

**The adoption of a harm reduction philosophy:
The development and operation of a needle exchange programme in
one former health board area**

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Table of contents

	Page
Abstract	6
Acknowledgements	7
List of Tables	8

Chapter 1

Introduction

1.1	Needle exchange programmes: Service objectives and delivery models.....	9
1.2	The National availability of needle exchange programmes: Research rationale and context.....	12
1.3	Research objectives.....	15
1.4	A summary of each chapter.....	16

Chapter 2

Literature Review

2.1	The philosophy of harm reduction.....	17
2.2	The controversial nature of the harm reduction approach and needle exchange programmes.....	18
2.3	The establishment of International harm reduction policies and needle exchange programmes.....	20
2.4	The emergence of Irish harm reduction policies and practices.....	21
2.5	The development of needle and syringe exchange services.....	24
2.6	The issues associated with the development of needle exchange services.....	25
2.7	The operation of needle and syringe exchange services: The role of the outreach worker.....	26
2.8	The issues associated with the operation of needle exchange services.....	27

2.8.1	Service impact on injecting drug users health: risk taking behaviours and the prevalence of blood-borne viruses.....	27
2.8.2	The relationship between service providers and service users.....	30
2.8.3	Facilitating the accessibility of needle exchange services to promote an effective public health response to injecting drug use.....	31
2.8.4	The issues associated with staff and resources.....	32
2.8.5	The importance of client assessment information and service evaluations.....	33
2.8.6	The implementation of policies and procedures that promote staff and client safety and service user-friendliness.....	34
2.9	Conclusion.....	35

<p>Chapter 3</p> <p>Research Methodology</p>
--

3.1	The case study methodology.....	36
3.1.2	The selection of the case.....	37
3.2	The scoping work.....	38
3.3	The research tools.....	39
3.4	The method of data collection.....	39
3.5	The ethical considerations.....	40
3.6	The data analysis.....	40
3.7	The research limitations.....	41
3.8	Conclusion.....	41

<p>Chapter 4</p> <p>The Case Study: The development and operation of the needle exchange programme</p>
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4.1	The development of the needle exchange service.....	43
4.2	The issues associated with the development of the service.....	44
4.2.1	Staff training and the development of policies and procedures.....	45

4.2.2	Finding a premises.....	46
4.2.3	The issues associated with the promotion of the service and reaching the client base.....	46
4.3	The operation of the needle exchange service.....	47
4.3.1	The procedure for accessing the needle exchange service and the strategies employed to reduce the harms associated with injecting drug use.....	49
4.3.2	Drug taking paraphernalia provided by the service.....	52
4.3.3	The evaluation report on the operation of the fixed site exchange service provided between December 2005 and November 2006.....	53
4.3.4	The description of this researcher’s observation of the fixed site needle exchange service in operation.....	56
4.3.5	The operation of the outreach backpacking services.....	57
4.3.6	Present backpacking provision.....	58
4.3.7	The evaluation report on the operation of the backpacking provision in county no.2 from March 2006 to November 2006.....	59
4.3.8	The role of the manager and the outreach workers.....	61
4.4	The issues associated with the operation of the needle exchange service.....	64
4.4.1	The relationship between service providers and service users.....	65
4.4.2	The accessibility of the needle exchange services: rural and urban provision.....	67
4.4.3	The issues associated with staff and resources.....	68
4.4.4	Strategic development of service.....	71
4.4.5	The importance of client assessment information and service evaluations.....	72
4.4.6	The implementation of policies and procedures that promote staff and client safety and service user-friendliness.....	75
4.5	Service providers opinions about alternative delivery models for distributing sterile equipment.....	77
4.6	A future prospect: the ideal service.....	78
4.7	Conclusion.....	80

Chapter 5
The discussion and conclusion

5.1 Contextualizing the case within its social and political framework.....81

5.2 Operation of the needle exchange service: the challenges for the service provider.....82

5.2.1 The relationship between the service provider and service user.....82

5.2.2 The provision of an accessible service: increasing the service provision.....83

5.2.3 The strengths and limitations of different service delivery models.....85

5.2.4 The measurement of the effectiveness of the service provision.....86

5.3 Conclusion.....89

References.....91

Appendix

Appendix 1: Interview guide for the Acting Regional Drug Co-ordinator for the HSE drug and alcohol service: the manager of the needle exchange service.....97

Appendix 2: Interview Guide for the Outreach Workers providing needle exchange services.....100

Appendix 3: Research Ethical Approval Form.....102

Appendix 4: Participant Information Form.....105

Appendix 5: Participant Consent Form.....106

Appendix 6: Client Assessment Form.....107

Abstract

This thesis explores the development and operation of a needle exchange service in one former health board area. It identifies the issues and barriers that are associated with these processes from the service providers perspective. This research shows why this provision is guided by the principles of the harm reduction philosophy and describes how harm reduction national policies have been translated into practice.

A single case holistic design was the methodology employed to complete the study. This design facilitated the collection of data from policy documents and service evaluation reports, qualitative interviews and observation of the service in operation.

This research found that the case exists within a social and political context. Anecdotal evidence suggested that despite having a mandate from the government, the social context hindered the first attempt to establish the service because the organization was concerned about the controversial identity of injecting drug users. However, a few years later the service was developed because there was support from senior management. A number of practical issues were involved with the service's development, including the implementation of policies and procedures that promoted service user-friendliness. The issues associated with the operation of the service included the importance of trust and confidentiality between service providers and service users; the adequacy/inadequacy of the current staffing levels and resources; facilitating the accessibility of the service in urban and rural communities. It was apparent that the service is designed to facilitate a client's engagement with the programme but responsibility for this engagement lies with the client.

This study finds that the effectiveness of the service provision can be assessed by reference to its ability to achieve its short-term objectives of changing risk taking behaviours and reducing the prevalence of blood-borne viruses and its long-term objective, of moving clients into drug treatment programmes. It is apparent that the service is effective in changing risk taking behaviours. However, at present the service cannot assess its efficacy in achieving the other two objectives. Therefore, systems should be implemented which facilitate their measurement.

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List of Tables

	Page
Table 1: Comparison of the strengths and limitations of different needle exchange delivery models.....	11
Table 2: The National availability of needle exchange services by the Regional Drug Task Force areas.....	14
Table 3: The monthly breakdown of client attendance at the fixed site service between December 2005 and November 2006.....	54
Table 4: The breakdown of the regularity of client attendance at the fixed site exchange between December 2005 to November 2006.....	55
Table 5: The number of client visits and the number of needle and syringes provided and returned for the periods, December 2005 to November 2006 and January 2007 to June 2007.....	56
Table 6: The monthly breakdown of client attendance at the backpacking service between March and November 2006.....	60

Chapter 1: Introduction

This chapter introduces the background to this case study by providing a description of the objectives of needle exchange programmes and the range of service delivery models. It will document the national availability of needle exchange services, which was employed to guide the research rationale and objectives.

1.1 Needle exchange programmes: Service objectives and delivery models

Needle exchange programmes are health promotion interventions for injecting drug users. They are low-threshold harm reduction services because they recognize that in the short-term it may not be possible to eradicate drug use and so work to reduce the negative effects of drug use without necessarily reducing the level of drug use itself (Mullen and Barry, 1999). Their primary objective is to reduce the transmission of blood-borne viruses, the Human Immunodeficiency Virus (HIV), the Hepatitis C (HCV) and Hepatitis B (HBV) Viruses, which can occur through the sharing of drug taking paraphernalia. A number of harm minimization strategies are employed to change injecting drug users risk taking behaviours:

- providing access to sterile injecting equipment
- education and information about safe injecting practices

The approach's long term objective is to engage problematic drug users with treatment services that will help them abstain from drug use on a permanent basis.

A range of needle exchange programme delivery models have been developed to operationalize these strategies. Services can be provided from clinics or 'fixed sites', through outreach services in the form of a mobile unit, backpacking or a peer-based outreach service. 'Backpacking' involves outreach workers providing the service either in a public place or the client's home. Peer-based outreach involves recruiting

an active injecting drug user to provide the service out among the community. Services can also be pharmacy based or accessed from a vending machine.

There are strengths and limitations associated with each service delivery model. The strengths of fixed site exchanges are that the services provide education about harm minimization strategies and facilitate the distribution and disposal of drug taking paraphernalia. Limitations may include limited opening hours, accessibility and a lack of privacy both in the clinic and when accessing it. The outreach provisions serve to rectify these limitations by increasing the accessibility, convenience and anonymity for clients. Backpacking in public places only has the capacity to provide the distribution of sterile drug taking paraphernalia and the return of used equipment, while all other forms of outreach also provide education about harm minimization strategies. Issues of staff safety especially during backpacking are apparent. Peer-based outreach is advantageous because by being an active drug user, the peer may be able to access hidden populations of drug users more readily and impart harm reduction information with more credibility and effectiveness than outreach workers (Madray et al., 2000). However, the training and supervision that peers require can be expensive. Pharmacy and vending machine service models are beneficial because by having extended opening hours they are accessible and convenient (Henman et al., 1998). Indeed, vending machines have twenty-four hour access but because they are in public places anonymity may be an issue. However, they only provide access to sterile injecting equipment and unlike all the other models, the services are not free. The case under consideration in this thesis operates a fixed site and backpacking needle exchange services. However, needles and syringes can be obtained from some pharmacies in the region. See Table 1 for the comparison of the strengths and limitations of different needle exchange delivery models.

Table 1: Comparison of the strengths and limitations of different needle exchange delivery models

Model Type	Strengths	Limitations
Fixed site clinics	<ul style="list-style-type: none"> - services are free - user friendly - education and other harm reduction services available - disposal of used equipment 	<ul style="list-style-type: none"> - limited hours of operation - location: limited and/or identifying - may lack privacy
Outreach: Mobile units	<ul style="list-style-type: none"> - services are free - user friendly - reaches hard-to-reach - education services available - disposal of used equipment 	<ul style="list-style-type: none"> - may be insufficient space for other harm reduction services - cost and maintenance of vehicle
Outreach: Backpacking	<ul style="list-style-type: none"> - services are free - increases accessibility - reaches hard-to-reach - education and other harm reduction services available * only provided by home visits - disposal of used equipment 	<ul style="list-style-type: none"> - safety for staff - potentially intrusive for clients
Outreach: Peer-based	<ul style="list-style-type: none"> - services are free - increases accessibility - reaches hard-to-reach - peer knowledge of drugs, drug user and the drug scene - peers have credibility and can be important role models for risk reduction 	<ul style="list-style-type: none"> - training/supervising of peers can be costly - conflicting identities as peer worker and injecting drug user community member - may violate worker/client boundaries
Vending machines	<ul style="list-style-type: none"> - location and 24 hour availability - convenience - ease of use - limited staffing required 	<ul style="list-style-type: none"> - no other harm reduction services offered - services not free - difficult to maintain anonymity when in a public space
Pharmacy based	<ul style="list-style-type: none"> - extended hours of operation - multiple locations - less stigmatizing/more anonymous 	<ul style="list-style-type: none"> - no other harm reduction services offered - services not free - no disposal of used equipment

Source: Strike et al., 2006: 141-142.

As each model possesses strengths and weaknesses, research has found that combining multiple models provides the most user-friendly provision that facilitates accessibility and a client's regular engagement with the service.

'Advantages and disadvantages of each particular approach make it likely that maximum effectiveness will be achieved through a combination of every possible form of needle distribution' (Henman et al., 1998: 1213).

1.2 The National availability of needle exchange programmes: Research rationale and context

'The preliminary primary research into practices among Irish drug services indicated that harm reduction methods are being used in Ireland. However, the general picture is that there is significant scope to expand drug services' role in delivering flexible and responsive initiatives to target shared use of drug-taking paraphernalia'

(Moore et al., 2004: 7)

Moore et al. (2004) completed research to ascertain the extent of harm reduction provision in Ireland and found that needle exchange services were only available within the Eastern Regional Health Authority (ERHA). The first needle exchange and outreach programme was established in 1989 by the Eastern Health Board. Also, in 1989 funding was provided to the Merchant's Quay Project for the provision of harm reduction services and in 1991, the Eastern Health Board established more needle exchange services (Butler and Mayock, 2005). Since then provision has extended throughout the ERHA region, with counties Dublin, Wicklow and Kildare being serviced by fixed site and outreach exchanges in the form of backpacking and mobile units.

This researcher was interested in discovering whether there had been developments in service provision, especially outside of the ERHA area. The co-ordinators of the seven Regional Drug Task Force (RDTF) areas outside of the ERHA region were

contacted. This researcher was then directed to the Health Service Executive (HSE) drug and alcohol services for each region. The following information was obtained. The Mid Western RDTF area covering Clare, Limerick and North Tipperary operates both fixed site and backpacking services. The Western RDTF area serving Galway, Mayo and Roscommon is about to begin operating these programmes. The North Eastern RDTF area, which includes East Cavan, Louth, Meath and Monaghan is in the process of developing a mobile unit. The Midlands RDTF, operating in Laois, Longford, Offaly and Westmeath is currently reviewing proposals for the provision of harm reduction services through outreach. The South East RDTF covering Carlow, Kilkenny, South Tipperary, Waterford and Wexford is in the process of discussing the development of services. There are no official needle exchange programmes available in Cork and Kerry in the Southern RDTF. The North West RDTF (Donegal, Leitrim, Sligo and West Cavan) together with the HSE drug and alcohol service are currently investigating the necessity for needle exchange services. Also, some pharmacies nationwide sell needles and syringes to injecting drugs users but they do not operate official needle exchange services. All needle exchange services are established and operated by the HSE drug and alcohol services. This information can be viewed in Table 2.

Table 2: The National availability of needle exchange services by the Regional Drug Task Force areas

Regional Drug Task Force	Region covered	Service provision
East Coast RDTF	Dun Laoghaire, Rathdown & Wicklow	A mobile van operates in the Dun Laoghaire and Rathdown area, on one day a week, for four hours. Backpacking operates in Wicklow on one day a week, for five hours. These services were established in 2001.
South West RDTF	South Dublin City, South Dublin, Kildare & West Wicklow	A number of fixed site exchanges have been established in South Dublin & South Dublin City. Merchant's Quay Ireland operates a fixed site from Monday to Friday. Home visits are available in Kildare & West Wicklow.
Mid Western RDTF	Clare, Limerick & North Tipperary	A fixed site needle exchange operates in Limerick City since 2005, on one day a week, for two hours. Outreach services through backpacking or home visits are available throughout the region, no fixed day or time.
Western RDTF	Galway, Mayo & Roscommon	A fixed site needle exchange will open in Galway in September 2007. It will operate either one day a week or for two half days. However, there are resources for additional services depending on need. Outreach services through backpacking or home visits will be available throughout the region, no fixed day or time.
North Eastern RDTF	East Cavan, Louth, Meath and Monaghan	In the process of developing a mobile unit.
Midlands RDTF	Laois, Longford, Offaly & Westmeath	The MRDTF currently is reviewing proposals for the provision of a needle exchange service to be provided through a mobile unit.
South East RDTF	Carlow, Kilkenny, South Tipperary, Waterford & Wexford	In the process of discussing the development of services.
Southern RDTF	Cork & Kerry	There are no official services available.
North West RDTF	Donegal, Leitrim, Sligo & West Cavan	HSE & RDTF are investigating the necessity for a needle exchange service.
Northern RDTF	North Dublin City & Fingal	A number of fixed site exchanges have been established in the region, most are operated in community health centres for two hours per week. In Blanchardstown, one service has operated for five days per week since 2003.

