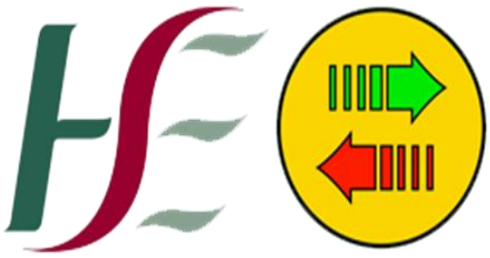
Review of Needle Exchange Provision in Ireland



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Foreword

In 2012 the Steering Group of the HSE Pharmacy Needle Exchange Programme, was requested by the HSE National Office for Social Inclusion to undertake an effectiveness review of all forms of needle exchange (NEX).

NEX, which falls under the auspices of the steering group for the Pharmacy Needle Exchange in compliance with the Key Results Area in the HSE's National Service Plan 2012, balances the need for information about needle exchanges across the country provided by statutory and non-statutory services with the need to keep information concise and uniform across reporting formats.

It also builds on the information provided in Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations, a joint report published in November 2008 by the National Drugs Strategy Team and the National Advisory Committee on Drugs.

The report is in line with the current National Drugs Strategy (2009 – 2016), specifically Action 34 relating to expansion of the availability of, and access to, needle exchange services where required. It provides a timely assessment of needle exchange services in the context of the external evaluation of the PNEX programme, assesses the enhanced provision of needle exchange services and how the various forms of needle exchange integrate/dovetail with one other.

This report on Needle Exchange Provision in Ireland is aimed at improving needle exchange coverage and enhancing service delivery as a way of reducing rates of new HCV and HIV infection and charts a way forward in identifying potential care pathways for drug and alcohol services in this country.

Joe Doyle
HSE National Planning Specialist: Social Inclusion

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- Blakestown CDT
- Bray Travellers
- Clondalkin Addiction Support Programme (CASP)
- Community Addiction Response Programme (CARP)
- Drug and Alcohol Services HSE South
- Drug and Alcohol Services HSE West
- Dublin Simon Outreach
- Jobstown Assisting Drug Dependency Project (JADD)
- Merchants Quay Ireland
- Community pharmacists from PNEX programme

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Executive summary

Recommendations

1. Service user feedback

A service user satisfaction survey of all the different NEX services should be carried out in line with Goal 6 of the HSE National Strategy for Service User Involvement in the Irish Health Service 2008-2013.

2. Data collection

a) A standardised electronic reporting mechanism for regular monitoring and reporting of all needle exchange transactions should be considered; preferably as part of the HSE Primary Care ICT system. NEX service information should ideally be reported to a central office on a quarterly basis.

b) Unique identifier

A unique identifier for each service user should be developed to remove the risk of an individual being counted more than once in a reporting year. The unique identifiers need to comply with the obligations of the Data Protection Act 1988, the Data Protection (Amendment) Act 2003 and SI535 of 2003 (as amended). The HSE has proposed to use a health service identification number for the each individual in the state for use in health or social care services and if possible the unique identifier should be linked to a health identifier, while preserving the anonymous nature of the service.

c) Image and Performance Enhancing Drugs (IPEDs)

NEX services should collect data from those who are using image performance and enhancing type drugs as this has been highlighted as an emerging trend.

3. NEX Service Training and Policies

a) All NEX service providers should ensure training complies with recognised standards, such as the Quality in Alcohol and Drug Services (QuADS) Organisational Standards (ALDP, HSE 2014); the Hepatitis C Strategy 2011, Recommendation 20; and Building a Culture of Patient Safety 2008- Report of the Commission on Patient Safety and Quality Assurance.

b) NEX service providers must ensure policies and procedures are in place to comply with QuADS Organisational Standards (ALDP, HSE 2014).

c) NEX service providers must also operate an effective clinical governance framework in line with QuADS Organisational Standards (ALDP, HSE 2014) or an equivalent professional body.

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4. Blood Borne Virus (BBV) testing and Hepatitis B vaccination

NEX service providers should examine potential barriers to BBV testing and immunisation in order to improve testing and immunisation uptake.

5. Equipment and supply considerations

a) Equipment supplied should be of high quality and meet European safety standards where available. Consideration should be given to including stericups, filters and foil in every NEX service (this is not currently the case).
b) Stock provision for all non-pharmacy NEX services should be centrally purchased and distributed to ensure value for money, quality and consistency of equipment.

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Background

Needle Exchange Programmes are intended to:

1. Prevent the spread of HIV and Hepatitis C through reducing their transmission by providing sterile injecting equipment
2. Prevent the development of localised bacterial infections, such as abscesses, by providing sterile injecting equipment
3. Prevent overdose through information on how to recognise it and what to do should it occur
4. Prevent the move from smoking to injecting and lower the incidence of injecting through the provision of tinfoil
5. Facilitate sterile and safe injecting through the provision of equipment, information and safer injecting training
6. Provide information on the importance and availability of HIV and Hepatitis C testing
7. Manage localised bacterial infections through referral for the provision of sterile dressing and medication (where necessary)
8. Provide information to the drug user in respect of relevant social and addiction services and refer the drug user to same when appropriate

NEX services should provide sterile injecting equipment and facilitate the return of used equipment in order to prevent the spread of BBVs. They should also supply condoms as applicable. NEX services may also refer an individual to other relevant services such as:

- Drug treatment
- BBV/testing
- Hepatitis B vaccination
- Homeless services

Where appropriate, some services may also have qualified outreach drug workers on site who can offer advice and provide specialist injecting equipment.

International evidence demonstrates that a mix of needle exchange models should be in place to maximise service user access to such services, (Cox & Robinson, 2008). There are advantages and limitations to the three most common models of exchange, i.e. fixed location; mobile/outreach; and pharmacy based.

1. Fixed location

Fixed-site exchanges allow services to provide education about harm minimisation strategies and to facilitate the distribution and disposal of drug-taking paraphernalia. However, they may have limited opening hours and be characterised by a lack of accessibility and privacy. Outreach provisions help to ameliorate such limitations by increasing accessibility, convenience and anonymity for service users.

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2. Mobile/Outreach backpacking

Outreach services can distribute sterile drug-taking paraphernalia and facilitate the return of used equipment as well as providing education about harm-minimisation. Typically, specially-trained staff (outreach workers) access service users via a purpose-built minibus or at a pre-appointed location, for example a service user's home. Such services have been shown to be the most 'economical' form of needle exchange provision, (Cox and Robinson, 2008**)**, and offer a high degree of discretion for the service user. This type of service is useful where injecting drug use is hidden, or rare, or is a widely dispersed phenomenon. However, concerns continue over staff safety - particularly during backpacking.

3. Pharmacy –based needle exchanges

The advantages of pharmacy-based needle exchanges are longer opening hours, greater service user convenience (pharmacies are usually situated in local residential areas) and the ability to serve small numbers of individuals in a specific place. Their relative ease of access also tends to facilitate contact between service users and healthcare professionals. Pharmacy-based needle exchanges can be a portal for referral to addiction services, as well as related health and social services. In the UK, pharmacies distribute a greater number of sterile injecting packs than any other type of needle exchanges service.

The structure and operation of needle exchange programmes vary widely depending on historic development, local conditions, funding and staffing levels. This has lead to the development of different models of operating needle exchange, influenced by economic and geographical factors, including urban/rural variations, all of which affect drug user up-take of the services. There are strengths and weaknesses to all three models. However, the combination of the three ensures the most user-friendly provision, accessibility to the service and regular engagement with the services. Pharmacy-based programmes complement other models as they provide access to a somewhat different population of injecting drug users, (Cox & Robinson, 2008; WHO, 2004).

Needle and syringe exchange services were first provided in Ireland in 1989 in the former Eastern Health Board AIDS Resource Centre in Baggot Street, Dublin 2, as a response to the emerging opiate misuse problem in the capital. Reflecting changing patterns of prevalence since then, the availability of needle exchange has grown significantly across the country, with a range of services offering this intervention.

The National Drugs Strategy 2009 – 2016 noted limited availability of NEX services in five of the 10 Regional Drug Task Forces and in 13 out of 14 Local Drug Task Forces, (NDS, 2008). Subsequently, the national PNEX service was initiated in 2011. It was based on a recommendation of Action 34 of the National Drugs Strategy 2009-2016, which highlighted the need to expand the availability of needle exchanges services, where required. The PNEX program is a joint initiative between the Elton John AIDS Foundation, the HSE and the Irish Pharmacy Union (IPU). Prior to this initiative, the provision of clean equipment for injecting drug users was mainly limited to the east of the country and was provided by both statutory and voluntary agencies funded by the HSE.

The PNEX programme covers all areas outside of Co. Dublin, Co. Wicklow and Co. Kildare.

To assess the effectiveness of needle exchange services, PNEX was asked to carry out a review of all fixed site, mobile/outreach and pharmacy-based services in 2012.

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The review was designed to assess:

- The existence of clinical governance and quality assurance policies and procedures
- Whether data collected regarding service users and needle exchange services met national and international standards
- Needle exchange activity in 2012
- Referral rates to healthcare and social services
- Needle exchange provision throughout the country

Research questions

The following issues were considered in the review:

1. What is the nature of the service provided by the various types of programme?
2. How are needle exchanges distributed throughout Ireland?
3. What types of injecting and other drug-use paraphernalia are distributed?
4. Are there gaps in service provision and, if so, where are they?
5. What quality assurance policies and procedures are used on the needle exchange programme?
6. Does the data collected follow international and national requirements? Are there data gaps; and, if so, where are they?
7. What are the trends in newly diagnosed cases of HIV and Hepatitis C?

