



Home Office

Monitoring the legal provision of foil to heroin users

Research Report 92

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Introduction and background

- This report presents findings from research designed to explore how legislation to allow the lawful supply of foil to heroin users by drug treatment services has operated in practice.
- The legislation, implemented in September 2014, followed advice from the Advisory Council on the Misuse of Drugs (ACMD, 2010) to exempt foil from Section 9A of the Misuse of Drugs Act 1971 (regarding the provision of drug paraphernalia). This advice was accepted by the Government in 2013 (Home Office, 2013a). The exemption was added to the Misuse of Drugs Regulations 2001 with the following conditions:
 - “A person employed or engaged in the lawful provision of drug treatment services may, when acting in that capacity, supply or offer to supply aluminium foil in the context of structured steps:*
 - (a) to engage a patient in a drug treatment plan, or*
 - (b) which form part of a patient’s drug treatment plan.”*
- The research uses data obtained from suppliers of foil designed for smoking drugs to monitor recent trends in foil provision across the UK. In addition, findings from a series of 30 semi-structured interviews with foil providers are used to explore how foil is distributed, considering:
 - how the provision of foil can benefit a user’s journey towards recovery; and
 - how the conditions attached to the lawful provision of foil are applied in practice.
- The intervention has a long history in the UK. Some needle and syringe programmes have provided foil since the mid-2000s, having sought the views of their local police force.
- Foil provision is expected to reduce the harms from heroin use by encouraging smoking rather than injecting. The ACMD’s advice summarised the potential benefits of foil provision (ACMD, 2010; 2012), which relate to both reducing harm (for example, the prevention of overdose and the transmission of blood-borne viruses) and building recovery (for example, engagement with treatment services) outcomes.

Findings

- Findings from this research show that the supply of foil has increased following the commencement of the legislation. Needle exchange professionals welcomed the law change, and considered foil provision as beneficial to treatment and recovery outcomes. The conditions attached to the lawful provision of foil were generally adhered to by providers, who considered their services to be an important first step towards a client's recovery.

The uptake of foil

- Industry data show an increase in the supply of foil, beginning ahead of the law change. Following implementation of the law change, the upward trend in supply to needle and syringe programmes accelerated, with supply in the 12 months post law change (September 2014 to August 2015) increasing by 71 per cent on the 12 months preceding the law change.
- Needle exchange professionals attributed this increase to the law change in two key ways. Firstly, the law change generated demand from new providers of foil who did not distribute prior to September 2014. Secondly, the legislation allowed existing providers to deliver a more consistent message, operate more transparently, and extend their provision.

Distributing foil

- Foil providers initially offered foil to their clients as part of a broader conversation on reducing the risk of overdose and the transmission of blood-borne viruses. Providers described how foil was particularly appealing to clients with injecting site issues, who may be at risk of or engaged in very high-risk injecting behaviour (for example, groin injection).
- Foil is largely distributed in packs of 20 or 50 sheets, though some providers distributed in smaller amounts, with the intention to encourage injecting clients to try smoking during periods of restricted venous access. Foil providers also advised clients on how to use foil safely and efficiently.

Foil as an intervention

- Providers agreed with the ACMD's assessment that foil was beneficial for reducing harm as well as improving treatment and recovery outcomes. Providers beginning foil distribution only after the law change confirmed that provision had broadened the reach of their services, allowing them to access clients with no injecting history who they might not have seen otherwise.

- Once users were engaged, foil provision assisted clients in achieving short- to medium- and long-term goals. These included engagement with drug services, reduced injecting occasions and reduced dangerous injecting. Long-term benefits included less chaotic lifestyles, contemplation of treatment and engagement with treatment services. For those already in treatment, foil provision was considered beneficial both in reducing overdose risk and maintaining progress toward recovery.

Complying with conditions

- Foil must only be provided by those engaged in the lawful provision of drug treatment services. Foil provision in the UK is largely based in specialist, fixed site needle and syringe programmes, and in a small number of pharmacy-based needle exchanges. Pharmacy provision is concentrated amongst specialised pharmacy services, where staff can engage in meaningful contact with clients, complying with conditions (a) and (b) of the exemption in doing so.
- To broaden the reach of needle and syringe programmes, and to engage with clients who may be hard-to-reach, most providers allowed secondary distribution of foil (peer-to-peer distribution). In order to comply with conditions, those who permitted secondary distribution did so as a preliminary step to engage the end user with both needle exchange and wider treatment services.
- A commonly held view amongst needle exchange professionals was that engaging clients into recovery-orientated treatment was very much “part of the job” regardless of the conditions attached to foil provision. Providers met the conditions by building relationships with their clients, reminding them of treatment options and intervening at the right time.

Acknowledgements

First and foremost we would like to thank the needle exchange professionals who gave up their time to be interviewed for this research. We would also like to thank colleagues from Public Health England for their advice throughout the development of this study, and the National Needle Exchange Forum and Scottish Drugs Forum, who helped to recruit participants to take part in the research. Finally, thanks are due to Annette Dale-Perera and Charlie Lloyd who peer reviewed an earlier draft of this report.

1. Introduction

Context

In September 2014 legislation was amended to allow the lawful supply of foil for drug use. This permitted drug services, including needle and syringe programmes (NSPs) to provide foil, under certain conditions (covered in section 2), to drug users for the purpose of smoking drugs,¹ as opposed to injecting.

This report presents findings from research designed to explore how the legislation to allow the lawful supply of foil has been implemented. This delivers on a commitment made by the Home Office to monitor the take-up of foil and adherence to the conditions attached to its provision.²

Aims

The research was designed to address the following aims.

- To monitor the uptake of foil following the law change.
- To explore how service providers adhere to the conditions attached to the distribution of foil, specifically:
 - whether and how the provision of foil can benefit a user's journey towards recovery;
 - and whether and how foil is used to engage drug users into treatment, or used as part of a treatment plan.

Methods

The research was limited in scope; it was not designed to quantify the impact of foil provision on treatment and recovery outcomes nor did it seek the views of NSP users. Instead, in-depth semi-structured interviews were undertaken with service providers who distributed foil, and data were collected on the number of foil sales before and after the change in legislation.

Information on the methods used is presented below. See Annex A for further information about the sample and Annex B for the topic guide used in the interviews.

i) Monitoring the take-up of foil: Quantitative data

To explore the first aim, data on the volume of foil sold across the UK before and after the law change was obtained from suppliers of foil designed for smoking drugs.

¹ 'Smoking' is used throughout this report to mean heating a drug on foil and inhaling its vapours.

² This commitment was made in the Written Ministerial Statement (Home Office, 2013b).

It is likely that the majority of foil distributed by needle exchange services across the UK is captured in these data.

The data are used as a proxy measure of the amount of foil supplied to users. It is possible that due to a delay in the supply chain between purchase and distribution, the uptake of foil may be higher or lower than reported here.

ii) Exploring the distribution of foil: Semi-structured interviews with foil providers

To explore the benefits of foil and how the conditions around its provision have been implemented in practice (aim 2), 30 semi-structured interviews with NSP professionals³ were conducted.

Participants were primarily recruited through an open call to members of the National Needle Exchange Forum,⁴ with elements of snowball sampling as respondents were encouraged to suggest other staff to take part.