This thesis began as a study posing two research questions that would have necessitated the use of a mixed methods approach. The first sought to establish the number and nature of needle exchange programmes outside the ERHA area by asking ‘what harm reduction services are available to intravenous drug users outside of the ERHA region?’ Moore noted that

‘there is a dearth of published literature on how Irish harm reduction services conduct their work’ (Moore et al., 2004: 49).

Therefore, the second question asked ‘what are the issues and barriers underlying the development and operation of harm reduction services in rural locations?’ However, once this national map of service availability had been completed it was evident that these questions required revision. At present, out of the seven regions there is only one that provides needle exchange services and this region possesses both urban and rural populations. It was decided that it would be of value to document the range of services available within this region in an in-depth manner through the utilisation of a case study methodology. Therefore, the case to be explored in this research is the needle exchange service provision operated by an HSE drug and alcohol service in this region¹. Consequently, the research questions were changed and the three revised research objectives are listed below.

1.3 Research Objectives

The research has three research objectives:

- To investigate the service providers role in the development and operation of needle exchange services in one former health board area, which combines both urban and rural populations.
- To identify the issues and barriers associated with the development and operation of the services from the service providers perspective.
- To explore how harm reduction national policies have been translated into practice within this former health board area.

¹ The region that the HSE drug and alcohol service operates was previously categorized as a former health board area.

1.4 A summary of each chapter

Chapter Two contextualises the case study by discussing the nature of the harm reduction philosophy and charts the emergence of harm reduction policies and practices in Ireland. The literature review includes National and International evidence about the issues involved with the development and operation of needle exchange programmes.

Chapter Three describes the methodology employed to complete the research. It explains why the case study method was appropriate to explore the research objectives. The scoping work completed to familiarise this researcher with needle exchange services prior to completing the primary research is discussed. Also, the data collection, analysis and limitations of the research are documented.

Chapter Four describes the research findings of the case study. It documents how the HSE drug and alcohol service in the region under investigation developed and operates their needle exchange service. It identified the issues and barriers associated with these processes from the service providers perspective and shows how harm reduction national policies were translated into practice.

Chapter Five contextualizes the findings of the case study by reference to its social and political context. It discusses the service's ability to measure its effectiveness in achieving its objectives. It concludes with recommendations for future research.

Chapter 2: Literature Review

This review of literature will define the philosophy of harm reduction which guides the operation of needle exchange services. It will discuss why the Irish National Drug Strategy, which traditionally adopted an abstinence based approach to problematic drug users, began accommodating this philosophy. A review of National and International research about the issues involved with the development and operation of needle exchange programmes will also be provided.

2.1 The philosophy of harm reduction

'To minimise the harm to those who continue to engage in drug-taking activities that put them at risk'

(National Drug Strategy, Building on Experience, 2001: 6).

The harm reduction philosophy is the framework that underpins needle exchange service provision. It is described as a pragmatic response to illicit drug use by recognizing that:

'people always have and always will use drugs and therefore, attempts to minimise the potential hazards associated with drug use rather than the use itself'
(Duncan et al., 1994: 281).

It is viewed as an intervention that seeks to support active drug users to adopt strategies than will minimize the harm that such use could cause. A reduction in risk taking behaviour is considered an indication of the effectiveness of the approach (Kiely and Egan, 2000). Watson's (1991) definition provides a detailed description of the interventions employed to reduce injecting drug users risk taking behaviour, which includes safeguarding the wider community. Harm reduction is a:

'philosophical and practical development of strategies so that the outcomes of drug use are as safe as is situationally possible. It involves the provision of factual

information, education, skills and the development of attitude change, in order, that the consequences of drug use for the users, the community and the culture have minimal negative impact'. (Watson, 1991: 14).

The harm reduction philosophy has been characterized as having four characteristics, a focus on harm, pragmatism, the balancing of costs and benefits and a humanistic approach (Riley and O'Hare, 2000). The first two are evident in the definitions provided. The third characteristic, balancing costs and benefits involves service providers evaluating the effectiveness of the service provision for reducing harm and in terms of economy of resources. The humanistic approach recognises the rights of drug users to receive health care services. Also, this describes the approach that service providers adopt when working with a client with the avoidance of moralistic judgements. As Hunt (2004) noted:

'respect for human rights is a defining feature of harm reduction, which is commonly characterised as a public health-based movement' (Hunt, 2004: 231) ².

2.2 The controversial nature of the harm reduction approach and needle exchange programmes

'Needle exchange programmes have had a controversial identity in some jurisdictions because they are associated with illicit behaviours (i.e. drug use) and socially stigmatized groups (i.e. injecting drug users and sex-trade workers), and because they are often perceived to foster illicit drug use' (Strike et al., 2004: 262).

The harm reduction strategy is a controversial approach because it could be viewed as condoning what is an illegal activity and can also be interpreted as purporting that drug use will always feature within society (Kiely & Egan, 2000). Following on from

² There is debate amongst some proponents of the harm reduction philosophy as to its conceptualization as a human rights and/or a public health issue. Some classify it as the right to good treatment, whilst others define it as a person's right to use drugs.

this some view harm reduction proponents as advocating the decriminalization of illicit drugs. However the majority of advocates of harm reduction do not seek to decriminalize drug use, rather they recognize the futility of taking a prohibition stance and so adopt a pragmatic and humanistic approach to respond to drug issues.

The necessity for a harm reduction approach is evident when the consequences of a criminal approach to problematic drug users is considered. Such an approach serves to marginalize the user from health services and does not facilitate the reduction of harm for the drug user.

‘A criminal approach to illicit drug use leads to aggressive attitudes towards drug users and forces them underground, thus hindering their access to Health Service outlets. It is consequently extremely difficult for drug users to obtain health information and assistance. Harm reduction strategies in a street context show that the drug user’s right to access publicly provided services should be approached as an integral issue in drug policy’ (Nigro et al., 2000: 300).

Needle exchange services have been criticized for having ‘iatrogenic effects’ or encouraging drug use (Ritter and Cameron, 2005). However, evidence does not support this assertion. Needle exchange services do not focus on decreasing the frequency of drug use. However, Cox et al. (2000a) reported that clients attending Merchant’s Quay Ireland’s Health Promotion Unit between May 1997 and October 1998, reported significant reductions in the frequency of heroin use due to their attendance at the needle exchange service. Evidence from Amsterdam also suggested that needle exchange services do not produce iatrogenic effects but rather decrease the prevalence of injecting (Van Ameijden and Coutinho, 2001). Also, several studies have suggested that needle exchange services are effective in achieving their long-term objective of operating as referral venues for addiction treatment services (Moore et al., 2004; Kuo et al., 2003; Heimer, 1998).

2.3 The establishment of International harm reduction policies and needle exchange programmes

The implementation of harm reduction policies and practices as a method of working with problematic drug users signified a move towards an approach that is ideologically opposed to the abstinence based approach. The abstinence based approach was the approach that all drug services worldwide had previously employed (Moore et al., 2004). It responded to problematic drug users by assuming that the

‘only valid health service function in this sphere was to detoxify heroin addicts and to support them subsequently in their pursuit of lifelong abstinence from illicit drugs, if not indeed from all psychoactive substances’ (Butler, 2003: 253).

However, due to the nature of drug dependency, abstinence as a short-term goal was unrealistic and problematic drug users required assistance prior to their accessing drug treatment programmes (Moore et al., 2004).

Harm reduction policies were first introduced in 1981 in Amsterdam. The first needle exchange programme was established in 1984, and in 1986 mobile units were distributing and collecting drug paraphernalia (ibid, 2004). These policies and practices were then implemented in England and Australia as a public health response to concerns about the rise in the incidence of HIV, HCV and HBV (Inciardi and Harrison, 2000). The first English and Australian exchanges were established in 1986 and now both countries have a range of fixed site, outreach and pharmacy exchanges in place. Australia also dispenses paraphernalia from vending machines. In 1988, needle exchange services were established in Scotland and the country is now serviced by fixed site and pharmacy-based exchanges and mobile units (Moore et al., 2004). In the United States needle exchanges were operated illegally for the first twelve years of their existence, it was not until 1992 that the harm reduction philosophy was adopted into their drug strategy (Hellman et al., 1998).

2.4 The emergence of Irish harm reduction policies and practices

Butler (1991) has defined the emergence of Irish drug policies into three distinct phases. The first phase (1966-1979) was characterised by the realisation by the state that drug use was beginning to feature in Irish society.

‘The early phase in which the state gradually came to the view that illicit drug use, in retrospect of a relatively low prevalence and low risk variety, was a feature of Irish society which demanded a policy response’ (Butler and Mayoock, 2005).

Problematic drug use was first officially mentioned in the 1966 Report of the Commission of Inquiry on Mental Illness. It stated that Ireland did not possess such a problem but the situation should be monitored. In 1968 a Working Party on Drug Abuse was established to monitor the extent of drug use and to propose strategies to reduce demand and for treatment. In 1971 the Report of the Working Party on Drug Abuse stated that the only acceptable solution to problematic drug use is abstinence and a drug free society. Thus, an abstinence based approach to drug treatment provided the framework for Irish policies and procedures for the next eighteen years.

Butler (1991) described the second phase (1980-1985) as the ‘opiate epidemic’, which was characterised by a major increase in heroin use and the beginning of an injecting culture. Despite this, the government was slow to respond. It was not until evidence from the Bradshaw Report (Bradshaw, 1982) documented the high level of heroin use amongst 15-24 year olds in a north inner city community, that the drugs problem in Ireland became official policy. However, Butler reports that the Misuse of Drugs Act of 1984 was characterised by a criminal justice approach rather than a health and welfare approach. Butler stated that it,

‘reflected a preoccupation with law and order and drug control, rather than care for the health and well-being of drug users’ (Butler, 1991: 6).

Butler described the third phase (1986-1991) as the ‘Aids connection’ due to the identification that intravenous drug users were a ‘high risk category’ in the transmission of blood-borne viruses amongst one another through the sharing of drug taking paraphernalia and potentially to the community (Butler, 1991). In 1991, the Government Strategy to Prevent Drug Misuse documented the necessity to include a harm reduction approach as a public health response for injecting drug users by stating:

‘It is clear...that the prevention of the transmission of HIV virus in this country must include strategies developed to deal with the drug misuse problem...they must include emphasis on outreach programmes involving counselling, methadone maintenance and needle exchange. Advice on risk reduction services generally must form our essential part of any such strategies to minimise the spread of the disease’ (Government Strategy to Prevent Drug Misuse, 1991: 7).

As mentioned in the introduction, the first needle exchange and outreach programmes were established in 1989 in the ERHA region (Butler and Mayock, 2005). In 1996, the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs recommended the establishment of a National Drug Strategy Team who would be responsible for overseeing the development and implementation of National drug policies. In April 2001, the National Drug Strategy (NDS) was produced which identified four core areas/pillars to be considered, supply reduction, prevention, treatment and research. Since then a fifth pillar, rehabilitation, has been developed. Even though harm reduction services have been available since the late 1980s, they were only officially documented in the NDS twelve years later. It is evident that these services were introduced as a public health response and in a discrete manner (Kiely et al., 2000). Indeed, Butler and Mayock (2005) stated that the discrete manner in which needle exchange services were introduced did

‘not facilitate the emergence of more tolerant or respectful attitudes towards drug users and may have delayed the introduction of a wider range of harm reduction practices’ (Butler and Mayock, 2005: 415).

The policy shift documented in the NDS to include the harm reduction philosophy is reflected in the treatment pillar. Three specific actions that relate to the provision of needle exchange services. Action 62 proposes:

‘to review the existing network of needle exchange facilities with a view to ensuring access for all injecting drug users to sterile equipment’ (NDS, Building on Experience, 2001: 118).

Action 63 is a commitment to set up a pilot Community Pharmacy needle exchange programme in the ERHA:

‘to pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange Programme in the ERHA area, and in the event of a successful evaluation, the programme to be extended where required’ (NDS, Building on Experience, 2001: 118).

Action 69 deals with the development and implementation of collection and safe disposal facilities for injecting equipment:

‘to develop and implement proposals for the collection and safe disposal of injecting equipment, in order to ensure that the wider community is not exposed to the dangers associated with unsafe disposal’ (NDS, Building on Experience, 2001: 118).

There are a range of applications of the harm reduction philosophy. The provision of services for the individual drug user and also a social perspective with interventions for the wider community (Moore et al., 2004; O’Hare et al., 1992). The application of harm reduction principles in the NDS reflects this. The treatment pillar contains several actions relating to the provision of treatment in the form of methadone maintenance and access to counselling. Also, policies and practices have been implemented which aim to reduce the risk behaviours that are associated with drug misuse for families and communities. The prevention pillar of the NDS aims to prevent drug use or delay the onset of drug use among young people, by providing primary and secondary school education programmes and community based

programmes. While recognizing the existence and importance of the many applications of the harm reduction approach, due to time limitations this case study will focus exclusively on the provision of needle and syringe exchange programmes.

2.5 The development of needle and syringe exchange services

'The approach taken to develop a needle exchange programme will depend on a number of factors such as the skills and experience of the organizing group, availability of community resources and support for the programme' (Strike et al., 2006: 31)

Strike et al. (2006) reported that the development of a needle exchange programme requires the consideration and completion of a range of tasks. Firstly, it is imperative to do a needs assessment, collecting information about the client group to ensure that the programme meets the needs of the group. Then an advisory committee should be established which includes support and expertise from staff working in existing programmes. Selection of a programme model involves consideration of the resources available and the region to be serviced. For example, if the area is extensive, a fixed site in a central location with outreach provision would be most appropriate. Accessibility in terms of opening hours requires deliberation and is dependent on resources. However, extended opening hours are deemed necessary to provide a user-friendly service. The development of policies and procedures for service provision can be aided by reference to existing service provisions. They include a needle exchange protocol and facilitate the operation of the service by defining the procedures for working with the target group. Staff training is an integral component which influences the effectiveness of the service. Training involves education about safer injecting and sexual practices, blood-borne viruses and overdose prevention techniques. Ongoing training is essential for the up-date of knowledge about quality service provision and drug taking trends.

2.6 The issues associated with the development of needle exchange services

Due to the controversial identity and stigmatization of the service user, there are several social and political issues that may be associated with the development of a needle exchange service. These issues are in relation to the general community and the public health system (Helliwell et al., 1992; Reilly, 1990).

Helliwell et al. (1992) discussed the development of a service in a medical centre in the small Australian rural community of Nimbin in 1988. They found that it was a contentious matter because of fears within the centre about its public perception. There was also some community resistance to the programme due to the belief that the programme would increase crime rates and decrease personal safety, attract injecting drug users into the area, identify Nimbin as a drug using population and effect property values (Helliwell et al., 1992). Consequently, the service was provided through outreach, meeting clients in cafes or doing exchanges from cars. Strike et al. (2004) reported the same issues in Ontario, Canada:

'Needle exchange programmes, their staff and clients are not always welcome additions to organisations or communities because of concerns about the 'dangerousness of clients and the potential contamination of communities and workplaces by stigmatized individuals and their artefacts (e.g. contaminated injection equipment)' (Strike et al., 2004: 261).

