Needle Exchange Provision in Scotland: A Report of the National Needle Exchange Survey

Substance Misuse Research
Needle Exchange Provision in Scotland:  
A Report of the National Needle Exchange Survey  

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Note regarding terminology

Throughout this report, the term “specialist needle exchange” is simply used as a shorthand to refer to all those services which are not pharmacy, police custody suite, or hospital A&E exchanges. Specialist services include those in both the statutory (usually NHS) and voluntary sectors.

Acknowledgements

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Executive Summary

Introduction (Chapter 1)

This document reports on the findings of a survey of needle exchange provision in Scotland. The study was part of a larger UK-wide study carried out in partnership with the National Treatment Agency (NTA) in England; the Welsh Substance Misuse Policy Development Team; and the Northern Ireland Department of Health, Social Services & Public Safety. The Scottish arm of the study was funded by the Scottish Executive under the Drug Misuse Research Programme and was carried out between 15 January 2005 and 30 September 2005.

The aims of the study were to:

- Map needle exchange provision in Scotland
- Investigate the nature of service provision
- Identify areas of good and innovative practice in this area
- Identify barriers and difficulties in commissioning and delivering needle exchange services.

Methods (Chapter 2)

The study was designed to gather information both from people responsible for planning and commissioning needle exchange services, and those responsible for delivering those services. A combination of qualitative and quantitative methods were used. The quantitative element consisted of three postal questionnaire surveys sent to:

- Drug Action Team (DAT) co-ordinators / commissioning managers, or their equivalent
- Non-pharmacy needle exchange service providers
- Pharmacy needle exchange co-ordinators

The qualitative element consisted of three focus groups — one with each of the three groups listed above. Through these different means, data was gathered about needle exchange services in every part of Scotland. Survey responses are shown below:

- All of Scotland’s 22 DATs were surveyed, 19 responded (response rate = 86%)
- Fifty out of 52 non-pharmacy services were surveyed, 45 responded (rate = 90%)
- Twelve out of 15 pharmacy co-ordinators were surveyed, 10 responded (rate = 83%)

FINDINGS – PART 1: NEEDLE EXCHANGE PROVISION AND ACTIVITY IN SCOTLAND

Mapping needle exchange provision (Chapter 3)

The study identified 188 needle exchange outlets — 136 pharmacy exchanges, 43 specialist exchanges, six police custody suite exchanges and three hospital A&E exchanges. Some form of needle exchange was available in every DAT area of Scotland. Nearly half of Scotland’s specialist service provision was through mobile / outreach facilities. Across the whole of the country, pharmacy exchanges outnumbered specialist services by a ratio of 3:1.

Accessibility of needle exchange (Chapter 4)

Not surprisingly, needle exchange was least accessible in the most remote and rural areas of Scotland. However, half of Scottish DATs said that all injectors living in their area had access to some form of needle exchange within five miles of their place of residence. Injectors living in mixed rural / urban areas appeared to have access to the widest range of needle exchange services.
Needle exchange activity, 2004-05 (Chapter 5)

A lack of robust monitoring systems for needle exchange services was especially apparent in relation to questions about basic needle exchange activity — that is number of "transactions" (or needle exchange contacts), number of clients, number of syringes distributed and number of syringes returned. Questions on number of clients and number of syringes returned, in particular, had only a small number of responses, and therefore, these data must be treated with caution.

**Number of transactions / contacts:** 36 (out of 45) non-pharmacy services reported 82,389 transactions in the period April 2004 – March 2005. The median number of transactions per service was 1,054 (mean: 2,289). Pharmacy co-ordinators (n=10) reported a total of 169,117 transactions in this same period, representing the activity of 116 pharmacies. The mean number of transactions per pharmacy was 1,458.

**Number of clients:** 29 (out of 45) non-pharmacy services reported a total of 14,229 clients in 2004-05. The median number of clients per service was 221 (mean: 491). Three (out of 10) pharmacy co-ordinators reported a total of 17,726 clients in the same period, representing the activity of 37 pharmacies. The mean number of clients per pharmacy was 479.

**Number of syringes distributed:** At least 3.5 million syringes were distributed by needle exchange services across Scotland in 2004-05. The actual totals are likely to be considerably higher, since these figures do not include numbers from three DAT areas, and some of the figures submitted by other DATs were incomplete. An approximately equal number of syringes was distributed by pharmacy and non-pharmacy services overall. However, this statement masks enormous geographical variation. The total number of syringes distributed by pharmacy services across Scotland was skewed by the very large number of syringes distributed by Glasgow pharmacies.

A calculation of the number of syringes distributed per injector (using estimates of injecting prevalence taken from the National Prevalence Study) showed very wide geographical variations in levels of syringe distribution, and suggested that in many areas, there was far from sufficient distribution of syringes.

**Return of used syringes:** At least 1,563,312 syringes were returned to needle exchange services across Scotland — 849,113 to non-pharmacy services and 714,199 to pharmacy services. These figures can only be taken as estimates. It is difficult to obtain accurate data on returns because, for obvious health and safety reasons, sharps bins are not opened.

On-site interventions provided by needle exchange facilities (Chapter 6)

Many needle exchange facilities in Scotland provide services and interventions beyond the simple distribution of sterile needles and syringes. This study found that a majority of non-pharmacy services in Scotland provided their clients with face-to-face harm reduction advice, a list of other needle exchange facilities in the area, referral to structured treatment, and brief motivational interventions. Only about half provided any form of on-site intervention related to BBVs, with the most common being HIV and Hepatitis C pre- and post-test counselling. There appeared to be an association between on-site provision of BBV interventions and NHS Board.

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1 As can be seen from the figures given for the median and mean, the data are very positively skewed – that is, a small number of services reported a very high number of transactions compared to all the others. In such a situation, the median is a more accurate representation of the average number of transactions per service.

2 It was not possible to calculate the median because data on pharmacy transactions was reported as an aggregate figure for all the pharmacies in each NHS Board.
Less than half of non-pharmacy services provided key working, structured counselling, care for minor infections or complementary therapies. Fewer still provided overdose prevention training for clients; housing, social welfare or legal advice; nutritional advice; primary care sessions or well-woman clinics.

Pharmacy schemes across Scotland offered a much smaller range of interventions to injectors than non-pharmacy services.

In terms of distribution of other injecting paraphernalia, the majority of both pharmacy and non-pharmacy services provided sharps bins and wipes / swabs. However, there was variation between services in relation to the distribution of other forms of paraphernalia (citric acid, filters, stericups, etc.). This variation was also associated with NHS Board.

Needle exchange policies and procedures (Chapter 7)

There was variation across Scotland in policies and practices related to syringe distribution. The majority of non-pharmacy services said there was a maximum number of syringes their service would give out at any one time. However, when asked to state what this maximum number was, nearly one-third of services stated a figure which bore no relationship to official guidance on syringe distribution issued by Scotland’s Lord Advocate. Nearly a quarter of Scottish non-pharmacy services said that the maximum number of syringes they would distribute depended on circumstances such as whether the client was known to the service, the number of syringes returned, where the client lived and whether the service had concerns about the health of the client. Responses from pharmacy co-ordinators were similar.

The majority of services in Scotland discouraged secondary (or peer) distribution of injecting equipment. However, only a few services had written policies on secondary distribution.

Just over a third of non-pharmacy services had a written policy or protocol on the provision of injecting equipment to young people under 18. Only three of these had agreed their policies with the local area Child Protection Committee.

Only about half of Scottish non-pharmacy services and two of 10 pharmacy schemes had mechanisms for assessing client satisfaction.

Comparisons with England (Chapter 8)

Specialist services made up 23% of all Scottish needle exchanges, compared to an estimated 20% in England. In Scotland, pharmacy services comprised 72% of all facilities, whereas in England, they made up approximately 79% of services.

Non-pharmacy needle exchanges in Scotland provided better out-of-hours coverage than similar services in England, but English pharmacy services provided better out-of-hours coverage than those in Scotland.

Scottish services had more contact with female injectors than English services.

In both Scotland and England, returns to non-pharmacy services were higher than returns to pharmacy services.

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3 The Lord Advocate’s guidance allows for provision of a maximum of 20 needles / syringes on a client’s first visit to a needle exchange; a maximum of 60 needles / syringes on subsequent visits; and an exceptional upper limit of 120 for holiday periods when facilities are closed or are difficult to access.
Services in Scotland were significantly less likely than their English counterparts to provide Hepatitis B immunisation on-site. Only one service in Scotland provided tetanus vaccination, compared to 11% of services in England.

Scottish services were significantly less likely than English services to offer their clients a range of other on-site interventions including: motivational interviewing, key working, structured counselling, GP / primary care sessions, housing / social / legal advice and well-woman clinics.

In terms of paraphernalia distribution, Scottish services were significantly less likely than English services to distribute filters, sterile water, stericups and Vit C to their clients. Scottish services were more likely than English services to distribute wipes or swabs. There were no statistically significant differences between Scottish and English services in relation to the distribution of sharps bins, citric acid and tourniquets.

Compared to Scottish services, a much larger percentage of English services said that there was no limit on the number of syringes they would give out during any one needle exchange transaction. This is probably because there is no equivalent to the Lord Advocate’s guidance in England.

Scottish services were significantly more likely than English services to report that they would provide injecting equipment to young people aged 16 or 17. However, there was no difference between Scottish and English services in relation to distribution among under-16s. English services were more likely to have a written policy on needle exchange among young people, and to have agreed their policy with the local area Child Protection Committee.

FINDINGS – PART 2: PLANNING AND COMMISSIONING OF NEEDLE EXCHANGE

Co-ordination, planning & commissioning (Chapter 9)

Needle exchange activity in Scotland is co-ordinated at the level of NHS Boards, rather than DATs. This is because needle exchange is largely funded by Blood-borne Virus (BBV) Prevention monies — an annual allocation made by the Scottish Executive Health Department to NHS Boards. This arrangement was seen to cause tension in some areas of Scotland where the boundaries of NHS Boards were not co-terminus with DAT boundaries.

This study found a lack of robust systems for monitoring needle exchange activity at a DAT level in many areas of Scotland, suggesting that the strategic planning activities related to needle exchange were limited. Greater standardisation in data collection and better use of the data was called for.

Systems for monitoring discarded sharps and needle stick injuries to the public appeared to be largely absent. The majority of DATs either did not have such systems, or were unaware of how to access them.

Staff training and qualifications (Chapter 10)

There is no standard training for needle exchange workers in Scotland. Consequently, staff competency and qualifications vary. This was considered by some participants in this study to be an impediment to good practice.

Regular training and on-going support were seen to be especially important for pharmacy needle exchange providers (including counter staff). This was seen to be the key in overcoming negative attitudes among pharmacy staff.
Good practice / Difficulties and impediments (Chapter 11 & 12)

Good and innovative practice in needle exchange was related to: providing a range of different services; use of outreach; good joint working relationships between services; use of pharmacy consultation rooms by specialist harm reduction nurses; the involvement of service users in the developing or delivering services; developing trust with service users; and ensuring good training and support for service providers — particularly pharmacy providers.

The biggest problems, or impediments to good practice were seen to be related to: funding shortages; lack of consistency and inability to implement recognised good practice in paraphernalia distribution; negative public attitudes; negative staff attitudes (especially among pharmacy staff); and staff shortages.

Conclusions and recommendations (Chapter 13)

This survey has highlighted variation in practice in relation to all aspects of needle exchange provision in Scotland. In some cases such as the provision of paraphernalia and on-site BBV interventions, this variation is associated with NHS Boards. But in other areas, it would seem that some needle exchange services simply do things differently to other needle exchange services. The question which must be asked is: Is this variation acceptable?

While it may be acceptable for pharmacy exchange services to be different from police custody suite exchanges, and for specialist services to deliver different interventions than A&E exchanges, it is not clear why there should be large variations in practice between specialist services, or between pharmacy schemes in different parts of Scotland.

Many of the needle exchange professionals, and commissioners of needle exchange services who participated in this study argued for greater standardisation. People wanted to see more standardised training for needle exchange providers, and greater standardisation in data collection and monitoring systems. People also wanted to see official guidelines in relation to paraphernalia distribution.

However, many also pointed out that their aspirations for service development were limited by lack of funding. Having said that, there were clearly also instances where local Health Board policy, rather than funding per se, was the main limiting factor.

Given the findings of this study, the following recommendations are made.

Recommendations to the Scottish Executive

- In co-ordination with the Scottish Drugs Forum and other stakeholders, develop standards for needle exchange services in Scotland. Different standards may be required for specialist, pharmacy, police custody suite and A&E exchanges.
- In co-ordination with STRADA and NHS Education Scotland, develop a module or standard training course for all specialist and pharmacy needle exchange providers, and ensure that this training is regularly updated.
- Develop guidelines regarding paraphernalia distribution in Scotland, and put in place mechanisms to ensure compliance with the guidelines by NHS Boards. There may be some delay in this until the results of on-going research regarding the safety and effectiveness of injecting paraphernalia are published. In the meantime, however, the Executive should ensure that citric acid is distributed for free by all needle exchange services throughout Scotland.
- Increase funding to needle exchange services, to ensure that services are able to distribute an adequate number of syringes and other paraphernalia to their service
users. Increased funding would also allow local areas to develop greater use of outreach services.

**Recommendations to NHS Boards and Drug Action Teams**

- Provide funding to all needle exchange services for citric acid distribution.
- Ensure that there is a balance between pharmacy and specialist needle exchange provision in local areas.
- Put in place systems for regular monitoring and reporting of needle exchange transactions (including gender and age of contacts) and numbers of syringes and other items of paraphernalia distributed.
- Put in place systems for regular reporting from local authority Environmental Health / Public Health services on discarded sharps and needle stick injuries to the public.
- Ensure that all needle exchange providers receive appropriate training, particularly in relation to injecting techniques, prior to providing a needle exchange service.
- Ensure that pharmacy exchange providers receive on-going training and support from a specialist harm reduction provider.
- Ensure that all needle exchange services have written protocols / policies on the distribution of sterile injecting equipment to young people under 18 and separate policies for under-16s. Ensure that these protocols / policies are agreed with local area Child Protection Committees.
- Reduce barriers to accessing BBV testing and immunisation services, by making such services available through needle exchange facilities.
- Improve integration between needle exchange and other local services, by arranging on-site access to primary care sessions, wound clinics, nutritional advice and housing, social welfare or legal advice.

**Recommendations to needle exchange providers**

- Put in place mechanisms for assessing the needs of clients and regularly reviewing those needs.
- Put in place mechanisms for assessing client satisfaction at regular intervals.
- Develop written policies and protocols regarding needle exchange provision to under-18s, and separate policies / protocols for under-16s. Involve local area Child Protection Committees in this process.
- Develop methods of better engaging with and educating injecting drug users, and share both failures and successes with other service providers. This can be done through the Scottish Needle Exchange Workers Forum.
Chapter 1: Background and context

Headlines from this chapter

- The National Needle Exchange Survey was a UK-wide study carried out in partnership with the National Treatment Agency (NTA) in England; the Welsh Substance Misuse Policy Development Team; and the Northern Ireland Department of Health, Social Services & Public Safety. The Scottish study was funded by the Scottish Executive under the Drug Misuse Research Programme, and was carried out between 15 January and 30 September 2005.

- Needle exchanges have a vital role to play in reducing the risks associated with injecting drug use. However, until now, there has been very little information available on needle exchange provision in Scotland. There has been no accurate data on the number and location of services, the ways in which they are organised, or the interventions offered by them. Previous research has suggested that there is a great deal of variation in service provision.

- The National Needle Exchange Survey aimed to:
  - Map needle exchange service provision
  - Investigate the nature of that service provision
  - Identify areas of good and innovative practice
  - Identify barriers and difficulties in commissioning and delivering needle exchange services.

This document reports on the findings of a survey of needle exchange provision in Scotland. The study was part of a larger UK-wide study carried out in partnership with the National Treatment Agency (NTA) in England; the Welsh Substance Misuse Policy Development Team; and the Northern Ireland Department of Health, Social Services & Public Safety. The Scottish study was funded by the Scottish Executive under the Drug Misuse Research Programme and was carried out between 15 January 2005 and 30 September 2005.

Policy and research context

Findings from the most recent Scottish prevalence study indicate there are an estimated 51,582 problem drug users in Scotland (Hay et al., 2005), where problem drug use was defined as the misuse of opiates and / or benzodiazepines. Of these, 18,737 individuals were estimated to be injectors.

There are a number of serious risks associated with injecting drug use. Compared to non-injectors, injectors have higher rates of drug-related mortality. They are also at increased risk of acquiring blood-borne viruses (BBVs) such as HIV and viral hepatitis, and bacterial infections (HPA et al., 2005).

Needle exchange services have a vital role to play in reducing the risks associated with injecting — particularly in relation to preventing transmission of BBVs. And while the effectiveness of needle exchange programmes in the prevention of HIV is now well-established (WHO, 2004), the evidence suggests that needle exchange has been less effective in controlling Hepatitis C infection. However, until recently, it has not been clear why.

In Scotland, it is estimated that 50,000 people are infected with the Hepatitis C virus (HPA et al., 2005). The vast majority of these individuals acquired their infection through injecting and roughly two-thirds have undiagnosed infections. Incidence among injecting drug users (IDUs) is also very high. Surveillance studies of injectors in Glasgow have shown that 50% of IDUs who had been injecting for less than two years in 2004 were
already infected with Hepatitis C (HPA et al, 2005). There is also some evidence that Hepatitis C prevalence among injectors may vary considerably across Scotland although it is not clear why this should be so. What is clear is that both incidence and prevalence of Hepatitis C have been on the rise in Scotland.

In Scotland, national policy in relation to needle exchange is different to other parts of the UK. In Scotland, there is a limit on the numbers of needles and syringes that may be given out to an individual in any one transaction in a needle exchange. These limits have been set by Scotland’s Lord Advocate, and were revised upwards in December 2002 in response to growing concerns about the Hepatitis C epidemic among IDUs (NHS HDL No.(2002)90). The current limits on needle and syringe provision are:

- Maximum 20 needles/syringes on the first visit (up from 5)
- Maximum 60 needles/syringes on subsequent visits (up from 15)
- An exceptional upper limit of 120 for holiday periods when facilities are closed or where facilities are difficult to access (up from 30).

An evaluation of the impact of this change in policy found that, over a year after the change had taken place, few injectors were aware of it. This same study also found wide variation in practices among pharmacy needle exchange services in Glasgow in terms of whether IDUs were encouraged to take a greater number of needles / syringes at each transaction. Furthermore, interviews with IDUs found that few injectors *wanted* as many as 60 needles / syringes when they visited the needle exchange, despite admitting that they frequently re-used needles / syringes (Taylor et al, 2005). These findings suggest that the current limits set by the Lord Advocate on needle / syringe distribution are not directly contributing to the growing prevalence of Hepatitis C in Scotland.

It has been suggested that the sharing of needles, syringes and other injecting paraphernalia such as filters, spoons and water may be a contributing factor, both in Scotland and elsewhere, and in August 2003, upon the recommendation of the Advisory Council on the Misuse of Drugs, an amendment to Section 9A of the UK Misuse of Drugs Act (paraphernalia) came into effect. The change in law allows doctors, drug treatment workers and pharmacists to supply drug users with ampoules of water for injection, swabs, spoons, filters and citric acid to help prevent disease and infection.

Ethnographic research among IDUs in Glasgow has provided an additional perspective on this issue. This research found little evidence of direct sharing of needles and syringes among IDUs, but frequent sharing and reusing of paraphernalia such as filters, spoons and water. IDUs also commonly engaged in “indirect” sharing of previously-used, potentially contaminated needles and syringes. The researchers concluded that IDUs need more information about the ways in which injecting equipment can become contaminated during the process of preparing drugs (Taylor et al, 2004).

The findings from this research have important implications for needle exchange services. The message is clear: it is not enough to simply give IDUs sterile needles, syringes and other paraphernalia; they need to understand how to use this equipment correctly. Needle exchanges therefore must take on much more of an educational role with IDUs.

