The government-sponsored syringe exchange schemes were announced following reports of high levels of HIV infection among some groups of injectors, particularly in Edinburgh.[1, 2] The McClelland Committee reviewed the situation in Scotland in 1986[3] and drew attention to the shortage of injecting equipment in Edinburgh. They recommended that injecting equipment be provided to addicts unwilling to stop injecting, coupled with counselling.

The issues raised by McClelland and concern about the spread of HIV were taken up by the Scottish Home and Health Department and the Department of Health and Social Security. In December 1986 the Secretary of State for Social Services and the Minister of State for Scotland announced that a number of injecting equipment exchange schemes would be established and also that a total of £1.3 million would be made available to enable drug agencies to enhance their AIDS and drug misuse counselling services.[4]

The policy was implemented at considerable speed, with only about four months between these announcements and the official launch of the schemes.

SYRINGE EX

Last June a government-funded project exchange schemes. The results will influe This first report is about whether the sch keep clients — the basis for achieving

Gerry Stimson, Kate Dolan, Mar

LAST APRIL the British government launched a number of schemes to attempt to prevent the spread of HIV infection among injecting drug users (see panel above for the background to this decision). The aim of the schemes (known as 'syringe exchange schemes') was to provide sterile injecting equipment for drug injectors, along with advice on risk-reduction.

The ground rules were that the equipment should be issued on an exchange basis to drug misusers already injecting drugs and unable or unwilling to stop. The schemes also had to provide counselling on drug problems, HIV testing, and safer sex advice, and the Scottish schemes included a medical input.

Fifteen agencies in England and Scotland were recruited to run the schemes and there is considerable variation in the way they operate. Some are linked to outpatient drug dependency clinics, others are outside the NHS in drug advice and information agencies. Most are office-based, but in Sheffield the equipment is supplied by local pharmacists. One started in an accident and emergency department but later moved to shopfront premises. Opening hours range from one half-day a week to daily.

Accommodation is minimal — it may be a corner of a multi-purpose room, a small room set aside for the purpose, or, at St Mary's Hospital in London, a converted caravan on a hospital site. For its first year, the Liverpool scheme operated from a converted toilet on the ground floor of a drug information agency. In Edinburgh the scheme runs from a hospital outpatient unit used at other times in the week for a child health clinic. In Sheffield syringes are sold at the pharmacist's counter.

Syringe exchange is still at an early stage of development and the picture is rapidly changing. Some of the developments may be influenced by the high levels of dedication and enthusiasm among staff in the schemes. Such is their commitment and energy that we fear some will suffer from exhaustion, and believe clear ways of providing support are needed, including a national forum for exchange workers. As it is still early days, we should be cautious about drawing conclusions about the success of the schemes in helping drug injectors reduce their risks of HIV infection.

We will be evaluating the schemes at two levels:
— their *implementation* — whether they are reaching drug injectors and managing to remain in contact with them, plus how the service is actually delivered; and
— their *impact* — whether they encourage and enable drug injectors to change their risk behaviour.

Measuring impact requires detailed interviews with clients over a period of time: the results of this work will be reported later this year. This report concerns the implementation of the schemes in their first few months up to October 1987.

Customers attracted but drop-out high

So far the schemes have been reasonably successful in reaching injecting drug users, with the three largest working at near capacity seeing 20-50 clients a day. At the largest schemes the numbers of clients who have attended at least once is in the hundreds. Between June and October 1987 (which includes time when some schemes were not operational) the 15 schemes saw about 750 new clients.

But for various reasons some schemes are failing to attract clients in sufficient numbers — four had seen fewer than 20 people. Schemes serving a rural population are faced with local transport problems while in many towns pharmacists offer an alternative source of syringes. Some schemes have yet to adequately inform injectors of their existence or establish a local reputation. In others there are problems of accessibility due to their geographical and institutional location. Most clients who stay with the schemes travel only a short distance — two miles or less — suggesting similar services may need to be established on a neighbourhood level.

There are some interesting differences between the drug users reached by the schemes and those reached by other drug services. As with many other services, the majority claim opiates are their main drugs, but the schemes are also attracting some primary amphetamine injectors. Over half of the clients interviewed had injected amphetamine in the last four weeks.

People attending the schemes tend to be older, longer term injectors: the average time since first injection is eight years. Fewer women attend than would be expected from the experience of other drug agencies, perhaps because men collect syringes for their partners.

The schemes are reaching people not in contact with other drug services. Nearly one third of clients have never had any treatment for drug problems and another third had received treatment in the past but were not in treatment when they contacted the scheme. Many had also *not* received help from other services and agencies, including social workers, probation officers, self-help groups, residential communi-

1. Peutherer J.F. *et al. Lancet*: 1985, *2* (8464), p.1129-1130.
2. Robertson J.R. *et al. British Medical Journal*: 1986, *292*, p.527-529.
3. Scottish Home and Health Department. *HIV infection in Scotland: report of the Scottish Committee on HIV infection and intravenous drug misuse*. 1986.
4. Department of Health and Social Security press release 86/418.