Even when service providers hold public forums with the aim of challenging the communities' opposition in a logical manner, the opposition to the harm reduction service remains due to their concern about public safety. Indeed in Ontario, one mobile outreach service was significantly curtailed because of community opposition. Thus, it is apparent that the

'sociospatial stigmatization of injecting drug use has had a negative impact on needle exchange programmes and perhaps limits HIV prevention efforts' (Strike et al., 2004: 262).

Therefore, prior to the establishment of a needle exchange programme a minimal consultation process should be completed (Reilly, 1990: 130).

Needle exchange services were introduced by various advocacy groups in New York City in the 1980's. However, they were illegal and operated despite opposition from authorities. Thus, the establishment of official needle exchange services in New York City was characterised by conflict:

'between community AIDS activists...and public officials and political leaders who remained ideologically opposed to the introduction of measures perceived as condoning illicit drug use' (Henman et al., 1998: 1213).

The legalization of the services necessitated regulation of the services, organizational re-structuring and the implementation of policies and procedures. Some service providers felt that these measures were too bureaucratic and hampered the operation of the services. They reported that these constraints were indicative of a

'wider circle of ideological opposition between mainstream political opinion and the unpopular 'minority' represented by illicit drug use' (Henman et al., 1998: 1217).

Therefore, Henman et al. stated that ideological opposition to harm reduction policies and practices from authority figures can decrease the effective delivery of services.

2.7 The operation of needle and syringe exchange services: The role of the outreach worker

Moore et al. (2004) documented the operation of needle exchange services in the ERHA from the perspective of the service provider. Their role involved the distribution of drug paraphernalia, liaising with other health or social care

organisations on behalf of the client and referring the client to drug treatment services. They also have an educative role, encouraging the client to reduce risk taking behaviours by the provision of information about safer injecting and sexual practices, blood-borne viruses and overdose prevention techniques. This involves an explanation of why it is necessary to change injecting practices and also providing the infrastructure to support this change. This information is also provided in leaflet form. Mullen et al. (1999) stressed that while these services are available, the harm reduction approach is operated on the assumption that the client is ultimately responsible for engaging with the service and modifying their risk taking behaviours.

2.8 The issues associated with the operation of needle exchange services

The issues that are associated with the operation of needle exchange services are challenges to the successful operation of programmes. Their consideration by service providers has the potential to increase best practice, achieve the service objectives and meet the requirements of the service user (Henman et al. 1998). They include changing risk taking behaviours and reducing the prevalence of blood-borne viruses; the relationship between service providers and service users; expansion of the range of programme delivery models to increase accessibility to sterile injecting equipment, especially in rural areas; sufficient resources, staffing levels and training; the importance of client assessment information and service evaluations; implementation of policies and procedures that promote service user-friendliness. The measurement of the impact of these issues produces evidence of the effectiveness of the programmes.

2.8.1 Service impact on injecting drug users health: risk taking behaviours and the prevalence of blood-borne viruses

The primary aim of needle exchange programmes is to reduce the prevalence of blood-borne viruses through the provision of sterile injecting equipment and

education about the risks associated with sharing drug taking paraphernalia or unsafe sexual practices.

The effectiveness of services educational interventions can be measured by assessing whether a clients risk taking behaviours have been modified. Research has suggested that Irish needle-exchange programs are effective in reducing the incidence of sharing needles and syringes among drug users (Cox et al., 2000a; Cox and Lawless, 2000b). An evaluation of the Merchant's Quay project needle exchange service suggested that a client's level of lending and borrowing injecting equipment was significantly reduced within three months of attending the service (Cox and Lawless, 2000b). In a study of a number of needle exchange services in England and Scotland, Donoghoe et al. (1989) found that 79% of respondents maintained or adopted lower levels of sharing throughout the course of the research. These findings are strengthened by a review of forty-two studies which also suggested that access to sterile injecting equipment and the provision of safer injecting information is effective in reducing risk taking behaviours (Gibson et al., 2001). However, Cox et al. (2000a) reported that drug users had misconceptions about safe injecting practices and despite interventions still proceeded to share other injecting paraphernalia, for example, the spoons used to prepare heroin. Also, Des Jarlais et al. (1989) noted that the availability of sterile equipment is not the only factor requiring consideration. They reported that the social norm of sharing among networks of injecting drug users is likely to be resistant to change despite interventions. Therefore, while most evidence does support the effectiveness of education as a harm reduction intervention, there are other issues which may impede its effectiveness. As a possible solution to this issue, research has suggested that the most effective model for changing risk behaviours is through peer-based outreach rather than traditional outreach as completed by outreach workers (Madray et al., 2000).

Long (2006) described the prevalence of blood-borne viruses among injecting drug users in treatment in Ireland. Seventy percent tested positive for antibodies for HCV, twenty percent have been infected with HBV and ten percent are HIV positive. However, in Ireland it is difficult to measure the incidence of blood-borne viruses

among injecting drug users not in treatment. As Long reported, the mode of acquisition of HCV has never been recorded and has only been recorded for HBV since 2005. The mode of acquisition of HIV has been recorded but this is limited to the tested population. Also, O’Gorman (1999) stated that injecting drug users are more likely to be tested than others at risk of receiving HIV through other routes. Therefore, these issues present a challenge for monitoring the effectiveness of needle exchange programmes to reduce the transmission of blood-borne viruses (Long, 2006). Nevertheless, several studies have suggested the effectiveness of needle exchange services in positively impacting on the health of injecting drug users by decreasing the incidence of blood-borne viruses. Smyth et al. (1999) reported that an increase in the amount of harm reduction services available in Dublin produced a lower incidence of HCV among injecting drug users who began injecting between 1991 and 1993. In Australia research found that cities with needle exchange services had a 60% prevalence of HCV compared to 75% for cities without these programmes (Commonwealth Department of Health and Ageing, (2002)). It is apparent that while services reduce the incidence of HCV, the prevalence of this virus remains high among injecting drug users. A study of 353 Irish injecting drug users in treatment from 1993 to 1996 found that 52% tested positive for HCV (Smyth et al., 1998). However, this may be due to the fact that there is no service provision in prisons, as research has suggested that there is a link between the incidence of HCV and imprisonment (Allwright et al. 1999).

In Ireland, the Department of Health and Children and the Virus Reference Laboratory produced statistics of the HIV positive tests for the period of 1982 to 1995 (Dillon and O’Brien, 2001). They suggested that the establishment of needle exchange services facilitated the reduction of the prevalence of HIV among injecting drug users. Between 1982 and 1985, they reported that 60% of injecting drug users were HIV positive and this dropped to 17.7% in 1997. However, there was an increase to 33% in 1999. In 1998, the ‘Misuse of Drugs Regulations’ was produced which stated that injecting drug users on methadone maintenance programmes must be screened for blood-borne viruses (Dillon and O’Brien, 2001). This policy was employed as an explanation for the increase in the number of injecting drug users testing positive for HIV. In Switzerland, the needle exchange services have been

associated with a decrease in HIV transmission amongst injecting drug users (Moore et al. 2004). Also, a review of eighty-one cities in the United States, found that the twenty-nine cities which had needle exchange services reported lower incidence of HIV amongst injecting drug users (Hurley et al., 1997). Not all the research on the impact of needle exchange services on HIV infection rates has been positive. Strathdee et al. (1997) reported that Vancouver experienced an HIV epidemic among injecting drug users five years after the establishment of needle exchange services. They concluded that while services were important for the distribution of sterile equipment, other strategies such as counselling and support should be factored into these harm reduction interventions.

While there is a range of evidence supporting the efficacy of needle exchange programmes it is evident that further efforts are necessary to continue the reduction of risk taking behaviours. Programmes require other harm reduction interventions, including counselling, more comprehensive education strategies and the investigation of the culture surrounding the sharing paraphernalia. The review of literature concluded that there is

‘the need for more comprehensive data collection in the area of all drug-related infectious diseases in order to monitor changes in the trends over time’ (Dillon and O’Brien, 2001: 60).

2.8.2 The relationship between service providers and service users

Research has suggested that the manner in which service providers interact with service users can affect the effectiveness of the harm reduction interventions. Mullen et al. (1999) reported that the humanistic approach adopted by service providers has the potential to facilitate a client’s engagement with the service and possibly lead to the establishment of a relationship with a client. A director of a needle exchange service in New York stated that:

'having direct contact with the person and developing a caring and respecting attitude toward drug users is the most important part of the programme' (Henman et al., 1998: 1224).

Griesbach et al. (2006) suggested that developing a trusting relationship, is fundamental for the service to achieve its aims. Also, service providers in Canada reported that client confidentiality was inextricably linked with trust and both are important for developing effective relationships:

'as clients entered service situations with the expectation and hope that service providers would maintain and not disclose information provided. The maintenance of confidentiality was seen as primary and essential to developing trust' (Allman et al., 2007: 196).

2.8.3 Facilitating the accessibility of needle exchange services to promote an effective public health response to injecting drug use

The evidence from research has suggested that in order to increase the accessibility of needle exchange services and promote an effective public health response a number of factors require consideration. The majority of Irish needle exchange programmes operate an open door policy and once the initial client assessment has been completed, clients are able to access the service without an appointment (Moore et al., 2004). However, some outreach services require an appointment. Also, minimal identification is required which can facilitate client anonymity. Reaching the target population and promoting the service was by word of mouth.

Moore et al. (2004) reported that the opening hours of services in the ERHA were mainly during office hours, with some providing evening and weekend services. Scottish services are more accessible because they have a greater range of services and longer opening hours (Griesbach et al., 2006). Also, Scotland has a lot of pharmacy based exchanges which provide more anonymity and convenience, whereas

Ireland has no official pharmacy based services. In terms of geographical proximity of services, the Scottish report found that those living in mixed urban and rural areas have access to the widest range of services, while those living in remote rural areas had the least amount of service accessibility.

Accessibility, restricted opening hours and limited number of needle exchange services, are barriers to service provision and more than likely contribute to the continued sharing of equipment. Thus, service providers stated that this necessitated the expansion of the range of services and the extension of opening hours (Griesbach et al., 2006; Moore et al., 2004; Reilly, 1990). In the ERHA, service providers suggested the expansion of mobile units and outreach work (Moore et al., 2004). The Scottish service providers also suggested this, along with distribution through vending machines (Griesbach et al., 2006).

Outreach models are considered an effective harm reduction intervention because they are designed to access hidden and marginalised populations. It was reported that outreach services were invaluable because they had the capacity to make contact with and complete exchanges with injecting drug users not in contact with fixed site services or indeed any other health services (Cox et al., 2000a; Reilly, 1990). Also, outreach was deemed advantageous to meeting the needs of clients living in remote rural areas and as an attempt to solve the disparity between the urban and rural availability of services. As Reilly (1990) reported, in rural areas in Australia, a major issue is attracting clients to the service due to either practical problems about accessing the service or simply a lack of knowledge about the service.

2.8.4 The issues associated with staff and resources

Griesbach et al. (2006) reported that service providers had identified a number of resource issues that affected service delivery. Insufficient funding was recorded as having a detrimental effect on service provision as it did not facilitate the strategic

development of the service. Also, best practice would be promoted if the services provided on-site access to blood-borne virus screening, vaccinations and treatment rather than having to refer a client to other services (ibid, 2006; Cox et al. 2000a). Cox et al. (2000a) also reported that the Health Promotion Unit in Merchant's Quay Ireland would benefit from the addition of medical staff who could tend to injection-related harms such as abscesses. In Scotland, insufficient staffing was apparent, with service providers in rural areas operating both the methadone maintenance and the needle exchange service. Indeed, it was reported that this deterred clients from accessing the needle exchange service. Also, in terms of training, service providers noted that staff knowledge about addiction issues was from previous academic or work experience and on the job training. In order to facilitate good practice, they requested standardized training in all needle exchange services. The service providers in the ERHA also reported that staff training required standardization to promote best practice. Australian and Canadian research identified that staff require psychological support to complete their role. It was reported that due to the emotionally demanding and varied nature of the role, outreach staff could experience burnout and so systems must be in place to deal with these issues (Allman et al., 2007; Reilly, 1990).

2.8.5 The importance of client assessment information and service evaluations

The documentation of service users and service provision is important because when collated this information provides an evidence base to assess the effectiveness of the service provision and identify if any improvements are necessary (Paone et al., 1995). However, it was noted that not all services in the ERHA record client information (Moore et al. 2004). Those that do, record demographic information and whether a client had been screened for blood-borne viruses. Client assessment was not completed by all needle exchange services in Scotland, with only a quarter of services systematically completing assessments before the client could avail of the services (Griesbach et al., 2006). The issues covered in the assessments varied from service to service, with most focusing on whether the client practiced safe injecting practices and safe disposal of injecting equipment. Other issues which were discussed included the care of veins, involvement in treatment and screening for blood-borne viruses.

Thus, the Irish and Scottish service providers reported that national standardisation was required for both data collection and the monitoring of services. Strike et al. (2006) produced best practice guidelines for service evaluation and stated that the following were necessary to maximise effectiveness:

- *‘Conduct on-going evaluation to determine how well the programme meets the needs of the clients*
- *Provide training for staff to ensure that the purpose of, and activities related to, evaluation are understood and accepted*
- *Develop a programme plan to review evaluation results and modify the programme as needed’.*

(Strike et al., 2006: 248).

2.8.6 The implementation of policies and procedures that promote staff and client safety and service user-friendliness

A flexible needle exchange policy is considered best practice by many service providers. The safe disposal of used works is of paramount importance in terms of public health. However, to facilitate a user-friendly service many programmes adopt a flexible needle exchange policy, where returning used equipment is not a prerequisite for receiving clean equipment (Griesbach et al., 2006; Strike et al., 2006; Nigro et al., 2000). In Scotland, there are official guidelines on the number of needles and syringes that can be provided per individual exchange (Griesbach et al., 2006). However, they reported that the number provided actually depended on whether the service providers knew the client or the number of syringes returned, with fewer syringes being provided to those not known or those who did not return equipment. Also, due to potential access issues, clients living in rural areas received more. Nigro et al. (2000) evaluated a pilot needle exchange programme in Catania, Sicily. A total of 206 injecting drug users used the service within a six month period, 376 syringes were distributed and 56 returned. Despite this low return rate of 15%, the study reported that the return of equipment increased as the programme progressed. The

researchers noted that this could be accounted for by the clients establishing confidence and trust in the service providers and thus engaging with the service.

From the literature it was evident that there are national differences in the provision of needle exchange services to under eighteen year olds. In Scotland, only a third of services had an official policy. Some reported that services are only provided on completion of an assessment and support from a youth support worker or if the youth is deemed to be able to provide informed consent (Griesbach et al. 2006). In Ireland, parental consent is required. Mullen and Barry (1999) noted that this could prevent access to sterile equipment and increase the risk of harm. They noted that while services are operating within constitutional restrictions, perhaps such policies require revision. Indeed, the policy adopted by the Eastern Health Board stated that consent is not required if attempts to get parental consent are unsuccessful and if there is definite evidence of injecting drug use, a psychiatric assessment is completed and the youth is aware of the risks associated with injecting drug use (Eastern Health Board, 1998).