In Spring 2005, input from key stakeholders to the drafting of Scotland’s Hepatitis C Action Plan identified the expansion and development of needle exchange services as one of Scotland’s top priorities for action in relation to Hepatitis C prevention (Scottish Executive, 2005, Annex B). This sentiment was echoed in the annual *Shooting Up* report published in October 2005 (HPA et al, 2005). The latter document made specific recommendations regarding needle exchange services, which included:

- Ensuring sufficient distribution of injecting equipment to prevent the sharing of needles and syringes
• Providing injecting-related equipment other than needles and syringes as appropriate
• Ensuring an appropriate range of needle exchange services are provided (i.e., through drug services, pharmacies and mobile or outreach services)
• Ensuring appropriate training for needle exchange staff
• Expanding the educational role of needle exchange services
• Expanding the services available through needle exchanges – to include on-site vaccination for Hepatitis B, and testing for HIV and Hepatitis C.

At the same time, in 2005, a decision was taken to update the Scottish guidelines on needle exchange published in 2000. National guidelines on needle exchange were produced in 1999 by a working party of the UK National Needle Exchange Forum. This document provided a guide to best practice in organising and delivering needle exchange services. A year later, a Scottish version of this document was published by the Scottish Drugs Forum (SDF), who host the Scottish Needle Exchange Workers Forum. The National Guidelines for Needle Exchange in Scotland included modifications of the UK guidelines which reflected local issues facing services in Scotland. The Scottish guidelines were intended to provide a standard against which needle exchange services in Scotland could be evaluated.

However, until now, there has been very little information available on needle exchange provision in Scotland. Corporate Action Plans, submitted annually to the Scottish Executive by Drug Action Teams (DATs), only require details on the total number of specialist, outreach and community pharmacy needle exchange facilities in their area, and the total number of needles / syringes distributed and returned for each category. Apart from this, it has not been clear how services are organised or what interventions are offered by needle exchange facilities, but previous research in local areas has suggested that there was a great deal of variation in service provision.

It is within this context that the Scottish Needle Exchange Survey was commissioned.

**Aims of the study**

The Needle Exchange Survey in Scotland had the following aims:
• To map needle exchange service provision
• To investigate the nature of that service provision
• To identify areas of good and innovative practice in this area
• To identify barriers and difficulties in commissioning and delivering needle exchange services.

The results of the study are intended to lead to improvements in needle exchange services.

**Structure of the report**

This report will look in detail at aspects of needle exchange provision in Scotland.

**Part 1 will focus on needle exchange service delivery and activity.** It will cover:
• The number, location and types of services (Chapter 3)
• The accessibility of needle exchange services (Chapter 4)

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4 The completion of the updated guidelines has been delayed pending publication of the present report.
• Day-to-day needle exchange activity – in terms of numbers of transactions / client contacts, number of clients, numbers of syringes distributed and returned (Chapter 5)
• Other on-site interventions provided by needle exchange services in Scotland (Chapter 6)
• Needle exchange policies and procedures (Chapter 7)
• Selected comparisons between services in Scotland and England (Chapter 8).

Part 2 of the report will focus on findings in relation to the planning and commissioning of needle exchange services in Scotland. It will cover:
• The co-ordination, planning and commissioning of services (Chapter 9)
• Staff training and qualifications (Chapter 10)
• Perspectives on good practice (Chapter 11)
• Problems and impediments in commissioning and delivering services (Chapter 12).

Chapter 13 will draw some conclusions from both parts of the report, and make recommendations to policy-makers, service commissioners and service providers.

A summary of the main findings (or “Headlines”) will be presented at the start of each chapter.

However, before going on to present the findings, Chapter 2 first describes the methods used to carry out the research.
Chapter 2: Methods

Headlines from this chapter

- The National Needle Exchange Survey was designed to gather information from those responsible for planning and commissioning needle exchange services, and those responsible for delivering those services.

- A combination of qualitative and quantitative methods were used. The quantitative element consisted of three postal questionnaire surveys. These were sent to:
  - DAT partnership / joint commissioning managers or their equivalent
  - Non-pharmacy needle exchange providers
  - Pharmacy needle exchange co-ordinators

- The qualitative element consisted of three focus groups – one with each of the three groups listed above.

- In addition, a complete directory of needle exchange services in Scotland was compiled.

- Scottish survey response rates were excellent:
  - 22 DATs were surveyed; 19 responded (86%)
  - 50 services were surveyed; 45 responded (90%)
  - 12 pharmacy co-ordinators were surveyed; 10 responded (83%)

- Data quality in relation to some questions was poor. In particular, there were incomplete or missing responses in relation to many of the questions on needle exchange activity (i.e., number of transactions, number of clients, number of syringes distributed and returned).

The Needle Exchange Survey was designed to gather information both from people responsible for planning and commissioning needle exchange services, and those who were responsible for delivering those services (both pharmacy and non-pharmacy providers).5

Both qualitative and quantitative methods were used. The quantitative element consisted of three postal questionnaire surveys:

- A survey of DAT partnership / joint commissioning managers or their equivalent
- A survey of non-pharmacy needle exchange services
- A survey of pharmacy needle exchange co-ordinators.

Most questions required a tick-box or short written response. In addition, at the end of each questionnaire, there was space for respondents to give examples of good practice and provide details of problems and impediments in commissioning and delivering needle exchange services. The questionnaires were piloted and the surveys administered in Scotland by staff in the Scottish Executive. Copies of the questionnaires are available from the first author upon request.

The qualitative element of the study consisted of three focus groups – one with each of the three groups listed above. The qualitative work in Scotland was carried out by Griesbach & Associates under contract to the NTA. Assistance and support in organising the focus groups was provided by staff in the Scottish Executive.

5 The study in Scotland did not involve getting the views of service users. However, the English arm of the study did include this element.
Compiling a needle exchange directory

Prior to undertaking this study, there was no comprehensive list of needle exchange services in Scotland. Information was available from the 2003-04 Corporate Action Plans on the names (but not the addresses) of non-pharmacy exchanges and the Scottish Drugs Forum helpfully provided a list of the members of the Scottish Needle Exchange Workers Forum along with their contact details. However, taken together, these lists were far from complete.

Therefore, a decision was taken to ask the co-ordinators of each of Scotland’s 22 DATs for the name(s) of one or more contact persons who could provide a comprehensive list of all pharmacy and non-pharmacy needle exchange services in their area. The resulting list was then circulated to DAT co-ordinators for checking and correction if necessary. By this means, it was possible to compile a complete directory of needle exchange services in Scotland by DAT area.

Analysis

Descriptive analysis of the Scottish survey results was undertaken by staff at the NTA using SPSS and Griesbach & Associates using Excel.

Analysis of the focus group discussions was undertaken by Griesbach & Associates. Key themes were identified, and these will be reported at relevant points throughout this document as a way of explaining, or providing a context for, the survey results.

In Scotland, DAT partnerships have responsibility for planning local drug services. However, needle exchange services are generally funded and commissioned by NHS Boards. Therefore, where appropriate, comparisons will be made between NHS Boards and in some cases, comparisons will also be made between DATs. However, because of the small numbers of services involved, meaningful statistical comparison between Scottish NHS Boards or DATs was not possible.

On the other hand, the data did allow comparisons to be made between needle exchange services in Scotland and England, and some of these comparisons will be presented in Chapter 8 of this report.

All data presented in this report relates to the period April 2004 to March 2005.

Survey response rates

Response rates to the surveys are shown in Table 2.1 below.

<table>
<thead>
<tr>
<th></th>
<th>Total number available</th>
<th>Number surveyed</th>
<th>Number responding</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATs</td>
<td>22</td>
<td>22</td>
<td>19</td>
<td>86%</td>
</tr>
<tr>
<td>Non-pharmacy services</td>
<td>52</td>
<td>50</td>
<td>45</td>
<td>90%</td>
</tr>
<tr>
<td>Pharmacy co-ordinators</td>
<td>15</td>
<td>12</td>
<td>10</td>
<td>83%</td>
</tr>
</tbody>
</table>

All 22 of Scotland’s DATs were invited to participate in the DAT survey. Responses were received from 19.

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6 There are 22 Scottish DATs, but are only 15 NHS Boards. Grampian Health Board includes Aberdeen City, Aberdeenshire and Moray DATs; Lothian Health Board includes East Lothian, Midlothian, West Lothian and Edinburgh City DATs; and Tayside Health Board includes Angus, Dundee City and Perth & Kinross DATs.
Fifty of the 52 non-pharmacy services identified in Scotland were surveyed. The specialist services in Orkney and the Western Isles were not surveyed because it was discovered in the DAT survey that these services had not been used in the previous year.

Pharmacy co-ordinators in 12 of the 15 Scottish NHS Board areas were surveyed. Western Isles was not surveyed because there is no pharmacy needle exchange scheme in the Western Isles. In the case of Dumfries & Galloway and Shetland, it had not been possible to identify a pharmacy co-ordinator.

It should be noted that pharmacy needle exchange schemes are co-ordinated at the level of NHS Boards. However, pharmacy co-ordinators were asked to complete separate questionnaires for each of the DAT areas they covered. As a result, the co-ordinators from Grampian, Lothian and Tayside completed multiple questionnaires. A total of 17 questionnaires were received from pharmacy co-ordinators throughout Scotland.

Further details of respondents are provided in Appendix 1.

**A note about data quality**

It must be noted that in any survey, the information reported can only be as accurate as the information that was provided. This study involved three surveys — a survey of DATs, a survey of non-pharmacy services and a survey of pharmacy co-ordinators. The three questionnaires focused on different issues, but also asked similar questions, particularly in relation to needle exchange activity (i.e., number of transactions, number of clients, number of syringes distributed and returned). This was done deliberately to allow for the triangulation of the data.

As it turned out, the lack of robust monitoring systems in needle exchange services was especially apparent in relation to these questions on needle exchange activity. For example, nearly every DAT respondent said that services in their area collected data on the number of transactions (or contacts) that took place in needle exchange services, and many said that they also collected data on the number of clients. However, when asked for these numbers, DATs found it very difficult to provide complete and accurate figures. In some cases, it transpired that the data was available from only some of the services in the DAT area. Other DATs reported that data was routinely collected, but it was not held electronically, and therefore, it was impossible to obtain a report of this information. Others stated that data collection systems had only recently been introduced, and so the information was unavailable for the period requested.

Where figures were provided, it must be pointed out that there was reasonably good correspondence between the figures provided by DATs and those provided by pharmacy co-ordinators for pharmacy services — at least with respect to needle exchange transactions. However, there were often quite substantial differences between the DAT figures and those provided by respondents from the non-pharmacy services in that DAT area. For example, one DAT respondent reported a figure for total transactions in non-pharmacy services that was nearly three times the figure reported by the services in that area. Another DAT respondent reported a figure for transactions that was about one-fifth of what the services in that area reported.

As much as possible, the findings presented in this report are based on the best data that was available. However, the issue of poor data quality must be kept in mind throughout this report — but especially in relation to the findings presented in Chapter 5.
FINDINGS PART 1:

NEEDLE EXCHANGE SERVICE DELIVERY AND ACTIVITY
Chapter 3: Mapping needle exchange provision

Headlines from this chapter

- This study identified 188 needle exchange outlets in Scotland:
  - 136 pharmacy exchanges
  - 43 specialist needle exchanges, of which half offered mobile / outreach services
  - 6 police custody suite exchanges
  - 3 exchanges based in hospital A&E or Emergency Care Units
- Some form of needle exchange was available in all DAT areas of Scotland.
- Just under one-quarter of needle exchanges were provided by specialist services. Half of these specialist services also delivered needle exchange through a mobile or outreach service.
- Across the whole of Scotland, pharmacy exchanges outnumbered specialist services by a ratio of nearly 3:1.

This section addresses the first aim of the study, which was to map needle exchange service provision in Scotland. Information about the number of services, and their locations are presented.

This study identified 188 needle exchange outlets in Scotland. These included:

- 136 pharmacy exchanges
- 43 specialist needle exchanges, of which 22 offered mobile / outreach services
- 6 police custody suite needle exchanges
- 3 based in hospital A&E or Emergency Care Units

Table 3.1 on the next page shows that some form of needle exchange was available in all DAT areas of Scotland — either through specialist services, pharmacy services or both. However, it should be noted that the services in Orkney and the Western Isles had not been used in the period April 2004 – March 2005.

It is also worth noting that, at the time of this study, a number of DATs were attempting to expand pharmacy provision in their area, and therefore, the total number of needle exchange outlets in Scotland may now be slightly higher.

Just under one-quarter (22.9%) of needle exchanges in Scotland were provided by specialist services. In addition, half of these specialist services delivered needle exchange through mobile / outreach services. Mobile / outreach services were usually provided by agencies which also had a fixed base site. Just over half of specialist services (n=24) were located within a wider drug treatment service.

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7 Note that “specialist needle exchange” services may be provided either by statutory or voluntary sector agencies.
Table 3.1: Number of needle exchange services, by NHS Board and DAT area

<table>
<thead>
<tr>
<th>NHS Board / DAT</th>
<th>Pharmacy exchanges</th>
<th>Specialist exchanges (mobile / outreach services)</th>
<th>Police custody suite exchanges</th>
<th>Hospital A&amp;E exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>4</td>
<td>5 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>7</td>
<td>3 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borders</td>
<td>2</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>3</td>
<td>3 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td>12</td>
<td>2 (1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Forth Valley</td>
<td>14</td>
<td>1 (1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Grampian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>5</td>
<td>1 (1)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>2</td>
<td>3 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moray</td>
<td>4</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>26</td>
<td>3 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td>7</td>
<td>1 (1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>17</td>
<td>4 (1)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lothian</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>4</td>
<td>0 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>10</td>
<td>7 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian</td>
<td>1</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Lothian</td>
<td>3</td>
<td>0 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orkney</td>
<td>2</td>
<td>1 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shetland</td>
<td>1</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tayside</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Angus</td>
<td>3</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dundee City</td>
<td>4</td>
<td>2 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>5</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>1 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>136</strong></td>
<td><strong>43 (22)</strong></td>
<td><strong>6</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

Specialist needle exchange services were not located in all DAT areas. However this is not to say that these areas did not have access to a specialist service. Neither East Lothian nor West Lothian DATs had their own specialist services, but both areas benefited from outreach services based in neighbouring Edinburgh City and Midlothian.

Most DAT areas had access to needle exchange provided through a mobile or outreach service. Edinburgh City had the largest number of outreach services. Three of the seven services based in Edinburgh offered some form of mobile or outreach provision.

Pharmacy needle exchanges existed in all but one DAT area. Only the Western Isles had no pharmacy exchange scheme.

Police custody suite exchanges were reported in Fife, Forth Valley (Central Scotland Police), Grampian, Lanarkshire, Lothian and Tayside.

Needle exchanges were based in hospital A&E departments in Highland and Lanarkshire.

In general, at the level of the DAT, pharmacy exchanges outnumbered specialist services. The exceptions to this rule were in Argyll & Clyde and Aberdeen. Across Scotland, pharmacy exchanges outnumbered specialist services by a ratio of nearly 3:1. This ratio varied considerably between DATs, with Forth Valley having 14 and Glasgow having 8.6 pharmacy exchanges for every one specialist service – whereas numbers in Edinburgh and Argyll & Clyde were more even.
Chapter 4: Accessibility of needle exchange services

Headlines from this chapter

- Half of Scottish DATs said that all injectors living in their area had access to some form of needle exchange service within five miles of their place of residence.
- Not surprisingly, needle exchange was least accessible in the most remote and rural areas of Scotland.
- Injectors living in mixed rural / urban areas have access to the widest range of needle exchange services.

Chapter 3 showed the distribution of needle exchange services across Scotland. This chapter looks at the issue of needle exchange accessibility in more detail. The focus will be on the geographical proximity of services and their opening times. The findings are taken from responses to the DAT survey.

Geographical proximity

To measure the accessibility of needle exchange services, DATs were asked if all injecting drug users (IDUs) in their area had access to some form of needle exchange facility within five miles of their home. At the same time, it was also recognised that in rural areas of Scotland, individuals may have to travel further than 5 miles to access any type of amenity (such as a shop, post office, GP surgery).

With this caveat in mind, half of DAT respondents (10 out of 19) reported that all IDUs in their area had access to some form of needle exchange within five miles of their place of residence. Those that did not were in Aberdeenshire, Argyll & Clyde, Borders, East Lothian, Highland, Lanarkshire, Moray, Orkney and the Western Isles.

It was expected that the rural nature of many areas in Scotland would have an impact on the accessibility of needle exchange. To explore these issues in more detail, DATs were grouped into one of six categories using a rurality classification scheme developed by the Scottish Executive (where 1 represents the most urban DATs and 6 represents the most rural). The classification takes into account both the size of settlements as well as their “remoteness”, or distance from other larger settlements. See Table 4.1.

### Table 4.1: Number of DATs by extent of rurality

<table>
<thead>
<tr>
<th>Category</th>
<th>DATs</th>
<th>Total no. of DATs</th>
<th>No. taking part in DAT survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (most urban)</td>
<td>e.g. Aberdeen City, Dundee, Edinburgh, Glasgow</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>e.g. Argyll &amp; Clyde, Forth Valley, Lanarkshire, West Lothian</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>e.g. Angus, Ayrshire &amp; Arran, Fife, Midlothian</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>e.g. Perth &amp; Kinross</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>e.g. Aberdeenshire, Borders, Dumfries &amp; Galloway, East Lothian, Highland, Moray</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>6 (most rural)</td>
<td>e.g. Orkney, Shetland, Western Isles</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>22</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

Notes to table
As indicated in Chapter 2 above, three DATs did not participate in the survey. These were Dumfries & Galloway, Edinburgh and Shetland. These three DATs would be classified in the table above in categories 1, 5 and 6.
Not surprisingly, the findings showed that needle exchange was least accessible in the most remote and rural areas of Scotland. See Figure 4.1. None of the seven DATs in categories 5 and 6 had any form of needle exchange service that was available to all injectors within five miles of their place of residence. It is also not surprising that all three of the most urban DAT areas (category = 1) had pharmacy needle exchanges available to all service users within five miles of their home.

What is perhaps more interesting is that all five of the DATs in categories 3 and 4 had specialist services which were available to all injectors within five miles of their residence. Furthermore, in four of these DAT areas, there was also an outreach or mobile service available, and in three of these DAT areas, there was also a pharmacy needle exchange available to injectors within the same five-mile radius. It is also interesting to note that none of the four DATs in category 2 had pharmacy services and only two of the three DATs in category 1 had specialist services that were available to all injectors within five miles of their place of residence.

These findings suggest that “the rural factor” plays a big role in the accessibility of needle exchange services. However, rural / urban variations alone do not account for the accessibility or lack of accessibility of services. Living in an urban setting does not guarantee access to both specialist and pharmacy services. Injectors living in mixed rural – town settings appeared to have access to the widest range of needle exchange services.

Opening times

**Non-pharmacy services** Accessibility can also be measured in terms of opening times of services. The majority of non-pharmacy services in Scotland were open Monday to Friday, mornings and afternoons, although, as Figure 4.2 shows, services were more likely to be open in the afternoon than the morning. Just over a third of services offered evening opening hours, usually on Monday, Tuesday and Thursday evenings. Less than a quarter were open on Saturday or Sunday, and these were mainly based in hospitals or police custody suites. Most hospital and police custody suites were open 24 hours a day, seven days a week but, in general, these services saw very few clients. Indeed police custody suites are obviously only available to individuals taken into custody. The only other service in Scotland that was open 24:7 was the Glasgow Drug Crisis Centre.

**Pharmacy services** Responses from pharmacy co-ordinators indicated that, in general, “all” or “most” pharmacy needle exchange services in their areas were open six days a week, Monday to Saturday, mornings and afternoons. Glasgow had “a few” pharmacy services and Highland had one service (in Inverness) open until 9pm on weekdays. Edinburgh City had “a few” pharmacy services available seven days a week, from 9am – 9pm. Only Edinburgh, Aberdeen and Highland (again, the one service in Inverness) had pharmacy needle exchange service provision on Sundays.
Figure 4.1: Needle exchange coverage, by rurality

Do all injecting drug users in your DAT area have access to the following types of needle exchange services, within five miles of their residence?

| Rural classification (1=most urban, 6=most rural) |
|---|---|---|---|---|---|---|
| 1 (n=3) | 2 (n=4) | 3/4 (n=5) | 5 (n=5) | 6 (n=2) |
| Specialist services | Outreach / mobile services | Pharmacy services |

Note to figure
Because there is only one DAT in category 4, this DAT has been grouped together with those in category 3 for the purposes of this analysis.