Interviews took place between October and November 2015, just over a year after the law change, to allow time for the new legislation to bed in. The majority (22) were conducted face-to-face, with 8 conducted via telephone. The sample was comprised of providers based across England, Wales and Scotland.⁵ In order to gather a diverse range of views interviews were undertaken with:

- different types of providers (including those who provided foil from fixed site NSPs as well as outreach and pharmacy-based services);
- a mix of staff (those in both managerial and front-line positions); and
- providers who distributed foil both before the law change and only after the law change.⁶

While efforts were made to interview a range of different providers, it should be noted that the sample was not intended to be fully representative of all providers. Providers who are more positive about providing foil may have been more likely to take part and this may have been compounded by the use of snowball sampling. Additionally, only a small number of pharmacy-based NSP staff were interviewed (two pharmacy co-ordinators, and one pharmacist), although it is likely that the majority of foil distributed across the UK is distributed by fixed site specialist needle exchange services. Given the differences in practice between pharmacy-based NSPs and specialist NSPs, findings from one may not be applicable to another.

³ The terms 'needle and syringe programme' (NSP) and 'needle exchange' are used interchangeably throughout this report.

⁴ The National Needle Exchange Forum (NNEF) is a membership organisation that exists to promote and support the provision of high quality needle and syringe programmes. The NNEF members are NSP staff, users and advocates.

⁵ Northern Ireland was not covered by the legislation change and therefore was not included in this research. Separate legislation has allowed the lawful provision of foil in Northern Ireland from 11 December 2014 onwards, and the Northern Ireland Department of Health has undertaken work to monitor this. For brevity, the report uses the term UK to refer to England, Wales and Scotland.

⁶ It was initially intended to recruit a small number of NSPs that did not provide foil, this was not achieved as this type of service did not volunteer to participate.

2. Background

Foil provision in the UK

The first needle and syringe programmes (NSPs) to supply foil began doing so in the early to mid-2000s, with the intervention growing in its reach across the UK as it gathered momentum across the needle exchange community. Prior to the legislation change in September 2014 services that provided foil did so in breach of Section 9A of the Misuse of Drugs Act 1971. However, some of these had a 'letter of comfort' provided by their local police force, which stated that foil provision was not a policing priority, and that they would not prosecute. Section 9A prohibits the provision of articles that may be used for administering or preparing an illegal drug unless exempted in Act or its regulations. Previous exemptions included needles, syringes, citric/ascorbic acid, and water for injection.

Box 1: Needle and syringe programmes

NSPs are services that supply injecting equipment (for example, needles, syringes, sharps bins) to drug users. Clients include those who inject heroin, and also those who inject other drugs (such as image and performance enhancing drugs). NSPs aim to discourage the sharing and reuse of injecting equipment, therefore reducing the transmission of infectious diseases and improving the health of users. They also aim to reduce drug-related litter, the risk of needlestick injuries to the public, and act as a referral point into the wider drug treatment system. Although reducing health harms is the primary aim of NSPs, these services may also have additional benefits. The low threshold nature of these services can help to make the first contact with users who are not in treatment. NSPs can subsequently engage users with treatment services, and act as a referral point into structured treatment. The National Institute for Health and Care Excellence (NICE) produces guidelines for NSPs, although these were last published (March 2014) before the legislation change (NICE, 2014).

In 2010 the Advisory Council on the Misuse of Drugs (ACMD) recommended exempting foil from Section 9A of the Misuse of Drugs Act 1971. On the basis that *“the balance of benefit favours exempting foil from Section 9A of the Misuse of Drugs Act 1971”*, the AMCD cited benefits largely related to reducing the harm from illicit drug use (ACMD, 2010). The ACMD provided further advice in 2012, which emphasised the potential benefits of foil on treatment and recovery outcomes: *“foil provision increases engagement with services. In turn, engagement increases the likelihood of recovery ... foil can support an individual in their first steps into getting off drugs”* (ACMD, 2012).

This advice was accepted by the Government in 2013 (Home Office, 2013a). The exemption was added to the Misuse of Drugs Regulations 2001 with the following conditions:⁷

“a person employed or engaged in the lawful provision of drug treatment services may, when acting in that capacity, supply or offer to supply aluminium foil in the context of

⁷ The conditions do not apply to the lawful provision of other paraphernalia.

structured steps: (a) to engage a patient in a drug treatment plan, or (b) which form part of a patient's drug treatment plan.

In this regulation 'drug treatment plan' means a written plan, relating to the treatment of an individual patient, and agreed by the patient and the person employed in the lawful provision of drug treatment services."

Legislation was laid in August 2014 and consequently the provision of foil became legal from September 2014 onwards (National Archives, 2014). This was accompanied by a Home Office circular for criminal justice agencies (Home Office, 2014), and guidance for practitioners issued by Public Health England (PHE, 2014) to support consistent interpretation of the legislation.⁸ This guidance provides an explanation of the conditions attached to foil provision, alongside advice on how services can adhere to them.

Foil as an intervention

Within the context of taking illicit drugs, foil is most commonly used to consume heroin.⁹ This is commonly done by placing heroin on top of the foil, and then applying heat to the bottom of the foil. This produces vapours, which are then inhaled by the user, often using another piece of foil that has been shaped into a tube.

Specialist aluminium foil is available for heroin smoking. This is thicker than the foil that is used for cooking, making it more durable and thus less likely for users to lose their drugs while smoking. It is pre-cut into appropriately sized sheets that are smaller and more discreet than cooking foil. It also lacks the vegetable oil coating of cooking foil, which users report having to burn off before use (ACMD, 2010).

Foil provision is intended both to reduce the harms associated with intravenous drug use and to facilitate a 'route transition' (Bridge, 2010). There is an existing body of research evidence that shows that some, but not all, heroin users will start their careers smoking, and then transition to injecting (see, for example, Griffiths *et al.*, 1994). Therefore foil provision should encourage a 'reverse transition', that is to say, it is designed to encourage those who currently inject drugs to switch to smoking them instead. Although smoking itself is not without risks,¹⁰ the ACMD's advice found that foil provision had a number of benefits:

- reduced injecting related harms (blood-borne viruses, infections, vein collapse);
- reduced risks of overdose;
- increased service engagement with users, to discuss options with a view to reduce harms, injecting and ultimately drug use; and
- reduced drug-related litter.

The ACMD also considered the potential for disbenefits or unintended consequences, such as a

⁸ This guidance issued by PHE also applies to both Wales and Scotland.

⁹ Foil may, less commonly, be used in the administration of other illicit drugs. However, only a small minority of service providers interviewed reported this, and when it did take place it was incidental use among a minority of their clients. Therefore the focus of this research is on the use of foil to consume heroin.

¹⁰ Including overdose (particularly when used alongside other substances); transmission of blood-borne viruses (if sharing a foil tube to inhale, which can risk cutting a lip); and risks related to smoking more generally (such as chest infections and aggravation of existing chest conditions).

potential increase in the use of heroin resulting from the greater availability of drug paraphernalia, although no evidence of this was found by the ACMD.

As the ACMD acknowledged, the overall assessment of foil was based on limited evidence; a small number of small-scale studies from the UK, alongside evidence emerging internationally (see Box 2).

Box 2: Key studies¹¹ on foil provision

UK studies

Pizzey and Hunt (2008) studied the provision of foil in four NSPs in South West England. They found that, out of 320 attendees, over half (54%) took foil when it became available. Needle exchange transactions increased by 33 per cent and 32 new clients (non-injectors) started attending NSPs to obtain foil. Among those who took foil, satisfaction with the quality and size of the foil packs was good and the availability of foil was viewed as a valuable extension to the NSPs' services.