Service providers in the ERHA reported that policies were easily transferable into practice because procedures were devised to promote safety for both staff and clients (Moore et al., 2004). However, they reported that in some circumstances, for the provision of extra needles, they may deviate from the policies. This study also found that one service which operated outside of the ERHA unofficially provided needles and syringes.

2.9 Conclusion

This literature review has contextualized the establishment and operation of needle exchange services within a social and political framework. It has highlighted the issues and barriers to service provision that require consideration by service providers, all of which is relevant to explore the research objectives as outlined in chapter one.

Chapter 3: Research Methodology

The nature of the research enquiry was exploratory and a single-case holistic design was employed to investigate the research objectives. The data was produced from documentary analysis of the service's policy documents and evaluation reports, qualitative interviews and the observation of the service in operation. A literature review was completed to contextualise the case within both Irish and International harm reduction service provision.

3.1 The case study methodology

'A unit of human activity embedded in the real world; which can only be studied or understood in context; which exists in the here and now; that merges in with its context so that precise boundaries are difficult to draw' (Gillham, 2000: 1)

The case study methodology has the potential to provide an in-depth investigation of a single case. A case is the focus of the research and is also known as the 'unit of analysis' (De Vaus, 2001). A case can be a range of things including a person, an event or an organization. Case studies are utilized when researchers wish to:

'retain the holistic and meaningful characteristics of real-life events – such as individual life cycles, organizational and managerial processes' (Yin, 2003: 2).

An understanding of the wider context within which the case exists is of paramount importance to this type of research design, indeed this is one of the strengths of this methodology. As De Vaus reported:

'To isolate the behaviour from this broader context and to strip it of the meaning given to it by actors is to invite misunderstanding, and thus threaten the internal validity of the study' (De Vaus, 2001: 235).

Thus, in order to investigate the research objectives whilst maximising internal validity, the case study must involve an examination of the context in which it exists. Another strength of the case study methodology is that it is a flexible and multi-method approach, as it allows the use of different sources of evidence and data collection methods (De Vaus, 2001). If the interviews, documentary analysis and observation of the service in operation produce the same data, this contributes to the validity of the research findings. This is known as the notion of convergence or triangulation (Gillham, 2000). Despite its strengths, the case study methodology is viewed by some:

‘as a weak sibling among social science methods’ because it possesses ‘insufficient precision (i.e., quantification), objectivity, or rigor’ (Yin, 2003: xiii).

Therefore, it should only be employed for exploratory research, for the production of issues necessitating further investigation using more scientific designs (De Vaus, 2001: 219). Despite this, for the aforementioned reasons case studies have been extensively used in a wide variety of disciplines within the social sciences.

3.1.2 The selection of the case

A single case holistic design was the appropriate methodology to employ for a number of reasons. Firstly, because it facilitated an in-depth exploration of the service providers experiences of the development and operation of the needle exchange provision in one former health board area. The particular case was chosen because it was a service that had needle exchange provision operating in both urban and rural areas, outside of the Dublin area. As De Vaus reported:

‘the strategic selection of cases involves selecting cases because they have particular characteristics’ (De Vaus, 2001: 241).

The unit of analysis was the issues associated with the development and operation of the service from the service providers perspective. Secondly, prior to the

data collection it was recognised that these issues would necessitate reference to their political and social contexts. Thus the case was contextualised within Irish drug policies that focused on harm reduction interventions and their place in Irish society. This study will show how and why a harm reduction approach to addiction service provision was adopted. Thirdly, the triangulation of data was evident, with issues discussed in the interviews being consolidated by information in the service's policy documents and evaluation reports, and also through observation of the service in operation.

3.2 The scoping work

Before the primary research began, this researcher met with two outreach workers who operated a needle exchange service in Dublin city, in order to develop a comprehensive understanding about the functioning of such programmes. This involved an informal interview and the observation of the needle exchange in operation. The service operated one day a week for two hours and this researcher was present for the duration of one of these sessions. The service was operated in a private room by one of the outreach workers. A total of five clients accessed the service, all of which were known to the outreach worker. It was apparent that the service was operated in an informal manner and each consultation began with a general conversation which led to a discussion about the client's health. A number of the clients had specific ongoing health concerns and the outreach worker informed the clients that the relevant health care services would be contacted to secure appointments. Also, as a number of the clients were injecting into the groin the outreach worker discussed the dangers associated with this practice. Then the clients were asked what drug taking paraphernalia they wanted, this was gathered and given to them. This completed the consultations.

3.3 The research tools

The interview guides were produced from consultation with the two outreach workers and observation of the service in operation. It was also compiled by reference to documentary analysis of the National Drug Strategy, the Regional Drug Task Force Action Plan for the region and evaluation reports from the service to be examined. A review of literature from Irish and International harm reduction service provisions also served to identify key issues to be examined. Two interview guides were produced. One designed for the manager of the service which focused heavily on policy (see appendix 1) and the other was produced for the outreach workers which focused more on operational issues (see appendix 2). The interview guides assisted the collection of data in a consistent manner, which could potentially facilitate the replication of the study.

3.4 The method of data collection

Access to the service was provided through a gate-keeper, the co-ordinator of the region's Regional Drug Task Force. Then the manager of the HSE drug and alcohol service for the region was contacted and consent was received to complete the study. There were five respondents, the manager of the service, three outreach workers and one former outreach worker. All of the respondents, excluding one of the outreach workers, were involved in the operation of the needle exchange service since its establishment. The other outreach worker undertook the role a year after the service's development.

The first interview was completed with an outreach worker from the service and as it proceeded in an appropriate manner, no adjustments to the interview guide were necessary. The remainder of the interviews were then conducted. All the interviews were completed between Monday 9th July 2007 and Wednesday 18th July 2007. The interviews were qualitative in nature and semi-structured. The service was observed

in operation to provide an understanding of the issues discussed during the interviews. Also, the service's policy documents were given to the researcher.

3.5 The ethical considerations

On the 28th May 2007, this researcher submitted an ethical approval form (see appendix 3) to the School of Social Work and Social Policy. The Research Ethical Committee reviewed the proposed study and provided consent to complete the research.

This researcher ensured that each respondent understood the aim of the study. The respondents were informed that the study was for a thesis for the Masters in Applied Social Research. They were told that interviews would be tape-recorded and take between an hour to an hour and a half to complete. Confidentiality and anonymity was ensured by the assurance that all identifying features, names and places, would be removed from the transcripts. Also, transcripts were only to be read by this researcher, her thesis supervisor and the external examiner. Before each interview, respondents were given a participant information form which restated this information (see appendix 4). Once briefed, informed consent was gained, respondents signed the consent form (see appendix 5) and the interviews began.

3.6 The data analysis

The interviews were transcribed to facilitate analysis. There were technical difficulties with the dictaphone and one of the interviews was largely incomplete. Despite this, the researcher transcribed what was available. Also, one interview took place in the lobby of a hotel and consequently, a small portion of it was inaudible. However, this did not affect the analysis because the majority of the interview was audible.

The analysis of case study data requires a general analytic strategy and in this case the researcher developed a case description (Yin, 2003). Due to the nature of the research objectives this was the appropriate strategy to adopt because it provided the reader with a comprehensive understanding about the development and operation of the service in a narrative form.

3.7 The research limitations

As with any methodology, this research design possessed a number of methodological limitations. The research focused on the development and operation of the needle exchange service from the perspective of the service provider. A more comprehensive understanding of the service provision would be provided by the addition of another unit of analysis to the case, by consultation with service users. Also, to increase the capacity for external validity in terms of its theoretical generalizability, the study should be repeated with a multiple case design, where every Irish needle exchange service is examined. As De Vaus stated:

‘the external validity of case studies is based on the logic of replication rather than on sampling logic’ (De Vaus, 2001: 247).

Thus external validity in terms of statistical generalizability is not the goal of case study methodologies.

3.8 Conclusion

As stated above, the single case holistic design was the most appropriate methodology for exploring the three research objectives. The following chapter will show how the utilization of the different types of data has provided a better understanding of the development and operation of the needle exchange service than if only qualitative interviews had been employed. Indeed, the service’s evaluation reports provided key

information about the operation of the service. It provided evidence for the final chapter's discussion about the effectiveness of the provision in achieving its objectives.

Chapter 4: The Case Study:

The development and operation of the needle exchange programme

This case study investigated the development and operation of the needle exchange service provision in one former health board area. The area encompasses three counties and a fixed needle exchange programme is operated once a week for two hours from the city centre of one of these counties³. This service was established in December 2005 and is managed and operated by the HSE drug and alcohol services for that area. Outreach services through backpacking and home visits are also available throughout the region, as and when required. There are three outreach workers for the region, one responsible for each county but all three work together to provide the services for the region. The service was set up to work with a specific target group, anyone from 14 years of age who are problematic drug users.

This chapter will document the service providers experiences of the development and operation of the needle exchange service. It will report the issues and barriers associated with the service provision and conclude with the service providers description of the ideal service.

4.1 The development of the needle exchange service

A fixed site needle exchange service was developed in one former health board area when it became apparent that there was a need for the service.

‘We heard lots of stories in terms of works being shared because of people not having... access to them’ (Ben, manager of service, p104).

³ To aid anonymity, the names of the three counties have been removed. They will be discussed as county no.1, county no.2 and county no.3. The fixed site needle exchange programme is situated in the city centre of county no.1.

It was reported that since 2005 there has been an increasing demand for access to methadone maintenance programmes, identifying that there was both a significant use of heroin in this region and a need for harm reduction services prior to treatment.

‘Over the last two years the demands for the primary care, for the methadone programme have been increasing on a sustained regular basis...that’s a very good indicator, people presenting looking for treatment in relation to heroin use...it was clear you know that there was a very definite need there’ (Ben, manager of service, p14).

4.2 The issues associated with the development of the service

There were a number of practical factors associated with the development of the service. These involved the acquisition of funding, staff training, the development of policies and procedures, finding premises and promoting the service.

The service was established by the manager and three outreach workers, who met on a monthly basis to progress the development of the service. It was reported that as there was support from senior management in terms of funding the service was established quickly and relatively easily within a matter of months.

‘Towards the beginning of the summer of 2005 we would have made the decision that we would go ahead and do it...Once the em...decision was actually made...it did happen fairly quickly’ (Ben, manager of service, p106).

‘There was very good support from senior management around the funding issue...it was very straight forward in terms of getting it set up’ (Ben, manager of service, p127/8).

Also, as there was a mandate from the National Drug Strategy for the HSE to provide the service, there was no consultation process with the community prior to its establishment.

'In terms of our work being determined by government policy, the question I'd have is what is the point of going out to consult these people because it wasn't a question 'should we do it?' or 'how should we do it?' because the evidence base was there, policy and procedures was very much there...I wouldn't be a fan of consultation for the sake of it, it does more damage I think' (Ben, manager of service, p128/9).

However, anecdotal evidence suggested that a number of years prior to this attempts to establish the service by an NGO were halted due to insurance reasons. Also, the former health board was reluctant to develop the service for fears that it would encourage people to use drugs or that the region would be associated with heroin use.

4.2.1 Staff training and the development of policies and procedures

Staff training for the outreach workers and the manager is an integral part of their role. The outreach workers went to England to receive training in safer injecting practices. They also completed practical work experience with an outreach team in Dublin, gaining knowledge about the operation of both fixed site and backpacking needle exchange programmes.

'We went over to England for safer injecting training...Then we went to Dublin for nearly a week to different needle exchanges to see how they ran their needle exchanges, we did home visits, we did backpacking' (Johnny, outreach worker, p62).

Upskilling is essential to keep staff up-to-date with changing trends in drug use and the techniques used to work with clients. A bottom-up approach was employed for the development of the service's policies and procedures. The outreach workers training, work experience and reference to existing service policy documents provided the evidence base for the development of the service's policies and procedures.

'The training and the work placement the outreach workers did...provided the evidence base for the production of our policies. Also, we utilized existing policies from some of the Dublin services...to identify what we would need to cover' (Ben, manager of service, p109).

4.2.2 Finding a premises

The drug and alcohol service has premises in the city centre of county no.1 that provide counselling and a methadone maintenance clinic. However, the fixed site needle exchange service could not operate from there because it would represent a conflict of interest in terms of supporting drug users accessing the needle exchange service and supporting those on drug-free treatment programmes.

'It just isn't a good idea to have them within the same location, there should be some degree of separation' (Ben, manager of service, p107).

Also, they shared the building with other organisations and so reported being conscious about maintaining good relations due to the nature of the client base. Finally, the exchange was set up in the basement of a sexual health project and the manager stated that the project was

'delighted to have a needle exchange established there because it was in line with their own ethos' (Ben, manager of service, p107).

4.2.3 The issues associated with the promotion of the service and reaching the client base

The respondents reported that when the fixed needle exchange service was established it was not publicised due to the controversy that might have been generated locally and in the media.

‘From the beginning when we started, our policy was that we weren’t going to go looking for any media coverage because the experience in Dublin is that you can generate opposition within the community and you can get very negative press around them’ (Ben, manager of service, p119).

Therefore, the service providers informed fellow colleagues, doctors, the Regional Drug Task Force and community and voluntary groups working within the drug services. Also, as some pharmacies sell needles and syringes to users, they were contacted and now give the services contact details along with the equipment. Clients attending the Primary Care Drug Assessment Unit, the methadone maintenance programme, were also informed about the service. Also, when a client accessed the needle exchange service they were encouraged to inform fellow drug users. This ‘word of mouth’ procedure worked and slowly a client base was developed.

‘I don’t think we had a client the first day. Then it started building very slowly and I think after a month we had six people coming in...after that they went back and they told people who they were using with, saying ‘this is available and there’s no problem’ and they came down and they told people’ (Johnny, outreach worker, p63).

4.3 The operation of the needle exchange service

The operation of the needle exchange service is guided by the principles of the harm reduction philosophy. The respondents described it as a practical approach because it allows drug users to engage with services while still using. The adoption of this approach is important as

‘people that become involved in regular heroin use and become dependent, they tend already to be quite distanced from key state services and from the community’ (Ben, manager of service, p103).

Thus the manager reported that the service is beneficial because it facilitates problematic drug users re-engagement with healthcare services. It also provides them

with a positive experience of services because due to their marginalised status they often experience hostility from society and other healthcare services.

'It can be a way of...getting people to re-engage with state services. Em, and to give them a positive experience of that because if you look at it from a drug users perspective...you're getting access to a range of drug injecting paraphernalia which can be very difficult to get. And you're getting it for free and you're getting it in a relatively comfortable environment and you're being met by friendly faces. Where for a lot of dependent drug users that wouldn't be the case you know there would be a whole lot of hostility towards them and fear towards them' (Ben, manager, p103/4).

As well as providing sterile drug taking paraphernalia, the service is designed to help a client reflect on the reasons for their drug use.

'I suppose it's a very practical, concrete approach...The model isn't that...you give them the paraphernalia and they go away...It's around...starting to work with them to get to question...why they're doing it' (Ben, manager of service, p103).

Also, the outreach workers provide the infrastructure to enable the client to use drugs in a safer manner but ultimately it is up to the client to modify their risk taking behaviours.