Figure 4.2: Opening hours of non-pharmacy services

Number of services (out of 45)

<table>
<thead>
<tr>
<th>Day</th>
<th>AM</th>
<th>PM</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>30</td>
<td>20</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Tue</td>
<td>35</td>
<td>25</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Wed</td>
<td>25</td>
<td>30</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Thur</td>
<td>35</td>
<td>20</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Fri</td>
<td>25</td>
<td>30</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Sat</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Sun</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Note to figure
AM = morning; PM = afternoon; evening = up until 9pm; night = after 9pm.
Chapter 5: Needle exchange activity, 2004-05

Headlines from this chapter

- Thirty-six (out of 45) non-pharmacy services reported 82,389 transactions in 2004-05. The number of transactions ranged from 31 in one service in Grampian (Moray) to 11,739 in a service in Ayrshire & Arran.

- The ratio of male-to-female contacts reported by non-pharmacy services was 2.7:1.

- Twenty-three (out of 45) non-pharmacy services reported 756 contacts with under-18s.

- Pharmacy co-ordinators reported 169,117 transactions for 116 pharmacies in 2004-05. The number of transactions ranged from 0 in the two pharmacies in Orkney to 59,435 in the 26 pharmacies in Glasgow.

- Thirty-one (out of 45) non-pharmacy services had a total of 14,229 clients in 2004-05. The number of clients ranged from 10 in one service in Lanarkshire to 4,052 in a service in Lothian.

- Pharmacy co-ordinators (3 out of 10) reported 17,726 clients for 37 pharmacies in 2004-05. The number of clients ranged from 243 in the seven pharmacies in Highland to 15,974 in the 18 pharmacies in Lothian.

- Figures on the number of clients must be treated with caution because of the large number of non-responses to this question. Focus group participants mentioned the difficulties of accurately monitoring the number of clients accessing their services.

- At least 3.5 million syringes were distributed by needle exchange services across Scotland. However, these figures can only be taken as approximations. The actual totals are likely to be considerably higher.

- An approximately equal number of syringes were distributed by pharmacy and non-pharmacy services (1.8 million each). However, this statement masks enormous geographical variation. A very large number of syringes were given out by pharmacies in Glasgow. In most other areas of Scotland, it appeared that specialist services were distributing a larger number of syringes than pharmacy services. This finding was unexpected, given that pharmacy exchanges outnumber non-pharmacy exchanges across Scotland by 3 to 1.

- There were very wide geographical variations in the levels of syringe distribution per estimated injector – ranging from approximately one syringe per injector per day, to one syringe per injector every 6.4 days. These findings should be seen as a cause for concern.

- Data on needle / syringe returns was generally poor, due to the obvious difficulty of counting the contents of sealed sharps bins. However, at least 1.56 million syringes were reported to be returned to pharmacy and non-pharmacy services in 2004-05.

This chapter provides details of needle exchange activity in Scotland for the one-year period April 2004 – March 2005. Information will be presented on the number of “transactions” (or needle exchange contacts), the number of clients, the number of syringes distributed, and the number of used syringes returned in this one-year period. Information about paraphernalia distribution, and other harm reduction interventions offered by needle exchange services will be presented in the next chapter.

As mentioned earlier in this report (Chapter 2, page 13), there were some major discrepancies between the figures reported by DATs and those reported by service providers and pharmacy co-ordinators in relation to questions on needle exchange activity. The reported figures from all three surveys are shown in Appendix 3.

Table 5.1 below presents a summary of the best information available from the study on needle exchange activity. These findings are discussed in further detail below.
Table 5.1: Summary of findings on needle exchange activity for the period April 2004 – March 2005

<table>
<thead>
<tr>
<th></th>
<th>Non-pharmacy services</th>
<th>Pharmacy services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of transactions</td>
<td>82,389 in 36 services</td>
<td>169,117 in 10 pharmacy schemes (116 pharmacies)</td>
</tr>
<tr>
<td>Number of clients</td>
<td>14,229 in 31 services</td>
<td>17,726 in 3 pharmacy schemes (37 pharmacies)</td>
</tr>
<tr>
<td>Number of syringes distributed</td>
<td>1,807,490</td>
<td>1,746,421</td>
</tr>
<tr>
<td>Number of syringes returned</td>
<td>849,113</td>
<td>714,199</td>
</tr>
</tbody>
</table>

Number of transactions

Information on needle exchange transactions has been taken from responses to the Services and Pharmacy Co-ordinator surveys.

Non-pharmacy services

Four-fifths of non-pharmacy services (36 out of 45) reported the number of transactions they had between April 2004 – March 2005. According to this data, these 36 services had a total of 82,389 transactions in this period. The number of transactions ranged from just 31 in one service in Grampian (Moray) to 11,739 by a service in Ayrshire & Arran. The median number of transactions per service was 1,054 and the mean was 2,289.

Non-pharmacy services were also asked if they recorded information about client age and gender. Only 29 out of 45 services were able to provide data on gender. These services reported a total of 45,007 transactions with males, and 16,578 transactions with females. This results in a male-to-female contact ratio of 2.7:1. It should be noted that the ratio of males to females in drug treatment services overall was reported to be 2.0:1 in the same period (ISD 2005).

Only 23 out of 45 services were able to provide data on the number of transactions they had with under-18s. These services reported a total of 756 contacts with young people under the age of 18.

Pharmacy services

All 10 pharmacy co-ordinators provided information on needle exchange transactions in the pharmacies in their area, representing the activity of 116 pharmacies. According to this data, there were a total of 169,117 transactions for these 116 pharmacies in 2004-05. The number of transactions ranged from 0 in the two pharmacies in Orkney to 59,435 in the 26 pharmacies in Glasgow. The mean number of transactions was 1,458 per pharmacy. It was not possible to calculate the median because data on pharmacy transactions was reported as an aggregate figure for all the pharmacies in each NHS Board.

Number of clients

Information on the number of needle exchange clients has been taken from the responses to the Services and Pharmacy Co-ordinator questionnaires. There was a large number of non-responses to this question. Therefore, these figures must obviously be treated with caution. Focus group participants pointed out the difficulties of accurately monitoring the number of clients accessing their services since, in many cases, people access needle exchange services anonymously.
Non-pharmacy services

Thirty-one out of 45 non-pharmacy services reported the number of clients they had in 2004-05. These **31 services had a total of 14,229 clients** in this period. The number of clients ranged from 10 in one service in Lanarkshire to 4,052 in a service in Lothian. The median number of clients per service was 221; the mean was 491.

Pharmacy services

Pharmacy co-ordinators from only 3 NHS Board areas (representing 37 pharmacy services) were able to provide information on number of clients. These **37 pharmacies** had a total of **17,726 clients**. The number of clients ranged from 243 in the seven pharmacies in Highland to 15,974 in the 18 pharmacies in Lothian. The mean number of clients per pharmacy was 479. It was not possible to calculate the median because, again, data was not available at the level of individual pharmacies.

Number of syringes distributed

Findings from the DAT survey were used to calculate the number of syringes distributed across Scotland in the period 2004-05. As DATs are required to provide this data in their annual Corporate Action Plans, this information was reasonably complete. However, in some cases, it is obvious that the reported figures were estimates, as they were rounded to the nearest thousand — or even ten thousand.

All 19 of the DAT respondents provided data on the number of syringes distributed by non-pharmacy services in their area, and 18 out of 19 also provided data on the number of syringes distributed by pharmacy services. The findings indicate that at least **3,553,911 syringes were distributed by needle exchange services across Scotland**. Table 5.2 shows that:

- Non-pharmacy services distributed a total of **1,807,490 syringes**.
- Pharmacy services distributed a total of **1,746,421 syringes**.

These figures can only be taken as approximations. The actual totals are likely to be considerably higher, since three DATs (Dumfries & Galloway, Edinburgh and Shetland) did not participate in the DAT survey, and therefore, their figures are not included. In addition, several DATs indicated in their responses that their figures were incomplete.8

Table 5.2: Number of syringes distributed by needle exchange services, 2004-05

<table>
<thead>
<tr>
<th>No. of syringes distributed from:</th>
<th>Range</th>
<th>Total reported distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pharmacy NEXes (n=19 DATs)</td>
<td>0 (Western Isles) - 378,082 (Glasgow)</td>
<td>1,807,490</td>
</tr>
<tr>
<td>Pharmacy NEXes (n=18 DATs)</td>
<td>0 (Orkney) - 671,688 (Glasgow)</td>
<td>1,746,421</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>3,553,911</strong></td>
</tr>
</tbody>
</table>

---

8 Interestingly, however, the overall figures reported by DATs were substantially higher than the figures reported by non-pharmacy services and pharmacy co-ordinators. (See Appendix 3, Table A.3.3.) The reason for this is unclear, although again, it suggests that inadequate monitoring systems existed in many areas.
Bearing these caveats in mind, it is nevertheless interesting to note that the reported numbers of syringes distributed by specialist and pharmacy services across Scotland were very similar – about 1.8 million in each case. However, this statement masks wide geographical variation. See Tables 5.3 and 5.4 below. For example, the very large number of syringes given out in pharmacy exchanges in Glasgow (671,688) was about 381,000 greater than the next largest total (290,607 given out in Aberdeen City) for pharmacy services. The figures in these tables would seem to suggest that specialist needle exchange services were distributing a larger number of syringes than pharmacy services in most areas outside of Glasgow.

This finding is interesting given that pharmacy needle exchanges across Scotland outnumber non-pharmacy services by 3:1. Even if we removed all 29 Glasgow needle exchange services (26 pharmacy and 3 non-pharmacy services) from the total number of services in Scotland, there would still be five pharmacy exchanges for every two non-pharmacy exchanges.

<table>
<thead>
<tr>
<th>Table 5.3: Reported no. of syringes distributed by non-pharmacy services, 2004-05, by DAT</th>
<th>Table 5.4: Reported no. of syringes distributed by pharmacy services, 2004-05, by DAT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAT</strong></td>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Glasgow</td>
<td>378,082</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>335,543</td>
</tr>
<tr>
<td>Fife</td>
<td>329,252</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>314,767</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td>99,047</td>
</tr>
<tr>
<td>Dundee City</td>
<td>82,678</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>72,000</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>64,106</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>40,000</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>32,970</td>
</tr>
<tr>
<td>Angus</td>
<td>24,194</td>
</tr>
<tr>
<td>West Lothian</td>
<td>15,677</td>
</tr>
<tr>
<td>Midlothian</td>
<td>8,200</td>
</tr>
<tr>
<td>East Lothian</td>
<td>3,949</td>
</tr>
<tr>
<td>Borders</td>
<td>3,309</td>
</tr>
<tr>
<td>Highland</td>
<td>3,160</td>
</tr>
<tr>
<td>Moray</td>
<td>556</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
</tr>
</tbody>
</table>

**Notes to table**
The figures shown for Argyll & Clyde and Dundee City are incomplete. Orkney is not included in the table above, because the specialist service in Orkney does not collect data on numbers of needles and syringes distributed.

Western Isles is not included in the table above because there is no pharmacy needle exchange in the Western Isles. Data from Ayrshire & Arran was unavailable. The figure for Borders is estimated.
By using findings from the National Prevalence Study and the National Needle Exchange Survey and/or the annual Corporate Action Plan (CAP) returns, it is possible to undertake a rough calculation of the total number of needles/syringes that were distributed per injector in each DAT area in the one year period April 2004 - March 2005. It must be remembered that the figures reported by some DATs for number of syringes distributed are clearly estimated. However, if the data provided by DATs are reasonably accurate, the results of this analysis indicate very wide geographical variations in levels of syringe distribution across Scotland. See Table 5.5 below.

Table 5.5: Injecting prevalence (2003) & the distribution of syringes, by DAT, 2004-05.

<table>
<thead>
<tr>
<th>DAT</th>
<th>Estimated prevalence of injecting (Hay et al)</th>
<th>Total no. of syringes distributed in 2004-05*</th>
<th>No. of syringes per injector per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fife</td>
<td>1,124</td>
<td>538,337</td>
<td>479</td>
</tr>
<tr>
<td>East Lothian</td>
<td>83</td>
<td>27,850</td>
<td>336</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>2,050</td>
<td>605,374</td>
<td>295</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway*</td>
<td>663</td>
<td>190,609</td>
<td>287</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>1,146</td>
<td>326,351</td>
<td>285</td>
</tr>
<tr>
<td>West Lothian</td>
<td>251</td>
<td>69,133</td>
<td>275</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>297</td>
<td>67,496</td>
<td>227</td>
</tr>
<tr>
<td>Dundee City</td>
<td>475</td>
<td>104,946</td>
<td>221</td>
</tr>
<tr>
<td>Glasgow</td>
<td>4,908</td>
<td>1,049,770</td>
<td>213</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran*</td>
<td>1,715</td>
<td>335,543</td>
<td>196</td>
</tr>
<tr>
<td>Moray</td>
<td>111</td>
<td>18,199</td>
<td>164</td>
</tr>
<tr>
<td>Midlothian</td>
<td>91</td>
<td>14,739</td>
<td>162</td>
</tr>
<tr>
<td>Angus</td>
<td>322</td>
<td>50,374</td>
<td>156</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>901</td>
<td>110,000</td>
<td>122</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>681</td>
<td>79,000</td>
<td>116</td>
</tr>
<tr>
<td>Highland</td>
<td>373</td>
<td>32,579</td>
<td>87</td>
</tr>
<tr>
<td>Borders</td>
<td>87</td>
<td>5,388</td>
<td>62</td>
</tr>
<tr>
<td>Argyll &amp; Clyde*</td>
<td>2,199</td>
<td>125,924</td>
<td>57</td>
</tr>
</tbody>
</table>

Notes to table
The one-year figures for syringe distribution shown for Dumfries & Galloway are estimated, based on figures for 9 months.

Accurate data on syringe distribution was unavailable for Edinburgh City, and data on injecting prevalence was unavailable for Western Isles, Orkney and Shetland. Therefore, these four DATs are not included in the table.

* Note that all the figures shown above for total syringe distribution are taken from the National Needle Exchange Survey for 2004-05, except where the figures were unavailable or incomplete (i.e., Dumfries & Galloway, Argyll & Clyde and Ayrshire & Arran). In these cases, figures from the annual CAP returns reported for 2004-05 have been used instead. A cursory comparison of CAP figures with figures from the Needle Exchange Survey indicates some discrepancies between the two. However, these discrepancies are not of such great magnitude that they drastically change the picture presented above.
The findings shown in Table 5.5 indicate that needle exchanges in Fife gave out the greatest number of syringes per client in the period 2004-05. Each of the estimated 1,124 injectors in Fife received, on average, 479 needles per year – that is, just slightly more than one needle per day per injector. Needle exchange services in Argyll & Clyde gave out the fewest syringes per injector in the same period. Each of the estimated 2,199 injectors in Argyll & Clyde received, on average, only 57 needles per year. That's one sterile needle every 6.4 days.

These very wide variations clearly cannot be accounted for in terms of rurality. Nor can they be explained in terms of the numbers of needle exchange services available in particular DATs (see again Table 3.1). The results suggest, rather, that some areas are simply getting more sterile syringes out to their clients than other areas. It should be emphasised that there may be problems with the data on syringe distribution from some areas. Nevertheless, these findings should be seen as a cause for concern.

**Return of used syringes**

DATs were asked whether needle exchange services in their area recorded the number of syringes returned. Five DAT respondents said their non-pharmacy services did not record this information, and four of these said their pharmacy services did not record the information either. One DAT respondent said it was only possible to give a rough estimate of the number of returns. These responses were somewhat unexpected as this information is required in the annual CAP returns. However, these messages were not altogether surprising.

The issue of returns was discussed at some length in the Scottish focus groups. Participants pointed out that it is not possible, using existing methods, to know how many needles are returned by clients. For obvious health and safety reasons, the disposal bins are not opened. The point was made that, as a performance monitoring measure, the use of return rates is largely meaningless.

With this in mind, Table 5.6 presents findings from the DAT survey on syringe returns. These findings indicated that in the one-year period from April 2004 – March 2005, at least 1,563,312 used syringes were returned to needle exchange services across Scotland.

- A total of 849,113 syringes were returned to non-pharmacy services (or 47.0% of syringes distributed by non-pharmacy services).
- A total of 714,199 syringes were returned to pharmacy services (or 40.9% of syringes reportedly distributed by pharmacy services)

These figures can only be taken as estimates. Again, the actual number of returns is likely to be considerably higher. And it is not clear from these responses how DATs have recorded data on syringes collected in sharps bins in hostels and public places.

Information on services’ policies on returns will be presented in Chapter 7.

**Table 5.6: Number of syringes returned to needle exchange services, 2004-05**

<table>
<thead>
<tr>
<th>No. of syringes returned to:</th>
<th>Range</th>
<th>Total reported returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pharmacy NEXes (n=11 DATs)</td>
<td>1,724 (Highland) - 312,977 (Ayrshire &amp; Arran)</td>
<td>849,113</td>
</tr>
<tr>
<td>Pharmacy NEXes (n=12 DATs)</td>
<td>262 (Midlothian) - 425,995 (Glasgow)</td>
<td>714,199</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,563,312</td>
</tr>
</tbody>
</table>
Chapter 6: Interventions provided by needle exchange services

Headlines from this chapter

• Practices regarding client assessment and review varied in needle exchange services. Less than a quarter of non-pharmacy services (10 out of 45) reported that an initial assessment was always undertaken with new clients before sterile injecting equipment was provided. About a third (16 out of 45) said they encouraged a client review. However, the majority (27 out of 45) said that a review of client needs was not systematically undertaken.

• There were differences between services in the types of interventions that they offered to their clients on-site. More than half of non-pharmacy services provided their clients with face-to-face harm reduction advice, a list of other needle exchange facilities in the area, referral to structured treatment and brief motivational interventions. Fewer provided key working, structured counselling, care for minor infections, complementary therapies, training in overdose prevention, housing, social welfare or legal advice, and nutrition advice.

• Pharmacy schemes across Scotland offered a much smaller range of interventions to IDUs than non-pharmacy services.

• Only about half of Scottish non-pharmacy needle exchanges (25 out of 45) provided any form of on-site intervention related to BBVs. The interventions most commonly provided were HIV and Hepatitis C pre- and post-test counselling. Two-fifths of services provided Hepatitis C testing, but a third or less provided Hepatitis B testing, HIV testing or any form of immunisation. Only one service in Scotland offered their clients tetanus immunisation. There appeared to be an association between NHS Board and provision of on-site BBV interventions.

• In terms of injecting paraphernalia, the vast majority of both pharmacy and non-pharmacy services in Scotland provided their service users with sharps bins and wipes or swabs. However, there was variation in relation to the distribution of citric acid, stericups / cookers, filters, tourniquets, sterile water and other paraphernalia. Variations in paraphernalia distribution appeared to be associated with NHS Board.

• Focus group participants felt that these variations were unfair and sent mixed messages to service users about what constituted safe injecting practice. Participants in this study argued in favour of formal standards for paraphernalia distribution.

• Concerns were voiced by specialist service providers about the wide use of ‘packs’ to distribute syringes and other paraphernalia in pharmacies. There was a feeling that the use of a ‘pick-and-mix’ system resulted in less waste, and provided a good basis for a discussion with clients about the nature of their drug use and injecting practices. However, pharmacists felt that the use of a ‘pick-and-mix’ system was not practical in many busy pharmacies.

Many needle exchange facilities in Scotland provide services and interventions beyond the simple distribution of sterile needles and syringes. This chapter will look in detail at some of these interventions. It covers practices regarding client assessment and review, since an assessment of need is the first step to any further intervention. Paraphernalia distribution and blood-borne virus vaccination and testing will also be discussed.

The focus here is mainly on interventions delivered on-site by non-pharmacy services. It was assumed that pharmacy needle exchange services would offer fewer on-site harm reduction interventions and the Pharmacy Co-ordinator questionnaires reflected this.
Client assessment and review in non-pharmacy services

Assessment practices

Non-pharmacy needle exchange services were asked about their arrangements for the initial assessment of new needle exchange clients. The term “assessment” was defined as the identification of a client’s needs based on an agreed and written set of questions. The results showed that:

• Less than a quarter of services (10 out of 45) reported that an initial assessment was always undertaken with new clients before sterile injecting equipment was provided.