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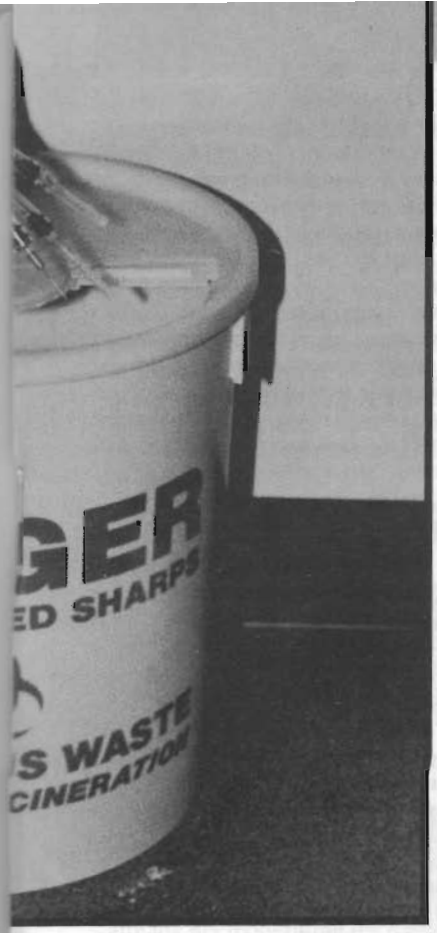

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began evaluating the work of 15 syringe nce the fate of schemes throughout Britain. emes are working in ways that attract and changes that reduce HIV risks.

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ties, hospital in- and outpatient units, or accident and emergency departments.

Some drug injectors who would need to be reached for an effective HIV intervention strategy are not yet being attracted to the schemes. Groups that need to be specially targeted are women and younger people with a shorter history of injecting — among present clients, even the 'younger' users with no previous treatment have been injecting for an average of six years.

Dropout from the schemes is high. Most clients make only two visits and just 34 per cent attend five times or more. In some cases there may be good reasons for this, such as referral for treatment elsewhere, or use of alternative sources of new equipment. In other cases it is hard to see how the aim of reducing the risk of HIV transmission can be achieved with such limited contacts, raising the issues of how schemes can improve retention rates and maximise the benefits of the first contact.

New methods of working develop

On average clients receive seven syringes each visit though a few schemes give out an average of only one syringe per visit — low compared to the number of times clients are likely to inject before returning.

The requirement for the schemes to distribute equipment on an *exchange* basis is important from infection control and public health perspectives, and for maintaining good relations with the local community. However, the rate of exchange — which averages 78 per cent — is extremely variable, with the pharmacy scheme achieving the lowest rate at 30 per cent. Being strict about exchanging on a one-to-one basis in order to achieve a high return rate may conflict with the desire not to deter clients.

The extent, intensity and quality of counselling is extremely variable. Drug workers appear to find it much easier to discuss reducing the risks of drug use than to discuss sexual practices — the reverse of what we hear from the staff of genito-urinary medicine clinics — a finding with clear implications for training.

All the schemes orient their work to *reducing the risk of HIV infection by* encouraging clients not to share injecting equipment and to adopt safer sexual behaviour. In a few, staff are developing a broader idea of their work beyond their initial remit, and we are seeing the emergence of a new way of working with drug users. Some staff have developed a more general harm-minimisation approach involving counselling in 'safer drug use'. This might include advice on health problems, injection sites, and drug dosages. Not everyone is able to work in this way — not surprising, given that British drug services have tended to adopt therapies which involve a 'contract' between the client and the agency leading towards abstinence.

The agencies report a wide range of problems in their clients which are not being satisfactorily dealt with by other agencies. Significant here is the lack of primary health care for many drug injectors, and a number of social welfare and drug-related problems. Some workers find they spend much of their time working on these problems rather than exchanging syringes. In response to these needs some agencies are considering introducing primary medical care services.

The combination of the client group being reached and their lack of use of other services, together with new methods of working, indicate that the schemes might be developing into a different level of service for drug injectors — a new tier of care oriented to risk-reduction, harm-minimisation, and primary medical and social care. Syringe exchange schemes can be seen as a 'low-threshold' contact point for drug users within an overall pattern of local service provision.

How successful have they been?

The main issue facing schemes as they develop in the coming months is that they do not have a monopoly over the supply of injecting equipment and must make particular efforts to attract clients. There is a wide variation in service delivery — possibly different kinds of schemes will succeed with different types of drug user, complicating the task of identifying generally applicable good practices.

Our provisional view is that if we define success in terms of attracting and keeping clients, then it is important that schemes are:

— in areas where there is a high prevalence of injecting;
— accessible, posing the minimum of physical or psychological barriers to attendance;
— staffed by people who take a non-judgmental attitude to the client and his/her behaviour; and
— informal in their relationships with clients.

Other factors that should be considered when establishing further schemes are:

— careful publicity by schemes to establish their reputation with drug injectors;
— local administrative support and enthusiasm;
— good record-keeping to identify client groups, client retention and exchange rates, and to monitor clients' risk-reduction behaviour;
— convenient opening hours;
— good relations with local media, police and community groups;
— clear goals and objectives;
— the issue of adequate supplies of injecting equipment. □

Syringe exchange in Scotland is to date more problematic than in England. One scheme faced considerable operating difficulties and closed after a few weeks. Until recently another faced a residents' picket, and the third operates only one afternoon a week. The difficulties arise from a combination of circumstances, including uncertainties at a financial and administrative level. The Scottish Lord Advocate agreed to guidelines which limited schemes to issuing up to three syringes each visit: with limited opening hours, this may mean only three syringes a week for each client. Nevertheless, Scottish schemes have succeeded in attracting more clients than some in England.

Fifteen schemes were monitored in the five months to the end of October 1987. Here are some of the critical statistics from the research.

The clients

Number seen	769
Average age	26.8
Below 20 years of age	9%
Proportion male	78%
Av. years since first injection	7.7
In treatment for drug problems:	
— now	34%
— previously	35%
— never	31%

The operation of the schemes

Reasons for clients attending:	
— AIDS worries	56%
— equipment scarce	38%
Proportion returning for:	
— 2nd visit	66%
— 5+ visits	34%
Syringes issued per visit	7