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▶ Needle and syringe programmes.

National Institute for Health and Clinical Excellence.
National Institute for Health and Clinical Excellence, 2014.

The UK's health advisory body recommends high coverage and if need be, 24-hour needle exchange to combat HIV and the hepatitis C epidemic. The aim they say is for every injector to have even more sterile injecting equipment than they need for every single injection.

SUMMARY These guidelines replace those issued in 2009 which resulted from a request by the Department of Health for the National Institute for Health and Clinical Excellence (NICE) to produce public guidance on the optimal provision of needle and syringe programmes for injecting drug users. Unlike the original guidelines, the update covers children as well as adults and extend to users of image- and performance-enhancing drugs. The remit was to consider what constitutes *optimal* provision. In other words, they were about what makes programmes *more* effective, not whether they *are* effective in the first place. However, the committee did express an opinion on the latter issue, concluding that "Evidence from systematic reviews shows that [needle and syringe programmes] are an effective way to reduce many of the risks associated with injecting drugs".

NICE's Public Health Advisory Committee developed these recommendations on the basis of an updated overall effectiveness review (see the Findings analysis of the original review), an economic analysis, expert advice, stakeholder comments and fieldwork, reports on which are available on NICE's web site.

Particularly significant recommendations are listed below.

Coverage is the priority

• Commissioning bodies and public health practitioners should assess the percentage of injections in their areas for which sterile needles and syringes were available among different user groups, including people who inject image- and performance-enhancing drugs, who inject occasionally and under-18s, as well as more traditional injector populations. They should also know what proportion of injectors were supplied more sterile needles and syringes than they needed (over 100% coverage) and what proportion are in regular contact with a needle and syringe programme.
• This and other information should be used to ensure services meet local need with a view to increasing the proportion of injectors who have more than one sterile needle and syringe available for every injection (over 100% coverage) and the proportion in contact with a needle and syringe programme.
• Commissioning bodies should ensure needle and syringe programmes aim to offer information on and referral to other harm reduction services, and to services (for example, opioid substitution therapy) which encourage people to stop using drugs or to switch to non-injecting methods, and those which address visitors' other health needs.

Services for young people

• Commissioning bodies and service providers should develop and implement a local, area-wide policy on providing needle and syringe programmes and related services to meet the needs of different groups of young people aged under 18 (including those under 16) who inject drugs.
• They should ensure the policy details how local services will achieve the right balance between the imperative to provide young people with sterile injecting equipment and the duty to protect (safeguard) them and provide advice on harm reduction and other services.
• The policy should emphasise the need to provide young people with sterile injecting equipment which where possible should be provided as part of a broader package of care to meet their other health and social care needs.
• Parental or carer involvement should generally be encouraged, with the consent of the young person. Where this is not possible (or appropriate), the policy should include strategies to address their needs.

Mix of services

• The local service mix should include three levels of service providing:
1 Injecting equipment either loose or in packs with written harm reduction information.
2 'Pick and mix' injecting equipment supply plus health promotion advice and referral to specialist services.
3 Level two plus provision of or referral to specialist services (for example, specialist clinics, vaccinations, drug treatment and secondary care).
• Links and referral pathways between these different levels of service should promote integration and the sharing of learning and expertise and services should be coordinated to ensure injecting equipment is available at times, and in places, that meet the needs of people who inject drugs.
• Services offering opioid substitution therapy should also make needles and syringes available to their patients.

Injecting equipment

• Needle and syringe programmes should distribute equipment numbers and types according to need rather than subject to a pre-set limit.
• They should also allow service users to take equipment for other injectors ('secondary distribution'), but ask them to encourage those people to use the service themselves.
• Disposal bins/advice for used equipment should be provided plus a means for safe disposal of used bins and equipment.
• Programmes should facilitate the use by injectors of other services including those which aim to reduce harm from injecting, promote switching to safer drug use methods, to stop drug use, and to address other health needs.

Services to be provided

• Pharmacy programmes should ensure staff are competent to provide the level of service offered and can and do refer customers to other healthcare services, including drug treatment services, and offer wider health promotion advice as relevant.
• Specialist services operating at level 3 (see above) should offer comprehensive harm reduction services including advice on safer injecting practices, assessment of injection site infections, advice on preventing overdoses, help to stop injecting, and referral to opioid substitution clinics and other drug treatments.