Boid and Waldock (2008, cited in ACMD, 2010) introduced a trial scheme in Sheffield that provided foil at a site-based NSP and in a mobile van. These provided 423 and 304 packs of foil respectively. A total of 85 service users took foil, of which 72 per cent had injected in the last 4 weeks and 12 per cent had not used the service before. Those who used foil reported that their injecting had reduced as a result and a few had replaced injecting entirely with smoking.

Experiences from the Netherlands

From the mid-1980s onwards there was cultural shift in the Netherlands, with an entire cohort of drug users moving away from injecting (Kools, 2010). For example, the prevalence of injecting among drug users in Amsterdam declined from 66 per cent in 1986–88 to 36 per cent in 1997–98 (van Ameijden and Coutinho, 2001).

This change took place along with a number of developments, such as community outreach, peer support, opioid substitution therapy, and housing support, alongside the provision of foil to encourage 'route transition'. This makes it unlikely that foil alone was responsible for the cultural shift, although it does suggest the potential of 'route transition' interventions when delivered as part of packages of measures.

While there is an absence of evidence confirming that foil provision has a direct and measurable impact on health and recovery outcomes, the considered view of the ACMD and drug treatment practitioners indicates that the intervention shows much promise.

¹¹ There is wider existing research evidence on NSPs and their effectiveness; however, this is not covered here as it does not fall within the narrow scope of this research.

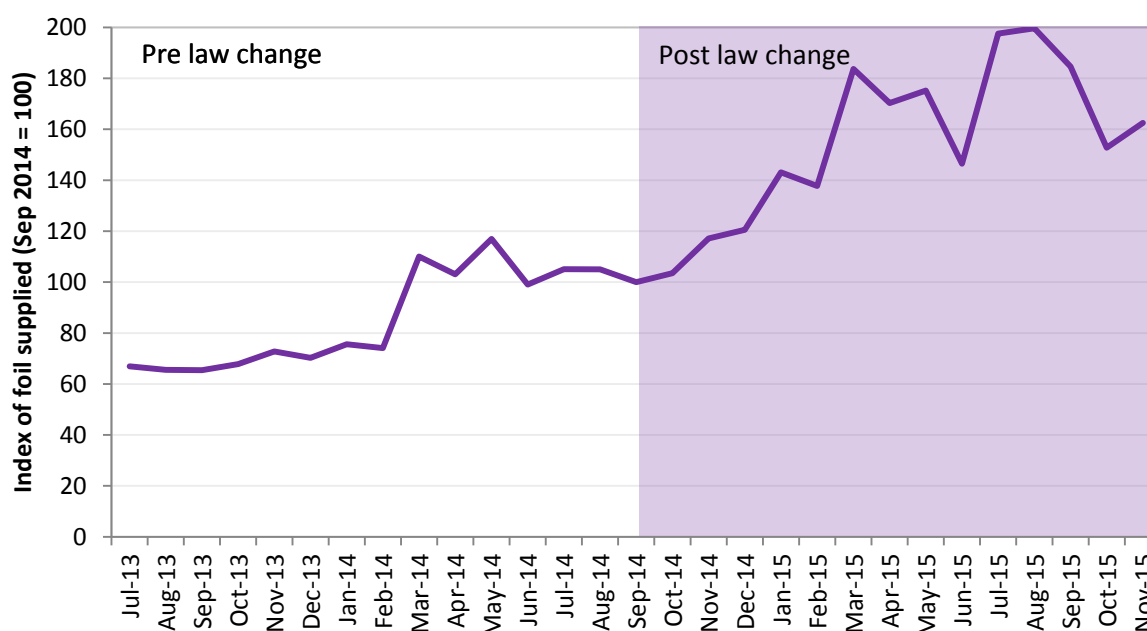
3. Monitoring the uptake of foil

This section addresses the first aim of the research: **To monitor the uptake of foil following the commencement of the new legislation.** It presents data on the volume of foil supplied across the UK, and draws on interviews with foil providers to assess the likely impacts of the law change.

Supplier data

Information on the volume of foil supplied¹² to needle and syringe programmes (NSPs) in the UK has been provided by industry.¹³ Data are available both pre and post commencement of the law change, which enables an assessment of change in the amount of foil supplied over this time. Figure 3.1 plots the sheets of foil supplied by industry from July 2013 through to November 2015, indexed to September 2014 (commencement of the law change).

Figure 3.1: Index of foil sheets supplied, July 2013 to November 2015, UK



The chart shows an increase in the supply of foil, which began ahead of the law change. This suggests a 'pre-implementation effect', with increased demand towards the end of the 2013/14 financial year,¹⁴ which was maintained through Q1 and Q2 2014/15. This might be attributed in part to NSPs beginning or increasing the provision of foil after the legislation had been laid (in July 2014) but ahead of its commencement.

Following the commencement of the law change, the upward trend in foil supply to needle

¹² As previously mentioned, these are sales data that have been used a proxy measure for distribution. However, it is uncertain how sales relate directly to the number of sheets supplied to users.

¹³ The majority of foil distributed by needle exchange services across the UK is likely to be captured here. Commercial confidence precludes further description of these data.

¹⁴ This is also likely to be in part due to NSPs 'stocking up' at the end of the financial year.

exchange services continued, and accelerated, with supply in the 12 months post law change (September 2014 to August 2015) increasing by 71 per cent on the 12 months preceding the law change.

Provider perspectives

As part of the interviews, foil providers were asked about the volume of foil they distributed. Their responses suggest that the increased supply of foil seen in the industry data can be explained by both new demand from NSPs, which began distribution only after the law change ('new providers'), and increased demand from those NSPs providing foil prior to its commencement ('old providers').

New providers of foil described how they stocked up on foil at the first opportunity.

"When it was announced it was going live, we got in touch with the commissioner and said, can we give foil out? and it was, 'Yes, go for it'. So we just ordered a shedload in from then, it was like, finally!"

North West, manager, new provider

The popularity of foil took some new providers by surprise.

"I do the ordering for the needle exchange and we were ordering 50 for a week, now I'm ordering over 100 for a week. It has been a massive success."

Scotland, key worker, new provider

However, other new providers offered a more tempered assessment.

"So we do distribute quite a lot, but it hasn't taken up as we expected really, I'd say from my point of view. We haven't had that kind of intake where people are running, rushing here for foil."

London, key worker, new provider

In addition to new demand from services beginning foil provision, old providers also reported an increase in the amount they distributed.

"We used to order I think 20 packs or 15 packs, and now I have ordered 300 and 500 packs. So it's flying off the shelves ..."

South East, key worker, old provider

Despite many of these providers having a long history of foil provision, the law change was seen to increase distribution by allowing NSPs to operate more transparently and offer a more consistent message across the piece.

“Yeah, definitely [the law change has had an effect]. Being able to order it for a start. You know, without raising too many questions.”

West Midlands, manager, old provider

“When the law changed it was helpful because NSPs can give a consistent message. It's encouraging because just as much as we are aware of it, other services that they may have gone to might say, ‘Oh, we don't give it out because it's not legal’, which then makes a mockery of the system.”

South East, manager, old provider

In addition, a further response to the law change by existing foil providers was the extension of provision from fixed sites to mobile and pharmacy-based NSP services.

“A lot of people avoid town because their use gets a lot worse as they can get both heroin and crack. We can now say you don't need to come just here for foil now, the pharmacies are going to be handing it out soon.”