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Methodology

The review was designed to gather information from those responsible for the planning and delivery of HSE-funded needle exchange programmes. Data collection was carried out from February to June 2013 using the questionnaire see appendix 1

It focused on a range of issues. In the case of non-pharmacy based services, it centred on data collection - particularly in relation to needle exchange activity (including the number of transactions, number of service users, number of syringes, needles and other paraphernalia distributed and returned), as well as quality assurance policies and procedures in individual needle exchange services.

As clinical governance and data collection procedures were already in place for pharmacy-based services (overseen by the National Liaison Pharmacist HSE Drug Addiction and supported by the Pharmaceutical Society of Ireland) the review focused on service delivery for pharmacy-based services.

Numeric and text based data was collected using a data collection template (Appendix 3). The questions were agreed by the steering group of the PNEX Programme. The PNEX office liaised with the Health Research Board to ensure this template met the overall objectives for the review and to provide assurance that the data requested met the data recording requirements of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

All members of the HSE National Advisory Addiction Governance Group (NAAGG) were consulted and requested to supply details of needle exchange services in their areas. These individual services were then contacted and requested to complete the data collection template using data from 2012.

Prior to undertaking this study, there was limited up-to-date data in relation to service users attending needle exchange services and on the provision of equipment. As a result of this, the data supplied for this review is incomplete in two exchanges. It is acknowledged that this omission may limit the completeness and robustness of the results. On the whole, however, the data is representative of needle exchange activity nationally.

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Findings

Response rates

All HSE areas completed the questionnaire, including 48% of pharmacies that recorded transactions. Data on all transactions and service users is also available from the Pharmacy Needle Exchange, which is submitted quarterly in arrears by the pharmacists participating in the programme.

Table 1: Sampling frame and response rates for review

	Total number in Ireland	Number invited to participate	Number responded	Response rate
HSE regions* with needle exchanges	4	4	4	100%
Voluntary sector needle exchanges in Ireland	6	6	6	100%
Total pharmacies	63	63	16*	25%
*Pharmacies which had transactions	33	16	16	48%

*The HSE regions are;

1. **Dublin Mid-Leinster:** Dun Laoghaire, Dublin South East, Dublin South City, Dublin West, Wicklow-Kildare/West-Wicklow, Dublin South West, Longford, Laois, Offaly, and Westmeath
2. **Dublin North East:** Louth, Meath, Cavan and Monaghan and north of Dublin city and county
3. **HSE South:** Cork, Kerry, Waterford, Wexfoxd, Carlow, Kilkenny and South Tipperary
4. **HSE West:** Donegal, Sligo, Leitrim, Mayo, Galway, Roscommon , North Tipperary and Limerick

Since the review was undertaken, reform / restructuring has taken place into Community Health Organisations and these regions do not presently exist, further information is available at http://www.hse.ie/eng/services/publications/corporate/CHO_FAQ.pdf

Models of Needle Exchange in Ireland

There are three models of needle exchange in Ireland:

1. Static - mainly in Dublin City
2. Outreach - mainly in Counties Dublin, Kildare, Laois, Offaly, Waterford and Wicklow
3. Pharmacy - in regions outside Dublin, Kildare and Wicklow

In 2012 there were:

- 24 static sites
- 14 outreach sites
- 63 pharmacies available to participate, of which 33 had needle exchange transactions.

In 2014, 129 pharmacies were participating in the scheme.

Geographical distribution of NEX

The study looked at the location of the different types of needle exchange services in Ireland. The details are presented below.

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Table 2: Number, type and location of needle exchange services, 2012

Area	Static	Outreach/Mobile	Pharmacy
HSE Dublin Mid-Leinster	14	6	11
HSE Dublin North East	4	2	9
HSE South	4	1	24
HSE West	2	2	19
Ireland	**24**	**11**	**63**

*MQI Dublin counted as 2 (1 outreach and 1 fixed)

The highest number of static needle exchanges is in Dublin Mid-Leinster, which reflects the numbers and clustering of injecting drug use in areas of Dublin. The number of reported outreach needle exchange services is relatively small and evenly spread throughout the region. Pharmacy-based needle exchange services are based outside counties Dublin, Kildare and Wicklow and serve the small clusters of injecting drug users in the towns throughout the remainder of Ireland. There are no static or outreach needle exchange services in counties Cork or Kerry, with very limited availability of static or outreach needle exchange in counties Louth, Meath, Cavan and Monaghan.

Access to static and outreach services varied. One of the static services opened between 9am-6pm Monday to Friday, while others had far more limited opening hours. The majority of static services opened between one and six hours a week and sometimes only once a week. None of the static or outreach services operated at weekends. Pharmacies usually open 48 hours a week or eight hours a day Monday-Saturday inclusive and some pharmacies also open on Sundays for limited hours. This indicates a potential 3,408 hours a week of pharmacy-based needle exchange delivered by 63 pharmacies. However, only 33 out of the 63 pharmacy needle exchanges reported any transactions in 2012.

Table 3: Opening hours for static and outreach services, 2012

	Static	**Outreach (including mobile and back packing)***
Open 3.5 hours or less a week	11	2
Open 4 hours to 8 hours a week	4	3
Open 9 to 24 hours a week	0	2
Open 25 to 43 hours a week	7	5
Open whenever needed	0	2
No hours recorded	2	0
Total	24*	14*

*MQI Dublin counted as 2 (1 outreach and 1 fixed

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Activity

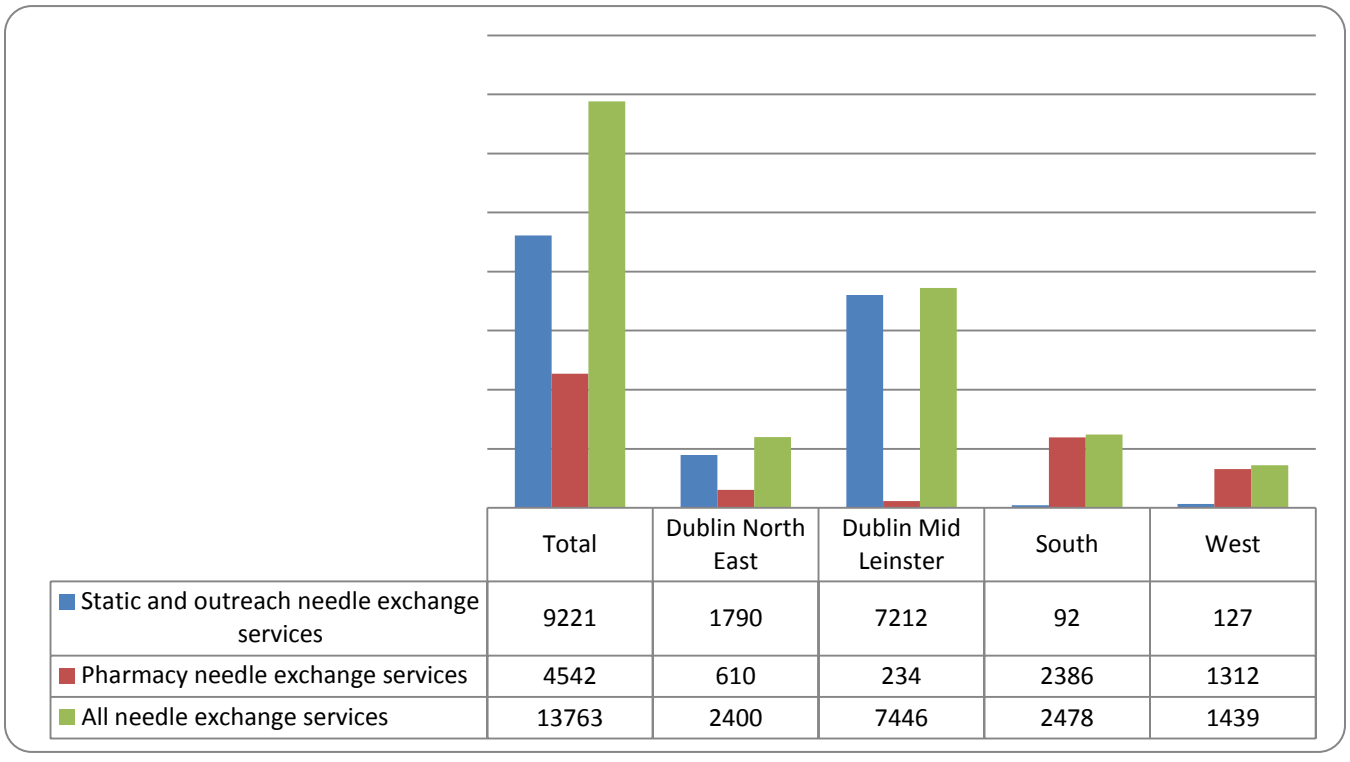
This section describes needle exchange activity in Ireland during 2012. Information includes the numbers of service users, transactions (or needle exchange contacts) and syringes distributed. The figures for static and outreach services were reported as a combined figure. Three static or outreach services were unable to provide data on the number of individuals attending their services. Two static services were unable to provide the numbers of needles or syringes distributed. Therefore, the data is an underestimate of needle exchange services in the Dublin North East, Dublin Mid-Leinster Region and HSE West.

