider system, which includes a range of other complementary measures.

It is cause for concern however, that this was often not taking place even when an injector was in touch with a specialist needle exchange service. This audit has shown that needle exchange interventions provided by many specialist services focused on the distribution and return of injecting equipment and provided access to a very limited number of other supports.

A typical injector accessing any needle exchange facility anywhere in England in 2004/05 would have been given sterile equipment, a sharps bin and limited paraphernalia. Apart from that, what injectors would have received, how much, and which harm reduction and BBV prevention interventions were provided to them appear to have been determined, not only by the setting of the exchange (pharmacy versus non-pharmacy) but also by what particular pharmacy scheme or particular specialist needle exchange, in what DAT and in some cases, what region.

What interventions injectors received was often not determined by their needs but by where they lived. Some services were providing a good and comprehensive range of interventions, using procedures and processes that reflect good practice. Many others fell short of the ideal and provided limited care and harm reduction, including interventions to prevent morbidity and mortality.

One of the recurrent themes of this audit was the variability in needle exchange commissioning and provision. There appears to have been no rationale for this lack of uniformity. The development of services can be more difficult in some areas, such as rural areas. However, variability appears to have been mainly determined by the commissioning policy and practice of the different DATs and the different providers. The paucity of data on needle exchange at DAT level is a salient example of the low level of importance attributed to needle exchange and harm reduction within a hierarchy of priorities.

As a result of this and other evidence, the 2006 Improvement Review (NTA/Healthcare Commission, 2007) will focus on harm reduction in drug treatment. This includes benchmarking each area in England against nationaly agreed criteria and requesting each area which falls below national standards to action plan to improve.

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7 Appendix

This appendix provides additional detailed information to findings discussed in the text. Most particularly, this appendix looks at significant differences by government region between DAT partnerships, drug services and needle exchange pharmacy schemes. It also looks at significant differences by geographic setting or rurality between DAT partnerships, drug services and needle exchange pharmacy schemes.

Region	Number of responses	% DATs responding
East of Englamd	9/10	90%
East Midlands	3/9	33%
London	22/33	66%
North East	9/12	75%
North West	14/22	64%
South East	15/19	80%
South West	12/15	80%
West Midlands	14/14	100%
Yorkshire and Humber	12/15	86%
Total	110/149	74%

Table 12: Response rate by government region

Region	% of responses (specialist needle exchange services)
East of Englamd	5.5% (n=8)
East Midlands	22.7% (n=33)
London	16.5% (n=24)
North East	12.4% n=18)
North West	4.8% (n=7)
South East	8.9% (n=13)
South West	14.4% (n=21)
West Midlands	5.5% (n=8)
Yorkshire and Humber	8.9% (n=13)

Table 14: Response rate by region

Category	% of DATs
1	40% (n=44)
2	16.4% (n=18)
3	15.5% (n=17)
4	10.9% (n=12)
5	15.5% (n=17)
6	1.8% (n=2)

Table 13: Percentage of DATs by urban/rural variation[10] (1= most urban; 6 = most rural)

Category	% of services
1	30.1
2	7.5
3	18.8
4	16.5
5	26.3
6	0.8

Table 15: Percentage of services by urban/rural variation[10] (1= most urban; 6 = most rural)

[10] DEFRA categories are as follows: 1= Urban Less Sparse (most urban), 2 = Urban Sparse, 3 = Rural Less Sparse Town & Fringe, 4 = Rural Sparse Town & Fringe, 5 = Rural Less Sparse Village & Dispersed, 6 = Rural Sparse Village & Dispersed (most rural)

Region	Number of pharmacy co-ordinators who completed and returned questionnaires	Total number of pharmacy co-ordinators and percentage of returns in each region
East of Englamd	2 (2.8%)	10 (20.0%)
East Midlands	5 (6.9%)	9 (55.5%)
London	21 (29.2%)	33 (63.6%)
North East	5 (6.9%)	12 (41.6%)
North West	6 (8.3%)	22 (27.2%)
South East	8 (11.1%)	19 (42.1%)
South West	11(15.3%)	15 (73.3%)
West Midlands	6 (8.3%)	14 (42.8%)
Yorkshire and Humber	8 (11.1%)	15 (53.3%)
Total	72 (100%)	149 (48.3%)