Yorkshire and Humber, manager, old provider

Summary: The uptake of foil following the law change

The data show that the provision of foil increased prior to commencement of legislation to allow its lawful provision, and accelerated thereafter. NSPs attributed this to the law change in various ways. Firstly, the law change generated demand from new suppliers of foil who were unable to distribute foil prior to September 2014. Secondly, the legislation allowed existing providers to deliver a more consistent message, operate more transparently, and extend their provision.

4. Distributing foil

This section summarises the practical aspects of foil provision in needle and syringe programmes (NSPs), including how foil is introduced to users, how barriers to provision are overcome, and how a typical exchange takes place. In doing so, it begins to address part of the second aim of the research, exploring how foil is used to engage users.

Providing foil to service users

For clients new to needle exchange services, foil tended to be introduced as part of a broader conversation on reducing the risk of overdose and transmitting blood-borne viruses.

“Well, we tell them all the risks and the benefits, we have a little chat with them. What we try and do is encourage them to obviously use the foil to go on to smoking instead of injecting, which is less harmful ... It's just safer and cleaner.”

South East, staff, old provider

A common route of introduction was with reference to injecting site issues, with foil being particularly appealing to some of these clients.

“If they're presenting with really nasty injecting injuries or struggling to find a vein, it would be within the context of those conversations around, look, have you thought of returning to smoking?”

Wales, manager, old provider

However, while foil appealed to some groups of clients straight away, providers described how other clients could be initially reluctant to engage with the idea of switching from injecting to smoking. Providers were asked to describe the initial reaction of clients when the provision of foil for smoking was raised, and the ways in which potential barriers to provision could be overcome. These are summarised in Table 4.1.

Table 4.1: Foil provision, barriers to take-up and potential solutions

Barriers	Potential solution
<p>Changing behaviour, particularly among entrenched, long-term injecting users</p>	<p>Regularly reminding these clients of the option to smoke was seen as very important.</p> <p><i>"[I'll say] You're okay, fair enough. But, so you're aware, we've always got foil; you can get it whenever, it's free. We supply it because it's slightly different than it is on the road, without the coating and everything. You know, if you get to a point where you are struggling and you can't get vein, this could be the one thing that helps you, so just bear in mind that we've got it."</i></p> <p>Yorkshire and Humber, manager, old provider</p>
<p>Concerns among clients that smoking does not offer the same 'hit' as injection</p>	<p>One response to this was to provide perspectives from clients who have tried smoking.</p> <p><i>"They're used to that intensity when they're injecting. We've had to dispel a couple of myths when people say it doesn't last as long. Whereas then we've had other people saying actually, it might take a bit longer to get into my system but I feel it holds me longer. So we can use those anecdotal bits of evidence that people have said to us."</i></p> <p>North West, manager, new provider</p>
<p>Perception that smoking is less cost-effective than injecting</p>	<p>Providers would challenge this perception.</p> <p><i>"I say well how big is your habit? They say '£40'. I'll say to them well, believe you me you can smoke £40 worth of heroin and it will hold you, it will do the exact same thing. It's the same quantity, it's still going into your bloodstream, you're just drip feeding it into your bloodstream rather than whacking it all in there at once."</i></p> <p>South East, staff, old provider</p> <p>In addition, practical demonstrations (using a substitute such as sugar) were seen as beneficial to those clients wary of the potential waste.</p> <p><i>"We get to go over smoking technique with them and make sure they're doing it as efficiently as possible."</i></p> <p>Scotland, manager, old provider</p> <p><i>"We'll quite happily sit down and show them how it's done, because if someone tried it once and loses all their gear they're not going to ... So we like to make sure people get it right first time."</i></p> <p>North West, manager, new provider</p>
<p>Low purity heroin can be hard to smoke</p>	<p>Providers would raise concerns about the safety of injecting adulterated heroin, and suggest attempting to smoke when higher purity heroin was available.</p> <p><i>"We've said to people if it frazzles, there's a lot of stuff in there that shouldn't be, so think then, do you really want to be cooking this up and putting it in [with] a pin?"</i></p> <p>South East, staff, old provider</p> <p><i>"If the gear doesn't run it is hard to get around that because if someone puts it on the foil it just burns out straightaway and they're left still in withdrawal. It's going to put them right off. It's just about if you get gear that runs, give it a try."</i></p> <p>Yorkshire and Humber, staff, old provider</p>

Typical exchanges

Foil designed with the specific purpose of smoking heroin is generally available in packs of 20 or 50 sheets. For NSPs that stocked packs of 20 and 50 sheets, the larger packs were provided to those clients who were regular smokers (to reduce risk of transition to injection and encourage contact with the service), while the smaller packs were provided to current injectors (as an encouragement to reverse transition). However, cost was an important consideration across many NSPs, with some services distributing only the smaller packs, and others splitting the larger packs to benefit from (albeit marginal) economies of scale.

The volume of foil supplied in each NSP differed according to the needs of the individual client, with frequency of use and frequency of service access (particularly for clients based in rural areas) being important factors. However, despite the volume of foil provided, workers stressed the importance of distributing amounts that ensured future engagement.

“Ideally we'd like to see someone every other day. So we wouldn't want to just give them a 50 pack out and then see them in a month. We do try to give them enough, but knowing that it's going to fit in with their routine of when they're going to be back into the town.”

North East, manager, old provider

“It depends how many we've got in stock and where they've come from ... if they say, 'I've come all the way from [location] on my bike' I might give them extra. If I know they're only from round the corner then ... but also depending on how they're engaging on the day. I ask them as well, how many sheets are you going to need before you can come back and get some more? So there is a few varying factors.”

North West, manager, new provider

In addition, some workers described how they would provide a small amount of foil to users who didn't necessarily request it, on the premise that simply having the foil may encourage safer practice and reverse transition.

“If you've hesitated [when offered foil], I'll put in a couple of sheets in there [with other equipment] and if you go back home and you have a little change of mind, at least you know it's there.”

South East, manager, old provider

Secondary distribution

The NSP staff would, in most circumstances, allow peer-to-peer distribution of foil (also known as secondary distribution).¹⁵

“Yes ... obviously the culture amongst service users is sometimes you get a lot of use in groups.”

South East, staff, old provider

¹⁵ Secondary distribution is recommended by the National Institute for Health and Care Excellence (NICE) for other paraphernalia supplied by NSPs (NICE, 2014). It is recognised that it may not be possible to prevent secondary distribution of foil taking place even if it were against the wishes of NSP staff.

There were examples whereby secondary distribution was used to ‘spread the word’ to ensure that foil was now available to those users who might benefit.

“One of the things that we really stressed when training was that one of our initial objectives was to just introduce foil locally, for people to get to know it was available.”

Yorkshire and Humber, manager, new provider

For those NSPs that allowed secondary distribution, this was done as a preliminary step towards engaging the end user, widening reach and access to those not yet in contact with needle exchange services.

“Although we don’t mind secondary pick up, we would prefer if we could see the person. It would be much better. So we do it once, and say next time, why don’t you get your friend to come with you or to come instead on their own? So it’s about always encouraging contact.”

West Midlands, manager, old provider

The implications of NSPs’ experiences of secondary distribution on the conditions attached to foil provision are explored in section 6.