Who attends needle exchanges?

The data collated showed that at least 13,763 individuals used needle exchange services during 2012 (Figure 1). More than two-thirds (67%) of transactions were at static or outreach services and one-third (33%) at pharmacy-based needle exchange services (Figure 2). The proportion of individuals attending either static/outreach or pharmacy-based models of needle exchange depended on the dominant model of needle exchange in an area.

Of the 13,763 individuals who received needle exchange services, 7,359 (80%) were men and 1,862 (20%)* were women. This ratio did not differ by model of needle exchange (Figures 3 and 4) and in general reflected the national proportion of four males to one female. The single exception was in HSE South, where the ratio was three males to one female (Figure 5).

*Currently there is no unique health identifier system in place in Ireland. This means service users can be counted more than once in a reporting year.



	Total	Dublin North East	Dublin Mid Leinster	South	West
Static and outreach needle exchange services	9221	1790	7212	92	127
Pharmacy needle exchange services	4542	610	234	2386	1312
All needle exchange services	13763	2400	7446	2478	1439

Figure 1: Number of individuals who attended needle exchange services by region and model of service, 2012

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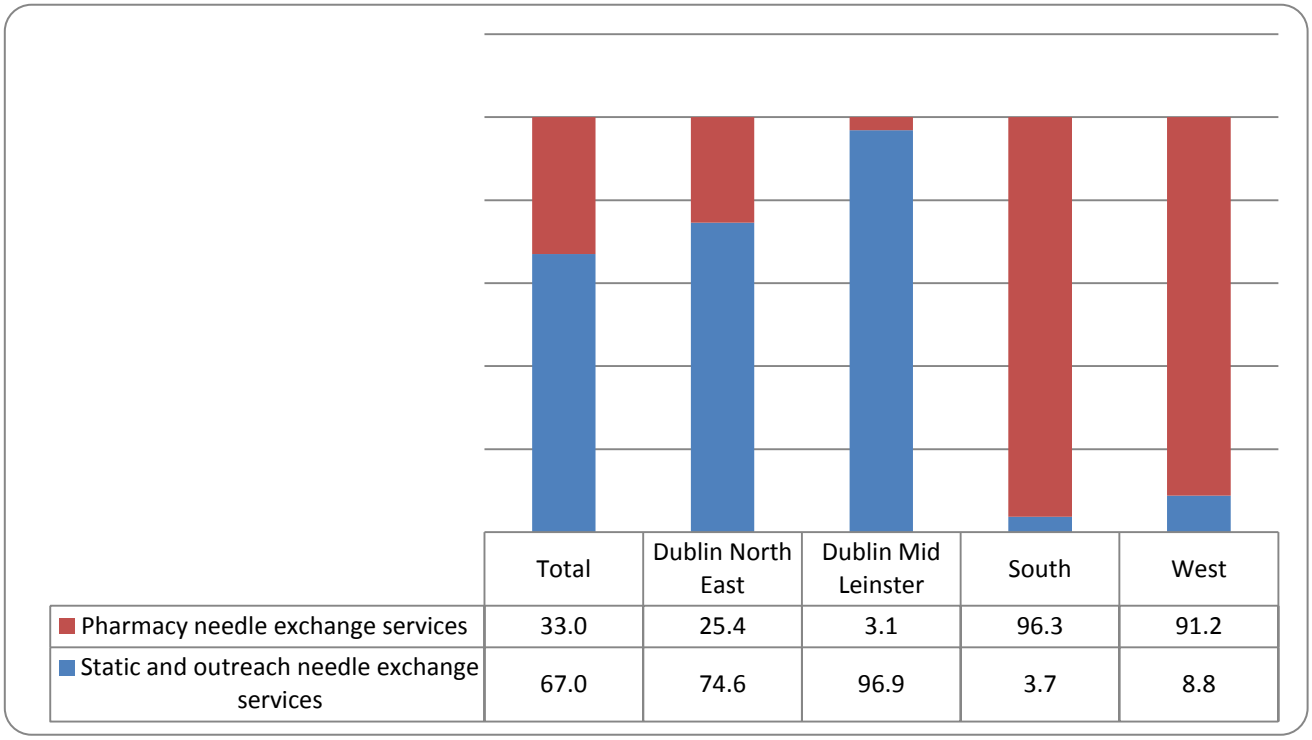
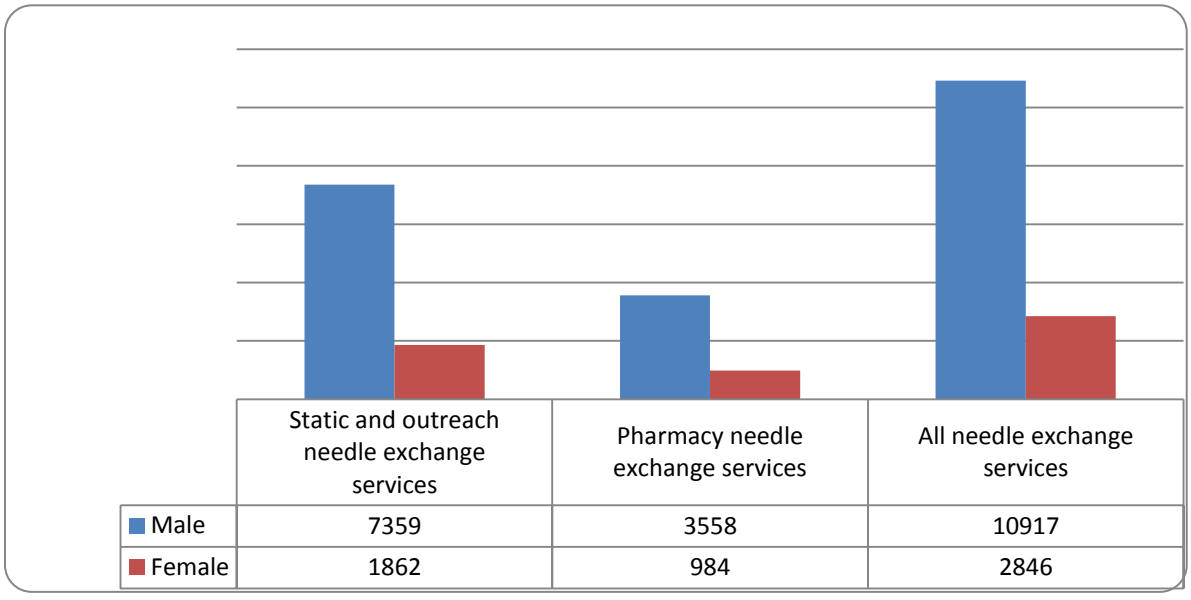


	Total	Dublin North East	Dublin Mid Leinster	South	West
Pharmacy needle exchange services	33.0	25.4	3.1	96.3	91.2
Static and outreach needle exchange services	67.0	74.6	96.9	3.7	8.8

Figure 2: Proportion of individuals who attended needle exchange services by region and model of service, 2012



	Static and outreach needle exchange services	Pharmacy needle exchange services	All needle exchange services
Male	7359	3558	10917
Female	1862	984	2846

Figure 3: Numbers attending needle exchange services by model of service and gender, 2012