• Specialist services should also offer or help people to access: opioid substitution and other drug treatments; treatment of injection site infections; vaccinations for hepatitis A and B and tetanus; testing and associated counselling for hepatitis B and C and HIV; services for image- and performance-enhancing drug users; psychosocial interventions; primary care services (including condoms and general sexual health services, dental care and general health promotion advice); specialist substance misuse services and specialist youth services for young people; secondary care services (for example, treatment for hepatitis C and HIV); welfare and advocacy services (for example, advice on housing and legal issues).

Services for people who inject image- and performance-enhancing drugs

• Commissioners, providers and public health practitioners should ensure needle and syringe programmes are provided at times and in places that meet the needs of people who inject image- and performance-enhancing drugs, for example, outside normal working hours, or at gyms.
• They should also ensure level 2 and 3 programmes whose caseload includes a high proportion of these injectors provide specialist services for this group, including: specialist advice about the drugs and their side effects; advice on alternatives (such as nutrition and physical training); information about and referral to sexual and mental health services and (if available) specialist clinics for user of image- and performance- enhancing drugs.

FINDINGS COMMENTARY In making its recommendation on coverage, the committee responsible for the guidance noted the need to balance the number of people who have sterile injecting equipment for each injection with the number in direct contact with needle and syringe programmes. Their thinking seemed to be that allowing people to take equipment for their associates who do not visit exchanges might increase coverage (how much sterile equipment is available to injectors in relation to the number of times they inject), but do little to encourage attendance. Because coverage is the biggest predictor of sterile needle and syringe use, they felt that how injectors get their sterile equipment was less important than that they get it in sufficient numbers, making coverage the priority. For this reason they recommended that it be considered acceptable to knowingly provide equipment for service users to pass on to others ('secondary distribution'), but did add the rider that those users be asked to encourage their associates to themselves become needle and syringe programme users.

From a coverage point of view this makes sense, but once in the hands of someone the exchange has no direct relationship with, the service loses any control of the disposal of its used equipment. On balance exchanges probably help prevent unsafe disposal of used equipment, and it can be argued that if (as intended) a secondary relationship with the exchange encourages non-service users to become users, that will extend the exchange's ability to prevent unsafe disposal. Nevertheless, exchange managers will be acutely aware of the potentially damaging impact of equipment originating with the service being found on the streets or other public places.

With an eye to the national drug strategy's focus on recovery from dependence – not excluding but de-emphasising harm reduction – the committee "noted that a focus on recovery (that is, encouraging people to stop taking drugs completely) should not compromise the provision of needle and syringe programmes and any associated harm-reduction initiatives".

The previous NICE report reached its conclusions partly on the basis of a cost-effectiveness analysis which was not updated for the current version of the guidance. In estimating benefits, this took in to account the potentially important role exchanges can play in bringing people who inject drugs in contact with a range of services. Though the contribution made by this 'gateway' function was uncertain, the conclusion was that providing sterile injecting equipment is cost-effective for the NHS and personal social services and for society as a whole.

There has however been an updated 'costing statement' based on the earlier analysis, taking in to account the extension of the guidance to services for people who inject image– and performance– enhancing drugs and injectors aged under 18. It reiterates the earlier cost-benefit argument that for "a relatively small investment there is the potential to avoid significant healthcare and societal costs in the future". The cost of supplying injecting equipment for someone who injects drugs like heroin and cocaine of £200 per year and for an injector of image– and performance– enhancing drugs of £6 per year (plus dispensing) is contrasted to the cost of treating someone infected with hepatitis C (£22,000 to £41,000 a year) or HIV (£10,000 to £42,000).

The earlier economic analysis also suggested that while increasing the coverage of syringe distribution and the recruitment rate in to substitute prescribing programmes are sufficient to control HIV, they are not sufficient to reduce the prevalence or incidence of hepatitis C infection; only multi-faceted interventions including for example these interventions and treatment of hepatitis C infection can achieve substantial decreases in new hepatitis C infections.

Thanks to Steve Taylor of Public Health England for alerting us the costing statement.

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