'It's not for us to tell them what they have to do, it's for us to be there and try and show them the options and let them make the decisions. It's their life for them to decide what it is that they need to do to change' (Emily, outreach worker, p16).

The respondents reported that their role in the needle exchange programme is to fulfil the short-term objective of assisting injecting drug users to reduce the harm that such use entails. A respondent stated that the service is

'a prop but it should be a short-term prop' (Brian, former outreach worker, p92).

Thus, the outreach workers also work to achieve the long-term objective of moving people into drug detoxification treatment programmes.

'Then starting to orientate them towards either a drug free programme or a methadone maintenance programme' (Ben, manager of service, p104).

4.3.1 The procedure for accessing the needle exchange service and the strategies employed to reduce the harms associated with injecting drug use

There are a number of ways to access the service, clients can either access the fixed site service directly or be directed from each of the counties HSE drug and alcohol main office. Clients are also referred from the Guards, Social Workers and Probation Services. When a client first presents to the exchange to aid anonymity the outreach workers record only their first name and the initial of their surname. The following information is recorded on client assessment forms (see appendix 6). This involves documenting their drug career, the type of drug(s) being used, whether they share drug-taking paraphernalia, if they have been screened for blood-borne viruses, the number of sexual partners they have had within the previous year and whether they practice safe sex.

'It's usually their first name and their initial, their date of birth, male or female. We would look at condom use, sexual partners, how many in the last year, would they have used condoms within the last year, have they ever been tested for HIV or Hepatitis, how long they're actually an injecting drug user' (Johnny, outreach worker, p72).

The service does not record whether a client has a blood-borne virus, they only document whether or not a client has been screened.

'I mean we would ask them when they come, when, on our cards, when is the last time they had screening...Although I don't know who has Hep C and who is HIV positive' (Emily, outreach worker, p9).

The client is then informed that the service is confidential and free.

'You tell them about the service, that it's confidential, it's free' (Paul, outreach worker, p30).

Then the outreach workers provide a range of information about harm reduction interventions. This information is provided to encourage clients to be responsible for their health and the health of others and includes information about safe injecting and safe sexual practices and overdose prevention techniques.

'Key principles...safe sexual practices, safer injecting practices, non-sharing of needles, education and training of the client. You're reinforcing all the time safe injecting and non-sharing' (Paul, outreach worker, p51).

The non-sharing of equipment is stressed to reduce the transmission of blood-borne viruses to their drug-taking peers. The respondents reported that some clients are often misinformed, they might not share needles but share the rest of their paraphernalia. Also, they may not be aware of the other risks attached with injecting, their veins collapsing or deep vein thrombosis.

'Just trying to get him to get good habits, using fresh stuff all the time and not using old equipment...Not sharing anything including spoons, filters, water, syringes, have all your own gear...because most of them find it very difficult using their left hand, they find it very hard to find the veins in the legs...so once they've found a spot in their arm, they keep going in this one spot...we'll say 'right, use that but go to the other arm, move around all the time before you go back there again, that gives your arm a chance to heal because if you keep hitting the same spot all the time...you're veins will collapse. But if you move along it means that you will be able to use it again...you'll find that you will be able to inject for an awful lot longer' (Johnny, outreach worker, p71/2).

Also, one outreach worker noted that as a client has learned to inject in an unsafe manner it may take time to correct this behaviour.

We're informing them about what they should be doing. Now, that doesn't mean they're going to do it, it takes time, em you know the saying 'you can't teach an old dog new tricks?' You can but it takes an awful lot longer' (Johnny, outreach worker, p71).

The outreach workers reported that they also check a client's veins to see if there are problems. This informs staff about whether the client is injecting in a safe manner and if not, lets staff know that they need to educate the client on the importance of safe injecting practices. This information is recorded on the client assessment form. The outreach staff also informs the client about the importance of being responsible for the health of their community by returning used works for safe disposal and thus reducing the potential transmission of blood-borne viruses.

'We really encourage them to bring them back...to get used syringes off the streets...Then I'd go through 'look if you have them lying around the house, if a cousin of yours...or your own child is around there and they find it, they could get a needle stick injury. Or if you leave them out in the street, it could be your sister's child' (Johnny, outreach worker, p63/4).

'One of the big things about harm reduction, it's about them to take responsibility for their health and their communities health by ensuring that the needles are disposed of safely' (Johnny, outreach worker, p71).

To encourage the return of used equipment, initially a limited number of sterile equipment is provided and when they bring back returns they will be provided with more.

'When the clients are assessed initially...there is a limited number of works that they would be given...the idea is that when they come back and they brings back their returns...it's to...create a situation where the client realises that there's value in terms of bringing back their used works because that will allow them to access more works' (Ben, manager, p113).

The consultation is finished with the provision of drug taking paraphernalia to the client. The service operates an open door policy, where clients do not require an appointment to attend the fixed site. However, appointments are required for the outreach services.

4.3.2 Drug taking paraphernalia provided by the service

The service provides clients with everything that they require for injecting. Different types of needles are available depending on where the client is injecting. Diabetic needles are the smallest and are used for injecting into the arm, but longer and thicker needles are available for injecting into the groin. Syringes are available in both 1ml and 2ml barrels.

‘Most of them use the diabetic syringes if they’re going in the arm. If they’re going in the groin they’re going to use longer needles...they may use a two mil barrel with a heavier gauge spike, right? It depends on what the person’s used to’ (Paul, outreach worker, p38).

The respondents reported that spoons with filters are available and used as the container for preparing the heroin before injecting. Citric acid and sterile water is provided and are heated with the heroin to remove impurities, preparing the heroin for injecting. Steri-wipes are provided so injectors can sterilise the injection site. Clients are also given small ‘sin bins’ so that they can return used equipment safely.

‘Plus we have the little bins for them, they’re individual black bins, so we would give them out so that they can bring them back used equipment’ (Emily, outreach worker, p7).

Condoms and lubricant are also available for the clients. Because the services operates once a week clients are supplied with enough works for one week and a few spare in case there are any problems.

'Because we're only open once a week...we give them a week's supply...If someone's...injecting four times a day, that's twenty-eight needles. But we can't just give him twenty-eight needles, what happens if one gets broken? Or if he misses three or four times trying to get a vein? So, we'll give him a few extra' (Johnny, outreach worker, p63).

4.3.3 The evaluation report on the operation of the fixed site exchange service provided between December 2005 and November 2006

The service produced an evaluation report of the fixed site exchange provision in county no.1 from December 2005 to November 2006. During this period twenty-eight clients accessed the service and two were female. Twenty-two lived in this county, four travelled from county no.2 and two from elsewhere. Twenty-seven of the clients were injecting heroin users, with one also using cocaine, another amphetamines and one reported injecting only cocaine. Ten of the clients reported sharing of drug taking paraphernalia with their peers. Table 3 reports the monthly breakdown of client attendance at the fixed site exchange between December 2005 and November 2006.

Table 3: The monthly breakdown of client attendance at the fixed site service between December 2005 and November 2006.

Month	No. of attendances	No. of clients
December 2005	2	2
January 2006	11	6
February 2006	5	4
March 2006	14	8
April 2006	4	4
May 2006	10	10
June 2006	8	7
July 2006	2	2
August 2006	13	9
September 2006	7	3
October 2006	10	4
November 2006	9	6
Total	95	28

Source: HSE fixed site exchange evaluation report, December 2006.

As can be seen in Table 3, two clients attended the fixed site exchange during its first month. Over the next five months, from January to May 2006, a further eight clients accessed the service and the regularity of their attendance varied. For the remainder of the year, another eighteen clients began using the needle exchange service and again, the regularity of their use was varied. Eighteen clients attended the service either once or twice and the remainder were more regular attendees, a breakdown of which can be viewed in Table 4.

Table 4: The breakdown of the regularity of client attendance at the fixed site exchange between December 2005 to November 2006.

Times attended	No. of service users
3 times	3
4 times	1
6 times	2
7 times	1
10 times	3

Source: HSE fixed site exchange evaluation report, December 2006

During this year a total of ninety-five exchanges took place and used equipment was returned on forty-five of these occasions. The report noted a return rate of 52%, with a total of 2200 needles and syringes being distributed and approximately 1150 being returned. The respondents reported that for the period of January 2007 to June 2007, 109 exchanges took place. They reported an increase in the return rate to 67%, with 2347 needles and syringes being distributed and approximately 1579 being returned. This information is shown in Table 5 below.

Table 5: The number of client visits and the number of needles and syringes provided and returned for the periods, December 2005 to November 2006 and January 2007 to June 2007.

Period of time	No. of client visits	No. of needles & syringes distributed	No. of needles and syringes returned	Return rate
December 2005 – November 2006	94	2200	1150	52%
January 2007 – June 2007	109	2347	1579	67%

Source: HSE fixed site exchange evaluation report, December 2006. The statistics for the period January 2007 to June 2007 were provided by the respondents.

As shown in Table 5, in the first half of the second year of the services operation, the number of clients accessing the services has increased and the return rate has also increased.

‘We’re open eighteen months roughly and I think we’ve had sixty-eight clients, different clients’ (Johnny, outreach worker, p63).

4.3.4 The description of this researcher’s observation of the fixed site needle exchange service in operation

This researcher observed the fixed site exchange in operation. On that day, two outreach workers were operating the exchange and three clients accessed the service. When the first client came in, it was evident that the outreach workers provided the service in an informal and relaxed manner. As they knew the client, they both greeted the client by name, had a brief conversation and then one of them brought the client into the consulting area. The consultation began with a general informal conversation which led to the outreach worker asking how the clients’ health was since the last visit.

Then the client was asked what drug taking paraphernalia was required and the outreach worker gathered this and gave it to the client. The client returned the used paraphernalia by placing it in a large bin in the consultation room, then said goodbye and left. After which, the outreach worker took out the client's information card and recorded the date of the exchange, what they had discussed about the client's health and the amount of equipment given out and returned. This process was completed for the other two clients. During the consultations the other outreach worker remained in the waiting area and served to greet the clients when they entered and chatted to them while they were waiting to do the exchange.

4.3.5 The operation of the outreach backpacking services

The outreach backpacking services are available for the whole region for clients who are not able to access the fixed site needle exchange service.

'The backpacking is there because if you have somebody who is living twenty-six miles away that may have transport difficulties...and so find it difficult to get into the clinic. Because our clinic is only open... two hours once a week. So, they might find it difficult to come in on that particular day' (Johnny, outreach worker, p67).

Before the backpacking can be operated the client needs to have a few meetings with the outreach worker in order for them to get to know and feel secure with the client.

'If they come into the clinic saying 'I can't make it in here... but look I could do with this' and I'd say, 'right, come in once or twice to us in the next two weeks, we need to meet you' (Johnny, outreach worker, p66).

Then the client would be contacted by phone to arrange the exchange which for staff safety would be carried out by two outreach workers in a public place.

'There would have to be two of us there... our policies and procedures dictate that for safety reasons...we have to operate in twos, in pairs' (Paul, outreach worker, p40).

The same procedure is followed before a home visit is contemplated.

'The first time you meet someone you wouldn't go to their home...you would have to build up some sort of a relationship and then go' (Emily, outreach worker, p11).

However, there are differences in the services provided by the outreach services. Home visits facilitate the same service provision as the fixed site exchange, whereas due to a lack of privacy, backpacking in a public place provides just the basic needle exchange without any other harm reduction interventions.

'So, literally he pulls up...its just there's the old stuff, there's the new stuff. See you next week, good luck'. That would be on the most basic level' (Paul, outreach worker, p36).

4.3.6 Present backpacking provision

At present, the backpacking provision only operates in county no.2. The respondents reported that due to lack of demand it does not operate in the other counties but the infrastructure is available to operationalize this service, as and when it is required.

'In (name of county no.3), it's very kind of one off...if I had an indication that somebody wanted to meet me in (town of county no.3) every week...and they wanted so many needles and they were willing to return them, that would be no problem. But they don't get themselves organised number one and they could be smokers as well you see? They may not be using needles at all' (Paul, outreach worker, p39).

4.3.7 The evaluation report on the operation of the backpacking provision in county no.2 from March 2006 to November 2006

The service produced an evaluation report about the backpacking provision in county no.2 from March 2006 to November 2006. The following client profile was reported. During this period, there were six clients, one female and all lived in this county. All clients were injecting heroin users, with one also using cocaine and another amphetamines. None of the clients reported sharing drug taking paraphernalia. Three clients used the service between six and seven times throughout this period and the others used the service between two to four times. A total of twenty-eight exchanges took place and the clients returned used paraphernalia on thirteen of these occasions. The report noted the high return rate of 69%, with a total of 575 syringes and needles being distributed and approximately 400 were returned. Exchanges were completed in a quite public car park with four of the clients, who were given a pre-packed bag containing injecting equipment. The other two clients were first met in this public place and when a few exchanges had been completed, they were visited in their homes. Table 6 provides a breakdown of the number of attendances by these clients between March and November.

Table 6: The monthly breakdown of client attendance at the backpacking service between March and November 2006.

Month	No. of attendances	No. of clients
March	1	1
April	2	2
May	6	4
June	8	4
July	2	1
August	3	1
September	1	1
October	1	1
November	4	3
Total	28	6

Source: HSE Backpacking evaluation report, December 2006.

Table 6 shows that within two months of the service being available, the number of clients accessing the service increased from one to four. During this time, the service operated one day a week from 1pm to 3pm. Then from July to October the number of clients requiring the service decreased, which was partly explained by two of the clients entering residential treatment detoxification programmes in July. The report concluded that there were a number of other reasons for the decrease in the lack of service demand, for example, the convenience of being able to purchase needles and syringes from pharmacies which are open six days a week. Also, this report and the respondents reported that the clients were often too chaotic to keep backpacking appointments.

‘They rarely keep appointments, so you could be running around chasing your tail after them’ (Paul, outreach worker, p39).

Since July, a small number of exchanges have taken place with four clients. This is evident from Table 6 and from the respondents interviews. This service provision is not provided on a specific day but is flexible to increase user-friendliness.

‘Since I’ve sort of come on there have been, I think it is four different one’s that I’ve done. Now I might have only done one exchange with one person. There’s one fella and he would be more regular. So, that, it seems to be coming back a bit more, it died off a bit’ (Emily, outreach worker, p14).

4.3.8 The role of the manager and the outreach workers

The outreach workers also provide other services to support both the client and the wider community. They maintain contact with clients when they are not accessing the needle exchange service. This can have the benefit of possibly getting the clients to come into the service on a regular basis and in the case of a particularly vulnerable client, it lets them know that someone is supporting them.

‘I think it’s good to be able to keep that contact to keep them coming back in on a regular basis...you know there might be some that are vulnerable and you would feel that you would need to keep a bit more contact with them. It’s just seeing where they’re at and not forgetting that they’re out there. You know one lad said to me last week ‘you know, I feel like nobody’s supporting me, nobody’s there’...and it’s a case of saying ‘well, I’m here and I’m supporting you’ (Emily, outreach worker, p17).

Outreach Workers also fulfil an advocacy role, engaging with other healthcare and social welfare organisations on behalf of their clients. The needle exchange service operates as a referral point for drug treatment services.

‘I’m in the process at the moment of trying to get a client into treatment. I have gotten clients into treatment...if they come to us...and...that’s what they want and they’re at that point. Then we will recommend it, we fill in a form and send it off

to the manager... then the manager comes back and either grants it or doesn't grant it, it depends on what he thinks' (Emily, outreach worker, p9).