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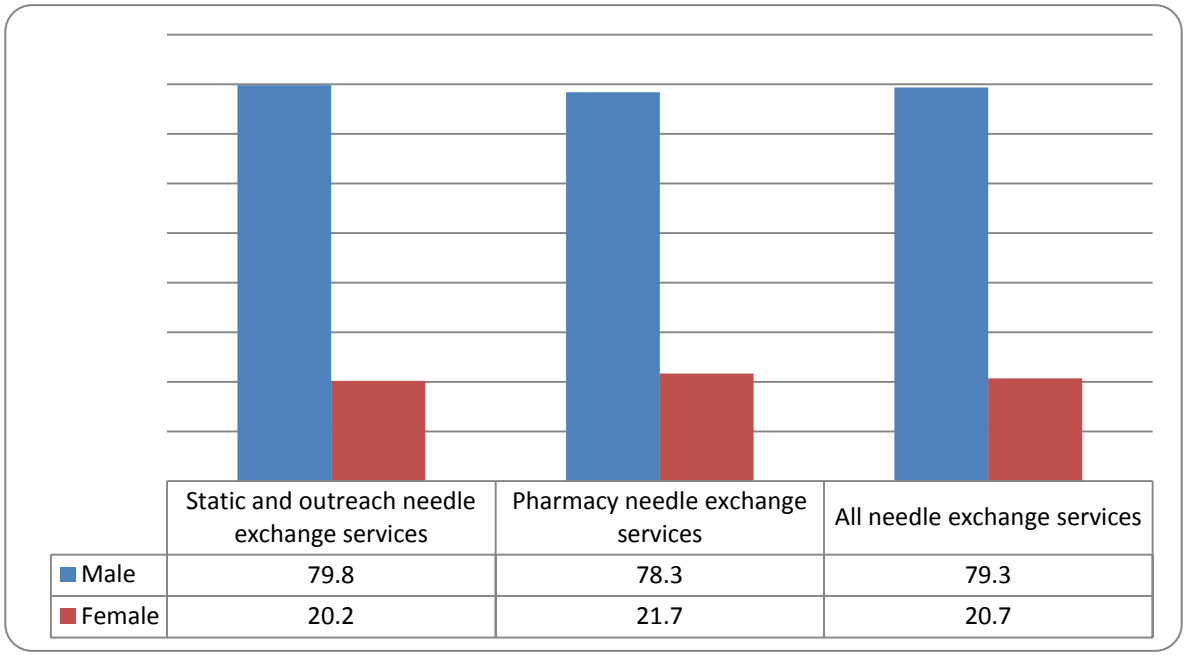
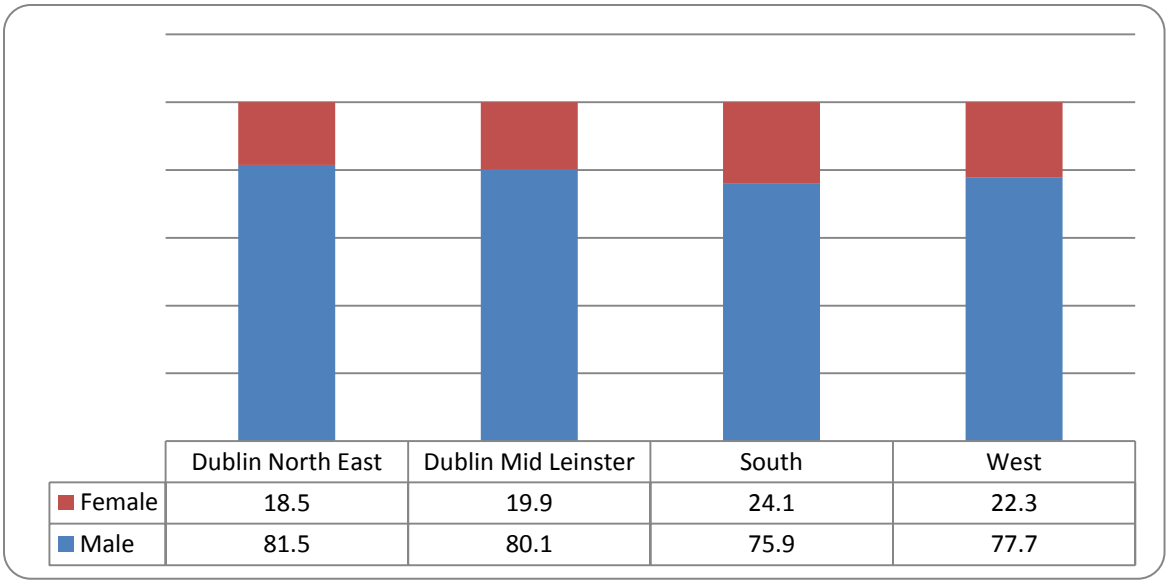


	Static and outreach needle exchange services	Pharmacy needle exchange services	All needle exchange services
Male	79.8	78.3	79.3
Female	20.2	21.7	20.7

Figure 4: Proportion (%) attending needle exchange services by model of service and gender, 2012



	Dublin North East	Dublin Mid Leinster	South	West
Female	18.5	19.9	24.1	22.3
Male	81.5	80.1	75.9	77.7

Figure 5: Proportions attending needle exchange services in each region by gender, 2012

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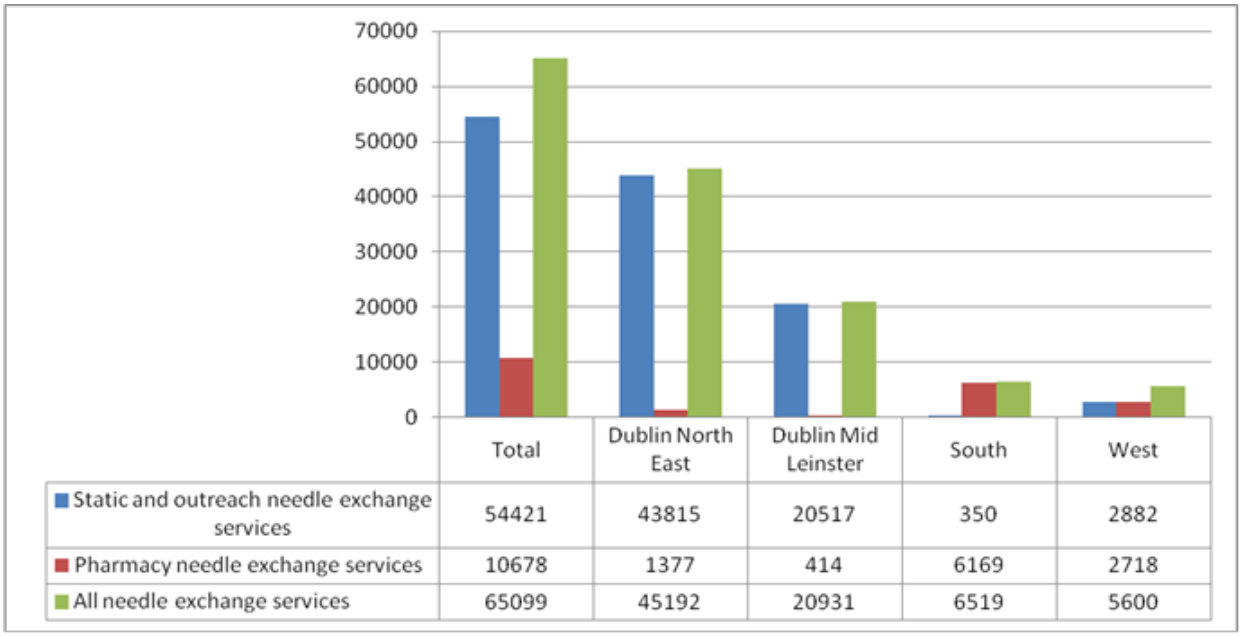
Transactions

Activities conducted through needle exchanges in 2012

The data presented in Figures 6 and 7 indicate 65,099 transactions took place at needle exchange services during 2012. The majority (84%) of transactions were at static or outreach services and 16% were at pharmacy-based needle exchange services. When HSE regions are compared, the majority of transactions were at static needle exchanges in Dublin Northeast followed by Dublin Mid-Leinster. In the south, the vast majority of transactions took place at pharmacy-based needle exchange services. In the west, just under half of the transactions took place at pharmacy-based needle exchange services and the balance at static or outreach services.



	Total	Dublin North East	Dublin Mid Leinster	South	West
Static and outreach needle exchange services	54421	43815	20517	350	2882
Pharmacy needle exchange services	10678	1377	414	6169	2718
All needle exchange services	65099	45192	20931	6519	5600

Figure 6: Number of transactions at needle exchange services by region and model of service, 2012

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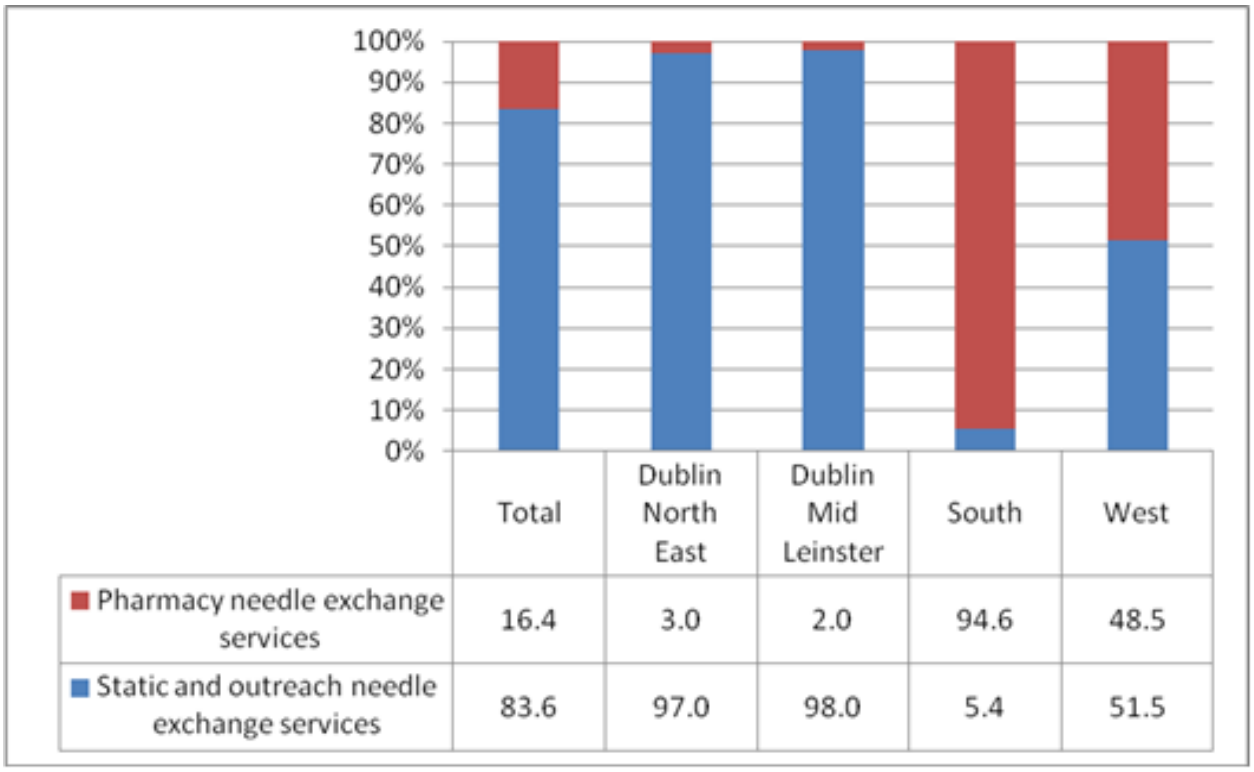