• Just over a quarter (12 out of 45) said that no assessment was ever undertaken of new clients; half of these were either police custody suite exchanges, or exchanges based in hospitals.

• The majority (20 out of 45) said that they encouraged an initial client assessment, but this was not a condition of access to the service.

There was no apparent relationship between assessment practices and NHS Board or DAT area.

Those that did carry out an initial assessment (n=33) were asked to indicate which issues they covered. The results are shown in Table 6.1 opposite.

Client review

Services were also asked about their arrangements for the planned review of clients’ needs. Again, it was specifically stipulated that “review” in this context meant a review based on an agreed and written set of questions. The findings showed that:

• Only one service in Scotland reported that a planned review was always undertaken as a condition of continued access to sterile injecting equipment.

• Just over a third (16 out of 45) said that they encouraged a client review, but it is not a condition of continued access to injecting equipment.

• The majority of services (27 out of 45) said that the review of client needs was not systematically undertaken.

Interventions provided on-site by non-pharmacy services

Non-pharmacy services were asked whether they provided other interventions which would be of benefit to injecting drug users. A list of possible interventions was provided. This question sought to determine what types of interventions were offered by services, and the extent to which they provided these interventions on-site — that is, without having to refer clients to other agencies. The results are shown in Figure 6.1.

Forty-four (44) of the 45 non-pharmacy services said they provided at least one of the interventions on the list. Police custody suite exchanges provided the smallest number of interventions – usually just a list of other needle exchange services in the area.

• More than half of services provided their clients with face-to-face harm reduction advice, a list of other needle exchange facilities in the area, referral to structured treatment, and brief motivational interventions.

• Less than half (n < 22 out of 45) provided key working or structured counselling, care for minor infections and complementary therapies.
Table 6.1: Number of services covering specified issues in initial client assessment

<table>
<thead>
<tr>
<th>Issue covered in assessment</th>
<th>Number of services (out of 33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe disposal of injecting equipment</td>
<td>33</td>
</tr>
<tr>
<td>Needle/syringe sharing</td>
<td>32</td>
</tr>
<tr>
<td>Safer injecting techniques</td>
<td>32</td>
</tr>
<tr>
<td>Paraphernalia sharing</td>
<td>31</td>
</tr>
<tr>
<td>Overdose risk</td>
<td>30</td>
</tr>
<tr>
<td>Injecting hygiene</td>
<td>28</td>
</tr>
<tr>
<td>Alternatives to injecting</td>
<td>25</td>
</tr>
<tr>
<td>Vein care</td>
<td>24</td>
</tr>
<tr>
<td>Involvement in treatment</td>
<td>22</td>
</tr>
<tr>
<td>BBV testing</td>
<td>22</td>
</tr>
<tr>
<td>Hep B immunisation</td>
<td>19</td>
</tr>
<tr>
<td>Sexual health risks</td>
<td>19</td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>15</td>
</tr>
<tr>
<td>Health status</td>
<td>14</td>
</tr>
<tr>
<td>GP registration</td>
<td>9</td>
</tr>
<tr>
<td>Other (housing status, family circumstances, wound care)</td>
<td>4</td>
</tr>
</tbody>
</table>

Figure 6.1: Number of non-pharmacy needle exchange services that provide the specified intervention on-site

Note to figure:
“Other” interventions included: podiatry services, personal development programmes, a clinic for complex abscesses and ulcers, antibiotic treatment, dental services, pregnancy testing, and access to social activities.
• Less than a third provided overdose prevention training for clients; housing, social welfare or legal advice; or nutrition advice.

• Few provided primary care sessions, well-woman clinics or other interventions.

There did not appear to be a relationship between number or type of interventions offered and NHS Board.

**Interventions provided by pharmacy needle exchanges**

Pharmacy co-ordinators were asked if their pharmacy schemes offered their service users interventions such as: leaflets containing written harm reduction information; face-to-face harm reduction advice; formal referral to drug treatment services by letter or phone; a list of drug treatment services in the area; and a list of pharmacy needle exchanges in the area. The findings are shown in Table 6.2 opposite.

The pharmacy schemes in Glasgow and Highland were the only ones that provided all five of the interventions listed above.

**On-site interventions related to blood-borne viruses**

Non-pharmacy services were asked whether they provided certain interventions related to BBVs within the needle exchange – that is on-site, without having to refer clients to another agency. The findings indicated that only about half of Scottish services (25 out of 45) provided any form of on-site intervention related to BBVs. Table 6.3 shows that the interventions most commonly provided were HIV and Hepatitis C (HCV) pre- and post-test counselling.

• Two-fifths of services provided HCV testing.

• A third or less provided Hepatitis B (HBV) testing, HIV testing, or any form of immunisation.

• Only one service in Scotland, a hospital-based service in Lanarkshire, offered tetanus immunisation.

These findings appeared to be contrary to findings from the focus group discussions, which had suggested that outreach needle exchange services in Scotland provided a wide range of BBV interventions. In fact, only 13 out of 22 outreach services offered any form of BBV testing or immunisation. There appeared to be an association between the availability of on-site BBV interventions and NHS Board (see Table 6.4) — however, the numbers are too small to undertake any meaningful statistical analysis.

Clients’ needs in relation to on-site BBV interventions appeared to be best catered for in Argyll & Clyde, Dumfries & Galloway, Grampian, Lanarkshire, Lothian and Shetland.

One respondent from Lanarkshire said that her service had an arrangement whereby the Infectious Diseases Unit provided a clinic within the needle exchange service one morning per week. A similar arrangement existed within one outreach service in Edinburgh regarding HBV testing and immunisation. Interestingly a respondent from Forth Valley reported that one aspect of good practice in their area was the links that had been established with local hepatology services and the participation in a Hepatitis C Managed Clinic Network. However, it would seem that these positive steps did not extend to the provision of BBV interventions on-site within needle exchange services.
Table 6.2: Interventions offered by pharmacy needle exchange schemes

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number of pharmacy schemes (out of 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaflets</td>
<td>9</td>
</tr>
<tr>
<td>List of pharmacy needle exchanges in the area</td>
<td>6</td>
</tr>
<tr>
<td>Face-to-face harm reduction advice</td>
<td>5</td>
</tr>
<tr>
<td>Formal referral to drug treatment services</td>
<td>2</td>
</tr>
<tr>
<td>List of drug treatment services in the area</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

Note to table
“Other” interventions provided by pharmacy schemes included: a list of the nurse-led needle exchange clinics in the area, and leaflets concerning local issues as and when they arose.

Table 6.3: Number of non-pharmacy services that provide on-site interventions related to blood-borne viruses and tetanus

<table>
<thead>
<tr>
<th>Intervention</th>
<th>n (out of 45)</th>
</tr>
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<tbody>
<tr>
<td>Any BBV intervention</td>
<td>25</td>
</tr>
<tr>
<td>HIV pre / post-test counselling</td>
<td>22</td>
</tr>
<tr>
<td>HCV pre / post-test counselling</td>
<td>21</td>
</tr>
<tr>
<td>HCV testing</td>
<td>18</td>
</tr>
<tr>
<td>HBV testing</td>
<td>15</td>
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<tr>
<td>HBV immunisation</td>
<td>13</td>
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<tr>
<td>HIV testing</td>
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<tr>
<td>HAV immunisation</td>
<td>7</td>
</tr>
<tr>
<td>Tetanus immunisation &amp; booster</td>
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</table>

Table 6.4: Distribution of BBV interventions in services across Scotland, by NHS Board

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>HAV immun</th>
<th>HBV testing</th>
<th>HBV immun</th>
<th>HCV testing</th>
<th>HCV counselling</th>
<th>HIV testing</th>
<th>HIV counselling</th>
<th>Tetanus immun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;C (n=4)</td>
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<td>√√√√</td>
<td>√√√√</td>
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<td>√√√√√</td>
<td>√√√√</td>
<td></td>
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<tr>
<td>A&amp;A (n=3)</td>
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<tr>
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<td></td>
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<tr>
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<td>√</td>
<td>√√√</td>
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<td>√</td>
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<tr>
<td>Shetland (n=1)</td>
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<tr>
<td>Tayside (n=5)</td>
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</tbody>
</table>

Note to table
In the table above, a tick (✓) represents one service. Note that services in Western Isles and Orkney did not participate in the Services survey. It should be noted that police custody suites were in Fife, Forth Valley, Grampian, and Tayside. These services would not be expected to provide on-site BBV interventions.
Paraphernalia distribution

Lively discussions took place in all three Scottish focus groups on the subject of paraphernalia distribution. Focus group participants reported that paraphernalia distribution varies from one health board to another across Scotland. And moreover, they suggested, the principle factor in deciding what gets distributed is, **first, funding, then knowledge of good practice**. Participants felt that existing funding constraints led to a number of unsatisfactory trade-offs needing to be made.

For example, in one health board, the decision to distribute paraphernalia meant that there was no funding to allow for an expansion of needle exchange services in the area. In other areas, one set of paraphernalia was being distributed by voluntary sector services, and another by pharmacies and/or NHS harm reduction services.

Service providers were especially concerned about this situation. They argued that it was not only patently unfair, but it sent mixed messages to service users about what constituted safe practice. One service provider expressed frustration with her local health board and suggested that their unwillingness to provide funding for citric acid distribution was undermining her credibility with her clients, and compromising her ability to deliver a high-quality service.

Service providers argued that paraphernalia provision should **not** be seen by the funders of services as an added luxury — the proper use of sterile paraphernalia was seen to be necessary to reduce harm. It was for this reason that the law regarding distribution of paraphernalia was changed. Service providers and pharmacists strongly felt that the **quality of harm reduction services and interventions should be the same for everyone**, regardless of where they live or where they access the service.

Findings from the survey

Given this context, it was expected that the findings from the survey would reflect variability across Scotland with respect to paraphernalia distribution. Service providers were asked to indicate which items of paraphernalia their service distributed for free. Table 6.5 presents the results. And indeed, as expected, there were differences between services, and as Table 6.6 suggests, **these differences appeared to be associated with NHS Boards**.

The vast majority of both pharmacy and non-pharmacy services in Scotland provided their service users with sharps bins and wipes / swabs. Only one pharmacy scheme, NHS Orkney, did not provide these items. However, as already mentioned, the pharmacy scheme in Orkney had not been used in the previous year.

Differences were noticed in relation to other forms of paraphernalia. For example:

- **Acidifiers (citric acid / Vit c):** Thirty-six (36) services (out of 45) said they supplied some form of acidifier to injectors free of charge. In all cases but one, the acidifier was citric acid (n=35). However, one service in Scotland, the Shetland service, supplied Vit C **instead** of citric acid, and one service in Edinburgh supplied **both** citric acid and Vit C. **Only nine services in Scotland said they did not supply any form of acidifier free of charge.** Eight of these services were located in two NHS Board areas — NHS Grampian and NHS Highland. The ninth service was a police custody suite in central Scotland which operated a needle replacement scheme only.

  Similarly, six out of 10 pharmacy schemes supplied citric acid. Those who did not were in Ayrshire & Arran, Grampian, Highland and Orkney. None of the pharmacy schemes distributed Vit C.
Table 6.5: Number of services that distribute injecting paraphernalia free of charge

<table>
<thead>
<tr>
<th>Item</th>
<th>Number of non-pharmacy services (out of 45)</th>
<th>Number of pharmacy schemes (out of 10)</th>
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</thead>
<tbody>
<tr>
<td>Wipes/swabs</td>
<td>44</td>
<td>9</td>
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<tr>
<td>Sharps bins</td>
<td>42</td>
<td>9</td>
</tr>
<tr>
<td>Citric acid</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>Stericups / spoons /cookers</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Filters</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>8</td>
<td>(not asked)</td>
</tr>
<tr>
<td>Sterile water</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Vit C / ascorbic acid</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Crack-related paraphernalia</td>
<td>2</td>
<td>(not asked)</td>
</tr>
</tbody>
</table>

Table 6.6: Distribution of paraphernalia in non-pharmacy services in Scotland, by NHS Board

<table>
<thead>
<tr>
<th></th>
<th>Citric acid</th>
<th>Stericups / cookers</th>
<th>Filters</th>
<th>Tourniquets</th>
<th>Sterile H2O</th>
<th>Crack-related para.</th>
<th>Vit C</th>
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</thead>
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</tr>
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</tr>
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<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
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</tbody>
</table>

Note to table
In the table above, a tick (✓) represents one service. Note that non-pharmacy services in Western Isles and Orkney did not participate in the Services survey.

- **Stericups / cookers:** Thirteen services said they supplied stericups / cookers to their service users. These services were in Argyll & Clyde (3 out of 4 services), Dumfries & Galloway (2/3), Lanarkshire (1/4), Forth Valley (1/2) and Tayside (5/5). In addition, one service in Edinburgh, an outreach service to homeless people, also supplied stericups. The services in Lanarkshire and Forth Valley are the two main needle exchange providers in these areas. Both operated a number of satellite clinics throughout the region. Only one pharmacy scheme, NHS Tayside, supplied stericups.

- **Filters:** Eleven services said they distributed filters to their service users. Only one pharmacy scheme distributed filters.

- **Tourniquets:** Tourniquets were distributed by eight services, and sterile water was distributed by only five services.

- **Crack-related paraphernalia:** Only two services in Scotland reported distributing crack-related paraphernalia. One of these was an A&E exchange and one was a police custody suite.
Standards for paraphernalia distribution

In focus group discussions, DATs, service providers and pharmacists unanimously agreed that **there should be standards for paraphernalia distribution**. However, when asked what those standards should look like, there was less clarity, and there was disagreement about whether the same standards should apply across pharmacy and non-pharmacy services. In general, people felt that standards for paraphernalia should be based on evidence of effectiveness, but there was also a view that there wasn't currently sufficient evidence available, except in the case of citric acid.9

The distribution of citric acid was seen by service providers and pharmacists to be extremely important — not only because of the evidence that it helps to reduce wound problems in injectors, but also because the provision of citric acid has been shown to attract injectors into services. (See Box 6.1.)

**Box 6.1: Good practice – provision of citric acid**

The Glasgow Drug Crisis Centre (GDCC) found that visits to their service had dropped significantly after the local pharmacy needle exchanges began to include citric acid in needle and syringe packs. At that time, GDCC wasn’t providing citric acid to their clients. GDCC responded to the situation by beginning to distribute citric acid. In less than four months, the number of visits to the service had increased by 31%.

When pressed on the question of standards for paraphernalia distribution, there were some interesting differences in views between DATs, service providers and pharmacists. DATs felt that, as a “basic” standard, all needle exchange services should provide clients with sterile needles and syringes and disposal bins, and then, depending on the availability of funding, additional items of paraphernalia could also be provided above the basic standard.

Pharmacists felt that, ideally, **all forms of paraphernalia should be available to clients**, but given constraints in funding, the “basic” standard should include at the very least, sterile needles and syringes, disposal bins, citric acid, filters and swabs. Non-pharmacy service providers were very uncomfortable with the idea of differing standards for needle exchange. One individual argued that there should not be any such thing as “two-star needle exchanges” and “four-star exchanges.” In general, service providers felt that **all forms of paraphernalia that are legally permitted to be distributed should be available to everyone**.

However, this is not to say that all forms of paraphernalia should necessarily be distributed to everyone automatically. Service providers made the point that clients need to know how to use paraphernalia safely, and that the distribution of paraphernalia needed to go hand-in-hand with client education.

Different injectors have different needs, and the view of service providers was that **it’s important to give people what they need, and only what they need**. This strategy would save money, result in less waste, and provide a good basis for a discussion with clients about the nature of their drug use and injecting practices. Service providers felt that just handing all clients a box with a full set of paraphernalia was doing them a disservice.

9 See the research undertaken by Jennifer Garden et al (2003) — available at http://www.drugmisuse.isdscotland.org/eiu/pdfs/citric_acid_full.pdf. Several people also referred to the ongoing Scottish Executive-funded study being undertaken by Dr Jenny Scott, Bath University, called Safety, risks and outcomes from the use of injecting paraphernalia, which is due to report in Summer 2006.
“If we just hand them a box and say, “Here you go, this is what you need,” we run the risk of appearing to be condescending. Needle exchange should involve a consultation with the client. It’s about providing a service.” (Non-pharmacy service provider, focus group attendee)

Pack syringe distribution vs pick-and-mix

In this respect, specialist service providers felt that a ‘pick-and-mix’ system was preferable to ‘pack’ distribution of syringes and other paraphernalia. However, pharmacists, while strongly in favour of establishing standards for paraphernalia provision, did not necessarily see this as extending to a ‘pick-and-mix’ option in all pharmacies, for the simple reason that pharmacy staff don’t ordinarily have the time (or the space) to give clients the customised service that a ‘pick-and-mix’ system requires.

“If a client has to ask for certain things specifically, it requires a conversation, and striking up a relationship with staff. The pick-and-mix system encourages the development of a relationship. The pack system means that you only get the person there for a matter of seconds. But most pharmacies don’t have the time for the conversation anyway.” (Pharmacy co-ordinator, focus group attendee)

In addition, pharmacists argued that the ‘pack’ system is more discreet and more economical. Given the public nature of most pharmacies, it was felt that pack distribution was more appropriate in that context. Furthermore, focus group participants pointed out that some injectors prefer to use pharmacy needle exchanges because of the speed of the transaction.

According to the Pharmacy Co-ordinator survey responses:

- Pharmacy schemes in Argyll & Clyde, Fife, Glasgow, Grampian and Lanarkshire distributed syringes and other paraphernalia only through packs.
- The schemes in Orkney and Tayside used only a pick-and-mix system.
- Pharmacy exchange providers in Ayrshire & Arran, Highland and Lothian used both pack and pick-and-mix systems.
Chapter 7: Needle exchange policies and procedures

Headlines from this chapter

- There was variation across Scotland in policies and practices related to syringe distribution. The majority of non-pharmacy services (28 out of 45) said there was a maximum number of syringes that their service would give out at any one time. However, in nearly a third of these services, the maximum levels reported bore no relationship to official guidance from Scotland’s Lord Advocate.

- A number said that the maximum number of syringes they would give out to a client at any one time was dependent on certain circumstances such as whether the client was known to the service, the number of syringes returned, etc. There appeared to be similar variation in pharmacy schemes.

- Regarding policies on returns, there was less variation among non-pharmacy services. The majority said that their policy was to “encourage the return of used equipment, but this was not a condition for accessing sterile equipment.”

- Secondary distribution (also known as peer distribution) was highlighted in Scottish focus group discussions as a possible way of improving the accessibility of needle exchange services in rural areas. However, the practice did not appear to be common in Scotland.

- Three-fifths of services (26 out of 45) said that they did not supply injecting equipment to young people under 16. However, 18 reported that they would supply to under-16s in certain circumstances.

- Three-quarters of services (34 out of 45) said they would supply sterile injecting equipment to young people aged 16-17. Many said that over-16s were treated in the same way as adults, but others said that they only supplied this group under certain circumstances, which were similar to those for under-16s.

- Just over a third of non-pharmacy services had a written policy or protocol on the provision of injecting equipment to young people. Only three of these had agreed their policies with the local area Child Protection Committee.

This section presents information about formal policies and procedures related to needle exchange in Scotland. The data is taken mainly from responses to the Services and Pharmacy Co-ordinator surveys.

Policies on the number of syringes distributed

Both non-pharmacy and pharmacy services were asked whether there was a limit on the number of syringes and / or packs that they would give out at any one time. This question was included in the Scottish questionnaires partly to allow comparison with other parts of the UK, and partly to investigate whether services had policies in addition to the official national policy established by Scotland’s Lord Advocate.

Interestingly 8 (out of 45) non-pharmacy services, and two (out of 10) pharmacy co-ordinators, said there was no limit on the number of syringes that their service or pharmacy scheme would give out to a client in any one transaction.

The majority of non-pharmacy services (28 out of 45) said there was a maximum number of syringes that their service would give out at any one time. However, when asked to state what this was, nearly a third of these entered figures which bore no relationship at all to the Lord Advocate’s guidance:

- Four services said that the maximum number of syringes they would give out in any one transaction would be five or less. Three of these were police custody suite
exchanges, and one was a hospital-based service. Police custody suites tend to operate needle-replacement schemes, and so this finding is not surprising in relation to these services.