Summary: Foil provision in practice

The fieldwork suggests that foil providers initially offered foil to their clients as part of a broader conversation on reducing the risk of overdose and the transmission of blood-borne viruses. Foil was commonly offered with reference to injecting site issues, and NSP staff members were able to advise clients on how to use foil safely and efficiently. Foil was largely distributed in packs of 20 or 50, but also in smaller amounts where providers consider it beneficial. To broaden the reach of NSP services, and to engage with clients who may be hard-to-reach, providers generally allowed secondary distribution of foil with a view to engaging with those clients further down the line.

5. Foil as an intervention

This section summarises views on the benefits of foil provision, and how these apply to a range of needle exchange clients. In doing so it addresses the second aim of the research, exploring how the provision of foil can benefit a user's journey towards recovery.

The benefits of foil provision

Those interviewed were keen to express the benefits of foil provision.¹⁶ The potential for foil to reduce the risk of overdose was a recurrent theme, so too the reduced risk of transmitting blood-borne viruses. A less common, though repeated, theme related to a reduction in drug-related litter.

"It's safer, we're reducing overdoses with people, we're reducing blood virus risks for people. It just really makes a difference. The drug-related paraphernalia and litter in the area – there's a massive reduction in that so there's less risk to the community, but for the individual it's reducing that overdose risk."

South West, manager, old provider

Those who began to distribute foil after the law change also observed that it had improved the reach of their services, allowing them to engage with those users who were not currently injecting.

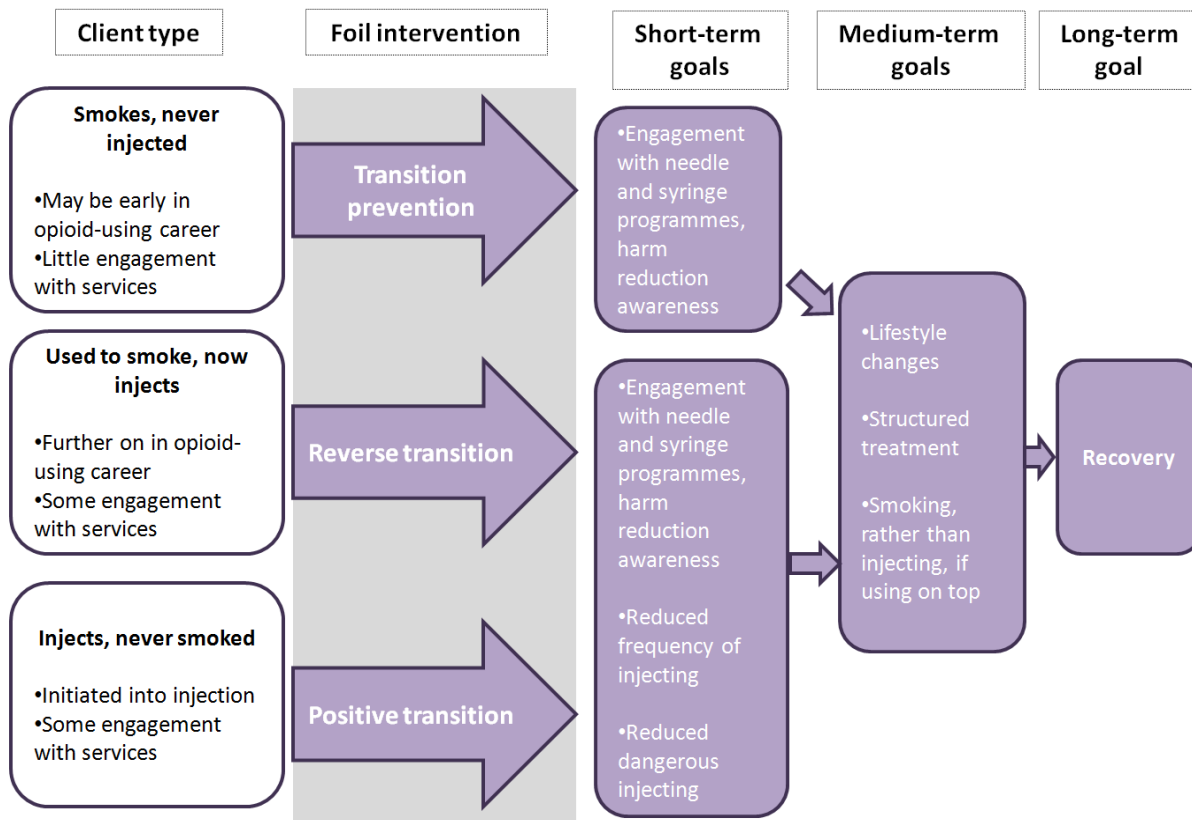
"Some of the people we're seeing are only smoking heroin, so we would never have seen them otherwise."

North West, manager, new provider

While the majority of those interviewed identified themselves as 'harm reduction first', and often had 'harm reduction' in their job title (prefixing, for example, 'worker', 'lead' or 'co-ordinator'), foil was routinely seen as having benefits beyond preventing overdose and the transmission of blood-borne viruses. Foil was commonly described as a tool that can facilitate further behaviour change, opening the door to treatment options and recovery. The short- and medium-term goals shown in Figure 5.1 represent the key themes described by the needle exchange workers. This is offered as a model of how foil can contribute to a recovery journey, though it is acknowledged that this will not reflect the diversity of all clients receiving foil.

¹⁶ As only those who were providing foil were interviewed, they may be more positive about the benefits of foil provision.

Figure 5.1: Client profile, transition routes and intended outcomes ('goals')



Short-term goals

a) Service engagement and treatment awareness

For those clients who had only ever smoked heroin, foil was provided to prevent transition to injecting. In doing so, foil provision led to increased engagement with drug treatment and wider health services.

“Yeah, we have quite a few people that we've assessed for foil only, that's all they ever used, but that's good because then we get an opportunity to talk to them about all the other services that we have, which is a big part of what needle exchange does. It's a gateway.”

South West, staff, old provider

Workers also associated foil provision with further, preventative and upstream benefits for those in this client group.

“Foil can cover the people who are perhaps maybe not be physically, psychologically dependent ... though if it does go pear-shaped and they find it problematic, they at least know where to go.”

South East, manager, old provider

b) Reduced injecting and related harms

The interviewees explained how most injecting drug users would have smoked heroin before transitioning to injecting. Providing foil to these clients was therefore intended to encourage reverse transition – switching back to smoking – as an initial step toward long-term, treatment

and recovery orientated outcomes. The 'used to smoke' client group were generally described as older, more entrenched, potentially injecting in the most dangerous areas and exhibiting problems with injection sites. In addition, many would have been in treatment previously, or were currently in treatment and using heroin 'on top' of opioid substitution therapy. A common early objective of foil providers was to reduce the frequency of injection occasions for these clients.

"If they replace one injection ... the number of circulation problems that I see, the number of people who can barely find a vein, the damage they've done through injecting, infection, abscesses and worse, deaths."

South East, pharmacy staff, new provider

"We don't necessarily say that you need to give up injection [instantly]. We'll say, look, your veins are bad, you've got balloons; why don't you try and smoke some of the time?"

Scotland, staff, new provider

Current injectors who had never smoked were described as rare; however, the workers reported that foil would be used to encourage positive transition (i.e. smoking for the first time).

c) Reduced dangerous injecting

The provision of foil was also seen as beneficial in reducing dangerous injecting behaviour, such as when in withdrawal.

"If someone's rattling and they're trying to get themselves with a needle, they're all over the place. So, using the foil first, just cooking it, burning a little bit off just takes the edge off, so they're able to, sort of, inject more safely and minimise the risk."