	Total	Dublin North East	Dublin Mid Leinster	South	West
Pharmacy needle exchange services	16.4	3.0	2.0	94.6	48.5
Static and outreach needle exchange services	83.6	97.0	98.0	5.4	51.5

Figure 7: Proportion of transactions at needle exchanges by region and model of service

As mentioned previously two services were unable to provide accurate data on their distribution of needle exchange equipment. Pharmacy-based services report syringe transactions on a quarterly basis to the office of the HSE Pharmacy Needle Exchange Programme. The data for static and outreach services were collected on a once-off basis for 2012. Some 274,475 syringes were distributed through needle exchange services in 2012 (Figure 8): 57% through static or outreach sites and 43% through pharmacy-based sites (Figure 9). Dublin Mid-Leinster distributed the highest number of syringes, mostly through static sites as this is the dominant model in this region. Almost all syringes were distributed through pharmacy-based exchanges in the HSE South and HSE West as this is the dominant model in these two regions.

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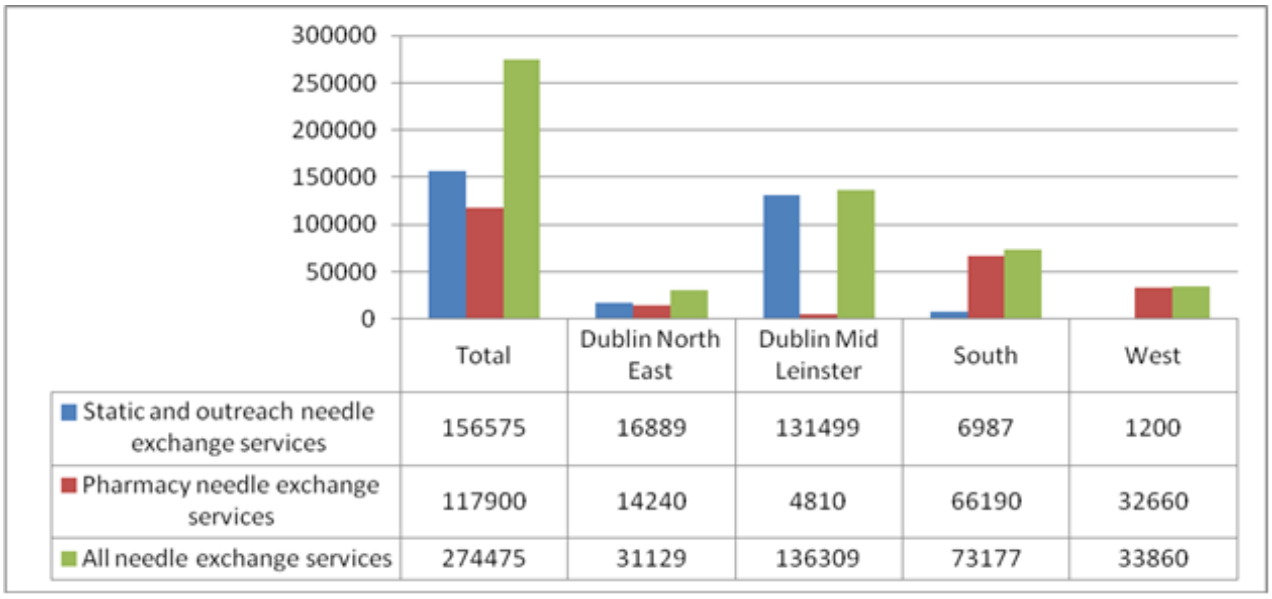
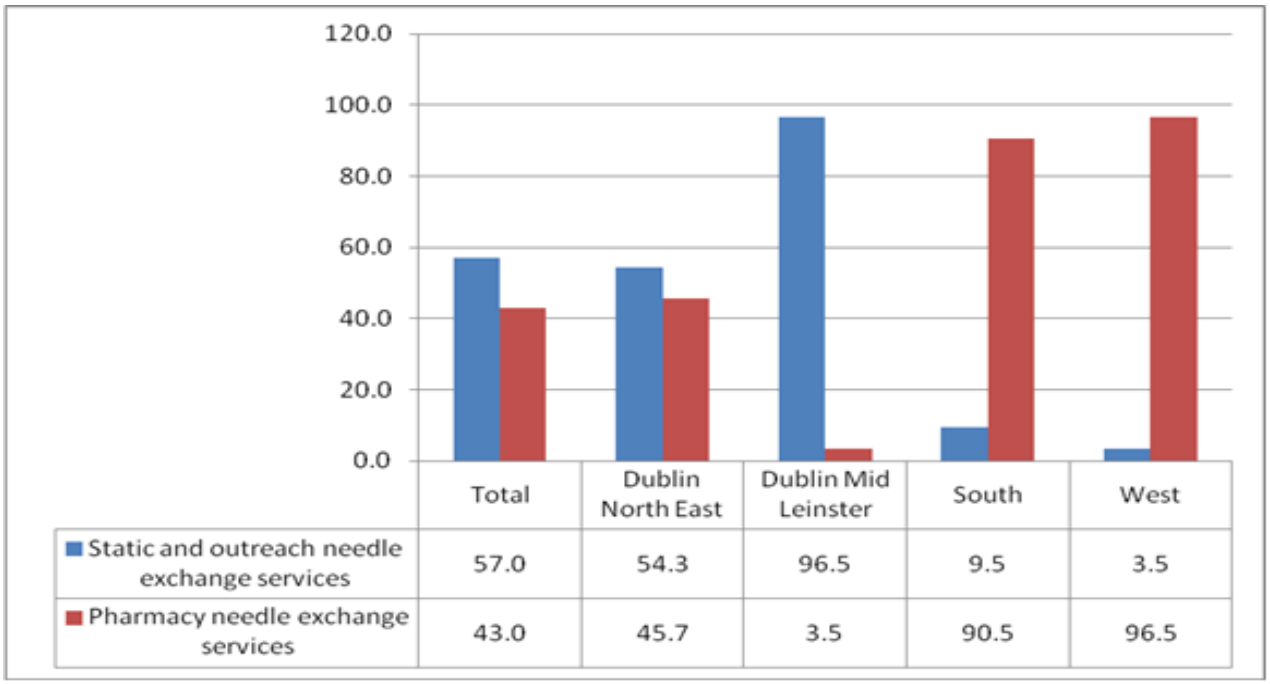


	Total	Dublin North East	Dublin Mid Leinster	South	West
Static and outreach needle exchange services	156575	16889	131499	6987	1200
Pharmacy needle exchange services	117900	14240	4810	66190	32660
All needle exchange services	274475	31129	136309	73177	33860

Figure 8: Number of syringes provided through needle exchange services by region and model of service, 2012



	Total	Dublin North East	Dublin Mid Leinster	South	West
Static and outreach needle exchange services	57.0	54.3	96.5	9.5	3.5
Pharmacy needle exchange services	43.0	45.7	3.5	90.5	96.5

Figure 9: Proportion of syringes provided through needle exchange services by region and model of service, 2012

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Paraphernalia distribution

Most static and outreach needle exchange services were able to provide detailed data on the quantities of injecting equipment distributed but two were only able to provide partial information. Combined, 156,575 syringes were distributed (Table 4):

- Fixed needle and syringe (49%)
- 2ml syringe (35%)
- 1ml syringe (11%)

Some 135,696 needles were also distributed. The most prevalent were needles fixed to the syringe (56%), and blue needles (34%). Blue needles are used by those who inject into their groin (Table 4). Additionally, 2,400 green needles were distributed, which could suggest steroid user attendance at needle exchange, as this is used by this particular group to inject.

Some 67,768 vials of water for injection were distributed, which comprised three quantities: 2ml (2%), 5ml (13%) and 10ml (85%), (Figure 10). There were 67,928 more needles distributed than vials of water for injection. There were 25,450 spoons distributed, indicating that 110,246 more needles than spoons were distributed. The discrepancy between needles and other injecting equipment could indicate that some equipment is being used more than once. This is not best practice: each piece of equipment should be used only once and then disposed of. Other equipment included foil - provided to encourage smoking, rather than injecting drug use - in 13 static and outreach services.

A further two services provided 404 crack pipe kits and tourniquets to their service users.