- One service stated that their maximum limit was 45.
- Two said the limit was 30.
- One service indicated that clients were permitted five syringes for their first visit, 10 for their second visit, and 15 for their third and subsequent visits, unless they were from a rural area, in which case they were permitted a maximum of 30 syringes.
- The remaining services said that the maximum number of syringes they give out would be 60 at any one time, and 120 in exceptional circumstances, in accordance with the Lord Advocate’s guidance.

Eleven services said that the maximum number of syringes they would give out to a client at any one time was dependent on certain circumstances. These included:

- Whether the client was known to the service — those who are not known to the service were given fewer syringes.
- The number of syringes returned — those who returned only a few or no used syringes were given only a few clean syringes.
- Where the client lived — those in rural areas were given more.
- Whether the service had concerns about the health of the client — fewer syringes were given to those with abscesses to encourage more frequent contact.
- Holidays — clients were given more syringes prior to holidays or when the service was going to be closed.

Responses from pharmacy co-ordinators were similar. As mentioned above, two pharmacy co-ordinators said there was no limit on the number of syringes that their pharmacies would give out at any one time. However, the majority (6 out of 10) said that there was a limit, but only one of these entered a number which bore no relationship to the Lord Advocate’s guidance (30). The remaining five said the maximum was either 60 or 120, in accordance with the Lord Advocate’s Guidance, although one of these also indicated that the maximum might be less if the client consistently returned little or no syringes. Two pharmacy co-ordinators said that the maximum depended on circumstances. One said the client would be given a maximum of 60 syringes, unless he/she had no returns, in which case, the client would only be given 20. Another said that pharmacies would follow the Lord Advocate’s guidance for clients who were known to the service, but if they were not, they would only be given one pack of 5 syringes.

These findings clearly indicate a great deal of variation across Scotland in policy and practice related to syringe distribution.

**Policies on returns of injecting equipment**

Non-pharmacy services were asked about their policy on the return of used needles and syringes. The majority (34 out of 44) said that their policy was to “encourage the return of used equipment, but this is not a condition for accessing sterile equipment.” Only one service had a strict one-for-one return policy; this service was a police custody suite exchange which operated a needle replacement scheme. Seven services said they always required some returns before new equipment was issued, and two — both located in hospital A&E Departments indicated that they dispensed sterile injecting equipment, but that used injecting equipment was not returned to their service.
Unfortunately, this question about policies on returns was not asked of pharmacy co-ordinators, as it was felt that any variation in practice would exist at the level of individual pharmacies, rather than at the level of an entire area scheme. However, focus group participants and survey respondents confirmed that pharmacy practices did vary.

**Policies and practices on secondary / peer distribution**

Services were asked about their practices in relation to the secondary distribution of sterile injecting equipment. Secondary distribution, also known as peer distribution, involves needle exchange clients in the distribution of sterile equipment to other injectors. The majority of services (31 out of 45) stated that they discouraged secondary distribution and ten others said they “neither encouraged nor discouraged it.” Only four services encouraged the practice. Differences between services did not appear to be associated with either rurality or health board.

Only six services (out of 45) said they had a written policy on secondary distribution. Of these, two encouraged the practice, one discouraged it and three did neither.

The subject of secondary distribution was discussed briefly in the focus group with non-pharmacy service providers. Secondary distribution was considered to be one way of improving the accessibility of needle exchange services in rural areas. While a few areas reported some success in this, the practice did not appear to be common in Scotland.

**Policies on needle exchange for young people**

Non-pharmacy services were asked about their policies and practices regarding needle exchange to young people. In the first instance, services were asked whether they provided injecting equipment to (a) young people aged under 16 and (b) young people aged between 16-17.

**Under 16s**

Nearly three-fifths of non-pharmacy services (26 out of 45) said that they did not supply injecting equipment to young people under 16. Unfortunately, it is not clear whether services did not do this because they have a policy which prohibits it, or because they simply do not have young people of this age accessing their services. Several respondents indicated that they had never been asked to supply injecting equipment to anyone under 16.

Eighteen respondents indicated that they would supply injecting equipment to under 16s and provided details of the circumstances in which this would be done. Some of these circumstances included:

- “A full assessment is required, and the young person is referred to [local drug service] for injecting advice from a nurse.”
- “If we can’t dissuade the person from injecting, we will supply, but we ask them to return on a regular basis.”
- “If the client is in an active working relationship with the youth support worker.”
- “Two workers would be involved in undertaking a risk assessment.”

Several of those who said they would supply to under 16s indicated that they would do so only if there was evidence that the young person had been injecting previously, and they were able to demonstrate that they understood what they were doing – i.e., able to give informed consent for treatment.
16- to 17-year-olds

In relation to 16- to 17-year-olds, three-quarters of non-pharmacy services (34 out of 45) said they would supply sterile injecting equipment to young people in this age group. Many respondents said that young people of this age were treated in the same way as adults.

However, others reported that they only supplied to this group in certain circumstances, often the same circumstances as for under-16s. Again, several said that they would only supply to young people aged 16 or 17 if there was clear evidence that they were already injecting. But again, it would appear that many services did not commonly see clients under the age of 18. As indicated in Chapter 5, 23 services reported only 756 contacts with under-18s in the period April 2004 – March 2005. On average, that works out to be about 2.7 contacts per service per month.

Service providers focus group participants said that when dealing with clients under 18, they tried as much as possible to ensure that the client understood what they were doing. There was a feeling that it was very important to provide specialist support for young people, and one service provider said that his service had two dedicated young people’s workers, who were responsible for working with young injectors.

Service providers and pharmacists also pointed out the difficulties in knowing just how old people are when they come into the service. Most service providers said they record client date of birth, but pointed out that clients could easily give false information.

Policies on supply to young people

Just over a third (18 out of 45) non-pharmacy services reported that they had a written policy or protocol on the provision of injecting equipment to young people. Only three of these indicated that these policies had been agreed with the local area Child Protection Committee, although one other reported that discussions were currently taking place.

Standard operating procedures for pharmacies

Pharmacy co-ordinators were asked whether they required their local pharmacy exchanges to have standard operating procedures on needle exchange. Seven (out of 10) respondents said that they did, and three said they did not.

Getting the views of service users

Both pharmacy co-ordinators, and non-pharmacy service providers were asked specifically if they had mechanisms for assessing client satisfaction. One-half of non-pharmacy providers (n=23 out of 45) and two of the 10 pharmacy scheme respondents (Fife and Glasgow) reported that they did.

The methods used for assessing client satisfaction varied from one service to another, and in some services, a combination of formal and informal methods were used. These included:

- Bi-annual questionnaire surveys
- One-to-one verbal feedback
- Customer complaints forms
- Service users’ comments book
- Regular service reviews
- Participation in formal research studies
Chapter 8: Comparisons between Scotland and England

Headlines from this chapter

- Specialist services made up 23% of Scottish needle exchanges, compared to 20% in England. In Scotland, pharmacy services comprised 72% of all facilities compared to 79% in England.

- Non-pharmacy needle exchanges in Scotland provided better out-of-hours coverage than similar services in England, but English pharmacy services provided better out-of-hours coverage than those in Scotland.

- Scottish services had more contact with female injectors than English services.

- In Scotland and England, similar levels of syringe distribution were reported by pharmacy and non-pharmacy services, and returns to non-pharmacy services were much higher than returns to pharmacy services in both countries.

- Services in Scotland were significantly less likely than their English counterparts to provide Hepatitis B immunisation on-site. Only one service in Scotland provided tetanus vaccination, compared to 11% of services in England.

- Scottish services were significantly less likely than English services to provide their clients with a list of other needle exchange services in the area. They were also less likely to offer motivational interviewing, key working, structured counselling, GP / primary care sessions, housing / social / legal advice and well-woman clinics.

- Scottish services were significantly less likely than English services to distribute filters, sterile water, stericups and Vit C to their clients. Scottish services were more likely than English services to distribute wipes or swabs. There were no significant differences between Scottish and English services in relation to the distribution of sharps bins, citric acid and tourniquets.

- Compared to Scottish services, a much larger percentage of English services said that there was no limit on the number of syringes they would give out during any one needle exchange transaction. This is because there is no equivalent to the Lord Advocate’s guidance in England.

- Scottish services were significantly more likely than English services to report that they would provide injecting equipment to young people aged 16 or 17. However, there was no difference between Scottish and English services in relation to distribution among under-16s.

- English services were more likely to have a written policy on needle exchange among young people, and to have agreed their policy with the local area Child Protection Committee.

This report presents findings of the Scottish arm of the National Needle Exchange Survey. However, it must be remembered that the study was a UK-wide study involving a collaboration between the Scottish Executive, the National Treatment Agency, the Welsh Substance Misuse Policy Development Team, and the Northern Ireland Department of Health, Social Services & Public Safety. At the time of writing this report, analysis of data from Wales and Northern Ireland was still on-going. However, findings from the English data were available.

Therefore, this chapter makes some selected comparisons between Scotland and England, and highlights areas where there were significant differences between the two countries in needle exchange service delivery. The focus here is mainly on interventions provided by non-pharmacy services, since the number of pharmacy schemes participating in the Scottish survey was too small to allow for meaningful statistical comparison in relation to most variables. However, it must also be remembered that there were poor response rates to certain questions on needle exchange activity in Scotland. This was so in England as well. Therefore, some of the findings presented below should be interpreted with caution.
Proportion of pharmacy and specialist exchanges

In this study, the process of identifying needle exchange facilities was different in Scotland and England. In Scotland, a complete list of needle exchange facilities was compiled prior to the survey; whereas in England, the identification of needle exchange facilities took place as part of the DAT survey. Therefore, at the time of this study, Scotland had a total of 188 needle exchange facilities. This represents a national total. In England, just over 70% of DATs participated in the survey (108 out of 149). The total number of needle exchange facilities identified in these areas was 1,326.

Overall, based on these figures, specialist services made up 23% of Scottish services. This proportion was slightly more than in England, where specialist services constituted approximately 20% of facilities (261 out of 1,326). In Scotland, pharmacy services comprised 72% of all needle exchange facilities; whereas in England, pharmacy services made up 79% of services (1,048 out of 1,326). See Figure 8.1.

Opening times

Non-pharmacy services in Scotland were significantly more likely than their English counterparts to be open on weekday evenings, at night and at weekends. On the other hand, Scottish pharmacies mainly operated during Monday – Saturday business hours whereas in England, pharmacy services provided better out-of-hours access to needle exchange than specialist services did.

Needle exchange activity

**Contact with women:** In comparison with English services, Scottish needle exchanges appeared to have had more contact with women in the period April 2004 – March 2005. The male-to-female contact ratio in Scotland was 2.7:1, whereas in England, it was 3.9:1.

**Number of syringes distributed:** The number of syringes distributed by pharmacy and non-pharmacy services across Scotland between April 2004 – March 2005 were found to be roughly the same — approximately 1.8 million in each case. Although there are some questions about the accuracy of this data, it is interesting to note that there were similar results in England: both pharmacy and non-pharmacy services distributed approximately the same number of syringes — 4.8 million in each case.

**Number of syringes returned:** In Scotland, returns to non-pharmacy services were considerably higher than returns to pharmacies, despite there being three times more pharmacy exchanges than specialist exchanges in Scotland. Again, there were similar findings in England — non-pharmacy services reported higher levels of returns.

Interventions provided by needle exchange facilities

**On-site BBV interventions:** Figure 8.2 shows how Scottish non-pharmacy services compared with those in England regarding provision of on-site BBV interventions. Services in Scotland were significantly less likely than their English counterparts to provide on-site Hepatitis B immunisation (p=0.01). Only one service in Scotland provided tetanus vaccination, compared to 11% of services in England.

It would appear that English services were also more likely to provide Hepatitis A immunisation and Hepatitis B testing, and that Scottish services were more likely to provide HIV pre- and post-test counselling. However, these differences were not statistically significant.
Figure 8.1: Percentage of needle exchange facilities in Scotland and England delivered by pharmacy, specialist and other services (A&E, police custody suite)

Figure 8.2: Percentage of non-pharmacy services in Scotland and England that provide BBV interventions on-site
Other on-site interventions: Figure 8.3 shows a comparison between Scottish and English non-pharmacy services in relation to other on-site interventions. Scottish services were significantly less likely than their English counterparts to provide clients with:

- a list of other needle exchange facilities in the DAT area (p=0.00)
- motivational interviewing (p=0.00)
- key working (p=0.03)
- structured counselling (p=0.00)
- GP/ primary care sessions (p=0.02)
- housing / social / legal advice (p=0.00) and
- well-woman clinics (p=0.00).

Figure 8.3 also suggests that, compared to Scottish services, a larger proportion of English services offered referral to structured treatment, complementary therapies, overdose prevention training and primary care sessions. However, these differences were not statistically significant.

Paraphernalia distribution: There were no statistically significant differences between Scotland and England in the proportion of non-pharmacy services that distributed sharps bins, citric acid and tourniquets. (See Figure 8.4). However, Scottish services were significantly less likely than English services to distribute:

- filters (p=0.01)
- sterile water (p=0.03) and
- stericups (p=0.02)

They were also less likely to give out Vit C (ascorbic acid) (p=0.00) generally associated with crack/cocaine injecting, probably reflecting little demand for it north of the border. On the other hand, Scottish services were more likely than English services to distribute wipes or swabs (p=0.02).

Needle exchange policies and procedures

Maximum number of syringes distributed: Compared with Scottish services, a much larger proportion of English services said that there was no limit on the number of syringes they would give out to clients in any one transaction. Nearly a third of English services said this, compared to just 2% of Scottish services. This is because there is no equivalent to the Lord Advocate’s guidance in England.

Similarly, a much larger proportion of English services reported that the maximum number of syringes given out would depend on certain circumstances (43% in England said this, compared to 24% in Scotland). The circumstances were similar in many ways to those reported by Scottish services: the number of syringes given out depended on the number of returns, whether the client was known or not known by the service, whether the client lived in a rural or urban area, and the client’s general health. In England, other circumstances that affected the numbers of syringes given out included: whether the client was acting as a point of secondary distribution, whether the client was a chaotic or stable injector, and general stock levels of syringes in the needle exchange.

Assessing client satisfaction: Half of Scottish non-pharmacy services said they had mechanisms for assessing client satisfaction, while 60% of English services reported the same. Pharmacy services in England also appeared to be more likely than those in Scotland to ask their clients for their views on the service – 42% of pharmacy schemes in England versus only two out of 10 schemes in Scotland.
Figure 8.3: Percentage of non-pharmacy services in Scotland and England that provide other harm reduction interventions on-site.

Figure 8.4: Percentage of non-pharmacy services in Scotland and England that distribute items of injecting paraphernalia for free
Needle exchange for young people: Scottish services were significantly more likely than English ones to report that they would provide injecting equipment to young people between the ages of 16 and 17 (p=0.00), but there was no difference between Scottish and English services in relation to distribution among under-16s. See Figure 8.5.

English services were significantly more likely to have a written policy or protocol on the provision of equipment to young people (p=0.02). See Figure 8.6. English services were also significantly more likely to have their policies agreed with the area Child Protection Committee (p=0.00).

Figure 8.5: Percentage of non-pharmacy services in Scotland and England that would distribute injecting equipment to young people

Figure 8.6: Percentage of non-pharmacy services in Scotland and England that have a written policy on needle exchange to young people, and percentage where policy has been agreed with area Child Protection Committee.
FINDINGS PART 2:

PLANNING AND COMMISSIONING
OF NEEDLE EXCHANGE
Chapter 9: Co-ordination, planning and commissioning issues

Headlines from this chapter

• Throughout Scotland, needle exchange activity is co-ordinated at the level of NHS Boards, rather than DATs. This is because needle exchange is largely funded by Blood-borne Virus Prevention monies — an annual allocation made by the Scottish Executive to NHS Boards. This arrangement was seen to cause tension in some areas of Scotland, where the boundaries of NHS Boards were not co-terminus with DAT boundaries (i.e., Grampian, Lothian and Tayside).

• There is a lack of robust systems for monitoring needle exchange activity at a DAT / NHS Board level across Scotland. Many services routinely collected data; however the systems for collating and reporting data were inadequate. This finding suggests that there was little information available to inform planning and commissioning of needle exchange.

• Systems for monitoring discarded sharps and needle stick injuries to the public appeared to be largely absent across Scotland. The majority of DATs either did not have such systems, or were unaware of how to access them.

• The organisations which were responsible for commissioning needle exchange services varied across Scotland, and included among others: the DAT joint commissioning group, the primary care trust, the local NHS Board, the local BBV prevention group, and the local Addictions Partnership.

• In general, pharmacy needle exchange in Scotland is delivered on the basis of formal contracts or service-level agreements. Only a few areas in Scotland did not have such agreements.

• In most areas of Scotland, pharmacists were paid for providing needle exchange through a combination of an annual retainer fee and a payment per transaction. At the time of this study, payments varied considerably from one NHS Board area to another.

• Many areas in Scotland have attempted to respond to the challenges of accessibility through providing outreach services and expanding pharmacy needle exchange schemes.

• Few DATs reported targeting specific populations of injectors through the allocation of specific resources or dedicated workers. Homeless injectors and injectors in rural areas were targeted by more than half of DATs, but only a handful targeted other groups such as female injectors, sex workers, stimulant or steroid injectors.

This chapter focuses on the co-ordination, planning and commissioning of needle exchange services in Scotland. Issues of data collection, the targeting of particular population groups, and funding for needle exchange will also be discussed. These findings are based primarily on responses to the DAT questionnaires. This data is supplemented, where appropriate, with findings from focus group discussions.

Co-ordination of needle exchange

Throughout Scotland, needle exchange activity is co-ordinated at the level of NHS Boards, rather than DATs. This is because needle exchange is largely funded by Blood-borne Virus (BBV) Prevention monies — an annual allocation made by the Scottish Executive Health Department to NHS Boards. This arrangement was seen to cause tension in some areas where the boundaries of NHS Boards were not co-terminus with DAT boundaries (i.e., Grampian, Lothian and Tayside), since DATs, rather than NHS Boards, are responsible for the planning and commissioning of services to drug users.

DATs were asked whether there was a specific individual responsible for co-ordinating specialist needle exchange activity in their area. Of those responding (n=18), 12 reported that there was a local co-ordinator of specialist needle exchange services. All DATs (n=19) had individuals who were responsible for co-ordinating pharmacy needle
exchange in their area, although as mentioned above, in all cases that individual was responsible for co-ordinating pharmacy exchange across an entire NHS Board area. In 10 DATs, the same person co-ordinated both specialist and pharmacy services.

**Data collection and monitoring**

This study found a general lack of robust systems for monitoring needle exchange activity at a DAT level across Scotland. This first became evident during the process of surveying DATs. It was particularly intended that the DAT questionnaire be completed by those who had responsibility for commissioning needle exchange services. However, very few of the DAT questionnaires were actually completed by commissioners or others working within a joint commissioning partnership. The questionnaires were often passed to other professionals — usually needle exchange service providers or needle exchange co-ordinators — for completion.

This suggests that there was no centrally-held data on needle exchange which could be used to inform planning and commissioning. The aim of the DAT questionnaire was to investigate issues at a strategic level. However, it appeared that, in many areas, work on needle exchange at this strategic level was absent or limited.

A certain level of frustration was expressed on the subject of data collection in the focus group discussions. Respondents suggested that even within a particular DAT area, different data collection systems were often used by pharmacy and non-pharmacy exchanges. In some services, SMR24 forms were completed for each new needle exchange client,\(^{10}\) while in others, only basic demographic information was recorded about the client the first time he/she accessed the service. It was suggested that voluntary sector services often had the most comprehensive monitoring systems because of a need to measure their activity to justify continued funding.

When DAT representatives were asked what information *should* be collected, they felt that specialist services should collect more detailed data than pharmacy services, and they appeared to be more interested in data on service activity (e.g., number of needles out, number returned, number of clients, services received). Service providers, on the other hand, felt it would be more useful to also collect data on client characteristics (e.g., drugs injected, sharing behaviour, whether the client is collecting needles for others). It was pointed out that certain data *had* to be collected in pharmacies, since in most areas, payments to pharmacists were based on the number of transactions or contacts.