South East, pharmacy staff, new provider

For those with injecting site issues, foil provision was described as beneficial in preventing injection into the femoral vein. Injection into the femoral vein is linked with increased risk of complications such as deep vein thrombosis, leg ulcers and vascular insufficiency. In addition, the femoral vein's close proximity to the femoral artery and nerve increases the risk of injury to these sites (Maliphant and Scott, 2005).

"A lot of our clients are at the end stages of their addiction ... so the veins are exhausted as such so they've collapsed. A lot of all of them are reverting to either other people injecting them, to try and find a route into their system, or they're neck injecting, groin injecting, the infection is in the groin, so stuff like that. [Foil provision can] minimise the impact it has physically on them."

North West, staff, new provider.

In addition, foil provision was seen as particularly beneficial for those clients in receipt of opioid substitution therapy, with smoking considered a much safer alternative to injecting.

“If people are using on top of their script, smoking is going to reduce the risk of overdose. If they’re mixing methadone with heroin, they’ll tend to be using something else as well. Probably another downer or something like that; a benzo. You are looking at a major, major problem. So smoking is always going to be a safer option than injecting.”

South West, manager, old provider

Medium-term goals

a) Lifestyle changes

According to the workers, switching from injecting to smoking helped clients to manage often extremely chaotic lifestyles.

“I can think of one in particular in the needle exchange who was a really chaotic injector, really, really, really chaotic ... they [his children] gave him an ultimatum, you know, ‘We don’t want anything to do with you unless you sort this out’. He immediately switched to foil because that option was there and just the transformation, because a lot of the other behaviours seemed to disappear as well.”

South West, staff, old provider

Some workers suggested that a move to a more stable lifestyle allowed room for wider reflection on their drug use, following an initial switch from needle to foil.

“If someone was quite chronically injecting and then they moved to smoking, they may then start to question, in the absence of the chaos and that, they might then start to consider ‘Well there are other changes I might like to make. Maybe I want to get to college, I feel a bit more stable, there’s not so much ups and downs in my day’ ... It’s kind of taking people back to a less risky place and a more controlled place where they can control their drug use a bit more.”

Yorkshire and Humber, manager, old provider

Other workers suggested that age was an important factor in the appeal of foil and the long-term benefits that its provision was intended to achieve.

“A lot of our clients are at an age where they want to make lifestyle changes, so offering foil as an alternative route is very appealing to them, and also the routes of coming into treatment is appealing to them. I think they’re more likely to engage and want to make changes in their lifestyle because they’re tired of what they’ve been doing for the last 30 years.”

North West, staff, new provider

b) Structured treatment

For clients who were quite far on in their opioid-using career, there was some suggestion that introducing foil ahead of referral to treatment services was effective where alternative routes to recovery had been less successful.

“Foil goes alongside a conversation about, you really need to start considering what you are going to do in the future, especially if you decide you don’t like smoking. So it’s that sort of last chance saloon for a lot of people like that. The next step is going onto a script. It works really well for encouraging people to get onto a script, that’s what we try and use it for. It’s that gateway to recovery.”

Yorkshire and Humber, staff, old provider

The more general consensus, across all client types, was that foil is an important tool that can encourage referral to and engagement with treatment services. There was variation in how this applied to different types of client, with an emphasis on individual needs.

“Quite a few people coming into treatment have actually gone from IV [intravenous] use to, reluctantly, somewhat at the start, to start smoking – then they’ve had to come into treatment. So it is a path that works and there is not set discussion you can have as everyone is different. Some people want to talk about it; some people just don’t. It can take months; it can take weeks, months, to get people to interact in a way that’s going to benefit them. It’s as simple as that.”

South West, manager, old provider

c) Smoking, rather than injecting, if using ‘on top’

It should be stressed that a large proportion of users of needle exchange services will be in receipt of opioid substitution therapy,¹⁷ or will have been previously. For example, statistics from the National Drug Treatment Monitoring System Treatment outcomes profiles 2014/15, issued by Public Health England (PHE, 2015), show that 41 per cent of clients presenting for opiate use achieved abstinence by the six-month review, while a further 25 per cent substantially decreased the number of days they used opiates. A small proportion (4%) deteriorated in their opiate use, and the remaining 30 per cent did not change reliably. With this in mind, workers stressed that for those who continue to use heroin while on opioid substitution treatment, a shift from injecting to using foil can be a significant outcome in itself.

“It still works. If one has to [use heroin], smoke rather than inject, it’s a better choice really and it doesn’t bring that person back down to day one. They actually can say, ‘I’m going to have a smoke but at least I’m not injecting again’. So it actually helps somebody to maintain that level of progress at least.”

South East, manager, old provider

Long-term goal (recovery)

While those interviewed retained a focus on long-term goals (considering needle exchange services to be ‘the gateway to recovery’), they were unlikely to see recovery in their day-to-day role by virtue of the services they provide.

¹⁷ Opioid substitution therapy is an umbrella term that includes both methadone and buprenorphine (under brand names of Subutex and Suboxone).

“As people transition away from the needle exchange, we ... we don't see them. I mean you might see them years and years later if they have a relapse or something like that, but often I can't lie. A good outcome for us is that I don't have to see them again, hopefully they've gone onto treatment and recovery.”

North West, manager, old provider

However, some of those interviewed were able to provide recovery stories from their wider experience and from particular relationships they had built with clients.

“Yes, a prolific injector for 10 or 15 years ... one of those people we used to provide injecting equipment to and she was one of the first people to get foil. When foil became available she didn't want any and that went on for some time. Gradually she did and a year later, she only ever took foil. She went into detox not long after that. She didn't go to rehab; she did a detox and she moved away. She still comes back to see us and she's got access to her child and a new partner who doesn't use and they're doing well. She sticks in my mind, really. I think some of the stories are still being written.”

Wales, staff, old provider

Disbenefits of foil provision

Providers of foil were asked whether they had experienced any downsides to foil provision, and whether there were any occasions when providing foil might not help a user's journey towards recovery. However, foil provision was considered entirely beneficial when delivered by experienced providers. Potential downsides or unintended consequences were largely theoretical, and centred on wider debates around needle and syringe programmes and public perceptions.

“To be honest, no, I can't. I think the only downside with any of the paraphernalia we offer is the image that maybe people who don't understand working in the drugs field have. They can just about get their heads round needles.”

Wales, staff, old provider

However, some argued that a long-term view should be taken when considering benefits.

“If people are looking for really big, short-term gains, I think they're going to be disappointed because the gains are going to be coming gradually. But over a long period of time, if we're able to sustain it in this country I think the big gains will come, I'm sure of that.”

Yorkshire and Humber, manager, new provider

Summary: Foil as an intervention

This research shows that foil providers supported the Advisory Council on the Misuse of Drug's (ACMD) assessment that foil is beneficial for reducing harm, as well as improving treatment and recovery outcomes. Providers who began foil distribution after the law change confirmed that

provision had broadened the reach of the services, and once users were engaged, foil continued to assist clients in achieving short- to medium- and long-term goals. These included awareness of ways to reduce the harm from drug use, reduced injecting occasions and reduced dangerous injecting. Upstream benefits included less chaotic lifestyles, contemplation of treatment and engagement with treatment services. For those in treatment, foil provision was considered beneficial both in reducing overdose risk and maintaining progress toward recovery.