Table 4: Quantities and proportions of needles and syringes distributed, 2012

	Syringes	Per cent
1ml syringe with needle	76206	48.7
2ml syringe	54875	35
1ml syringe	25494	16.3
Total	156,575	100
	Needles	Per cent
1ml syringe with needle (peripheral vein)	76206	56.2
Needle blue 30mm (groin vein)	25878	19.1
Needle: blue 25mm (groin vein)	20056	14.7
Needle orange (25G peripheral vein)	8648	6.4
Needle brown (28G peripheral vein)	2513	1.9
Needle green 40mm (commonly used to administer steroids)	2395	1.7
Total	135,696	100

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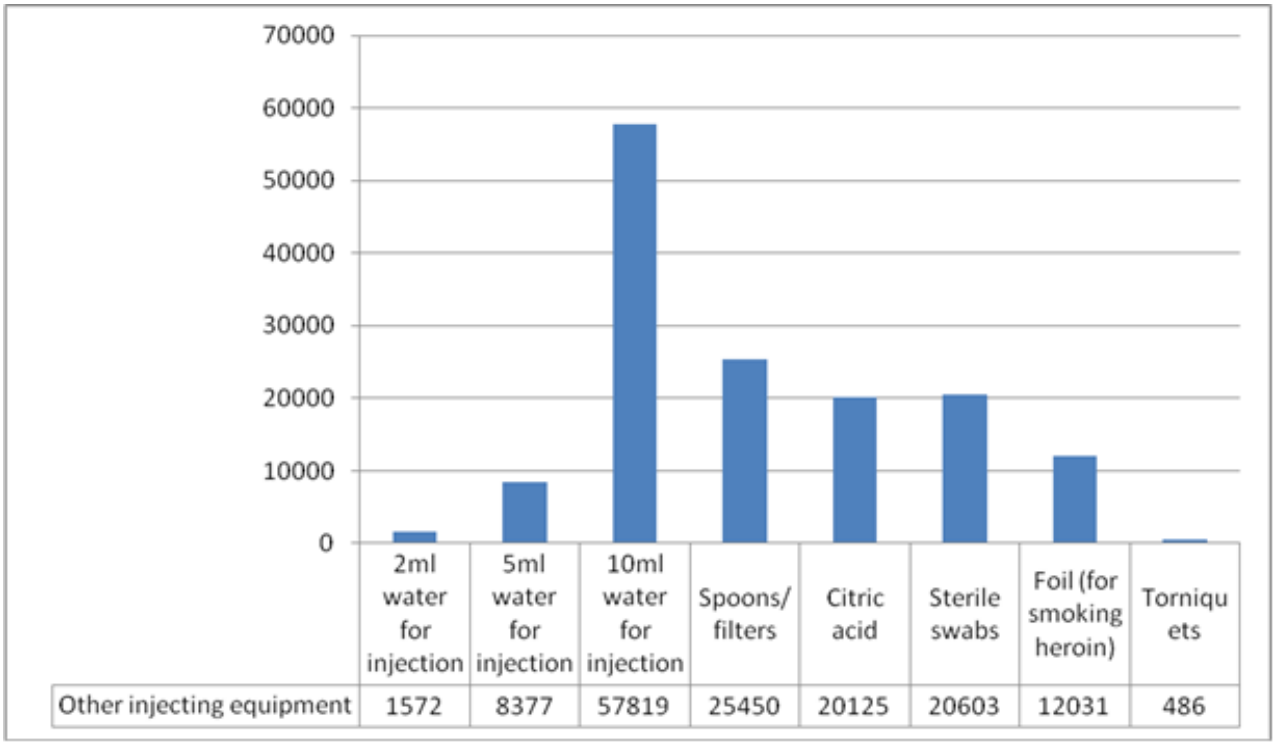

Figure 10: Numbers of needles distributed at static and outreach sites, 2012

Pharmacy-based needle exchanges

Pharmacy-based needle exchanges distribute packs containing the equipment required to administer 10 sterile injections. The pack contains 10 filter syringes (including needles), 10 stericups, 10 swabs, 10 citric acid packs, 10 vials with 5ml water for injection and one information leaflet (which contains harm reduction and safer injecting advice).

During the period, pharmacy needle exchange services dispensed 117,900 of each of the following: filter syringes, stericups, swabs, citric acid and vials of water for injection.

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Needle Exchange impact on the spread of BBVs

Although all services said they provided information on BBVs, only two static or outreach needle exchange services provided a record of the number of referrals for BBV testing and Hepatitis B vaccination. Five static and outreach services reported that a doctor or nurse would have referred patients but such interventions were not recorded. The remaining static or outreach services indicated that they did not know the numbers or they left the relevant data field blank. Eleven static or outreach services recorded referrals to treatment services and a further three reported referrals of service users to other treatment services but did not have a record of the number of such referrals.

Referrals from pharmacy-based needle exchange services are recorded systematically and reported to the HSE each quarter. This reflects the important role they play in linking affected individuals with preventative, diagnostic and treatment services. The numbers presented in Figure 11 are an underestimate of the referral activities provided by static and outreach needle exchange services as not all referrals were recorded. Referral rates collated as part of the Pharmacy Needle Exchange Programme are more complete as participating pharmacies record referrals as part of the data which is returned to the PNEX office.

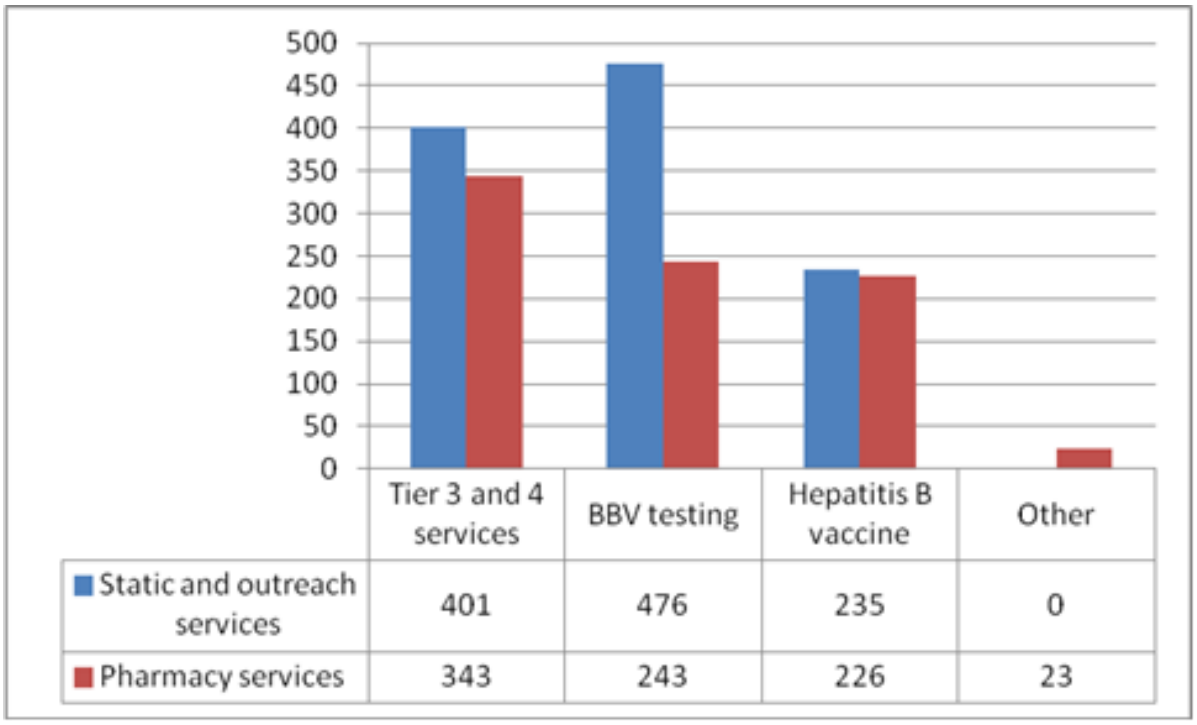

Figure 11: Numbers of referrals recorded by model of needle exchange, 2012

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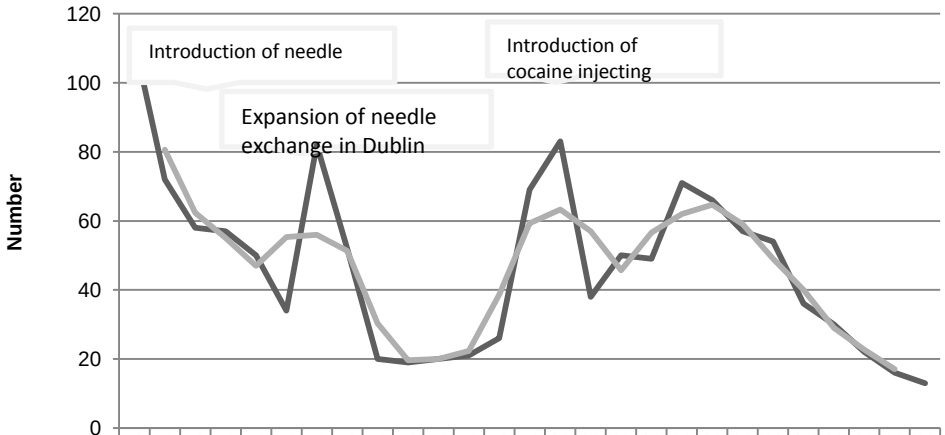
Contribution of needle exchange to the decrease in the number of HIV and Hepatitis C diagnoses

HIV surveillance, 1986-2012

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1982. Figure 12 presents the number of new cases of HIV among injecting drug users (IDUs) reported in Ireland by year of diagnosis. Data from 1982 to 1985 are excluded as these four years were combined in the source records. According to the most recent report of the Health Protection Surveillance Committee (HPSC), at the end of 2012, 341 people were newly diagnosed with HIV in Ireland (crude notification rate of 7.4 per 100,000 per population) and the figure has been declining since 2004.