In many areas, data collection was done using paper forms, which were completed at each transaction and sent back to a central office for collation. Unfortunately, in several areas, there wasn’t sufficient funding to pay for data entry and analysis. Pharmacy co-ordinators particularly expressed frustration at this situation, and suggested that getting regular reports of their own needle exchange activity might actually be an incentive for some pharmacists to continue offering a service.

**Minimum data set**

None of the focus group participants voiced strong views about whether it would be useful to introduce a nationally agreed minimum data set, although there was a general feeling that *more standardisation would be welcome* — particularly *within* DATs.

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\(^{10}\) The SMR24 is a detailed form used to monitor the number of people who enter drug treatment services. The form is completed by treatment providers and the completed form is sent back to the Information Services Division, where the data is entered into the Scottish Drugs Misuse Database and used to compile an annual statistical report. From April 2006, the SMR24 has been replaced by the SMR25. A copy of the SMR24 may be viewed at: [http://www.drugmisuse.isdscotland.org/publications/05dmss/05dmss-059.htm](http://www.drugmisuse.isdscotland.org/publications/05dmss/05dmss-059.htm).
areas. In addition, service providers felt that DATs should make better use of the data that was already being collected for the purposes of on-going needs assessment.

**Monitoring drug litter**

Also in relation to the issue of data collection and monitoring, DATs were asked whether there were local systems in place for monitoring discarded sharps and needle stick injuries to the public. Only six out of 19 DAT respondents said they systems for monitoring discarded sharps (Aberdeen City, Borders, Glasgow, Highland, Perth & Kinross and West Lothian). However, only four of these were able to provide figures on discarded needles for the period April 2004 – March 2005. Only two DATs (Borders and Highland) said they had routine systems in place to monitor needle stick injuries to the public. In the remaining DAT areas, there either were no systems for monitoring, or the DAT respondent was unaware them.

**Budgets and funding**

As already mentioned, funding for needle exchange mainly comes from annual ring-fenced funding to NHS Boards for BBV prevention. However, some DATs indicated that other sources of funding for needle exchange also included:

- The local primary care trust (n=7)
- Pooled or DAT treatment budget (n=6)\(^{11}\)
- Pharmaceutical funding negotiated at a local level (n=1)
- Lottery / charitable foundations (n=1).

DATs were asked whether “in real terms (accounting for inflation)”, the budget for needle exchange in their area had increased, decreased or remained the same over the last three years. The majority of respondents (n=12) indicated that overall, the budget for needle exchange in their area had increased in the last three years, even when taking inflation into account. However, when asked about the budgets for specialist and pharmacy exchanges, some interesting differences emerged. Only 8 DATs reported that the budget for specialist services had increased in the last three years, whereas 10 reported increased budgets for pharmacy services.

Interestingly, very few DATs reported that budgets for needle exchange services had decreased in recent years. However, a sizeable proportion indicated that these budgets had remained static. And as will be seen in Chapter 12, lack of sufficient funding was seen as one of the main impediments to good practice in providing needle exchange. As one DAT survey respondent wrote:

> Our actual needle exchange budget has remained the same. However, our overspend has increased by 74.5% over three years.

**Commissioning and purchasing needle exchange services**

DATs were asked which organisations are responsible for commissioning needle exchange services in their area. Responses included: the DAT joint commissioning group / manager (n=7) and the primary care trust (n=5). However, it was clear from the responses that in many DATs, one or more multi-agency groups were responsible for commissioning needle exchange services. These included:

- The local BBV prevention group
- The local NHS Board, in partnership with the local DAT

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\(^{11}\) In Scotland, in general, DATs do not have their own budgets, but rather draw on the budgets of their member agencies.
• The BBV strategy group in co-ordination with the needle exchange working group
• The integrated Addictions Partnership
• The DAT in partnership with local Joint Future groups

**Commissioning pharmacy needle exchange services**

Additional information on the commissioning of pharmacy services was sought from pharmacy co-ordinators. Namely, pharmacy co-ordinators were asked whether the pharmacies in their local needle exchange scheme had formal contracts, service-level agreements or other written agreements regarding the provision of their services. Eight out of 10 co-ordinators said they did. Only Orkney and Highland did not have such agreements.

Pharmacy co-ordinators were also asked for details about the payments made to pharmacies for needle exchange services. Most respondents indicated that their pharmacies were paid through a combination of an annual retainer fee and a payment per transaction (contact). As Table 9.1 shows, these payments varied considerably.

Annual retainer fees ranged from £120 to £1342 per year, while payments per transaction ranged from £1.60 to £2.25.

Pharmacy co-ordinators felt that existing arrangements were inequitable and suggested that this unfairness was having an impact on pharmacists’ willingness to participate in needle exchange schemes. However, they expressed hope that the new national pharmacy contract (currently under negotiation) would resolve a number of problems.

**Table 9.1: Arrangements for payments for pharmacy needle exchange services**

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Annual retainer</th>
<th>Amount</th>
<th>Payment per transaction</th>
<th>Amount per transaction</th>
<th>Other method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>√</td>
<td>£984 / year</td>
<td>√</td>
<td>£2.16 / transaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>above 200 transactions</td>
<td></td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>√</td>
<td>£700 / year</td>
<td></td>
<td></td>
<td>£500 – start up fee</td>
</tr>
<tr>
<td>Fife</td>
<td></td>
<td></td>
<td>√</td>
<td>£2.00</td>
<td></td>
</tr>
<tr>
<td>Glasgow</td>
<td>√</td>
<td>£525 / year</td>
<td>√</td>
<td>£2.25</td>
<td></td>
</tr>
<tr>
<td>Grampian</td>
<td>√</td>
<td>£780 / year</td>
<td>√</td>
<td>£1.60</td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£50 – start up fee + £9.00 / client visit for first 5 clients; and £4.00 / client visit for 6 or more clients.</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td></td>
<td></td>
<td>√</td>
<td>Variable</td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td>√</td>
<td>£120 / year</td>
<td>√</td>
<td>£1.70</td>
<td></td>
</tr>
<tr>
<td>Orkney</td>
<td>√</td>
<td></td>
<td></td>
<td>(Not specified)</td>
<td></td>
</tr>
<tr>
<td>Tayside</td>
<td>√</td>
<td>£671 / year for 0-24 exchanges per month; £955 / year for 25-49 exchanges per month; £1,342 / year for 50+ exchanges per month</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Making services more accessible

The issue of accessibility was discussed in each of the Scottish focus group discussions. Respondents indicated that they had attempted to respond to the challenges of accessibility through:

- providing outreach services,
- encouraging secondary distribution of needles and syringes, and
- expanding pharmacy exchange schemes.

Service providers suggested that outreach services, in particular, were often more successful in reaching a wider range of service users, or indeed, a completely different client group than fixed site services. In Highland, the backpacking service was reported to have a much higher proportion of female clients than the pharmacies in Inverness did. It was thought that this was due not only to a lack of public transport — making it difficult for women from rural areas to travel into Inverness for services — but also a lack of affordable childcare. There was a feeling that female injectors were very unwilling to access local pharmacy needle exchanges with a young child in tow.

Outreach methods were also seen to be more effective in reaching certain populations that traditional drug services have found it difficult to engage with, for example, homeless injectors and sex workers.

Targeting special populations

DATs were asked in the survey whether they specifically targeted certain populations of injectors — for example, women, sex workers, the homeless or those who inject steroids or stimulants. Targeting could occur through the allocation of specific resources or dedicated workers to meet the needs of those populations, and would indicate the recognition of an identified need in an area.

Few DATs reported targeting specific populations. See Table 9.2. Homeless injectors and injectors in rural areas were targeted by more than half of DATs. But only a handful targeted other population groups. Interventions included among other things: a drop-in centre for homeless people; needle exchange in hostels for the homeless; a needle exchange clinic in a local Women’s Aid service; a separate clinic for steroid users with specialist advice and support; and back-packing to injectors in rural areas.

Table 9.2: Number of DATs targeting specific populations

<table>
<thead>
<tr>
<th>Target population</th>
<th>No. of DATs (out of 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless injectors</td>
<td>11</td>
</tr>
<tr>
<td>Injectors in rural areas</td>
<td>10</td>
</tr>
<tr>
<td>Women injectors</td>
<td>5</td>
</tr>
<tr>
<td>Sex workers</td>
<td>4</td>
</tr>
<tr>
<td>Stimulant injectors</td>
<td>3</td>
</tr>
<tr>
<td>Steroid injectors</td>
<td>3</td>
</tr>
<tr>
<td>Young injectors</td>
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</tr>
<tr>
<td>Offenders</td>
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</tr>
<tr>
<td>Injectors with dual diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Black &amp; minority ethnic populations</td>
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</tr>
</tbody>
</table>
Chapter 10: Staff training and qualifications

Headlines from this chapter

• There is no standard training for needle exchange workers in Scotland. Consequently, staff competency and qualifications vary. This was considered by some participants in this study to be an impediment to good practice.

• Many services employed very highly-qualified staff: nearly half of non-pharmacy services employed a worker with academic qualifications in drugs work, and a large proportion also had staff with formal nursing or social work qualifications. However, half also employed staff who had only in-house harm reduction training, and over two-fifths employed a worker with no formal qualifications, but with relevant experience.

• Regular training and good on-going support were seen to be especially important for pharmacy needle exchange providers. This must be provided not only for the pharmacist, but also for counter staff. High staff turnover among counter staff means that on-going training is necessary.

This chapter focuses on the training and qualifications of staff employed in needle exchange services across Scotland. The subject of training was raised by a number of survey respondents in their comments at the end of their questionnaires. The lack of standardised training for needle exchange workers in Scotland was clearly considered to be an impediment to good practice by some survey respondents.

Staff competency and qualifications in non-pharmacy services

Non-pharmacy services were asked to indicate whether staff currently working in the service had any formal qualifications or training in relation to needle exchange. The results are shown in Figure 10.1 below.

Figure 10.1: Number of Scottish services employing needle exchange staff with certain qualifications / training

![Figure 10.1](image-url)
These findings indicate that:

- Nearly half of services in Scotland employed a staff worker with an academic qualification in drugs work (for example, a certificate, diploma or degree).
- Nearly half also employed a staff worker who had only formal in-house harm reduction training.
- A substantial proportion had staff with formal nursing or social work qualifications.
- Eight services employed staff with a relevant vocational qualification (NVQ or SVQ).
- Just over two-fifths (19 out of 45) employed staff who had no formal qualifications, but who had relevant experience.
- Five services had staff with other qualifications – such as a degree / diploma in Community Work or Community Education.

It was clear from these responses that needle exchange services frequently employ a number of different staff, all of whom may have different qualifications. Furthermore, in some cases, staff may have more than one qualification — for example, a Registered Mental Nurse (RMN) and a Registered General Nurse (RGN) qualification — or in-house harm reduction training and a diploma in community development.

Police custody suite exchanges were generally delivered by support workers or police officers with no formal harm reduction training.

**Training for pharmacy needle exchange staff**

**Training for pharmacists prior to service delivery:** Pharmacy co-ordinators were asked in the survey whether pharmacy staff are required to undertake any specific training before they can run a needle exchange facility. Nearly every co-ordinator (9 out of 10) said they were. Only one co-ordinator indicated that the pharmacists in his scheme were not required to receive training before delivering a needle exchange service.

**Training for counter staff prior to service delivery:** Seven (out of 10) pharmacy co-ordinators said that training was also provided to pharmacy counter staff involved in the delivery of needle exchange. Unfortunately, because of the way the question was asked, it is not clear whether staff were required to undertake this training before they could deliver the service. Only one pharmacy co-ordinator indicated specifically that counter staff were required to attend a 2-3 hour training session before they can provide needle exchange.

**On-going training:** Two (out of 10) pharmacy co-ordinators said that on-going training was not provided to needle exchange pharmacists in their area. Eight co-ordinators said that on-going training was provided. However, the nature of this training varied from one scheme to another, and in some cases, from one pharmacy to another. For example, on-going training might involve:

- An annual or bi-annual update session and monthly visits from the pharmacy co-ordinator or harm reduction staff
- Face-to-face training delivered within the pharmacy
- Instruction in safer injecting techniques
- Information about overdose and injecting wound recognition
- One-off optional training events on blood-borne viruses.
**Other forms of support:** All ten pharmacy co-ordinators said that support was provided to needle exchange pharmacies over the phone. Nine said they provided their pharmacists with written policies and procedures, and eight said that pharmacy staff were supported through regular visits to the service.

The training of pharmacy needle exchange staff was discussed at length in all three of the Scottish focus groups. One DAT respondent made the point that pharmacists often require more support and training for needle exchange provision than they do for supervised methadone dispensing.

Concerns were voiced about the negative attitudes of some pharmacy staff towards drug users. This was seen to be a particular problem in rural areas, but was not necessarily restricted to rural areas. However, focus group participants also had experience of pharmacy staff attitudes becoming more positive when they were given regular training and good on-going support. Both Fife and Tayside (see Box 10.1) were cited as schemes where pharmacist exchange providers were well-supported. Focus group participants pointed out that training has to be provided not only for the pharmacist but also for counter staff. Moreover, because of the high turnover of counter staff, it was felt that training had to be an on-going process, not just a once-a-year event.

One specialist service provider made the point that through their involvement in needle exchange and supervised methadone dispensing, **pharmacies have become front-line drug services.** Therefore, they need to be treated as part of the multi-disciplinary team that works with drug users, and they need adequate support to provide these services.

### Box 10.1: Good practice in providing support to pharmacy needle exchange staff

In Tayside, the nurse-led harm reduction service has fostered close working relationships with local pharmacy needle exchange staff. This has been done in a variety of ways.

First, all Tayside pharmacies are supplied with injecting paraphernalia by the harm reduction service, and these supplies are delivered to the pharmacies by a nurse from that service. This face-to-face contact provides an informal opportunity for pharmacists to get specialist support and advice on a regular basis.

Second, the harm reduction team also provide formal training to all new pharmacy counter staff involved in the delivery of needle exchange. This training is provided on a rolling basis, as and when new staff come into post. The training generally involves small groups of no more than four people, and is delivered in pharmacy premises immediately after the working day.

Finally, one of the busiest Tayside pharmacy exchanges — a pharmacy in Perth — holds a weekly harm reduction session in their consultation room. During this session, service users have the opportunity to meet with a harm reduction nurse on a drop-in basis, to receive treatment for injecting injuries, referral to other services, and advice about safer injecting techniques.

Because of their regular face-to-face contact with the harm reduction nurses, pharmacy needle exchange staff in Tayside feel very supported.
Chapter 11: Good practice in the commissioning and delivery of needle exchange

Headlines from this chapter
Participants in this study highlighted a number of examples of good or innovative practice including:

- Expanding the range of needle exchanges
- Use of outreach services
- Good joint working between needle exchanges and other local services
- Use of pharmacy consultation rooms for harm reduction clinics
- Getting service users involved in the development and delivery of services
- Developing good rapport and trust with service users
- Providing on-going training and support to pharmacy exchange providers.

As part of this study, DATs, pharmacy and non-pharmacy services were asked to give examples of good or innovative practice in their areas. This chapter summarises this data – both the written responses from the survey, and the themes that arose in the focus group discussions.

Expanding the range of needle exchange services

Some respondents talked about their efforts to expand the number and range of needle exchange services in their area. The expansion of pharmacy services and the use of hospitals and police custody suites for needle exchange were cited as examples of this. The use of needs assessment and service review was also considered by both DATs and service providers to be good practice in the planning of needle exchange services.

Use of outreach services

The use of outreach services was considered to be an important way of improving the accessibility of needle exchange in remote and rural areas. However, outreach services were seen to have other advantages over fixed site services, in terms of:

- a higher rate of returned used needles / syringes
- the fact that outreach services don’t require planning permission,
- the greater range of interventions (compared to pharmacies) which can be delivered by a specialist harm reduction worker or nurse.

These services were also seen to be more successful in reaching women injectors and certain high-risk, groups — for example, sex industry workers and homeless people. See Box 11.1. One rural respondent reported that plans were underway to develop a mobile exchange service to people with dual diagnosis.

For these reasons, DATs felt that outreach was the most cost-effective way of providing a specialist harm reduction service in rural areas and among hard-to-reach groups.

Box 11.1: Example of good practice in reaching out to sex industry workers

Drugs Action in Aberdeen and Scot-PEP in Edinburgh both provide outreach needle exchange services to women working in the sex industry — in the evening in places where the women are working.
Joint working

Good joint working was seen to be an example of good practice in many areas. Several respondents cited good partnership working between drug treatment services and needle exchange services, and between needle exchange services and sexual health, BBV screening and hepatology services. Other respondents mentioned positive collaborations between voluntary and statutory sector agencies, and between specialist harm reduction staff and pharmacy needle exchange providers.

Box 11.2: Examples of good practice in joint working

One voluntary sector outreach service in central Scotland had agreed with the local Children & Families Social Work Department to visit local injectors in their homes at least fortnightly where there were concerns about child protection. Clients of the service were aware of the agreement.

One Glasgow needle exchange service provided their clients with a range of related services from a single point of contact. These included: a well-woman clinic, a health clinic for homeless people, and access to legal advice from solicitors paid for by the Legal Aid Board.

One NHS needle exchange service used the premises of a Women’s Aid service to distribute injecting equipment to female injectors.

Use of pharmacy consultation rooms

A number of areas made use of pharmacy consultation rooms, not only, in some cases, to provide the needle exchange service itself, but also to provide Hepatitis B vaccinations, wound management clinics and advice and information about safer injecting techniques from a specialist harm reduction nurse.

Service user involvement

Two service providers specifically mentioned that they had sought formal input from service users in the development of services. One service in Aberdeen had developed a successful service users’ group. A DAT respondent from Lothian reported that a service in her area had employed a former injecting drug user to do sessions in the mobile needle exchange bus. This respondent said:

“This is proving to be very effective, as existing users can see how he has managed to put his drug use behind him and secure a job.” (DAT survey respondent)

Developing rapport and trust with service users

Many service providers felt that “good practice” in delivering needle exchange had to go beyond simply giving out sterile equipment and taking in used equipment. Developing rapport and trust with clients was also necessary. One service provider said that because she ran her local exchange facility single-handed, her clients had come to know and trust her and, as a result, talked to her about a range of issues in their lives, including financial matters, legal matters, and relationship problems. Another said that whenever clients requested a certain type of needle, this triggered a discussion about injecting sites and information about the local nurse-led wound clinic.

Training and staff development

The issue of training for staff who deliver needle exchange services – particularly pharmacy staff – was also cited as an example of good practice in some areas. Good practice involved in-depth initial training for needle exchange providers, and regular ongoing support and supervision – preferably offered within the pharmacy.
Chapter 12: Problems and impediments

Headlines from this chapter

Problems in relation to commissioning and delivery of needle exchange included:

- Problems of funding and budget shortfalls
- Lack of consistency and inability to implement recognised good practice in paraphernalia distribution
- Negative public attitudes towards harm reduction interventions
- Negative attitudes among pharmacy (and police custody suite) staff in some areas
- Staff shortages

Survey respondents were given an opportunity to describe some of the problems that affected the provision of needle exchange in their area in the last 12 months. This was done through an open-ended question at the end of the questionnaire and through the three focus group discussions. In addition, there was also one question in each of the three surveys which asked whether there had been any difficulties in relation to a specific list of problems. The findings in relation to this question are shown in Table 12.1 below.

These findings suggest that the main problems facing commissioners and providers of needle exchange services across Scotland are: (i) budget shortfalls affecting the provision of injecting paraphernalia; (ii) complaints from local residents and businesses; and (iii) difficulties in recruiting or keeping pharmacies in the scheme.

In relation to the latter issue, focus group and survey respondents suggested that the problems were mainly due to lack of interest among pharmacists in joining the scheme and, once joined, difficulties in retaining them. In addition, one DAT respondent reported that they had recently had to ask a rural pharmacy to leave their scheme because of the negative and punitive attitudes of staff towards injecting drug users.