6. Complying with conditions

This section addresses the second aim of the research by considering adherence to the conditions attached to foil provision. It first describes who provided foil, considering the implications of pharmacy-based provision and peer-to-peer distribution. It then explains how providers used foil to engage people in a drug treatment plan, and/or as part of a drug treatment plan.

Who provides foil: “A person engaged in the lawful provision of drug treatment services”

The Misuse of Drugs Regulations 2001 allows practitioners, pharmacists and persons employed or engaged in the lawful provision of drug treatment services to supply swabs, spoons and cups (for drug preparation), citric acid, filters and water for injection. The provision for foil is more restrictive as it may only be supplied by “a person employed or engaged in the lawful provision of drug treatment services”. Public Health England (PHE) guidance¹⁸ to practitioners on the provision of foil confirms that those working in needle exchanges, including in pharmacies, are providing drug treatment (PHE, 2014). Those interviewed were employed across 19 needle and syringe programme (NSPs) sites in England, Wales and Scotland, and were predominantly based in fixed site specialist services (see Annex A).¹⁹ Most reported that foil was currently not available at local pharmacy needle exchanges and only available from their specialist fixed sites.

Only a small handful of sites distributed foil from pharmacy-based needle exchanges, although some were considering rolling out foil provision to appropriate pharmacy sites. Pharmacy provision of foil was restricted to those sites with established needle exchange services (often attached to the main pharmacy via a separate entrance for service users), where the staff members were best placed to support users and comply with the latter conditions.

“They [the pharmacy needle exchanges providing foil] tend to be the ones that will dispense suboxone and methadone, so they’re more used to our client group. Those types of pharmacies are much better at signposting and asking all the right questions and eliciting a response from service users.”

Yorkshire and Humber, manager, new provider

Providers described how the typical exchange would take place in this type of pharmacy. There appeared to be little difference in the approaches used when compared with fixed site specialist services, although this is based on interviews with only a small number of pharmacy staff.

¹⁸ This guidance issued by Public Health England also applies to both Wales and Scotland.

¹⁹ Those interviewed in fixed site NSPs often had a holistic understanding of needle exchange provision in their areas (and were often responsible for co-ordination of this), therefore findings on pharmacy-based foil provision is based on interviews with pharmacy staff and fixed site NSP staff.

“We use it [foil] as a prompt to give them further advice and to take any literature that we’ve got and signpost them towards the services that we think they need. We’re trying to get them to engage with the person who is prescribing if they’re in treatment, or we’re using it as a tool to push them into treatment if they’re not.”

South East, pharmacy staff, new provider

As described at section 4, most of those interviewed co-ordinated, managed or worked in NSPs that would allow secondary (peer-to-peer) distribution. In line with PHE guidance (PHE, 2015), this was often to provide foil to users already engaged with services.

“They have a little smoking cohort in [location], one day one will come up and then the next day someone else will come up and then they might come together or you might get three of them come in.”

North West, manager, new provider

However, most services also allowed secondary distribution to users not currently engaged with their service. In doing so, they applied a range of self-imposed, locally defined rules to ensure that secondary distribution was with a view to engagement into a treatment plan.

“I do have a problem in some cases with secondary distribution because I want to see the whites of their eyes. I want to talk to them. [I ask] can you tell me about the people who you are giving it to? Why don't they come in? Are they in treatment? ... I push for them to come in next time and say, yes, not a problem okay, I can give you some that you can distribute to your friends, but bring them in, let me see them, let me meet them. Let me have a chat with them first.”

North East, manager, old provider

“The only way we do it is by saying, we'll do it this once or maybe even twice. So, you're kind of building a relationship with them even though they're not there because the person that's taking it says, ‘You know, they didn't want to do it really but they've done it for you this time’. Then you can say, they really need to come in and register now.”

South West, manager, old provider

Providers therefore allowed secondary distribution as part of wider efforts to engage hard-to-reach individuals, as a preliminary step toward engagement with recovery-orientated treatment. In doing so, providers adhered to the condition to provide foil as part of structured steps *“to engage a person in a drug treatment plan”*.

Structured steps *“to engage a person in a drug treatment plan”*

Staff emphasised that NSP services were the ‘gateway to recovery’, with the interventions they delivered beginning a journey toward treatment and recovery outcomes. This applied to interventions with an initial focus on reducing the harm from illicit drug use, such as the provision of safe injecting equipment and foil. However, workers were keen to stress that this journey was often a long process, and that immediately raising treatment options with clients could be counter-productive.

“We don’t want to be dead pushy in the needle exchange so they don’t want to come back. They’ll be like ‘Oh bloody hell, I’m not going there again!’”

North West, manager, new provider

Rather, the initial focus was on keeping the client engaged with the service, and developing relationships.

“Part of my job is to know the client, know a little bit more about them. I’d hate to be stony faced, there you go, there’s your foil, bye-bye. That’s not what I do. Every time that person comes in I will have a conversation with them or find out what’s happening with them, has anything changed. If people are in a rush we still touch on it a little bit, how is everything going? What’s happening with you? ... I’ll try and use all the classic open questions and elicit a bit of conversation from them. We tell the client when they’re looking well and we tell them when they’re looking rough. All of these things just bring down barriers; make them more comfortable to speak to us.”

North East, manager, old provider

In turn, this could create an environment where achievements can be built upon; making the prospect of treatment less likely to be met with resistance.

“We use it [foil] to build a relationship with people and to help them trust us. It is a journey; very much moving them along a journey. So now you’ve managed to do this; you didn’t think you’d get that far. You didn’t think you’d be able to give up injecting. You wouldn’t think you’d be able to cut down your injecting but you did. So what do you think the next step would be? Do you think coming into treatment would help?”

Scotland, manager, new provider

With specific regard to complying with conditions, although a minority of interviewees were not aware of the specific conditions, there was a general perception that engaging clients into recovery is very much a ‘part of the job’ regardless of legislation. This view was routinely expressed by those providing foil ahead of the law change, as well as those who began foil provision only after the law change.

“If you’re running a needle exchange and you’re not trying to encourage people in to treatment in any way, then you shouldn’t really be running a needle exchange.”

Yorkshire and Humber, manager, new provider

“I see the harm reduction service as the front door for treatment services. We see a lot of people who are not known by treatment, treatment naïve, and it’s my job to try and bring those people into treatment.”

North East, staff, old provider

“Even though we’re harm reduction at the forefront, providing foil is harm reduction, but also in your mind is all about people going through recovery isn’t it? That’s the first step. My team are harm reduction workers but we never kind of lose sight of getting people [into treatment] ... it’s about moving people through.”

South West, staff, old provider

The consistency of opinion across the sample interviewed suggests that this condition was being complied with; those providing foil were doing so with a plan to engage their clients into recovery-orientated treatment. Although it was acknowledged that due to differences between clients, this may happen sooner for some clients than others.

Structured steps “which form part of a patient’s treatment plan”

A large proportion of NSP service users might already be engaged with treatment services or might have had some engagement with treatment services historically. As discussed in section 5, some people in receipt of opioid substitution therapy may continue occasional use of street heroin.

Some clients who are engaged with structured treatment services may continue to use illicit drugs alongside their prescription opioid substitution therapy. These clients will use NSPs in much the same way as those who are not engaged in treatment, with NSPs continuing to provide safer injecting equipment, and foil, to both types of client. It is important to note that NSPs will intentionally not share some information with structured treatment services, in order to preserve the confidentiality of their service users and avoid disincentives for users to visit.