Table 16: Response rate by region

Region	Percentage of services, by region, that provide keyworking in NEX ($p<0.02$)	Percentage of services, by region, that provide face-to-face harm reduction ($p<0.02$)	Percentage of services, by region, providing care for minor infections ($p<0.00$)
East of Englamd	62.1%	65.5%	55.2%
East Midlands	50%	37.5%	12.5%
London	72.2%	94.4%	88.9%
North East	28.6%	71.4%	42.9%
North West	43.5%	70%	39.1%
South East	53.8%	61.5%	30.8%
South West	71.4%	64.3%	28.6%
West Midlands	75%	75%	37.5%
Yorkshire and Humber	100%	100%	46.2%

Table 17: Percentages of services providing interventions, sorted by region

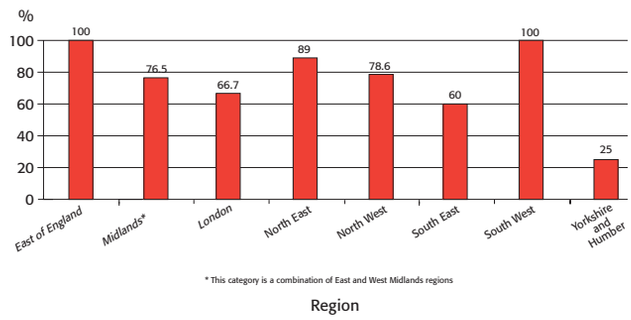

Figure 14: Percentage of DATs with a DAT-wide needle exchange coordinator

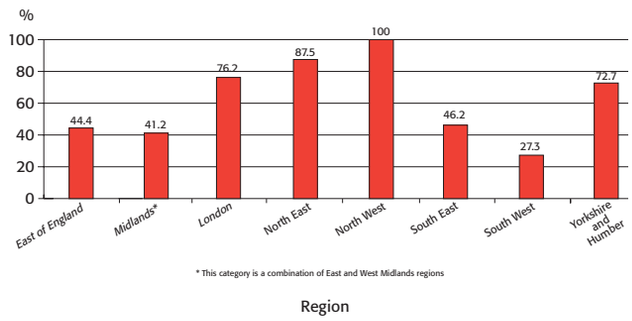

Figure 15: Percentage of DATs with at least one service that provides hepatitis B immunisation on-site

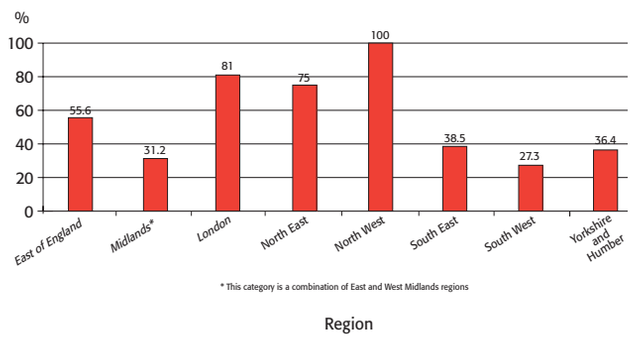

Figure 16: Percentage of DATs with at least one service that provides hepatitis B testing on-site

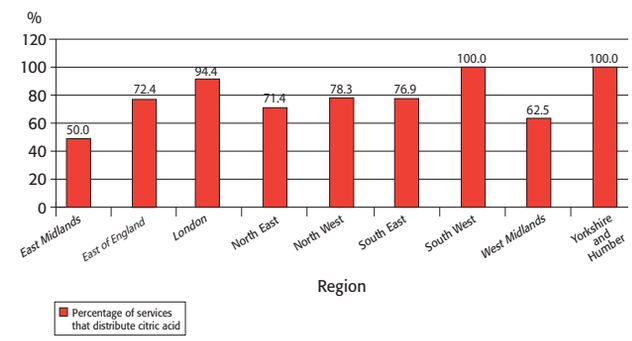

Figure 17: Percentage of specialist needle exchange services that distribute citric acid by region

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