### Table 12.1: Problems affecting needle exchange provision in the last 12 months

<table>
<thead>
<tr>
<th></th>
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<tr>
<td><strong>DAT respondents (n=19)</strong></td>
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<tr>
<td>Budget shortfalls affecting supplies</td>
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<tr>
<td>Planning permission for needle exchange service</td>
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<tr>
<td>Pharmacies withdrawing from needle exchange schemes</td>
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<td>Problems obtaining insurance for needle exchange services</td>
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<tr>
<td><strong>Non-pharmacy service provider respondents (n=45)</strong></td>
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</tr>
<tr>
<td>Budget shortfalls affecting supplies</td>
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</tr>
<tr>
<td>Problems with complaints from local residents / businesses</td>
<td>9</td>
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<tr>
<td>Problems with obtaining insurance for needle exchange</td>
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</tr>
<tr>
<td>Inability to recruit / retain staff</td>
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<tr>
<td>Problems with planning permission</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pharmacy co-ordinator respondents (n=10)</strong></td>
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</tr>
<tr>
<td>Budget shortfalls affecting supplies</td>
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</tr>
<tr>
<td>Recruitment of new pharmacies</td>
<td>6</td>
</tr>
<tr>
<td>Attrition / drop-out of pharmacies</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacy staff being asked to leave the scheme</td>
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</tbody>
</table>
The remainder of this chapter summarises respondents’ written and verbal comments on the difficulties or impediments to good practice in relation to commissioning and providing needle exchange services.

**Problems of funding and finance**

The problems of funding and finance seemed to touch on every aspect of needle exchange service provision. Focus group participants expressed serious concerns about the chronic shortage of funding for these services, and felt that this was undoubtedly affecting the health and safety not only of injecting drug users, but of the public.

National funding allocations for blood-borne virus prevention were seen to be insufficient. In most areas of Scotland, needle exchange is funded by NHS Boards with monies allocated and ring-fenced by the Scottish Executive for the prevention of blood-borne viruses. One DAT focus group participant suggested that too much of this scarce BBV prevention money was spent on sexual health interventions that were completely unrelated to BBVs — for example, interventions to prevent sexually transmitted infections such as chlamydia. Other DATs said that their local budget for needle exchange was overspent every year, but so far they had been successful in “borrowing” the necessary funding from other budgets. However, there was a recognition that this situation was rather precarious.12

In some areas, voluntary sector needle exchange services had been successful in bidding for funds for the distribution of injecting paraphernalia. Concerns were voiced about what would happen when this funding had run out. Services were faced with having to withdraw items of paraphernalia they had previously provided for free.

In the view of many respondents, insufficient funding not only prevented the distribution of paraphernalia, but it also disallowed the expansion and development of services more generally. Added to this, was a belief by many service providers that needle exchange was simply not seen as a priority. Participants expressed the view that, at both a national and local level, needle exchange was a “Cinderella service”. As one service provider said: “Needle exchange is under-resourced and under-valued.” Priorities for funding and service development focused mainly on structured treatment services (in particular, maintenance prescribing), and in some areas, local decision-making made it impossible to use treatment funds for needle exchange. Some DATs had attempted to pool a variety of local budgets for needle exchange, but again, persuading local partners to contribute was sometimes difficult given their other competing priorities.

**Paraphernalia distribution**

Problems related to the provision of paraphernalia clearly impacted on many services. As already mentioned, the root of many of these problems was the lack of sufficient funding. However, this was not always the case. A comment from an individual who provided a service in an NHS Board that does not currently fund paraphernalia distribution suggested that she had not been permitted to sell citric acid to her service users:

> I am (and have been) trying very hard to be allowed to sell citric acid or ascorbic acid to the clients. This one problem creates a huge difficulty for clients who cannot buy citric elsewhere. They commonly resort to lemon

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12 Note: For more than a decade, allocations for BBV prevention funding were based on HIV prevalence figures. NHS Boards have been calling, for some time, for a revision in the funding allocation formula — claiming that it should take into account the growing incidence of Hepatitis C. A review of this formula took place in 2005, and in June 2005, NHS Boards were informed of revised allocations for 2005-08. Unfortunately, not all NHS boards benefited. Indeed, under the new formula, some stood to lose a substantial amount of their current funding. To prevent this — and the damaging impact it would have on existing services — the Scottish Executive has frozen allocations to these Boards at current levels for the next three years.
Throughout Scotland, the distribution of paraphernalia was seen as a balancing act – with difficult decisions having to be taken. Service providers expressed concern that these decisions were too often taken on the basis of funding, rather than best practice.

**Negative public attitudes**

All focus groups participants felt that work needed to be done to change public attitudes towards harm reduction interventions. In many areas, the public have a “not-in-my-backyard” attitude to needle exchange.

* A zero-tolerance community response makes it difficult for individuals to seek support or information. A harm reduction policy is seen by many as colluding with drug use. This limits how open the service can be about its activities. (Non-pharmacy rural service provider)

Several respondents had spoken about fierce resistance in their areas to plans for locating sharps boxes in public places.

Negative public (and political) attitudes towards harm reduction interventions were seen to be fuelled by the tabloid press. Adopting a positive, pro-active relationship with the local press was seen to be one of the solutions to this problem, but it was also recognised that more needed to be done to educate the public and local politicians about the importance of needle exchange to public health.

**Negative staff attitudes**

All focus group participants considered that “having the right attitude” was an essential requirement for staff in a needle exchange service. And there was a view that “attitude problems” tended to be found more in pharmacies than specialist needle exchange services. Several respondents mentioned problems with pharmacists refusing to give service users sterile needles if they had no returns.

However, focus group participants also had experience of pharmacy staff attitudes becoming more positive when they were given regular training and good on-going local support. Focus group participants pointed out that training has to be provided not only for the pharmacist but also for counter staff. Moreover, because of the high turnover of counter staff, the delivery of training had to be an on-going process, not just a once-a-year event. Unfortunately, current training of pharmacy staff often has to take place in the evening to avoid the cost of paying for locums. Therefore it happens infrequently.

Attitude problems were not only seen in pharmacy staff. One police custody suite respondent wrote:

* At present, the scheme is viewed [by staff] with some trepidation and unease. This attitude requires to be changed so it [the service] can run more efficiently. (Custody suite exchange provider)

**Staff shortages**

Staff shortages in needle exchange services were apparently widespread. One service provider reported that staff sickness and absence created particular difficulties for outreach services. In addition, in some rural areas, outreach workers may be responsible for providing a number of services. In one area, clients stopped using the needle exchange service because the outreach worker responsible for delivering it was also responsible for supervised methadone dispensing.
Other problems affecting needle exchange

Other problems mentioned less frequently by survey respondents and focus group participants included:

- Separate management structures in some areas for pharmacy and non-pharmacy exchanges
- Poor communication between the NHS agencies in control of BBV prevention funding and the local DAT
- Problems in accessing suitable accommodation for the service
- Concerns about the practice of secondary distribution
- A perception that national research undertaken on this topic is only ever based in Glasgow – and so is not representative of Scotland as a whole.
Chapter 13: Discussion, conclusion and recommendations

The National Needle Exchange Survey was the most in-depth study of needle exchange service provision ever undertaken in the UK. The Scottish arm of the study involved three postal surveys (of DAT officers, non-pharmacy service providers and pharmacy co-ordinators) and three focus group discussions. Through these different means, the study gathered data about needle exchange services in every part of Scotland.

The first two aims of the study were: (i) to map needle exchange provision and (ii) to investigate the nature of that provision.

Mapping needle exchange provision in Scotland

The survey identified a total of 188 needle exchange outlets in Scotland — 136 pharmacy exchanges, 43 specialist exchanges, six police custody suite exchanges and three A&E exchanges. Nearly half of Scotland’s specialist services were delivered through mobile and/or outreach provision.

This study included a survey of pharmacy needle exchange co-ordinators, but did not involve a direct survey of pharmacy needle exchange providers. However, the aims of the study did not require this additional survey, nor did the timescales for the study permit it. Moreover, several studies of pharmacy drug services have previously been undertaken in Scotland (Matheson et al 1999; Matheson & Bond 1999; Matheson 1998). One of these — a large survey of all community pharmacies — identified 91 pharmacy needle exchange schemes in Scotland in 2000. This level of pharmacy provision had not changed significantly in the previous five years (Matheson et al 2002). This would suggest that the current level of 135 pharmacy exchanges represents a relatively recent growth in pharmacy provision. This point is supported by findings from the present study which indicated that, in many areas of Scotland, budgets for pharmacy needle exchange have increased over the past three years while budgets for non-pharmacy exchanges have decreased or remained static. (See again Chapter 9.)

The nature of needle exchange provision in Scotland

The study found variation in practices among needle exchange services across Scotland. In some cases, these variations appeared to be strongly associated with NHS Boards. Citric acid — and paraphernalia provision in general — were examples of this. On-site BBV interventions such as testing and immunisation were also examples. (See again Chapter 6.)

In other cases, the variations appeared to be at the level of individual services, and indeed, there were numerous examples where needle exchange facilities within the same NHS Board or DAT area provided quite different types of services.

Practices related to client assessment and review are examples of this. Less than a quarter of non-pharmacy services (10 out of 45) reported that an initial assessment was always undertaken with new clients before sterile equipment was provided. Other examples of variation related to on-site interventions such as counselling, care for minor infections, overdose prevention training and nutritional advice. Some services offered these interventions and others didn’t.

At a more basic level, a third of non-pharmacy services (17 out of 45) said they did not offer their clients referral to structured treatment. Similarly, the co-ordinators of 8 out of 10 pharmacy schemes said that their pharmacists neither provided formal referral or even a list of local treatment services. This finding was somewhat unexpected given the view held by many of the participants in this study that needle exchange services acted as a gateway to treatment services.
Some of these issues are discussed in more depth below. However, it may be worth focusing here on the variations that appeared to exist in relation to needle exchange provision for young people.

**Needle exchange for young people**

Only two-fifths of non-pharmacy services in Scotland (18 out of 45) had a written policy or protocol on the provision of injecting equipment for young people. And in only three cases had these policies been agreed with the local area Child Protection Committee. Services in England were significantly more likely than services in Scotland to have written policies and protocols on needle exchange for young people, and to have agreed these policies and protocols with local Child Protection Committees.

To some extent, this situation will be related to the fact that needle exchange services in Scotland see relatively few young people under the age of 18. Service providers from all over Scotland reported that it was very rare indeed for under-16s to present to needle exchange services. And yet, Scottish service providers were more likely than their English colleagues to say that they would provide injecting equipment to young people aged between 16 and 17.

In June 2005, DrugScope published guidance on needle exchange to young people (DrugScope 2005). This document made the point that needle exchange for young people under 18 must be delivered as part of a planned package of treatment.

> Independent, anonymous needle exchange provision for young people is not good practice due to the different legal status of young people (p. 1).

The document also discussed the issues of consent, confidentiality and staff competencies required to provide needle exchange to young people. Many of these same issues were raised by Scottish practitioners participating in the current study. (See again, Chapter 7.)

The lack of a written policy or protocol does not necessarily imply the lack of a protocol altogether, nor does it imply that services are not operating according to agreed best practice in this area. However, it does suggest there may be variation in the way Scottish needle exchange services respond when they are presented with a young injector.

Given current political priorities in Scotland in relation to preventing drug use among young people, services should be encouraged as a matter of urgency to develop and agree written protocols and policies in this area, and to agree these protocols and policies with other local stakeholders including local Child Protection Committees.

**How are services in Scotland doing in relation to the Shooting Up recommendations?**

At the very beginning of this document, it was pointed out that the annual Shooting Up report published in October 2005 made specific recommendations regarding needle exchange services in the UK (HPA et al., 2005). These included:

- Ensuring sufficient distribution of injecting equipment to prevent the sharing of needles and syringes
- Providing injecting-related equipment other than needles and syringes as appropriate
- Ensuring an appropriate range of needle exchange services are provided (i.e., through drug services, pharmacies and mobile or outreach services)
- Ensuring appropriate training for needle exchange staff
- Expanding the educational role of needle exchange services
- Expanding the services available through needle exchanges — to include on-site vaccination for Hepatitis B, and testing for HIV and Hepatitis C.
The findings from the National Needle Exchange Survey provide an indication of what and how Scottish services are doing in relation to these recommendations.

**Ensuring sufficient distribution of injecting equipment**

In Chapter 5, it was reported that at least 3.5 million syringes were distributed by Scottish needle exchange services in the one-year period between April 2004 and March 2005, with roughly an equal number of syringes distributed by pharmacy and non-pharmacy services across the whole of the country.

It is of concern, however, that in some DAT areas, there would appear to be far from sufficient distribution of sterile injecting equipment. A calculation of the number of syringes distributed per injector in each area showed considerable variations between DATs. (See again Table 5.5.) Even taking into account questions about data quality, even if only half of the estimated injectors in each DAT area are actually attending needle exchange services, and even if some of the injectors in each DAT area obtain their syringes from a neighbouring area, the level of syringe distribution in most areas of Scotland is inadequate. This finding echoes a statement made in the Greater Glasgow AIDS (Control) Act Report for 2003-04, which found that 1 million needles / syringes had distributed by Glasgow needle exchange facilities in the year 2002-03. However, it estimated the total number of injecting episodes among Glasgow injectors to be 7-12 million a year (NHS Greater Glasgow 2004, p. 16).

What is also of concern is the practice that some services had of setting arbitrary limits on the number of syringes that were given out to injectors – particularly, as focus group participants mentioned, where these limits were used punitively. Such practices are not conducive to safer injecting.

However, setting these issues aside, it must also be acknowledged that injectors themselves often choose not to take a sufficient number of syringes for their own injecting needs (Taylor et al 2005). This behaviour presents a serious challenge to needle exchange services — and it requires the development of new and innovative methods of engaging with and educating IDUs.

On a more positive note, home delivery / back-packing services are clearly very well-placed to ensure that their clients have a sufficient number of syringes. Reports from focus group participants suggested that these services were more successful than other types of needle exchanges in reaching “hard-to-reach” populations. Women injectors in particular were often better served by back-packing services than fixed-site, or pharmacy services. Furthermore, these services also had better return rates.

**Providing injecting-related equipment other than needles and syringes**

The majority of Scottish needle exchange services — both pharmacy and non-pharmacy services — distributed wipes and swabs, sharps bins and citric acid in addition to sterile needles and syringes. Services that did not supply citric acid were located mainly in two NHS Boards — Grampian and Highland, although it would seem that the pharmacy schemes in Ayrshire & Arran and Orkney did not distribute it either. At the time of writing this report, steps were being taken to pilot citric acid provision in services in Highland.

Very few Scottish services provided stericups (or other forms of spoons or “cookers”), filters or sterile water to injectors, and it would appear that Scottish services were significantly less likely to provide these items of paraphernalia than English services.

The participants in the study saw it as patently unfair that service users in some NHS Boards received a wide range of paraphernalia and others received none. This situation was seen to send mixed messages to clients about what constitutes safe practice, and services felt it also undermined their credibility with their clients.
What is even more worrying is that some NHS Boards are currently faced with the prospect of having to cease distribution of certain items of paraphernalia which had previously been provided for free.

Written comments on the questionnaires and focus group discussions in Scotland highlighted that many service providers and commissioners felt the need for national guidance and standards on paraphernalia distribution. It was felt that such guidance would help to significantly reduce inequalities in provision, although it must also be noted that, at the present time, there is no evidence of the effectiveness or safety of some items of paraphernalia.

**Ensuring an appropriate range of needle exchange services**

Across Scotland, pharmacy services outnumbered specialist services by a ratio of 3:1. The *Shooting Up* report did not specify what an "appropriate range" of services would entail. Nevertheless, the findings from this study would indicate that **both pharmacy and specialist services are needed**. Furthermore, data from the focus groups suggests that pharmacies must been seen as providing a complementary, rather than alternative, service to specialist needle exchange facilities, as pharmacies are not generally able to provide the necessary range of interventions that are required to reduce injecting-related harm.

According to participants in this study, the main benefits of pharmacy needle exchange were that:

- Pharmacies were often more accessible than other types of needle exchange services in some areas. Most pharmacies are open 9.00 – 5.30 six days a week.
- Transactions in pharmacies are fast and discreet. Some clients prefer to use pharmacy exchanges for this reason.
- It is cheaper to provide needle exchange through a pharmacy, rather than a specialist service, because pharmacies can distribute sterile injecting equipment as part of their existing business, without additional overheads.

However, it was felt that efforts to expand pharmacy service provision in many areas of Scotland had to be better balanced with good provision of specialist services too. The concerns voiced about pharmacy provision were that:

- Pharmacies don’t, and can’t, provide the same breadth and depth of service as a specialist harm reduction service.
- There isn’t sufficient time and space in a pharmacy to have a consultation with service users about safer injecting practices. Similarly, most pharmacies have limited space for storage and cannot get involved in pick-and-mix distribution of paraphernalia for this reason.
- There can be a problem with negative attitudes to drug users among pharmacy staff, particularly in rural areas.
- Pharmacy services generally get fewer returns.
- The high turnover of pharmacy counter staff requires regular and on-going training which can be difficult to keep up with.

In addition to this, it must be noted that injectors in rural areas were often reported to be reluctant to use the local pharmacy exchange for reasons of confidentiality.

Focus group participants felt that pharmacy services were most appropriate for older, stable injectors, while younger and chaotic injectors were seen to be better served by
specialist services. This view is echoed in the DrugScope guidance on services for young people:

_We expect that pharmacists will neither have all the appropriate skills or time to undertake the level of assessment and care planning required to provide needle exchange to those under 18 years old. As such, we recommend that pharmacists do not provide a needle exchange service for [this population], but rather encourage young people to visit appropriate alternatives (p. 5)._ 

While on the one hand, specialist service providers often expressed concern about what they perceived as differing standards between pharmacy and specialist needle exchange, it was generally accepted that needle exchange is just one of many services provided by community pharmacies.

There was a feeling that pharmacies and specialist harm reduction services _should, can and do_ work together and complement each other. Examples were given from across Scotland of positive collaborative working relationships between pharmacy and non-pharmacy providers, particularly in relation to using pharmacy consultation rooms to host BBV testing and immunisation, wound clinics and other specialist harm reduction interventions. Examples were also given of specialist harm reduction nurses providing regular and on-going support to pharmacy exchange providers, and this support resulting in improvements in knowledge and attitudes among pharmacy staff.

**Ensuring appropriate training for needle exchange staff**

Again, the _Shooting Up_ report did not specify what would constitute “appropriate training” for needle exchange staff. Nearly half of non-pharmacy needle exchange services in Scotland employed a member of staff with an academic qualification in drugs work, and many employed a qualified RMN or RGN. These findings are positive and would seem to suggest a very high level of qualification among Scottish needle exchange workers. However, it was also clear that there is currently no standardised training for non-pharmacy needle exchange workers.

It seems there is also no standardised training for _pharmacy_ needle exchange providers. Training was organised locally, and the nature and frequency of on-going support and training for pharmacy staff appeared to vary widely across Scotland.

A number of survey respondents highlighted the lack of standardised training among needle exchange workers as an impediment to good practice in their area.

**Expanding the educational role of needle exchange services**

This study did not address the educational role of needle exchange services in depth. However, in drawing together the findings from a number of questions, some inferences can be made about the extent to which needle exchange services in Scotland are taking on an educational role.

For example, it was found that, in those services which undertook an initial assessment of their clients’ needs, over two-thirds said they discussed safer injecting techniques, the sharing of needles, syringes and other paraphernalia, and overdose risks.

Nearly all non-pharmacy services (apart from the police custody suite exchanges) provided face-to-face harm reduction advice to their service users. About a third said they provided on-site overdose prevention training, and slightly less than a third provided nutritional advice.

In terms of the educational role of needle exchange services, these findings seem relatively positive, although it must be pointed out that Scottish services were less likely than English services to provide many of these interventions.
Few pharmacy exchange schemes seemed to have much of an educational role with their service users. While nine of the 10 pharmacy co-ordinators who participated in this study said that their pharmacy schemes distributed written information on harm reduction, only half said that their pharmacists provided harm reduction advice to their clients. Again, with adequate training and support, it should be possible for the educational role of pharmacy staff to expand in relation to needle exchange. However, these findings would again argue (as above) in favour of ensuring a more balanced provision of pharmacy versus specialist needle exchange services in local areas.