The staff also operates the Primary Care Drug Assessment Unit, the methadone maintenance treatment clinic which functions to detoxify problematic users from heroin. Blood-borne virus screening is not available at the needle exchange service but staff reported that they can refer clients to other services for screening and even accompany a client to the appointment⁴. If a client's results are positive, staff can refer them to services that provide post-test counselling. It is also within the outreach staff's remit to provide support and information to parents of drug users and to the community at large.

The manager of the service is responsible for the operation of the HSE drug and alcohol services in the region. This role includes the day-to-day management and overall financial responsibility for the services.

'I have overall responsibility for drug and alcohol services in the region. So, that's everything from an operational perspective on a day to day basis around things like rotas for clinics, over, the administrative side, as well as clerical support' (Ben, manager of service, p93)

'From the financial perspective I would be ultimately I'm the person who signs off with any decisions which would be made which have a financial impact' (Ben, manager of service, p96).

In relation to the needle exchange service, due to the small size of the service the manager is closely involved with the operation of the service.

'So, because we're a very small service and we've a got a flat management structure...you're going to be very intimately involved in terms of what's going on

⁴ However, the respondents reported that blood-borne virus screening is available to clients attending the Primary Care Drug Assessment Unit.

and there would be times when I would be in the needle exchange... you're physically there in terms of what's going on in it' (Ben, manager of service p97).

Both the manager and the outreach workers have a role in the strategic development of the service.

'I would play a role in any developments, in the strategic development of the service. So, the expansion of the established needle exchange...I would be involved in terms of process. So...the frontline staff they'll put forward, if you like, the kind of the client care argument, they'll put forward the argument in terms of the need for it. Then my perspective is coming at it from the financial perspective, from the strategic perspective' (Ben, manager of service, p96).

As the manager is responsible for the operation of the service, part of his role is to resolve any issues or complaints about either staff or client behaviour.

'If something goes wrong...if it's an operation issue, like if a client complained about how they were spoken to or there was a difficulty in terms of client behaviours, em I would tend to be much more involved in terms of addressing it. (Ben, manager, p96/7).

In terms of service delivery, the National Drug Strategy specifies the actions that the service must respond to. This necessitates the compilation of progress reports.

'The National Drug Strategy provides us with our key mandate in terms of what we do, in terms of how we do it. So, there would be very specific actions in there which we would have to report on, em, it can vary between quarterly to every six months. They call it critical implementation document and that list gives us the explicit actions that are specific to the HSE and the Department of Health and then we comment on where we stand in relation to those, in terms of how far advanced we are in terms of delivering in relation to the National Drug Strategy' (Ben, manager of service, p95).

4.4 The issues associated with the operation of the needle exchange service

As stated in the literature review, the issues that are associated with the operation of needle exchange services are challenges to their successful operation. They include the relationship between service providers and service users; the accessibility of service provision in urban and smaller or rural communities; staffing levels and resources; the expansion of the service provision; the importance of client assessment information and service evaluations; the implementation of policies and procedures that promote service user-friendliness. The chapter will conclude with a description of the respondents ideal service provision and their views about the distribution of sterile injecting equipment through pharmacies and by vending machines. Before this, a brief discussion about how the establishment of the service did not produce any controversy from the community or the media and why one county's service received support from Gardaí will be provided.

The operation of needle exchange programmes can be susceptible to controversy. However, the outreach workers report that there are no issues from the community with regard to the operation of the service.

'I have to say 99% are supportive, from the communities...that I would have engaged with' (Johnny, outreach worker, p69).

However, another outreach worker reported that because they do not publicly advertise their service, the majority of the community is probably not aware that the service exists.

'If you walked out in the street and said 'where's the needle exchange?' people would look at you as if you had two heads. So, we've, we've kind of deliberately kept it low key' (Paul, outreach worker, p48).

Also, the respondents reported that they have not received any negative attention from the media.

'The local radio here, my experience has been very positive around drug and alcohol issues...The local press has been okay as well...it hasn't been a significant issue and hopefully it'll remain the same' (Ben, manager of service, p120).

One respondent reported that in one county the Gardaí support the operation of the service because they are conscious of its benefits, despite the fact that the service users are engaging in illicit drug use which conflicts with Gardaí policy.

'It's great for the Guards to be in support of it knowing full well really what we're doing...it could cause conflict of interest but I think they can... see the bigger picture, you know if you are reducing harm then there can't be anything but good' (Emily, outreach worker, p19).

4.4.1 The relationship between service providers and service users

The respondents reported that the way they interact with the service users can impact on the effectiveness of their harm reduction interventions. When working with the clients, the outreach workers try to create a comfortable and relaxed environment for the clients.

'It's trying to make the client comfortable and relaxed, feeling safe' (Johnny, outreach worker, p59).

The outreach workers stressed that their relationship with clients is based on trust and confidentiality. This is important as an attempt to encourage clients to attend the service on a regular basis and perhaps even to achieve the service's long-term objective of moving clients into treatment.

'They have to know when they come in here that it's not going anywhere else and what they tell you is private. Otherwise they wouldn't come back to us, if they don't trust us you're going nowhere' (Emily, outreach worker, p26).

'From an outreach point of view, you can't lose the trust of the client...because at the end of the day it's that credibility and that trust that will keep the client in the service and that might eventually led to them going on a programme' (Paul, outreach worker, p54).

However, one outreach worker reported that even if a relationship has been created due to the chaotic nature of the client, sometimes this does not seem to impact on whether they will keep regular contact with the service.

'If...you are relating to them well, there are times when they won't come back anyway, half the time they won't remember what day it is...that's the client, that's just the nature of it' (Emily, outreach worker, p16/7).

The evaluation report for the outreach home visit service in county no.2 stated that this service delivery model facilitated the establishment of good working relationships with clients in a more effective way than the fixed site exchange. The respondents noted that the home visit exchange service is operated in a more relaxed environment and allows staff to spend more time with clients compared with the fixed site exchange. However, it is more time consuming and the fixed exchange facilitates consultation with more clients.

'When you're doing backpacking you're going to the client, sitting down, he might make you a cup of tea, it's a bit more of a relaxed environment...whereas when you're coming into the needle exchange, you get the needles and you get out a lot of the time...backpacking is better in terms of I suppose meeting with the client. It's also more time-consuming as well...you could have ten people through the exchange in the same time' (Brian, former outreach worker, p90).

4.4.2 The accessibility of the needle exchange services: rural and urban provision

The RDFT action plan for the region stated that the region's population while dominated by a major urban centre in county no.1. is roughly equally divided between rural and urban areas.

'57% of the population live in rural areas...because of the mix of rural and urban there is the need to ensure that the response to the issues of drug misuse are sensitive to the local needs. The responses required for (name of city no.1) are different to those needed in smaller rural settings' (RDFT action plan, 2005).

Therefore there are differences in the service provision requirements for the region. As previously stated, the fixed needle exchange service is operated once a week for two hours from the city centre of county no.1. The other two counties do not have fixed site exchanges because at present, due to lack of demand, it would be neither necessary nor financially viable.

'Where you have a larger population the fixed site makes sense because in terms of the economy of scale, you have one central location where people would be coming to. The thing with (county no.2 and no.3) is that the numbers would be were a lot, lot lower...I mean (county no.1) accounts for roughly 70% of our opiate using clients, together the split between (counties no.2 and no.3) is roughly the same and it varies between you know 13 to 14% on either side...just from a financial perspective it doesn't make sense in terms of doing it' (Ben, manager of service, p108).

Therefore, the outreach services are in place to increase regional accessibility to the service. Also, the outreach services provide the service user with more anonymity. This is of particular importance in small close-knit communities because if they had to access a fixed site service, the client may be identified as being a problematic drug user. It was reported that as one of the county offices is on a main street in a small community, its location could be a barrier to people initially accessing the service. While this is probably not an issue for people accessing the fixed service because the city's large size provides more anonymity.

'I think people access services better in (city centre of county no.1) than in (town in county no.2) because I think (town in county no.2) is a very tight knit community and everybody knows everybody. I think people do have difficulty coming to any drug service. I just think because it's like if they come to here...they feel that everybody is going to know that they're here for the drug services...So, I'd say that's a definite barrier whereas in (city centre of county no.1) it's not...I feel that they're more open to going because there's a bit more anonymity there' (Emily, outreach worker, p20/1).

4.4.3 The issues associated with staff and resources

There are a number of issues associated with staff and resources that impact on the service provision. The respondents reported that because there are only three outreach workers for the whole region this is a barrier to the expansion of the service provision. While recognising the effectiveness of the present provision, they noted that more comprehensive outreach work is curtailed due to insufficient staffing levels.

'At the moment you have three outreach workers covering the area of (county no.1), (county no.2) and (county no.3). Now that's not three in each area, that's three outreach workers covering all that area... you show me the feasibility of that...The work they do is very good, they do it to a very high standard but...more staff is required if we're doing quality and good, good practice outreach work' (Johnny, outreach worker, p70).

A respondent reported that these staffing issues were due to a staff embargo implemented by the HSE, which has also limited the services' strategic planning.

'In the last couple of years there's been an embargo in terms of taking new staff on or new posts being create. The strategic planning has been quite limited... because we don't have the staff' (Ben, manager of service, p109).

The issue of client confidentiality is of particular significance because the outreach team works in both the needle exchange service and the methadone maintenance clinic. The staff reported that in order to maintain the clients trust they cannot make any other service provider aware of the fact that a client may be accessing both services. Thus, this creates confidentiality issues.

'As a needle exchange worker, I'll be giving a guy needles. Then I'm in the clinic that afternoon and the doctor's asking him 'well how's things?', 'everything's fine doctor'...I might know that he's injecting three times a day and I can't broach that because that knowledge is based on that client coming to the needle exchange...that's a drawback for not having separate staff in the clinic and the needle exchange' (Paul, outreach worker, p34).

Although Outreach Workers are not counsellors, due to the nature of the job they sometimes find themselves acting in this role.

'Although we don't do counselling, they do come in and it all comes out and you can't say hey hold on a minute stop, don't tell me that I need to get a counsellor to talk to you' (Emily, outreach worker, p12).

Therefore, the staff has an informal system of support and can discuss any issues with fellow outreach workers, the counsellor or with the manager.

'If there's particular difficulties and you feel you would need something, you could go to the line manager and he's always accessible... our colleagues here, the counsellors...they're wide open for us to actually go in and sit down and say 'look, where do you think I should go with him and this is what's happening' (Johnny, outreach worker, p58).

However, they reported that they would like to see more formal supervision in place.

'As far as like where counsellor get group supervision...we don't get that, which I feel we should...that you can download to somebody' (Emily, outreach worker, p12).

In terms of resources the staff reported that a more client-friendly premises is required. The current premises has only one room with a screen dividing the waiting room from the consulting room, thus it does not support confidentiality. This was also apparent from this researcher's observations of the clinic.

'We actually need better facilitative rooms...we do need two rooms, one where we can actually have a client and have that confidentiality. Because we have only one room...there's a partition in that room and behind that partition you're dealing with a client and you have other clients just outside the partition. It's very difficult if you have someone injecting to ask them can you see their arms and there's people listening and looking and how much they're using, information that is supposed to be confidential' (Johnny, outreach worker, p76).

Also, as the fixed site exchange is only open for two hours a week there are issues around the accessibility of the service.

'One of the drawbacks of the service is that eh, it's only open...for two hours a week...you know, you're not necessarily going to make it every week' (Paul, outreach worker, p31).

Therefore, this sometimes necessitates operating backpacking out of service hours.

'I've done a bit of backpacking with them from (city centre of county no.1) literally outside of clinic times...I suppose under the counter if you like because if somebody was stuck for needles we'd sort them out' (Paul, outreach worker, p39).

4.4.4 Strategic development of service

It was reported that the service intends to respond to some of the issues associated with service accessibility, staffing and resources by the end of 2007.

'Now this year extra resources and staff have been identified for the services but it will be towards the end of 2007 before they come in...I hope by this autumn we will have a full-time nurse who will take...responsibility around if people are presenting with abscesses or they've particularly bad sites in relation to poor injecting practices...look at the wound, do dressings, make referrals to A&E' (Ben, manager of service, 109).

They plan to expand the service provision by operating on another day in the fixed site and are also in the process of discussing the possibility of establishing two new fixed sites in health centres on the south side and north side of the city centre of county no.1.

'We're looking at the possibility of opening a second...exchange possibly on Friday afternoons...at the same location. We're also looking at the possibility of going out to Health centres in either (the north side of the city centre in county no.1) or (the south side of the city centre of county no.1)' (Paul, outreach worker, p31).

Also, a hostel that provides accommodation for homeless men has asked whether it would be feasible for the service to place and collect 'sin bins' in their hostel on a weekly basis. The service is currently in discussions with the hostel because the staff believes it would be more beneficial to operate a needle exchange service there on a weekly basis. This service would only be for the residents of the hostel.

'We met with our manager...and decided it was a better option to do a fixed needle exchange there once a week, of an hour just go in and actually you know monitor what was happening and get some coming back to us, give them out...that you're actually able to give information and to sort of promote safer injecting' (Emily, outreach worker, p5).

4.4.5 The importance of client assessment information and service evaluations

The evaluation of the service is an important part of its operation. The client assessment information and the internal and external service evaluations facilitate the monitoring of both the service user and the service provision. It provides an evidence base which enables the assessment of whether the service is effective and what improvements may be required. Every time a client accesses the service, the outreach workers record information on the client assessment form.

‘Every visit we make notes of what’s said and you know what we’ve discussed, what we’ve said to them’ (Emily, outreach worker, p16).

This information includes the type and mode of drug taking, whether equipment was returned and what was provided. It assists the monitoring of a client’s health status and their risk taking behaviours. Also, any interventions undertaken by staff would be recorded, for example if the client requested information about the methadone maintenance programme.

‘On the card we would have how many needles were returned to us and how many they’re looking for. Basically what drug they’re using...and on top of that then you’d have a comment. So, basically if somebody had very bad veins ‘veins are bad’ is reported. Also we’d say ‘discussed methadone programme, discussed safer injecting’...the client might say ‘I started using coke, I’m injecting more often’ (Johnny, outreach worker, p73).

This information is confidential and only outreach staff has access to it.

‘So, that information you have that would be for the outreach service, not to go back to the counsellors, not to go back to the doctor em, it’s for the outreach team to see what’s going on with clients’ (Johnny, outreach worker, p74).

It is also employed to compile monthly and yearly service reports. The monthly reports consist of the number of clients accessing the service, the amount of

equipment given out and the number of returns. This information is also used for the yearly service evaluation report, which has previously been discussed.

The information is important because it is used to monitor and track trends in drug use in the region, ensuring that the service is able to respond with the appropriate provision.

‘There’s an enormous focus within...the broader community around the level of cocaine use and drug services will need to re-orientate and re-train around that...Now, in (county no.1) we are starting to hear about people starting to inject cocaine and using crack cocaine as well...and having those kind of records you can start to track it in a much more rigorous, kind of scientific way’ (Ben, manager of service, p117).

All of this information is reported to management and to the government’s social inclusion unit, providing an overview of the issues associate with injecting drug users in the region.