“I wouldn’t want anyone to feel as though they couldn’t come here because they were at a different stage in their treatment, reporting to treatment providers that they’re doing really well and then felt, ‘Oh I can’t go to the needle exchange and I’m going to have to scattle around and find some spare needles’, or whatever. And foil would apply to that, yes.”

North West, manager, old provider

As discussed previously, the majority of those interviewed worked in NSPs, and as such did not prescribe opioid substitution therapy. However, those who both prescribed opioid substitution therapy and provided needle exchange services offered some insight into how foil would form part of a treatment plan.

“Foil is more towards recovery, so you can, for example, take a step down from injecting to [smoking]. Our clients, it’s about assessing them on a weekly basis or monitoring them and giving them the right dose until it helps them to stop use completely.”

London, staff, new provider

There was an understanding amongst those working in NSPs that smoking heroin, in addition to reducing the risk of overdose amongst those prescribed treatment, could be seen as progress for some clients (see also section 5, Figure 5.1).

“I’ll tell them to let their key worker know they’re using foil because it can be seen as a positive thing in terms of their journey to recovery, especially if their key worker knows that previously they were injecting. It’s a step in the right direction ...”

South East, pharmacy staff, new provider

Summary: Complying with the conditions

The fieldwork suggests that treatment professionals providing foil were predominantly based in fixed site specialist needle exchanges, with a minority based in pharmacy needle exchanges, confirming that those providing foil were engaged in drug treatment services. In order to comply

with latter conditions, staff who permitted peer-to-peer distribution of foil did so as a preliminary step to engage the end user with both needle exchanges and wider treatment services.

A commonly held view amongst participants was that engaging clients into recovery-orientated treatment was very much 'part of the job' regardless of the conditions attached to foil provision. Providers met the conditions by building relationships with their clients, reminding them of treatment options and intervening at the right time. Clients already in treatment were encouraged to have honest relationships with their prescribers, who in turn considered smoking heroin (as opposed to injecting) as progress towards recovery.

7. Conclusions

This report has presented findings from research that explores how the legislation to allow the lawful supply of foil to heroin users has been implemented, and its likely impacts on the volume of foil distributed across the UK.

This research found that the volume of foil distributed increased prior to commencement of legislation, and accelerated thereafter. Needle exchange professionals welcomed the law change, and considered foil provision as beneficial to treatment and recovery outcomes. The conditions attached to the lawful provision of foil are generally adhered to by providers, who consider their services to be an important first step towards a client's recovery.

Commissioners and providers of needle and syringe programmes that do not currently provide foil should consider the findings of this report in deciding whether it is appropriate to do so in the future. Similarly, the National Institute for Health and Care Excellence may also want to consider these findings when it next reviews its guidelines on needle and syringe programmes.

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Annex A: Further information on the interview sample

Participants were based across 19 needle and syringe programmes (NSPs) in England, Wales and Scotland. Most areas of England were covered, with the exception of the East of England and East Midlands regions. The researchers carried out 2 interviews with staff from 11 of these NSPs, while single interviews were undertaken with staff in the remaining 8 (30 interviews in total). While every effort was made to capture a range of experiences, the sample was not intended to be fully representative of all foil providers.

Two-thirds of the participants were based in NSPs that had been distributing foil ahead of the law change, with the remaining third based in NSPs that began distribution only after the new legislation commenced (Table A1). While the precise national make-up of NSPs and the services they provide is unknown, it is estimated that this split is broadly reflective of NSPs providing foil at the time that the fieldwork was undertaken (October and November 2015). This estimate is also supported by internal analysis on NSPs undertaken by Public Health England (PHE).

Table A1: Participant information, by area and when foil distribution began

Area	When foil distribution began	
	Post law change	Pre law change
London	2	-
North East	-	2
North West	3	1
Wales	-	2
Scotland	2	1
South East	1	8
South West	-	3
West Midlands	-	1
Yorkshire and Humber	2	2
Grand total	10	20

The sample contained a mix of professionals from predominantly fixed site NSPs, many of which provided a range of further needle exchange services, including in mobile sites, hostels

and pharmacies.²⁰ These NSPs were based in a mix of urban, sub-urban and rural areas. The interviewees held a variety of roles, including those who co-ordinated and managed NSP services ('managerial') and those manning needle exchanges or working with a caseload of clients ('staff'). The majority of those in managerial roles still worked with clients day-to-day, or otherwise had experience of doing so (Table A2).

Table A2: Participant information, by region and staff role

Region	Staff role	
	Managerial	Staff
London	-	2
North East	1	1
North West	3	1
Wales	-	2
Scotland	2	1
South East	3	6
South West	2	1
West Midlands	1	-
Yorkshire and Humber	3	1
Grand total	15	15

²⁰ The sample contained two pharmacy co-ordinators, a pharmacist and a small number of staff based in fixed site NSPs who provided training in needle exchange (including foil provision) to their pharmacist colleagues.

Annex B: Topics guide used in semi-structured interviews

1. Opening questions

- Before we go into detail, would you be able to start off by telling me a little about the service you work in, and your day-to-day role?
 - Do you work with clients directly?

2. Foil and your service

- Do you know when your service started giving out foil?

****If pre legislation (i.e. prior to September 2014), remember to ask later questions about changes in practice following law change****

- Do you provide any additional information or advice alongside foil?
 - Information/advice about risks such as chest infection?
 - Information/advice on how to use foil?
 - What form does the advice take?

Prompt: leaflets, demonstrations, etc.

- How many packs of foil would you typically provide a client?
- Are the pharmacies in your area giving out foil?
- Is foil ever provided through vending machines, or distributed from one user to another?
 - Could you tell me a little about how this works in practice?

3. Your experience of foil

- What do you think are the benefits of providing foil?
- What type of clients do you give foil to – what situation might they be in?

Prompts: Periods of restricted venous access, when moved to dangerous deep vein or femoral injecting, on release from custody, following detox, amongst the newly initiated.

- If foil is given to those who are not in treatment, is this used to engage them into treatment?

Prompt: Is it used to engage users? To build relationships?

- If foil is given to those who are currently in treatment, what part does this play in their treatment plan?

- As you know the new legislation allows services to provide foil as long as this is done as part of an effort to engage these clients into recovery-orientated treatment. Has your service been able to adhere to this requirement?
 - How do you do so?
 - Are there any circumstances where it has been more difficult to fulfil the requirement?
- Can you think of any specific clients where foil has helped their treatment journey? Or any clients where it hasn't?

4. Barriers and difficulties

- And are there any downsides to providing foil?
- Do you come across any barriers getting users to transition from injecting to smoking?
 - What are they?
 - Do any clients refuse foil?
 - How are these barriers overcome?

5. Law change

****This section only applies to those working in services that did not provide foil before the law change****

- You said previously that your service only began distributing foil after the change in the law. Some other services provided foil before the law changes, were there any specific reasons your service didn't?
- How did the change to the law affect your decision to give out foil?

****This section only applies to those working in services that provided foil pre and post law change****

- I recall you telling me that your service(s) began distributing foil in [CONFIRM DATE]. Were any practical changes made to how you provide foil following the change in the law?
- To the best of your knowledge, is your service(s) providing foil to a larger or smaller proportion of your clients since September 2014?

End

That's all the questions I'd like to ask. Before we finish, is there anything else you'd like to mention?

Thank you for your time.

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