Expanding services available through needle exchange — to include on-site vaccination for Hepatitis B, testing for HIV and Hepatitis C

The use of needle exchange and drug treatment services to provide injectors with access to vaccination, testing, and indeed, treatment for BBVs has been recommended not only in the Shooting Up report but also by the Royal College of Physicians of Edinburgh in the statement from their Consensus Conference on Hepatitis C, held in April 2004.13

The latter has reported that only half of individuals referred for Hepatitis C testing and treatment actually attend clinic appointments (item 3 of the Consensus Statement). A new community-focused model of care was called for, and it was suggested that this should be delivered through outreach nurse-led clinics in primary care, in prisons or in drug services.

This study found that less than half of Scottish needle exchange services offered any form of on-site intervention related to BBVs. The interventions offered most frequently were HIV and HCV pre- and post-test counselling. Two-fifths of services offered on-site HCV testing, but less than a third offered HBV testing or immunisation, HIV testing or HAV immunisation. And again, Scottish services generally appeared to be less likely to offer these interventions than their English colleagues.

Of course, the fact that services do not provide BBV interventions on-site does not imply that service users do not have any local access to these interventions. However, agreed “best practice” would be to offer these interventions where injectors are already accessing services, rather than to refer them to other services. This would almost certainly result in greater uptake.

Areas of good and innovative practice

The third objective of the National Needle Exchange Survey was to identify areas of good and innovative practice. In Scotland, these were identified as:

- providing a range of services — pharmacy, specialist, outreach and mobile;
- developing and expanding services on the basis of formal needs assessment;
- use of outreach in general for remote and rural populations and to target high-risk groups;
- positive joint working relationships between services;
- use of pharmacy consultation rooms by specialist harm reduction nurses;
- the involvement of service users in developing or delivering services;
- developing trust with service users; and
- ensuring good training and support for service providers — particularly pharmacists.

Difficulties and impediments to good practice

The final objective of the study was to identify difficulties and impediments to good practice. In Scotland, the biggest problems were seen to be related to:

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• funding shortages;
• lack of standardisation in paraphernalia distribution;
• negative public attitudes;
• negative staff attitudes (especially among pharmacy staff); and
• staff shortages.

Strategic issues in relation to needle exchange

The problem of under-funding

One of the messages voiced most strongly by focus group participants throughout this study was that **needle exchange services across Scotland are under-funded and under-valued.** People referred to them as “Cinderella services.” Policies on anti-social behaviour were often seen to have higher priority and attract more funding than public health policies for injecting drug users.

Focus group participants in this study reported that the lack of sufficient funding contributed not only to the lack of accessibility of services in some areas, but also many of the variations in practice between services.

Recent changes in allocations of BBV prevention funding have benefited some areas in Scotland, but have resulted in frozen budgets (effectively a loss of funding) for other areas. Service providers expressed frustration that recent legislative changes have made it permissible to distribute a wide range of paraphernalia to injectors, but that funding allocations haven’t changed to reflect this.

Data collection and management

However, it must also be pointed out that this study highlighted problems throughout Scotland in data collection, management and co-ordination of needle exchange services at DAT level. It was clear that in many areas, those who are responsible for commissioning services do not routinely have access to sufficient and detailed information upon which to base their planning decisions. While there were examples of comprehensive needs assessments being undertaken in one or two areas, these tended to be the exception rather than the rule in relation to planning needle exchange service provision in Scotland.

Concluding remarks

This survey has highlighted variation in practice in relation to all aspects of needle exchange provision in Scotland. In some cases such as the provision of paraphernalia and on-site BBV interventions, this variation is associated with NHS Boards. But in other areas, it would seem that some needle exchange services simply do things differently than other needle exchange services. **The question which must be asked is: Is this variation acceptable?**

While it may be acceptable for pharmacy exchange services to be different from police custody suite exchanges, and for specialist services to deliver different interventions than A&E exchanges, it is not clear why there should be large variations in practice between specialist services, or between pharmacy schemes in different parts of Scotland.

Many of the needle exchange professionals, and commissioners of needle exchange services who participated in this study argued for greater standardisation. People wanted to see more standardised training for needle exchange providers, and greater standardisation in data collection and monitoring systems. People also wanted to see official guidelines in relation to paraphernalia distribution.
However, many also pointed out that their aspirations for service development were limited by lack of funding. Having said that, there were clearly also instances where local Health Board policy, rather than funding per se, was the main limiting factor.

**Recommendations**

Given the findings of this study, the following recommendations are made.

**Recommendations to the Scottish Executive**

- In co-ordination with the Scottish Drugs Forum and other stakeholders, develop standards for needle exchange services in Scotland. Different standards may be required for specialist, pharmacy, police custody suite and A&E exchanges.

- In co-ordination with STRADA and NHS Education Scotland, develop a module or standard training course for all specialist and pharmacy needle exchange providers, and ensure that this training is regularly updated.

- Develop guidelines regarding paraphernalia distribution in Scotland, and put in place mechanisms to ensure compliance with the guidelines by NHS Boards. There may be some delay in this until the results of on-going research regarding the safety and effectiveness injecting paraphernalia are published. In the meantime, however, the Executive should ensure that citric acid is distributed for free by all needle exchange services throughout Scotland.

- Increase funding to needle exchange services, to ensure that services are able to distribute an adequate number of syringes and other paraphernalia to their service users. Increased funding would also allow local areas to develop greater use of outreach services.

**Recommendations to NHS Boards and Drug Action Teams**

- Provide funding to all needle exchange services for citric acid distribution.

- Ensure that there is a balance between pharmacy and specialist needle exchange provision in local areas.

- Put in place systems for regular monitoring and reporting of needle exchange transactions (including gender and age of contacts) and numbers of syringes and other items of paraphernalia distributed.

- Put in place systems for regular reporting from local authority Environmental Health / Public Health services on discarded sharps and needle stick injuries to the public.

- Ensure that all needle exchange providers receive appropriate training, particularly in relation to injecting techniques, prior to providing a needle exchange service.

- Ensure that pharmacy exchange providers receive on-going training and support from a specialist harm reduction provider.

- Ensure that all needle exchange services have written protocols / policies on the distribution of sterile injecting equipment to young people under 18 and separate policies for under-16s. Ensure that these protocols / policies are agreed with local area Child Protection Committees.

- Reduce barriers to accessing BBV testing and immunisation services, by making such services available through needle exchange facilities.
• Improve integration between needle exchange and other local services, by arranging on-site access to primary care sessions, wound clinics, nutritional advice and housing, social welfare or legal advice.

**Recommendations to needle exchange providers**

• Put in place mechanisms for assessing the needs of clients and regularly reviewing those needs.

• Put in place mechanisms for assessing client satisfaction at regular intervals.

• Develop written policies and protocols regarding needle exchange provision to under-18s, and separate policies / protocols for under-16s. Involve local area Child Protection Committees in this process.

• Develop methods of better engaging with and educating injecting drug users, and share both failures and successes with other service providers. This can be done through the Scottish Needle Exchange Workers Forum.
References


Appendix 1: Survey responses

DAT survey respondents

The following DATs participated in the DAT survey.

- Aberdeen
- Aberdeenshire
- Angus
- Argyll & Clyde
- Ayrshire & Arran
- Borders
- Dundee City
- East Lothian
- Fife
- Forth Valley
- Glasgow
- Highland
- Lanarkshire
- Midlothian
- Moray
- Orkney
- Perth & Kinross
- Western Isles
- West Lothian

Non-respondents were: Dumfries & Galloway, Edinburgh City and Shetland.
Responses to the Services survey

Fifty-two non-pharmacy needle exchange facilities were identified in Scotland. Fifty of these were surveyed, and 45 responded. Respondents were located in the following NHS Board / DAT areas:

<table>
<thead>
<tr>
<th>NHS Board / DAT</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>4</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>3</td>
</tr>
<tr>
<td>Borders</td>
<td>1</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>3</td>
</tr>
<tr>
<td>Fife</td>
<td>3</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>2</td>
</tr>
<tr>
<td>Glasgow</td>
<td>2</td>
</tr>
<tr>
<td>Grampian</td>
<td>1</td>
</tr>
<tr>
<td>Aberdeen</td>
<td>1</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>3</td>
</tr>
<tr>
<td>Moray</td>
<td>1</td>
</tr>
<tr>
<td>Highland</td>
<td>2</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>5</td>
</tr>
<tr>
<td>Lothian</td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>0</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>7</td>
</tr>
<tr>
<td>Midlothian</td>
<td>1</td>
</tr>
<tr>
<td>West Lothian</td>
<td>0</td>
</tr>
<tr>
<td>Shetland</td>
<td>1</td>
</tr>
<tr>
<td>Tayside</td>
<td>1</td>
</tr>
<tr>
<td>Angus</td>
<td>1</td>
</tr>
<tr>
<td>Dundee City</td>
<td>2</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Notes to table

Responses from Fife, Forth Valley, Grampian, Lothian and Tayside include a police custody suite exchange. The Midlothian service is based in Midlothian, but shared between Midlothian and East Lothian.
Responses to the pharmacy co-ordinator questionnaire

Pharmacy co-ordinators from all NHS Board areas in Scotland were surveyed, except the Western Isles (which had no pharmacy needle exchange scheme), and Dumfries & Galloway and Shetland (where pharmacy co-ordinators had not been identified. Responses were received from the pharmacy co-ordinators in:

- NHS Argyll & Clyde
- NHS Ayrshire & Arran
- NHS Fife
- NHS Grampian
- NHS Glasgow
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Orkney
- NHS Tayside
Appendix 2: Participants in Scottish focus groups

DAT focus group attendees

- Lesley-Anne Brown, Harm Reduction Centre, Tayside Primary Care Trust
- John S Cameron MBE, Ayrshire & Arran Community Health Division
- Liz Coates, Midlothian DAAT
- Grahame Cronkshaw, NHS Grampian
- John Glenday, NHS Highland
- Karen Irvine, Argyll & Clyde ADAT
- Maggie Jamieson, Aberdeenshire ADAT
- Jackie Johnston, Signpost Forth Valley
- Rita Keyte, Fife DAAT
- Maggie Murray, Action Team on Alcohol and Drugs in Edinburgh
- Graham V Nisbet, Community Alcohol & Drug Service, Forth Valley
- Donna Reid, Argyll & Clyde ADAT
- Ruth Shepherd, Ayrshire & Arran Alcohol and Drug Action Team

Service provider focus group attendees

- Erja Aalto, Harm Reduction Centre, NHS Tayside
- Owain Ashworth, Glasgow Drug Crisis Centre
- Heather Black, NHS Argyll & Clyde Health Board
- Isabell Buenz, Lothian Harm Reduction Team
- John Cosgrove, Moray Drug and Alcohol Services
- Michael Finlay, Renfrewshire Council
- Nick Fuller, Harm Reduction Service, NHS Tayside
- George Hunter, Glasgow Drug Crisis Centre
- William Kirk, Lanarkshire Harm Reduction Team / Lanarkshire HIV Hep Centre
- Denise Mair, Drugs Action
- Elaine McLellan, Renfrewshire Drug Service
- Jim Steel, Fife Constabulary
- Norma Westland, NHS Fife Addiction Services (Harm Reduction)
- Maureen Woods, Lanarkshire Harm Reduction Team

Pharmacist focus group attendees

- Frances Donachie, NHS Ayrshire & Arran
- Lucy Eagles, NHS Grampian
- Carole Hunter, Glasgow Addiction Services
- Jennifer Kelly, Glasgow Addiction Services
- Sarah Harris, Dumbarton Joint Hospital
## Table A.3.1: Number of transactions, 2004-05: Comparison of DAT responses with Services and Pharmacy Co-ordinator responses

<table>
<thead>
<tr>
<th>NHS Board / DAT</th>
<th>Number of transactions by non-pharmacy services</th>
<th>Number of transactions by pharmacy services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DAT response (n responding/total n)</td>
<td>Services response (n responding/total n)</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td>4,232 (4/4)</td>
<td>6,672</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>12,590 (1/3)</td>
<td>11,739</td>
</tr>
<tr>
<td>Borders</td>
<td>340 (1/1)</td>
<td>340</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>N-R</td>
<td>1,124 (1/3)</td>
</tr>
<tr>
<td>Fife</td>
<td>9,532 (2/3)</td>
<td>6,697</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>4,350 (2/2)</td>
<td>1,657</td>
</tr>
<tr>
<td>Glasgow</td>
<td>Missing</td>
<td>11,602 (2/2)</td>
</tr>
<tr>
<td>Grampian</td>
<td>54 (1/1)</td>
<td>11,500 (1/1)</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>11,500 (1/1)</td>
<td>11,158</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>2,000 (3/3)</td>
<td>4,346</td>
</tr>
<tr>
<td>Moray</td>
<td>Missing (1/1)</td>
<td>31</td>
</tr>
<tr>
<td>Highland</td>
<td>119 (2/2)</td>
<td>104</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>3,810 (2/5)</td>
<td>5,461</td>
</tr>
<tr>
<td>Lothian</td>
<td>63 (1/1)</td>
<td>N/A</td>
</tr>
<tr>
<td>East Lothian</td>
<td>63 (1/1)</td>
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</tr>
<tr>
<td>Edinburgh City</td>
<td>15,097 (7/7)</td>
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<tr>
<td>Midlothian</td>
<td>619 (1/1)</td>
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<tr>
<td>Orkney</td>
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<tr>
<td>Shetland</td>
<td>N-R</td>
<td>228 (1/1)</td>
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<tr>
<td>Tayside</td>
<td>122 (0/1)</td>
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<tr>
<td>Angus</td>
<td>122 (1/1)</td>
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</tr>
<tr>
<td>Dundee City</td>
<td>885 (2/2)</td>
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</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>231 (1/1)</td>
<td>231</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0 (1/1)</td>
<td>Not surveyed</td>
</tr>
<tr>
<td>Total transactions</td>
<td>50,799</td>
<td>82,389 (36/45)</td>
</tr>
</tbody>
</table>

### Notes to table

N/A – Not applicable: DAT area has not have this type of service.
N-R – Non-respondent to the survey.
Missing – Data not collected, or not provided.
The figure shown for transactions by Grampian-wide services (54) was for the police custody suite exchange only. Data was unavailable from the Tayside-wide police custody suite exchange.
Table A.3.2: Number of clients, 2004-05: Comparison of DAT responses with Services and Pharmacy Co-ordinator responses

<table>
<thead>
<tr>
<th>NHS Board / DAT</th>
<th>Number of clients of non-pharmacy services</th>
<th>Number of clients of pharmacy services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DAT response</td>
<td>Services response</td>
<td>Pharmacy response</td>
</tr>
<tr>
<td></td>
<td>(n responding/total n)</td>
<td>(n responding/total n)</td>
<td></td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td>Missing</td>
<td>1,923 (3/4)</td>
<td>Missing</td>
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<tr>
<td>Ayrshire &amp; Arran</td>
<td>Missing</td>
<td>Missing (0/3)</td>
<td>Missing</td>
</tr>
<tr>
<td>Borders</td>
<td>91</td>
<td>91 (1/1)</td>
<td>Missing</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>N-R</td>
<td>382 (2/3)</td>
<td>N-R</td>
</tr>
<tr>
<td>Fife</td>
<td>1,261</td>
<td>1,035 (2/3)</td>
<td>1,509</td>
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<tr>
<td>Forth Valley</td>
<td>615</td>
<td>183 (2/2)</td>
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<tr>
<td>Glasgow</td>
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<tr>
<td>Grampian</td>
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</tr>
<tr>
<td>Aberdeen City</td>
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<td></td>
</tr>
<tr>
<td>Aberdeenshire</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Moray</td>
<td>Missing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>1,984 (0/1)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>576 (3/3)</td>
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</tr>
<tr>
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<td>25 (1/1)</td>
<td>Missing</td>
</tr>
<tr>
<td>Highland</td>
<td>12</td>
<td>25 (2/2)</td>
<td>243</td>
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<tr>
<td>Lanarkshire</td>
<td>Missing</td>
<td>10 (1/5)</td>
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<td>Lothian</td>
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<tr>
<td>East Lothian</td>
<td>31</td>
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<td>667</td>
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<tr>
<td>Edinburgh City</td>
<td>N-R</td>
<td>5,701 (6/7)</td>
<td>N-R</td>
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<td>Midlothian</td>
<td>243</td>
<td>221 (1/1)</td>
<td>276</td>
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<tr>
<td>West Lothian</td>
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<td>Orkney</td>
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<td>Missing</td>
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<tr>
<td>Shetland</td>
<td>N-R</td>
<td>37 (1/1)</td>
<td>N-R</td>
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<tr>
<td>Tayside</td>
<td>796</td>
<td>796 (3/5)</td>
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<tr>
<td>Angus</td>
<td></td>
<td></td>
<td>Missing</td>
</tr>
<tr>
<td>Dundee City</td>
<td></td>
<td></td>
<td>Missing</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td></td>
<td></td>
<td>Missing</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>Not surveyed</td>
<td>N/A</td>
</tr>
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<td><strong>Total clients</strong></td>
<td><strong>3,177</strong></td>
<td><strong>14,229 (31/45)</strong></td>
<td><strong>4,160</strong></td>
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</tbody>
</table>

**Notes to table**

N/A – Not applicable: DAT area has not have this type of service.
N-R – Non-respondent to the survey.
Missing – Data not collected, or not provided.
The figure shown for number of clients in Tayside non-pharmacy services (796) was a Tayside-wide figure for three of the five Tayside services. Breakdowns were not available by DAT.
Data was unavailable from the Grampian-wide police custody suite exchange.
### Table A.3.3: Number of syringes distributed, 2004-05: Comparison of DAT responses with Services and Pharmacy Co-ordinator responses

<table>
<thead>
<tr>
<th>NHS Board / DAT</th>
<th>Number of syringes distributed by non-pharmacy services</th>
<th>Number of syringes distributed by pharmacy services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DAT response</td>
<td>Services response (n responding/total n)</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td>99,047</td>
<td>72,984 (3/4)</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>335,543</td>
<td>244,234 (1/3)</td>
</tr>
<tr>
<td>Borders</td>
<td>3,309</td>
<td>3,358 (1/1)</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>N-R</td>
<td>109,627 (1/3)</td>
</tr>
<tr>
<td>Fife</td>
<td>329,252</td>
<td>185,797 (2/3)</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>40,000</td>
<td>69,850 (2/2)</td>
</tr>
<tr>
<td>Glasgow</td>
<td>378,082</td>
<td>134,325 (1/2)</td>
</tr>
<tr>
<td>Grampian</td>
<td></td>
<td>304 (1/1)</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>314,767</td>
<td>197,555 (1/1)</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>72,000</td>
<td>133,581 (3/3)</td>
</tr>
<tr>
<td>Moray</td>
<td>556</td>
<td>Missing (0/1)</td>
</tr>
<tr>
<td>Highland</td>
<td>3,160</td>
<td>8,128 (2/2)</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>64,106</td>
<td>92,317 (3/5)</td>
</tr>
<tr>
<td>Lothian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>3,949</td>
<td>N/A</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>N-R</td>
<td>98,909 (5/7)</td>
</tr>
<tr>
<td>Midlothian</td>
<td>8,200</td>
<td>12,185 (1/1)</td>
</tr>
<tr>
<td>West Lothian</td>
<td>15,677</td>
<td>N/A</td>
</tr>
<tr>
<td>Orkney</td>
<td></td>
<td>0 Not surveyed</td>
</tr>
<tr>
<td>Shetland</td>
<td>N-R</td>
<td>4,206 (1/1)</td>
</tr>
<tr>
<td>Tayside</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angus</td>
<td>24,194</td>
<td>Missing (0/1)</td>
</tr>
<tr>
<td>Dundee City</td>
<td>82,678</td>
<td>24,194 (1/1)</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>32,970</td>
<td>116,268 (2/2)</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>Not surveyed</td>
</tr>
<tr>
<td>Total</td>
<td>1,807,490</td>
<td>1,540,792 (32/45)</td>
</tr>
</tbody>
</table>

**Notes to table**

N/A – Not applicable: DAT area has not have this type of service.
N-R – Non-respondent to the survey.
Missing – Data not collected, or not provided.
The figure shown for number of syringes distributed by Grampian-wide services (304) is the number of syringes distributed by the Grampian police custody suite exchange only.
Data was unavailable from the Tayside-wide police custody suite exchange.