In 2012, 13 (3.8%) newly diagnosed HIV cases were IDUs. The number of diagnoses among IDUs has been steadily decreasing - from 71 in 2004 to 13 in 2012 (a decline of 82%). Of the 13 newly diagnosed cases who were IDUs, 10 were men and the median age was 34 years (age range 22-to-50 years). Five cases were born in Ireland, three in Central and Eastern Europe and two in Western Europe. Among the IDUs newly diagnosed with HIV infection, 69% were co-infected with Hepatitis C (Donnell, et al. 2013).



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Actual number	112	72	58	57	50	34	82	52	20	19	20	21	26	69	83	38	50	49	71	66	57	54	36	30	22	16	13
Rolling centred three year average number		80.7	62.3	55	47	55.3	56	51.3	30.3	19.7	20	22.3	38.7	59.3	63.3	57	45.7	56.7	62	64.7	59	49	40	29	22.7	17	

Figure 12 Number and rolling average number of new cases of HIV among IDUs by year of diagnosis reported in Ireland, 1986–2012
Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2013

Hepatitis C notifications, 2012

There were 1,036 Hepatitis C notifications in 2012 (Table 5), a 17.5% decrease on the 1,257 reported in 2011. Previous annual numbers have included cases diagnosed in the past, which were not previously notified. Decreasing Hepatitis C notifications and increasing median age are indicative of a decline in Hepatitis C. Demographic data in 2012 were similar to previous years, with males representing 66% of the 689 cases; the median age at notification being 37 years; and 67% of cases being aged between 25 and 44 years.

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Table 5: Hepatitis C cases and notification rates per 100,000 population, 2004–2012

Year	n	Notification rate
2004	1119	26.4
2005	1403	33.1
2006	1210	28.6
2007	1541	36.5
2008	1511	35.8
2009	1240	29.3
2010	1236	29.2
2011	1257	29.6
2012	1036	24.4

Source: Unpublished data from HPSC, 2013

Risk factor data were available for 637 (61%) of the 2012 cases. Of these, 484 (76%) were predominantly at risk from injecting. Among this subset, 348 (72%) were men with an average age of 37 years. In the 484 cases where injecting was the predominant risk factor, 399 (82%) lived in Dublin and the adjoining counties of Kildare and Wicklow.

What other activities do needle exchange services provide?

All of the services reported providing their service users with face-to-face advice on harm reduction and overdose as well as referrals to other treatment options and counselling services.

A list of possible interventions was provided in the questionnaire to determine the types of interventions that could be offered to the service user.

All of the services reported that they provide at least five or more of the ten interventions listed below:

1. Specific harm reduction advice
2. Overdose awareness
3. Basic harm reduction messages repeated at each attendance
4. Service user referrals to A&E or a GP
5. Service user referrals to other health, outreach and social care services
6. Wound care advice
7. Injection site inspection
8. Service user referrals for BBV testing and Hepatitis B vaccination
9. Service user assistance with the referral process e.g. making phone calls
10. Other health advice

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Returns Policy

All needle exchange services were asked about their policies on the return of equipment. All services stated that while they encouraged the return of used needles and syringes it was not a condition for accessing new equipment.

The review requested data on needle exchange returns. The collection of this data from static and outreach needle exchange services varied. For example, one service averaged the contents of the returned sharps containers; two regions reported data on the number of sharps containers and needles returned while some services were unable to provide any estimate of returns. The numbers of containers returned are routinely reported by pharmacy-based services and are recorded.

Quality Assurance

The questionnaire asked static and outreach needle exchange services to describe the quality assurance and clinical governance processes and procedures for needle exchange services. The governance for pharmacies is a statutory requirement under the Pharmacy Act 2007 which gives the Pharmaceutical Society of Ireland powers of inspection, investigation and enforcement.

All static and outreach needle exchange services except one said they had a clinical governance policy in place. The statutory services said this fell under the aegis of their regional HSE Addiction services.

Three voluntary-based services reported that SafetyNet (a Primary Care Network for Homeless Health Services) provided their clinical governance.

One voluntary service reported that the nurse employed in the service provided its clinical governance.

Two voluntary services reported the receipt of in-house clinical governance, stating that:

> *'The service is responsible for the quality and satisfaction of service users in the care we deliver'*
>
> *Service 1*

> *'The board of directors are responsible for clinical governance or they can appoint a person'*
>
> Service 2

It would appear all static and outreach needle exchange services work within the NDRIC framework, which is designed to ensure service providers offer individuals affected by drug misuse a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway.

The service provision for children (under 18 years) was reported by two service providers, one statutory HSE DML and one voluntary (ALDP) who were providing services within the former DML Region.

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These services had in place policies for the provision of needle exchange which complied with QuADS and a referral pathway to treatment as these individuals are prioritised for access to services.

Static and outreach needle exchange services were asked how often staff received up-skilling as part of their continuous professional development. The replies varied greatly. Most of the services indicated they received ongoing training but one statutory service highlighted that its training was:

> *'Irregular and ad hoc. It was dependent on: (A) staff motivation to apply for courses. (B) Whether they are allowed to attend training course. (C) Whether there is any training available. There is no ongoing training whatsoever. There is generally none [competency assessment] specific to our services which have only had a competency assessment once in over 13 years.'*

The Pharmacy Act 2007 introduced mandatory continuing professional development for pharmacists. They are therefore required to fulfil the statutory requirement for continuous professional development on an annual basis.

Emerging trends

Services reported a variety of emerging drug trends:

- Crystal meth
- Crack cocaine
- Ketamine
- Steroids
- Tanning products
- Problematic cannabis smokers
- Other new synthetic drugs

Services reported the following harmful practices:

- Steroid users reusing equipment
- Poor injecting practices amongst sporadic spontaneous users
- Homemade crack pipes
- Cannabis use and debt among the younger population
- Increase in alcohol use
- Increase in benzodiazepine and related medication, especially among young women
- Increase drug use among the Traveller community
- Greater array of tablets on offer through the internet and on the street
- Use of tanning products

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Conclusions

There is little or no doubt that the numbers of newly diagnosed cases of HIV and Hepatitis C in injecting drug users have been reduced through a combination of interventions, one of which is needle exchange.

However, information on the provision of needle exchange services seemed to be limited to an up-to-date list of needle exchange services. Information tended to be regional and there was no national list of non-pharmacy based needle exchange services.

Data requirements

It is clear that, in contrast to pharmacy-based needle exchange services; there was no standardised approach to collecting data on static or outreach needle exchange services. In addition, specific services reported difficulties with the continued use of paper-based systems, with inputting data onto the Drug Addiction Information System (DAIS) and a lack of availability of computers.

Data collection is very important to ensure that the information on the numbers attending and the processes followed by each service are recorded to demonstrate service output and to provide evidence that objectives are being achieved. Static and outreach services should be facilitated to provide a minimum dataset to ensure that national and European standards are met. In addition, a consensus on the recording of returns is required.

Hepatitis C strategy

It is evident pharmacies are using the referral pathways to their local services and providing a point of contact to assist in informing service users of prevention, testing and treatment options. Ad hoc reports indicate that static and outreach needle exchange services do refer people to drug treatment, BBV testing services and other health and social services. However, hard data to confirm this is essential.

The National Hepatitis C Strategy 2009-2014 states that needle exchange services need to:

> '*Offer and promote screening for Hepatitis C and other blood-borne diseases to those who attend services such as needle exchange programmes and other harm reduction services*.'

At present, needle exchange sites are not trained or resourced to provide such services and training and up skilling should be considered.

Reducing or preventing injecting

Currently in the Netherlands, foil is available in all needle and syringe exchange programmes and consumption rooms which has led to a reduction in the incidence of HIV and overdoses, (Kools, 2009).

Over the past decade *'HIV prevalence had fallen from 8.5 per cent to virtually zero in Amsterdam, and the number of fatal overdoses had also drastically decreased'* (Kools, 2010). The distribution of foil could be considered a useful intervention to prevent the move from smoking to injecting and reduce the incidence of injection among smokers.

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Ensuring single use only

According to WHO, best infection control practices for intradermal, subcutaneous and intramuscular injections recommend the use of a new, single use injection device for each injection and, in addition, the equipment required to prepare heroin and other drugs, such as spoons, filters and water, (Hutin et al, 2003).

Procurement approaches

The quantities and prices of equipment, staffing, building and other related costs were not provided in this report. Such data should be made available to determine whether expenditure is in line with budgets and if economies of scale might be achieved through a tender process.

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Key Recommendations

Service user feedback

A service user satisfaction survey of all the different NEX services should be carried out in line with Goal 6 of the HSE National Strategy for Service User Involvement in the Irish Health Service 2008-2013.

Data collection

A standardised electronic reporting mechanism for regular monitoring and reporting of all needle exchange transactions should be considered; preferably as part of the HSE Primary Care ICT system. NEX service information should ideally be reported to a central office on a quarterly basis.

Unique identifier

A unique identifier for each service user should be developed to remove the risk of an individual being counted more than once in a reporting year. The unique identifiers need to comply with the obligations of the Data Protection Act 1988, the Data Protection (Amendment) Act 2003 and SI535 of 2003 (as amended). The HSE has proposed to use a health service identification number for the each individual in the state for use in health or social care services and if possible the unique identifier should be linked to a health identifier, while preserving the anonymous nature of the service.