‘I’d report directly into the social inclusion unit...feeding into the national picture. Em, then I suppose feeding up the issues that we would have from the localised area’ (Ben, manager of service, p93).

This information is also employed for good practice, for staff and service accountability and in order to secure funding.

‘In terms of good practice...documenting what we’re doing in terms of our accountability but also in terms of if anything was to happen. So, if a client was, does become suicidal and does commit suicide and the question comes like ‘did you engage with this client?’ our outreach worker will be able to say ‘I saw them five times, gave them interventions’ and it’s documented. Again, in terms of audit function em, you know if that questions asked ‘you’ll get the funding for x amount of outreach workers,

what are they doing? We have there the paper records in terms of saying 'this is what they've done' (Ben, manager of service, p116).

The service is subjected to both internal and external evaluations. The service's policies and procedures were designed with reference to best practice standards to enable the staff to evaluate the provision.

'Working within the...best practice standards. So, it's being able to act on them and being able to document them' (Ben, manager, p100).

Also, the service has just been audited from a financial and operational perspective. The service has not yet received feedback from the Comptroller and Auditor General about this assessment.

'We were audited recently by...the Comptroller and Auditor General...as well as looking at the economic input...they're also looking at what checks and balances are there to support what we're doing' (Ben, manager, p101).

Quads, a tool for assessing the quality and validity of drug and alcohol services, is being currently being piloted. It is envisaged that in the event of a successful evaluation, the tool will be implemented on a national level.

'The issue of quality standard is being looked at within drug and alcohol services...At a national level Quads is being considered em, to be adopted for the Irish health service in relation to drugs and alcohol services and issues around validation and accreditation are being looked at again in terms of the national picture' (Ben, manager of service, p101).

4.4.6 The implementation of policies and procedures that promote staff and client safety and service user-friendliness

The service operates a flexible returns policy, where returning used equipment is not a prerequisite for receiving clean equipment. This is because the service is guided by the principles of harm reduction. Therefore, no outreach worker has ever refused to provide sterile equipment if used works are not returned.

'I don't think we've actually refused anybody for not returning, based on harm reduction principles...you're not going to refuse them needles' (Paul, outreach worker, p30).

Indeed as, another respondent stated:

'there's no point in us not giving them enough sterile needles, barrels, syringes because they're only going to do damage to themselves' (Ben, manager of service, p113).

While there are official guidelines about the maximum number of works that can be provided to one client, the actual number of works provided depends on how often the client is injecting.

'I mean obviously it's made on assessing our guidelines there around actual numbers but it's made pretty much on where somebody's at in terms of their use' (Ben, manager of service, p113).

The health and safety of both staff and clients is of paramount importance in the operation of the service, thus there are strict policies and procedures which must be adhered to. This was apparent from the interviews and the policy documents. One outreach worker and one multi-tasking attendant, who fulfils a security role, must be present at any exchange in the fixed clinic. Two outreach workers must complete the backpacking provisions.

'Health and safety is a big issue, there has to be two of us' (Emily, outreach worker, p10).

The policy documents stated that when completing a home visit, outreach workers must inform colleagues about where they are going, when they will be finished and are obliged to contact colleagues when an exchange has been completed. If staff has not made contact, the manager should be informed of the client's address and when a specified time has lapsed the Gardaí should be informed.

However, the respondents reported that there are rarely any issues because service users realize that they are there to help them.

'They know that it's in their benefit to work appropriately with us because if they don't, there's no enormous value in terms of what they're going to get, in terms of making life difficult for us or behaving inappropriately... I would think that they would know that you don't need to go banging and shouting to get what you want because the service is there to help you and they will work with you' (Ben, manager of service, p115).

It was apparent from the policy documents that the service has strict guidelines for working with under eighteen year olds. The policy documents stated that parental consent is required. However, if attempts to get parental consent are unsuccessful, the service may be provided if there is definite evidence of injecting drug use, a psychiatric assessment is completed and the youth is aware of the risks associated with injecting drug use.

The outreach workers stated that the service's policies translate into practice because not adhering to them could jeopardise the safety of staff and clients. However, it is policy to breach confidentiality if there are concerns about the welfare of the client or if the client has stated that they are going to harm someone else.

'I would say to them that everything they say to me is confidential and that if they disclose that they are going to harm themselves or anybody else, that is the only time that I would break their confidence' (Emily, outreach worker, p26).

4.5 Service providers opinions about alternative delivery models for distributing sterile equipment

The respondents provided their opinions about the provision of harm reduction interventions through alternative delivery models. In particular, they were asked for their opinions about Action 63, which proposed:

'to pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange Programme in the ERHA area, and in the event of a successful evaluation, the programme to be extended where required' (NDS, Building on Experience, 2001: 118).

The respondents stated that because pharmacies provided localized services and operated extended opening hours, they would be a useful addition to harm reduction services in Ireland. Also, it would be financially viable option.

'It gives very good value for money and very good coverage' (ben, manager of service, p125).

However, the respondents had a number of concerns. It would have to operate a fully functional exchange service, similar to that provided by the outreach workers. Otherwise, there would be no safe disposal of used works, no harm reduction interventions in terms of providing information that would reduce risky injecting practices, and there would be no treatment referrals. Also, there would be no information about the client base.

'Is the pharmacist going to spend time with that person?...Are we going to lose out on the information that is gathered by the outreach staff all over the country...and

is bad practice going to increase due to the fact of no interventions from outreach workers...saying 'now you're actually injecting wrong, the reason you blew that vein is you injected the wrong way...are they going to be referred on for treatment' (Johnny, outreach worker, p80/1).

However, it was noted that the current industrial relations difficulties between the Department of Health and the Irish Pharmaceutical Union is an obstacle to the development of this service.

'There is ongoing industrial relations difficulties between the Irish Pharmaceutical Union and the Department of Health...that would make it difficult to develop something like that' (Ben, manager of service, p125).

One respondent reported that the provision of drug paraphernalia from vending machines would be beneficial in terms of increasing access to sterile equipment outside of services opening hours. However, a number of controls would need to be in place so that the clients are not just receiving clean works without any of the other harm reduction information and support.

'I would agree with the vending machines but I would say to them instead of putting them in as coins, why can't you put it in as card? And then they go to the outreach service and get their card...and they can go to every vending machine that's in the country. That means that they have...been educated' (Johnny, outreach worker, p82).

4.6 A future prospect: the ideal service

From the interviews a range of suggestions were presented about how an ideal service would be resourced. More staff would be required to facilitate the adoption of a more traditional model of outreach, where staff would engage in more street work to access the drug using communities.

'We'd have a larger team, we would look at that more traditional model of outreach...What we would like to see would be I suppose more street work, kind of going out and engaging with drug users within their community' (Ben, manager of service, p110/1).

To aid confidentiality a client-friendly premises with a separate entrance and exit is required. The service should operate five days a week and with longer opening hours, which would provide staff with more time to spend with clients.

'Ideally you should have separate entrances and exits to keep it confidential...you would want more opening hours, you would want more time for interventions with the client' (Paul, outreach worker, p49).

Staff should include more outreach staff and some medical staff. Also, the service should be a drop in centre where clients could also receive tea or coffee and sandwiches.

'It would be a drop in, it would be open Monday to Friday, nine to nine or nine to twelve...If you're looking at the ideal situation...maybe a doctor there to look at abscesses, a nurse there for dressings. You'd have more outreach workers there dealing with clients, doing exchanges. A place where clients can actually sit down and get a cup of coffee, even have a sandwich because an awful lot of the clientele would be living rough' (Johnny, outreach worker, p77).

While it is evident that the ideal service would maximise user-friendliness and possibly increase the effectiveness of the service, a respondent reported the necessity of working with the resources that are available.

'So, it's around...being practical around what you can and you can't offer. If we were to wait to have everything in place to run the gold standard needle exchange, it would probably never happen' (Ben, manager of service, p114).

4.7 Conclusion

These findings have provided a comprehensive description of the development and operation of a needle exchange programme from the service providers perspective. The role of the outreach worker and the manager in this provision has been clearly illustrated. Their issues associated with the provision have been reported. Also, the service providers have identified the barriers to the provision and have discussed the strategies suitable for addressing these issues.

Chapter 5: The discussion and conclusion

This chapter will contextualize the findings of the case study within a social and political framework with reference to the literature reviewed in chapter two. It will discuss the challenges associated with the operation of the needle exchange programme. It will conclude with a discussion about the ability to measure the effectiveness of the service provision in achieving its objectives.

5.1 Contextualizing the case within its social and political framework

It is important to contextualize the needle exchange service within its social and political context. The political context refers to the policy shift documented in the National Drug Strategy which, in 2001, accommodated the harm reduction philosophy in three actions in its treatment pillar. In particular Action 62 proposed:

‘to review the existing network of needle exchange facilities with a view to ensuring access for all injecting drug users to sterile equipment’ (NDS, Building on Experience, 2001: 118).

The social context relates to the reality of the situation, where regardless of government policies, problematic drug users are stigmatized and thus, marginalized from society and health services because of their illicit behaviours. Thus, the literature reported that the establishment of needle exchange services often produces controversy within organizations and the community. Strike et al. (2004) reported that in Ontario, Canada, despite public forums being held to inform the community about the benefits of the service, one mobile outreach service was significantly curtailed because of community opposition. Therefore, the researchers concluded that minimal consultation should be completed before the development of a needle exchange service. Also, the introduction of needle exchange services in New York was characterised by opposition from public officials and political leaders which according to the service providers decreased the effectiveness of the service provision (Henman et al., 1998). In reference to the case, anecdotal evidence suggested that

despite the government mandate, as stated in Action 62, social issues challenged this action's translation into practice. Therefore, the establishment of the needle exchange service was delayed by a few years because the organisation responsible for its development, the former health board, feared that it would encourage people to use drugs and that the region would be associated with heroin use. This opposition from organizations was also experienced in Nimbin, Australia (Helliwell et al., 1992). However, unlike the case, the opposition did not halt the establishment of the service and instead it was provided through an outreach provision. The second attempt to introduce harm reduction services in the region was successful. This was due to having support from HSE senior management and because of the service providers strategy of dealing with the potential social issues that could have emerged. As, there was a mandate from the government to operate the service there was no community consultation prior to the development of the service. Also, for the same reasons, the service was not publicly advertised and a 'word of mouth' method for promoting the service was chosen.

5.2 Operation of the needle exchange service: the challenges for the service provider

The service is designed to promote user-friendliness and facilitate a client's engagement with the service. It is evident that there are a number of challenges to the operation of the service, the chaotic nature of clients, service accessibility, the strengths and limitations of different service delivery models and the measurement of the effectiveness of the service provision.

5.2.1 The relationship between the service provider and service user

The needle exchange programmes are guided by the principles of harm reduction which was characterized by Riley and O'Hare (2000) as a humanistic response. It was evident from the case that this was the approach that the service providers took

when working with the clients. They provided the service in a friendly and non-judgemental manner and worked to develop trust and gain their clients confidence. Indeed, a number of research studies described this approach as being fundamental for needle exchange services to be effective (Allman et al., 2007; Mullen et al., 1999; Henman et al., 1998). This is especially important because due to their stigmatized identity, problematic drug users are marginalized from healthcare services. Therefore, the service was required to assist their re-engagement with health services. Despite this approach, the case noted that due to the chaotic nature of the client, irrespective of the way outreach workers relate with a client they might not attend regularly. In the previous chapter, Table 4 showed the regularity of client attendance at the fixed site exchange between December 2005 to November 2006. A total of twenty-eight clients used the service in this period, with five clients attending between six and ten times. Also, the respondents reported that one of the reasons for the decrease in demand for the backpacking service in July 2006 was also due to their chaotic nature and an inability to keep appointments. This information highlights a challenge for the service providers, the engagement of clients with the service on a regular and sustained basis. The respondents reported that to attempt to overcome this issue, more outreach work should be completed to encourage injecting drug users to use the service. Therefore, it was apparent from both the case and the literature that the service is designed to provide the infrastructure to help injecting drug users' engage with the service but responsibility for this engagement lies with the client.

5.2.2 The provision of an accessible service: increasing the service provision

Another challenge to the operation of the service is providing an accessible service in urban and rural communities. The type of service delivery provision was chosen by reference to the region's needs assessment, the geographical spread of known injecting drug users throughout the region and the level of resources that were available. Because the region is comprised of one major urban area and a mixture of smaller and more rural areas, different service delivery models were employed. Also, as the majority of potential clients lived in county no.1, a fixed site was established in the city centre of this county and an outreach provision was developed to meet the

needs of those not able to access the fixed site. This outreach provision is of particular importance because over half of the region's population and approximately twenty-seven percent of the known injecting drug users live in small or rural communities in counties no.2 and no.3. An issue associated with accessing the fixed site exchange is that it is only open for two hours per week and because of this, backpacking sometimes has to be completed out of official operating hours. Indeed, the services provided in the ERHA area (Moore et al., 2004) and in Scotland (Griesbach et al., 2006) stated that restricted opening hours and a limited number of needle exchange services were a barrier to service provision. Both studies concluded that the service provision required expansion to improve access to the services. Also, the respondents reported that due to an HSE staff embargo, insufficient staffing levels means that the outreach workers completed their role in pressurised circumstances and this has also affected the strategic development of the service. Indeed, it was reported that insufficient funding did not facilitate the strategic development of the Scottish service provision. Also, outreach staff working in rural areas in Scotland operated both the needle exchange and the methadone maintenance programmes. As the methadone programme requires that a client is drug free, the research found that this practice stopped clients accessing the needle exchange service. The case stated that due to the current level of staff, the three outreach workers are in the same position. However, in the first half of the second year of the operation of the exchange service, the number of clients had increased from twenty-eight to sixty-eight. While this could be used as an indication that this practice is not an issue for the clients, this cannot be stated with absolute certainty. It is apparent that the implications of this practice would be difficult to examine, as if it is a reason for a clients withdrawal from the service, this information may not be forthcoming.

To address the issue of accessibility to the fixed site, the service is planning to operate an exchange on another day and establish two new fixed sites in health centres on the north side and south side of county no.1. While the need for more outreach workers was discussed, at present there are no plans to increase this provision. However, the service will benefit from the employment of a nurse who will tend to injection-related injuries and provide blood-borne virus screening. Cox et al. (2000a) reported that the Health Promotion Unit in Merchant's Quay would also benefit from this provision.

Therefore, it is apparent that the expansion of the service will increase the access to harm reduction interventions and possibly increase clients' engagement with the service. Nevertheless, it must be restated that the present provision has been effective in doubling the number of clients accessing the service.

5.2.3 The strengths and limitations of different service delivery models

From the discussion above it is apparent that the utilisation of different service delivery models was necessary due to the geographical spread of injecting drug users in the region and also from a resource perspective. However, as discussed in the introduction, different service delivery models have different strengths and limitations (Strike et al., 2006). The strength of the fixed site exchange is that it provides sterile equipment, disposes of used equipment and provides education about harm minimization strategies. However, the limitations include accessibility and convenience for the service user. The outreach provision serves to rectify this by increasing the accessibility and convenience for clients. It also provides the service user with more anonymity, which is especially important in smaller or more rural areas where it would be easier for them to be identified as problematic drug users if there was a fixed site provision in these counties. The home visits, in comparison with the fixed site exchanges, were reported as being more effective in establishing relationships with the clients because they were completed in a more relaxed environment. However, in terms of resources they were more time consuming. Despite the strengths of the outreach service and the limitations of the fixed site, the case has shown that the fixed site was the clients preferred method for accessing the services in the region. Indeed, the respondents reported that there was a lack of demand for the backpacking service in counties no.2 and no.3.

