Syringe Exchange in England

AN OVERVIEW

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CONTENTS

INTRODUCTION

England's syringe-exchange experiment began in 1987, and since then has been subject to close critical scrutiny and probably the most intensive monitoring of any service for drug users in the UK. As researchers, we have been in the privileged position of being able to assess the implementation, impact and development of a new and innovative service. The evidence presented draws on research conducted by the Monitoring Research Group between 1987 and 1990, funded initially by the Department of Health and Social Security and the Scottish Home and Health Department, and later by the Department of Health.

This report summarises what we have learned about the successes and limitations of syringe-exchange and considers its usefulness as an HIV prevention strategy.

WHAT IS SYRINGE-EXCHANGE?

Syringe-exchange is a facility where drug injectors can obtain sterile needles and syringes and return used injecting equipment. This service is free to the client, and available on a regular and reliable basis at a known location.

Syringe-exchange is an HIV prevention strategy intended to help drug injectors change their behaviours to reduce their risk of HIV infection and the risk to others. It is based on a knowledge and means approach to encouraging behavioural change, where it is assumed that people require both the knowledge about the need to change, and the means to change their behaviour. It also assumes that most people who share syringes do so because syringes are hard to obtain. It targets people who are injecting drugs and are unwilling or unable to stop doing so.

Syringe-exchange should be considered as a strategic response to the potentially high levels of HIV infection among injecting drug users and as part of an overall HIV prevention strategy rather than as an isolated solution to an isolated problem.

Although commonly known as "syringe-exchange", the strategy goes beyond the straightforward exchange of sterile injecting equipment for "dirty works", with the agencies involved providing a wide range of other equipment and services.

HOW DID SYRINGE-EXCHANGE DEVELOP?

The pilot programme

Syringe-exchange began officially in April 1987 when the UK government launched experimental exchange programmes. Before this, some agencies had already started their own schemes—as early as April 1986 in Peterborough, and later that year in Surrey (Kaleidoscope), Dundee, Sheffield and Liverpool (the Maryland Centre). The pioneering work of these schemes and that of the Cleveland Street Exchange scheme in London should not be forgotten. In the latter part of 1986 and the early part of 1987, the Department of Health and Social Security (DHSS), and the Scottish Home and Health Department (SHHD) decided to support pilot syringe-exchange schemes in England and Scotland. The establishment of the schemes was a bold and, at that time, controversial response to rising levels of HIV infection in the United States (in particular, New York City) and closer to home in Edinburgh, and to the potential threat of similar epidemics elsewhere in the United Kingdom. Such a policy was controversial because *prima facie* it seemed unreasonable that drug injectors should be provided without charge, by the government (albeit indirectly), with the tools to facilitate an illegal and self-destructive activity. At that time, the government was in the midst of an anti-heroin media campaign, and the possibility of contradictory messages was obvious.

Indeed, for many years in many countries, policies were pursued which *restricted* the supply of syringes in an attempt to prevent or limit drug injecting: in the United States, for example, laws which limit the availability and possession of syringes still exist in many of the states which also have high prevalence of drug injecting and HIV infection. Prior to 1987 in Scotland, the common law offence of reckless conduct was thought by some to make the supply of syringes to drug injectors illegal. In England, while the sale of syringes to drug injectors was never illegal, pharmacists operated a voluntary ban from 1982 until 1986, under the direction of their professional body.

In the late 1980s, a pragmatic approach to the threat posed by HIV began to emerge in several countries. Syringe-exchange in the Netherlands

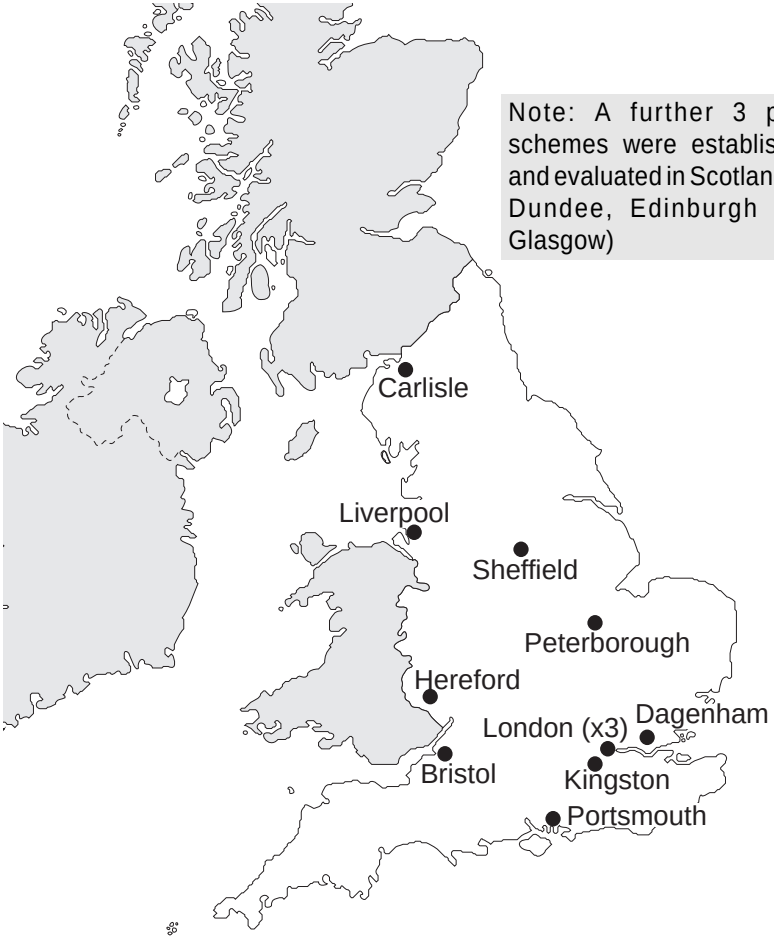
started in 1984 in response to an epidemic of Hepatitis B infection. In October 1986, the idea of syringe-exchange in terms of HIV prevention was discussed at a World Health Organisation (WHO) conference in Sweden. By that time, some agencies in the UK had already begun to experiment with syringe-exchange, with the Maryland Centre in Liverpool starting immediately after the WHO meeting.

Establishment of Pilot Schemes in England and Scotland:

1985-86	Worldwide emerging awareness of HIV and AIDS in injectors
1986	Evidence of HIV epidemic among injectors in Edinburgh
1986	December: Public announcement of decision to establish pilot schemes
1987	January to March: 15 pilot schemes selected, research team recruited
1987	April: First evaluation commenced

This new pragmatism provided the rationale for the establishment of pilot syringe-exchanges in England and Scotland. The 15 agencies participating in the pilot experiment (12 in England and a further three in Scotland) were required to provide injecting equipment on an exchange basis so that used equipment did not become a health risk to the general public, and to discourage the circulation of used equipment in the drug injecting population. The agencies were then subject to close scrutiny, and research and evaluation were an integral part of the experiment. The DHSS and SHHD

commissioned the Monitoring Research Group to undertake the evaluation,



which started in April 1987 and ended in September 1988.

FIGURE 1: Pilot syringe-exchange schemes in England (1987)

Government requirements for 15 pilot schemes:

* To provide injecting equipment on an exchange basis to drug misusers already injecting and unable or unwilling to stop
* To provide assessment of, and counselling for, clients' drug problems

* To provide advice on safer sex and to offer counselling on HIV testing
* To collect information on clients and collaborate with a monitoring and evaluation project

Conclusions of the first evaluation, 1987-88

In this pilot phase, the assessment of syringe-exchange was cautiously optimistic. The final report on *Injecting Equipment Exchange Schemes* (Stimson et al 1988, reprinted 1992) reported that the syringe-exchange programme was satisfactorily established and operated approximately as planned, and that the exchanges reached potential clients in substantial numbers, many of whom were not in contact with other drug services. Furthermore, drug injectors attending exchanges were helped to make important changes in their HIV risk behaviour. Reflecting caution and the inability to draw direct causal links between syringe-exchange and HIV prevention, the first report concluded that these changes "*could* be of cumulative importance in reducing the spread of HIV".

Some problems were identified. It was found that syringe-exchanges attracted injectors who already had lower HIV risk behaviour than other injectors, and that some injectors attending schemes appeared to be resistant to change and continued to share syringes. Moreover, many clients did not remain in contact with the exchanges and there was high client turnover. The assessment also noted that there was less change in sexual risk behaviour and concerns were raised about the ability of drugs workers to provide effective counselling and advice on sexual transmission.

Expansion of syringe-exchange

The conceptual changes to tackling drug problems in the light of HIV were reflected in the 1988 *Report on AIDS and Drug Misuse* from the Advisory Council on the Misuse of Drugs, which recognised HIV and AIDS as a greater threat to individual and public health than drug use. The report lent support to the idea of syringe-exchange as a means for preventing the spread of HIV among injecting drug users, and recommended that resources be given to an expansion of the service. This was greeted with caution by the DHSS at the time, but in August 1988, Department of Health (DoH) circular HC(88)53 gave guidelines and recommendations for such schemes to Health Authorities where local decisions were made to implement schemes.

Optimism regarding the efficacy of the syringe-exchange strategy during that initial pilot period and following the study report was reflected in a rapid expansion in the number of exchange schemes. At the end of 1989,

approximately 120 schemes in England and Wales were providing free sterile injecting equipment to drug injectors on a regular and reliable basis, together with provision for the return of used equipment, at a known location. Worldwide, syringe-exchanges were launched and developed in many countries including Australia, New Zealand, Holland and Sweden.

The syringe-exchange strategy continued to undergo major change in the late 1980s and early 1990s. In many ways, the service did not develop as anticipated by service providers and policy-makers at the outset in 1987, and the need for a continued assessment of the strategy was recognised. On this basis, the DoH decided to fund a further four linked studies for a two-year period from 1 December 1988 (described in Annex).

Expansion of syringe-exchange:

1987-89	Expansion of non-pilot schemes to a total of 120
1988-90	Second evaluation
1989-90	Number of schemes continues to grow to 200 (two in three of all drug agencies in England and Wales)

Measures of success

The success of syringe-exchange as an HIV prevention strategy will ultimately be judged by the levels of HIV infection among drug injectors and their sexual partners. At this stage, it is both too early in the history of the epidemic and too methodologically difficult to make a conclusive case for the impact of syringe-exchange on levels of HIV prevalence and incidence. Interventions made now will have an impact on AIDS figures any time up to 10 years from now. The evaluation therefore looked at the implementation of the schemes, including their establishment and operation, and their ability to attract clients in the target group. It also looked at the impact of schemes on clients' self-reported HIV risk behaviours.

Short-term criteria for the evaluation of syringe-exchange:

* Was the programme established and operated as planned?
* Did it reach and retain potential clients?
* Were they helped to change their HIV risk behaviour?