Image and Performance Enhancing Drugs (IPEDs)

Needle Exchange services should collect data from those who are using image performance and enhancing type drugs as this has been highlighted as an emerging trend.

NEX Service Training and Policies

All NEX service providers should ensure training complies with recognised standards, such as the Quality in Alcohol and Drug Services (QuADS, UK) Organisational Standards; the Hepatitis C Strategy 2011, Recommendation 20; and Building a Culture of Patient Safety 2008- Report of the Commission on Patient Safety and Quality Assurance.

NEX service providers must ensure policies and procedures are in place to comply with QuADs, (UK) Organisational Standards.

NEX service providers must also operate an effective clinical governance framework in line with QuADS, (UK) Organisational Standards or an equivalent professional body.

Blood Borne Virus (BBV) testing and Hepatitis B vaccination

NEX service providers should examine potential barriers to BBV testing and immunisation in order to improve testing and immunisation uptake.

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Equipment and supply considerations

Equipment supplied should be of high quality and meet European safety standards where available.
Consideration should be given to including stericups, filters and foil in every NEX service (this is not currently the case).
Stock provision for all non-pharmacy NEX services should be centrally purchased and distributed to ensure value for money, quality and consistency of equipment.

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Submissions

One submission has been made regarding the expansion of the pharmacy needle exchange programme:

Better City for All Implementation Group

Following a presentation made to the group by Tim Bingham and Denis O' Driscoll, the Better City for All report (2012) recommended an extension of the pharmacy needle exchange programme across Dublin City and County. This document highlights the trend whereby a significant amount of individuals are using services in Dublin City from regions outside of the capital, which is putting additional pressure on resources. Since these recommendations were published, the data suggests a reduction in the number of individuals using services in the Dublin Region because as they are accessing them locally instead.

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Dublin City Council
Comhairle Cathrach Bhaile Átha Cliath

Príomhoifig an Lárcheantair, An Lárcheantar,
51-53 Sráid Sheáin MhicDhiarmada Íochta, Baile Átha Cliath 1.

Dublin City Council, Central Area Headquarters, Central Area,
51-53 Seán McDermott Street Lower, Dublin 1.
T. 01 222 2987 F. 01 222 5328 E. alison.kingdd.dublincity.ie

Tim Bingham
National Liaison Pharmacy Worker
Irish Needle Exchange Programme
Addiction Services HSE
PO Box 486 Corporate House
Mungret Street
Limerick

10th May 2013

Dear Tim,

By way of introduction, my name is Charlie Lowe and I am an Area Manager with Dublin City Council; however on this occasion I am writing to you within my capacity as the Chairperson of the "A Better City for All" Implementation Group. The work of this group centres on addressing the issues of substance misuse related anti-social behaviour in Dublin City Centre. The group is made up of managers and leaders from statutory, voluntary, community and business sectors working in Dublin City Centre.

The group is aware that you are currently conducting a review of Needle Exchange Services across Ireland and I would be grateful if you would include this submission within the review.

BACKGROUND:
In January 2011, in his capacity as Chairman of the Policing Forum, former Lord Mayor of Dublin, Councillor Gerry Breen, called a meeting of representatives of some of Dublin City's key stakeholders. At the meeting it was proposed that a generic Good Neighbour policy which could be localised by any drug service would be developed. The Ana Liffey Drug Project was tasked with the job of interviewing relevant stakeholders to develop a suitable policy. During this process those involved expressed an interest in establishing a cross city/inter-agency group to address the issues in a co-ordinated manner. This led to the establishment of the *'Strategic Response Group'* and it was this initial group that oversaw the development and publication of both the underpinning research and the "A Better City For All" document. Once, this research and planning phase was complete the group entered into a phase of implementation of the recommendations from the "A Better City For All" report.

TREATMENT SERVICES
Within the "A Better City For All" report there is one specific recommendation which relates to the National Pharmacy Needle Exchange Programme:

> Medium to long term actions:
>
> - There should be an extension of the current pilot of Regional Pharmacy Needle Exchange across Dublin City and County.
>
> (A Better City for All, (2012), P8)

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The "A Better City For All" Implementation Group is committed to promoting sustainable localised responses to the issue of drug addiction across Ireland. Therefore, it is the opinion of the group that serious consideration should be given to the expansion of the National Pharmacy Needle Exchange Programme across Dublin City and County; to ensure that people who inject drugs intravenously have improved access locally to clean injecting equipment. As this, in turn, will go some way in reducing the need for people to have to travel into Dublin City Centre to access needle exchange services.

I look forward to your comments on the above, however, if you think it would be more appropriate, I would like to offer you the opportunity to address the group on this issue. The next scheduled meeting of the group is Thursday, 6th June 2013 at 11.00 a.m. in the Civic Offices, Dublin 8. Please contact Alison King on (01) 222 2987 if you wish to attend this meeting.

If you require any further information please contact Mr. Tony Duffin

Yours sincerely,

Charlie Lowe
Chairperson
"A Better City for All" Implementation Group

C.C. Tony Duffin, Director, Ana Liffey Drug Project and member of the "A Better City for All" Implementation Group.

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Appendix 1

Name of service provider_____
Type of service, (please fill out separate forms if more than one type of service provided by your organisation)

Static	
Backpacking (Only)	
Van (Only)	

1. **Coverage of the service provided**

- Details of towns covered by mobile outreach services
- Static Address of service(s)

2 .How many hours a week is the Needle Exchange service open

	Day Time 9am – 6pm	Evenings 6pm onwards	Weekends	Total Hours
Static				
Outreach				
Mobile				

3. Number of staff who are trained - provide needle exchange service

4. Please provide details of the level of service delivery and peripatetic service

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5. How many Needle Exchange transactions were reported 2012?

	Male	Female	Unknown	Total
2012				

6. How many unique individuals made contact with the service in 2012?

	Male	Female	Unknown	Total
2012				

7. Amount of equipment which was distributed in 2012 to each service user – per transaction

Key B = Blue, G= Green, O = Orange, 1ml fixed = 1ml diabetic / orange top , BR =Brown

	Barrel		**Needle**	**Water for Injection**								
	1ml fixed	**1ml**	**2ml**	**5ml**	**B 25mm**	**B 30mm**	**G 40mm**	**BR 26G**	**O 25mm**	**2ml**	**5ml**	**10ml**
Static												
Outreach												
Mobile van												
Total												

	One hit kit packs	**Sharps Bins**	**Condoms**	**Foil packs**	**Wipes swabs**	**Citric acid/Vit C**	**Tourniquets**	**Filters**
Static								
Outreach								
Mobile								

8. Please give details of the supplier of the stock for the needle exchange service

9. If an emergency pack has been supplied, what were the contents of the pack ?

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10. Other equipment supplied please give details

11. Does your service provide Crack Pipes Yes / No
If yes please provide details of the kits and name of manufacturer

12. Number of crackpipe Kits distributed in 2012

Male	**Female**
Total	

13 . Return rate of sharps containers in 2012

Male	Female	Unknown	Total

14. Policy on return of used needles /syringes

Service operates a strict one individual needle / syringe for one exchange policy	
Service always requires some return of used needles / syringes before new equipment is provided	
Service encourages return of used needles and syringes but this is not a condition for accessing new equipment	

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15. How is data recorded, (e.g. if a computer system is used which computer system) and who is it reported to ?

16. What is the organisation's peer /secondary exchange policy ?

17. How many referrals for Blood Bourne Virus Testing in 2012 were made?

	Male	Female	Unknown	Total
Hep B Testing				
Hep C Testing				
HIV testing				
Other				

18. In how many of these referrals was it possible to track from referral through to treatment assessment?

	Male	Female	Unknown	Total
Hep B				
Hep C				
HIV				
Other				

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19. How many people were referred on to tier 3 and tier 4 services in 2012 ?

	Male	Female	Unknown	Total
Methadone programme				
Counselling				
Stabilisation				
Residential treatment				
Detox service				
Other				

20. How many service users were given

	Male	Female	Not quantified	Total
Overdose awareness training				
Safer injecting advice				

21. Does the organisation work within the framework of NDRIC care planning and referral pathways
Yes /No

22. Briefly summarise the organisation understand about the NDRIC care planning and referral pathways work

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Clinical Governance

23. Does the organisation have a Under 18's policy Yes/No

If yes , outline what is it? And who or which organisation provides the governance (oversight) ?

24. Does the organisation have appropriate insurance to undertake Needle Exchange service:

A. **Within the buildings you operate?** Yes/No

B. **Backpacking?** Yes /No

C. **Mobile units?** Yes / No

25. Does the organisation have clinical governance for needle exchange and who / what organisation provides such governance?

26 . What does the organisation understand by the term clinical governance ?

27. What policies does the organisation have in relation to the provision of needle exchange? Please provide the evidence

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28. How often does the organisation undertake an audit and what is their job title?

29. How often do staff receive up skilling and competency assessments?

30. Has the service seen any new drugs (i.e. steroid use, tanning, new psychoactive substances) or new emerging harmful practices ?

New Drugs
Emerging harmful practices

Please supply the template used for recording needle exchange transaction

Name and contact details of person completing the effectiveness review

_____

Date _____

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