Henman et al. (1998) stated that services provided through vending machines or pharmacy based exchanges are beneficial because they have extended opening hours and are more accessible and convenient than other models. Indeed, vending machines have twenty-four hour access but unlike all the other models these services are not

free. The current industrial relation difficulties between the Department of Health and the Irish Pharmaceutical Union means that at present pharmacy based exchanges are not an option in Ireland. However, the respondents stated that the provision of sterile injecting equipment through vending machines would increase the effectiveness of the Irish harm reduction provision. The strengths and limitations of different service delivery models require consideration by service providers, as different models have different challenges which need to be deliberated. Nevertheless, the most important factor to consider when evaluating the different delivery models is their level of use by the clients.

5.2.4 The measurement of the effectiveness of the service provision

The effectiveness of the service can be assessed by reference to its ability to achieve its short-term objectives of changing risk taking behaviours and reducing the prevalence of blood-borne viruses and its long-term objective of moving clients into drug treatment programmes. These are measured through the collection of client assessment information. As Paone et al. (1995) stated the client assessment information is very important as it monitors the service user and the provision, providing an evidence base to assess the effectiveness of the service and also identify any gaps in the service provision. The service providers of the needle exchange services in the ERHA area (Moore et al., 2004) and Scotland (Griesbach et al., 2006) stated that national standardization was required for the collection of client assessment information. However, as this research focused on one region, it is not known whether there have been improvements in the information collected in other services in Ireland. Nevertheless, it was evident from the case that the service provision is rigorously evaluated.

The client assessment information monitors the clients health status and their level of engagement with the service by documenting whether the harm reduction strategies are effective in reducing their risk taking behaviours. As stated in chapter four, when a client first accesses the service the staff records whether the client shares drug

taking equipment. Since information is recorded at every visit, staff can ascertain whether the safer injecting information provided has been effective in changing the client's risk taking behaviours. The respondents reported that it was a challenge to change these behaviours but one that was overcome with time. With reference to the literature reviewed, most of the evidence supported the effectiveness of service providers harm reduction education and information for changing injecting drug users sharing of equipment (Gibson et al., 2001; Cox et al., 2000a; Cox and Lawless, 2000b; Donoghoe et al., 1989). However, it was reported that despite interventions, the social culture of sharing was resistant to change and required consideration (Des Jarlais et al., 1989). Madray et al. (2000) found that the most effective method to change this behaviour was peer-based outreach, employment of an active injecting drug user to deliver the interventions. As the service is considering the expansion of their service, perhaps this is something that they could consider.

The service can be assessed for its effectiveness in increasing access to sterile injecting equipment and reducing the amount of used equipment in circulation, so safeguarding the general public. It is effective in terms of providing access to sterile equipment because apart from some pharmacies, which only sell needle and syringes, there is no other way to receive this equipment. Also, the proposed expansion of the service provision will serve to increase access to drug taking paraphernalia. It was evident from the case that it is effective in increasing access to sterile equipment, as the number of clients accessing the service has increased since its establishment. It also documented an increase in the number of used equipment being returned, from 52% in the services' first year to 67% for the following six month period. As Nigro et al. (2000) reported the increase in the return rate was probably because the clients were engaging with the service and establishing confidence in the service. Also, the literature and the respondents reported that a flexible returns policy was best practice in this situation (Griesbach et al., 2006; Strike et al., 2006; Nigro et al., 2000). The respondents stated that regardless of whether used equipment was returned, the client was always provided with enough sterile equipment.

At present the service is not able to assess its effectiveness in reducing the prevalence of blood-borne viruses or the number of clients moving to drug treatment programmes. The service documents whether a client has been screened for a blood-borne virus but does not have information about whether a client has tested positive for a virus. As Long (2006) reported, on a National level there are difficulties measuring the prevalence of viruses among injecting drug users and at present it is only possible to quantify the incidence of HIV and HBV among injecting drug users in treatment. It is apparent that systems are required that will collect information about drug-related infectious-diseases. Despite this, the majority of the Irish and International literature reviewed suggested that needle exchange services are effective in reducing the prevalence of blood-borne viruses (Moore et al., 2004; Dillon and O'Brien, 2001; Smyth et al., 1999; Hurley et al., 1997). Also, the service has no system for recording the number of clients who move from the needle exchange service to treatment programmes. Nevertheless, research has suggested that services are effective in achieving this long-term objective of being a referral venue for treatment services (Kuo et al., 2003; Heimer, 1998). It is apparent that such a system should be implemented.

The effectiveness of the service provision is also monitored by the production of internal and external evaluation reports. The respondents reported that these are produced on a monthly, three-monthly, six-monthly and yearly basis to assess best practice and provide accountability on a regional and national basis. The client assessment information provides the evidence for these reports and is also employed to track trends in drug use in the region, ensuring that the service provision is responding appropriately. The evaluation systems are in line with Strike et al.'s (2006) best practice guidelines which stated that ongoing evaluations are necessary to examine the effectiveness of the provision for meeting the needs of the client. Also, a respondent reported that at present a tool for assessing and monitoring drug and alcohol services on a national level is being piloted. Indeed, this was something that the services providers of the needle exchange services in the ERHA area (Moore et al., 2004) and Scotland (Griesbach et al., 2006) stated was required.

5.3 Conclusion

In recognition of a lack of research in this area, this study explored the issues and barriers associated with the development and operation of a needle exchange programme from the service providers perspective. This research found that the issues involved with the service's development included:

- the implementation of policies and procedures that promote service user-friendliness
- support from senior management to provide the service
- recognition of the controversy that needle exchange programmes can produce and responding appropriately to avoid these social issues

This research found that the issues relating to the operation of the service included:

- the importance of trust and confidentiality between service providers and service users
- the current staffing levels and resources
- facilitating the accessibility of the service in urban and rural communities: the necessity for expanding the service provision

In addition to these findings the research showed the importance of client assessment information and service evaluations for measuring the effectiveness of the provision. The central findings of this study were produced with reference to the services ability to achieve its short-term objectives of changing risk taking behaviours and reducing the prevalence of blood-borne viruses and its long-term objective, of moving clients into drug treatment programmes. From the client assessment information the service has the ability to assess whether clients are modifying their risk taking behaviours. Also, the service is effective in encouraging clients to be responsible for the health of others by getting used equipment out of circulation. However, the challenge for the service is the implementation of a system for evaluating whether the service is effective in reducing the incidence of blood-borne viruses and moving clients onto drug detoxification treatment programmes.

It is evident that the service providers' provide the infrastructure to assist injecting drug users but ultimately, the decision to engage with the service lies with the client. In conclusion, to provide a more comprehensive exploration of the issues associated with the operation of needle exchange services, future research could focus on the experiences of the service user.

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Appendix 1

Interview guide for the Acting Regional Drug Co-ordinator for the HSE drug and alcohol service: the manager of the needle exchange service

1) Role

- Can you describe for me your involvement in the management of the needle-exchange programme?
- Are there official guidelines on how to carry out your role?
- What is the management structure of the service?
- Who do you report to?
- When you started the job was there an induction process?
- Is there on-the job training?
- Are there any concerns around personal safety whilst on the job?
- Are emotional supports necessary and available?

2) Harm reduction

- How do you define the harm reduction approach to service provision?
- What are the key principles of this approach?

3) Development of Harm Reduction Services

- When did you discover there was a need for a needle exchange service in your region? And how?
- Who was responsible for the development of the service?
- What was your role in the development of the service?
- How was the service developed?
- Were there any issues or barriers around the development of the needle exchange service in the region?

4) Operation of Harm Reduction Services

- Were there any issues or barriers that you have to consider when operating the needle exchange service?
- Is the service monitored and evaluated?
- Can you describe for me the ideal harm reduction service for the region?

5) Service policies

- How were your policies for the needle exchange service developed?
- What are the policies in terms of the nature of the service provision?

- The regions RDTF Action Plan stated that the HSE and RDTF are responsible for: ‘researching and delivering a broad range of harm reduction interventions’.
- What is your relationship with the RDTF in your region regarding the operation of the following policy?
- NDS Action 62: ‘to review the existing network of needle exchange facilities with a view to ensuring access for all injecting misusers to sterile equipment’.

- The regions RDTF Action plan stated that ‘the responses required for (city centre of county no.1) is different to those needed in smaller rural settings’ and that due to smaller populations it is ‘difficult to provide equitable services across the urban/rural divide’...‘rural injecting drug users are disadvantaged and at greater risk of injecting related harms because of limited service provision, increased stigmatisation and discrimination and social and geographical isolation’.
- These are difficult issues, how do you work around them when developing and operating services?

- NDS Action 63: ‘to pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange

Programme in the ERHA area, and in the event of a successful evaluation, the programme to be extended where required’.

- Has this been acted on and is it present in your region?

- NDS Action 69: ‘to develop and implement proposals for the collection and safe disposal of injecting equipment.

- Has this been acted on and is it present in your region?

6) In your evaluation report on the operation of the needle exchange service in the (city centre of county no.1) from December 2005 to November 2006, a number of recommendations were made:

- ‘To promote services to attract those not in contact with treatment services’.

- How have the services been promoted?

- ‘To consider opening a needle exchange programme on an additional occasion or locate a needle exchange service at a venue within a community’.

- Has this recommendation been progressed?

- ‘Further efforts to be made to increase return rate of used equipment’.

- What kind of strategies would you employ to achieve this?

Appendix 2

Interview Guide for the Outreach Workers providing needle exchange services

1) Role

- Can you tell me about your role as an outreach worker?
- Can you describe for me a typical day working within the needle-exchange programme?
- Are there official guidelines on how to carry out your role?
- When you started the job was there an induction process?
- Is there on-the job training?
- Are there any concerns around personal safety whilst on the job?
- Are emotional supports necessary and available?

2) Harm Reduction

- How do you define the harm reduction approach to service provision?
- What are the key principles of this approach?

3) Development of the Harm Reduction service

- Who was responsible for the development of the services?
- What was your role in the development of the services?
- How were the services developed?
- What were the issues that you had to consider when developing harm reduction services?
- Were there any barriers to the development of the service?

4) Operation of the Harm Reduction service

- What type of harm reduction services are available?
- Are different services provided at fixed clinics and through backpacking?
- In terms of recording information about clients, what is recorded? What do you do with this information?
- Is the service monitored and evaluated?
- Are there any the issues that you have to consider when operating harm reduction services?
- Are there any barriers to the operation of the service?
- How do you reach your client base?
- Can you describe for me the ideal harm reduction service for the region?

5) Policies

- Can you tell me about the policies that guide your service provision.
- Are there ever any issues around policies, in terms of adherence?
- NDS Action 63: 'to pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange Programme in the ERHA area, and in the event of a successful evaluation, the programme to be extended where required' What do you think about this action?

6) Service provider and client relationship

- How do you establish relationships with clients?
- Are there any issues that you need to consider when working with clients?

Appendix 3

Research Ethical Approval Form



**School of Social Work
and Social Policy**

Research Ethical Approval Form

Forms must be submitted at least TWO WEEKS before a School Research Ethics Committee meeting. If you are a taught MSc student please submit form to your course administrator. If you are a member of staff or MPhil/MLitt/PhD please submit form to Rebecca Casey (rcasey@tcd.ie / Room 3053 / Arts Building)

Title of Project: The issues associated with the development and operation of a needle exchange programme from the service providers perspective.

Name of Applicant(s): Janet Robinson

Applicant(s) email address: robinsjm@tcd.ie

Application Date: 28th May 2007

Staff project (<i>tick as appropriate</i>) <input type="checkbox"/>	Student Project(<i>tick as appropriate</i>) <input checked="" type="checkbox"/>
Project start date:	Student Number: 0613240501
Lead researcher:	Supervisor: Not allocated
Research Methods	Title of Course: MSc in Applied Social

Recruitment Procedures

		Yes	No	N/A
1.	Does your project include children under 18 years of age?		√	
2.	Does your project include people with learning or communication difficulties?		√	
3.	Does your project include people in custody?		√	
4.	Is your project likely to include people involved in illegal activities?		√	
5.	Does you project involve people belonging to a vulnerable group, other than those listed above?		√	

6.	Does your project include people who are, have been, or are likely to become your clients or clients of the School?		√	
7.	Does your project include people for whom English/Irish is not their first language?		√	
8.	Will you tell participants that their participation is voluntary?	√		
9.	Will you obtain written consent for participation?	√		
10.	If the research is observational, will you ask participants for their consent to being observed?			√
11.	Will you tell participants that they may withdraw from the research at any time and for any reasons?	√		
12.	Will you give the potential participants a significant period of time to consider participation?	√		

Possible harm to participants and/or researchers

		Yes	No	N/A
13.	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		√	
14.	Is there any realistic risk of any participants experiencing a detriment to their interests as a result of participation?		√	
15.	Does this research pose any risk of physical danger to the researcher?		√	
16.	Does this research pose any risk of mental harm to the researcher?		√	

Data Protection

		Yes	No	N/A
17.	Will any non-anonymised and/or personalised data be generated and/or stored?		√	
18.	Will you have access to documents containing sensitive data about living individuals? If 'Yes' will you gain the consent of the individuals concerned?		√	

If there are any other potential ethical issues that you think that Committee should consider please explain them on a separate sheet. It is your obligation to bring to the attention of the Committee any ethical issues not covered on this form.

Supervisor's Declaration

As the supervisor for this project, I confirm that I believe that all research ethical issues have been dealt with in accordance with School policy and the research ethics guidelines of the relevant professional organization.

Signed: _____

Date:

Print Name:

Office Use Only:

Decision of the Ethical Approval Committee

REFERENCE NUMBER	
Research Ethics Meeting Date	
Approved	
To be resubmitted	
Reasons for resubmission	
Date	

Appendix 4

Participant Information Form



Thank you for agreeing to take part in this research study. It is about harm reduction services with particular reference to the development and operation of needle exchange services in your region. The aim of the research is to explore your experiences about the development and operation of these programmes.

This research is being undertaken to produce my thesis for the Masters in Applied Social Research in Trinity College Dublin. The research will take the form of a face-to-face interview that will last approximately 1.5 hours. The interview will be taped and transcribed to facilitate analysis, however all information will remain anonymous. Only myself, my thesis supervisor and the external examiner will have access to the transcript. Your participation is voluntary and please feel free to stop the interview at any time. If you have any questions please do not hesitate to ask.

Appendix 5

Participant Consent Form

The aim of the research and this consent form has been explained to me. I have been told that any information I give will be strictly confidential and I will not be identified in the research. I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction and I voluntarily agree to be interviewed.

Participants name:

Participants signature:

Date:

Researcher's statement: I have explained the aim of the research, that participation is voluntary and what information is required from the participant. I have offered to answer any questions and fully answered such questions. I believe the participant understands my explanation and has freely given informed consent.

Researchers name:

Researchers signature:

Date:

