Title: Impact assessment of regulatory changes to enable the lawful provision of foil by drug services providers **IA No:** **Lead department or agency:** Home Office **Other departments or agencies:** Department of Health	**Impact Assessment (IA)** **Date: 16 July 2014** **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries:** Des Niimoi (020 7035 3533) Desmond.niimoi@homeoffice.gsi.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
Unknown	N/A	N/A	No	N/A

What is the problem under consideration? Why is government intervention necessary?

The provision or supply of aluminium foil, for the purposes of inhaling controlled drugs, by drug services providers is currently illegal under UK law. The Advisory Council on the Misuse of Drugs has advised that the lawful provision of foil to drug misusers to move them away from injecting would lead to health benefits and a reduction in the spread of blood borne diseases through injecting. Providing foil with conditionality on service users being in treatment could encourage more drug misusers into treatment.

Government intervention is necessary to implement legislative changes to enable the lawful provision of foil.

What are the policy objectives and the intended effects?

The policy objectives are to:

- Encourage users to take their first steps into treatment, reducing the immediate harm and facilitating the journey towards recovery and abstinence
- Tackle the significant health risks associated with injecting behaviours, including the transmission of blood borne viruses.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Do nothing.
Option 2: Enable the lawful provision of foil by drug services providers without conditions.
Option 3: Enable the lawful provision of foil by drug services providers, but with strict conditionality.

Option 3 is the preferred option as enabling the lawful provision of foil with strict conditionality supports the aims of the Government's Drug Strategy; to support people to choose recovery as an achievable way out of dependency and to live a drug free life. Option 3 could achieve this by encouraging more drug users into treatment.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** N/A

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Norman Baker Date: 4th August 2014

Summary: Analysis & Evidence — Policy Option 2

Description: Enable the lawful provision of foil by drug services providers without conditions.

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: 0.49	**High: 1.98**	**Best Estimate: 1.23**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0.01m	1	0	**0**
High	0.01m		0	**0**
Best Estimate	0.01m		0	**0**

Description and scale of key monetised costs by 'main affected groups'

There is expected to be a transitional cost associated with training needle exchange workers to show drug users how to use foil. This is estimated to be around £7,900.

Other key non-monetised costs by 'main affected groups'

No key non-monetised costs have been identified.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		0.06m	**0.49**
High	0		0.23m	**1.98**
Best Estimate	0		0.14m	**1.23**

Description and scale of key monetised benefits by 'main affected groups'

Key monetised benefits comprise the reduced cost to drug services providers of providing foil to drug users compared to providing needles and syringes. Each individual who previously received needles but takes up the use of foil will result in a saving of £12 per year of use.

Other key non-monetised benefits by 'main affected groups'

Key non-monetised benefits include benefits to drug users from a reduced risk of disease.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5%

A key risk is that that enabling the lawful supply of foil could lead to people taking up the use of drugs through this medium. There is a risk that those who are not needle exchange clients could take up foil, thereby imposing additional costs on drug services providers.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 0	**Benefits: 0**	**Net: 0**	No	N/A

Summary: Analysis & Evidence

Policy Option 3

Description: Enable the lawful provision of foil by drug services providers, but with strict conditionality.

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	Price Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Unknown	High: Unknown	Best Estimate: Unknown

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0.04m	1	Unknown	**Unknown**
High	0.04m		Unknown	**Unknown**
Best Estimate	0.04m		Unknown	**Unknown**

Description and scale of key monetised costs by 'main affected groups'

There is expected to be a transitional cost associated with training needle exchange workers to show drug users how to use foil and to enrol drug users into treatment programmes. This is estimated to be around £39,400.

Other key non-monetised costs by 'main affected groups'

No key non-monetised costs have been identified.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		Unknown	**Unknown**
High	0		Unknown	**Unknown**
Best Estimate	0		Unknown	**Unknown**

Description and scale of key monetised benefits by 'main affected groups'

Key monetised benefits comprise the reduced cost to drug services providers of providing foil to drug users compared to providing needles and syringes. Each individual who previously received needles but takes up the use of foil will result in a saving of £12 per year of use. The scale of this saving is expected to be lower than under option 2 due to the conditional nature of the foil provision. Furthermore, a net benefit of £6,500 is expected to result from any individual successfully encouraged to enter drug treatment.

Other key non-monetised benefits by 'main affected groups'

Key non-monetised benefits include benefits to drug users from a reduced risk of disease and from entering into treatment, and the resulting benefits to society from reduced drug use.

Key assumptions/sensitivities/risks | **Discount rate (%)** | 3.5%

Key assumptions are that conditional provision of foil will not result in more people using drugs and will encourage more drug users to enter treatment.

A key risk is that attaching conditionality to provision will limit take-up. There is a risk that those who are not needle exchange clients could take up foil, thereby imposing additional costs on drug services providers.

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	Benefits: 0	Net: 0	No	N/A

Evidence Base (for summary sheets)

A.1 Background

1. The Government's Drug Strategy published in 2010 set out its ambition and commitment to reduce demand, restrict supply, build recovery and support people to live a drug free life. The strategy aims to offer every support for people to choose recovery as an achievable way out of dependency and has recovery at its heart.

2. Since 1986 it has been an offence under section 9A of the Misuse of Drugs Act 1971 (the 1971 Act) to supply any article (with the exception of hypodermic syringes) – often referred to as drug paraphernalia – which may be used for administering or preparing an illegal drug, believing that the article is to be used in this way. The section 9A offence was originally introduced to outlaw the commercial sale of cocaine kits (razor blades, foil and lemon juice) marketed in the mid-1980s.

3. Drug treatment providers, and some healthcare professionals, are already permitted to provide certain articles to drug users for injecting illegal drugs. The purpose is to reduce the sharing of injecting equipment and therefore the spread of water and blood-borne diseases (HIV, Hepatitis C). To date, in addition to syringes, swabs, utensils for the preparation of a controlled drug, citric and ascorbic acid, ampoules of water and filters have been added to the exemptions from the legislation (by secondary legislation) on a case by case basis following assessment by the Advisory Council on the Misuse of Drugs (ACMD) that the health benefits of the provision of these paraphernalia outweigh any associated risks.

4. The ACMD has recommended that legislative changes should be implemented to enable the lawful provision of foil by drug services providers as a means of reducing the harms from the spread of blood borne diseases through the sharing of needles for injecting. It also advised that "foil, as an intervention, can support an individual in their first steps into treatment and towards recovery ie getting them off drugs". The ACMD findings, conclusions and advice are available in its three reports on foil[1].

5. In light of the Government's commitment under the 2010 Drug Strategy, the Government accepted the ACMD advice to enable the lawful provision of foil, *"… by drug treatment providers as part of structured efforts as to get individuals off drugs, whether for the purpose of getting them into treatment in the first place or in the initial stages of their treatment and recovery plan".*

6. Legislative changes are thus being implemented to make the provision of foil by drug services providers lawful, but only in circumstances where such provision forms part of a structured effort to help individuals on their way to recovery. As distinct from current exempt paraphernalia, aluminium foil is only to be lawfully supplied by "a person employed or engaged in the lawful provision of drug treatment services".

A.2 Groups Affected

7. Groups affected by the policy are drug services providers and persons addicted to drugs.

A.3 Consultation

Within Government

8. The Government has consulted the ACMD (as statutorily required), the Department of Health and Public Health England who are all supportive of the change to legislation under Option 3.

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[1] (1) https://www.gov.uk/government/publications/foil-report
(2) https://www.gov.uk/government/publications/acmd-consideration-of-the-use-of-foil-as-an-intervention-to-reduce-the-harms-of-heroin-and-cocaine-december-2011
(3) https://www.gov.uk/government/publications/acmd-further-advice-on-foil-2013

B. Rationale

9. Without legislative provisions enabling the lawful supply of foil, subject to strict conditionality, there will be no incentive for drug users to consider agreeing or entering into treatment to tackle their addiction. The majority of drug users who currently visit needle drug services providers are provided with clean needles (and other exempt injecting paraphernalia) to reduce the risk of transmitting blood borne diseases from injecting. There is no requirement to engage in or agree to treatment prior to provision of drug paraphernalia. Drug users are therefore supported to administer drugs safely to prevent the spread of blood and water borne diseases as well as other infections, but not encouraged to consider ridding themselves of their addiction.

10. The risk from injecting is not totally absent when using clean needles as drug users are still able to share needles, possibly due to a lack of information. This risk leads to both individual and social harms. Engaging drug users and signing them up for treatment Reducing harmful health effects and risks associated with injecting requires steps to be taken, including encouraging inhaling rather than injecting and encouraging drug users to seek treatment for their addiction. The shift from injecting to inhaling will not happen without intervention.

11. Government intervention is necessary to make legislative changes enabling the lawful provision of foil by drug services providers. This can assist engagement with the drug-misusing population, enable a shift from injecting to inhaling, and encourage entry into treatment. There is some evidence, as described in the ACMD report on the use of foil as an intervention, that this will reduce prevalence of blood borne diseases. For example, an increase in popularity of foil use in Holland was followed by a significant fall in HIV prevalence in Amsterdam.

C. Objectives

The policy objectives are to:

- Encourage users to take their first steps into treatment, reducing the immediate harm and facilitating the journey towards recovery and abstinence
- Tackle the significant health risks associated with injecting behaviours, including the transmission of blood borne viruses.

D. Options

Option 1: **Do nothing- make no changes.**

Option 2: **Enable the lawful provision of foil by drug services providers with no conditionality.**

Option 3: **Enable the lawful provision of foil by drug services providers but with strict conditionality on service users being in treatment.**

12. The Government's **preferred option is option 3**. This option will make it lawful for drug services providers to supply or provide foil for inhaling controlled drugs but with strict conditionality.Under this option the provision of foil by drug services providers will only be lawful if supplied "… *as part of structured efforts as to get individuals off drugs, whether for the purpose of getting them into treatment in the first place or in the initial stages of their treatment and recovery plan".* This provides an incentive to both drug service providers and drug users to increase engagement with treatment. If the conditionality element successfully encourages more drug users to enter treatment, the benefits under option 3 could be significantly higher than under option 2

E. Appraisal (Costs and Benefits)

GENERAL ASSUMPTIONS & DATA

13. Foil will only be provided by drug services providers as a replacement for injecting needles.

14. Foil will only be provided by those service providers who comply with the conditionality i.e. that foil is provided as part of structured efforts to help individuals into treatment.

15. It is assumed that the majority of services who will provide foil will be current needle supply providers (NSPs). However, not all NSPs will offer foil (e.g. those who do not meet the conditionality) and there are also specialist drug treatment providers outside the scope of NSPs that will provide foil.

16. In 2005, there were 39,178 reported needle exchange clients in England[2]. Scaling up by population, this implies an estimated 48,060 needle exchange clients in England, Scotland and Wales in 2013.

17. 50.3% of needle exchange workers agreed that "the distribution of foil by needle and syringe programmes will encourage a significant proportion of injecting drug users to move away from injecting on an ongoing basis"[3]. Based on this, we have conservatively assumed that 25% of existing needle exchange clients will switch to foil on an ongoing basis, with a lower bound of 10% and an upper bound of 40%.

18. It is assumed that conditional foil provision will provide an additional incentive for drug users to enter treatment. As no policy of this kind has been implemented before, no data is available on which to base an estimate of how many drug users will switch to foil and how many additional drug users will enter treatment. As such, we were unable to calculate reasonable estimates of the monetised impact of option 3.

19. However, there is indicative data from a National Needle Exchange Forum survey to suggest that the provision of foil is expected to increase drug misusers' interaction with drug services provides[4]. This could in turn lead to increased entrance into treatment.

20. It is assumed that foil provision will not lead to an increase in the number of people using or injecting drugs[5]. The ACMD also notes in its report that "*previous studies have indicated that the intervention does not encourage the use of illegal drugs*"

21. It is assumed that the majority of prospective foil users are currently using free needle and syringe provision.

22. The cost of needle and syringe provision per individual per year is £84[6].

23. The projected cost of provision of foil per individual per year is £72[7].

<u>OPTION 2</u>: Enable the lawful provision of foil by drug treatment services providers with no conditionality

COSTS

Costs to the public sector

Cost of training and staff

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[2] National Needle Exchange Survey, http://www.nta.nhs.uk/uploads/nta_nes1_needle_exchange_survey.pdf

[3] National Needle Exchange Forum, http://www.nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf

[4] National Needle Exchange Forum, http://www.nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf

[5] National Needle Exchange Forum, http://www.nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf

[6] Public Health England

[7] Public Health England

24. Costs to the public sector associated with the proposals arise from staff costs and training costs. Staff costs are ongoing costs. However, with the exception of the initial training cost, these costs will replace the staffing costs relating to needle provision (and other exempt injecting paraphernalia). Staffing costs for foil provision are therefore transferred costs.

25. Costs also arise from initial training costs. This is a transition cost, and is expected to be small. According to the most recent estimates available there were around 1,500 needle exchange facilities in England in 2005 (this includes facilities in pharmacies and specialist drug treatment services and those in custody suites and A&E departments). A survey of Needle and Syringe Programme (NSP) managers, workers and users estimated that 75% of staff in NSPs already have the required knowledge to show drug users how to use foil[8]. Assuming that an hour of training would be required for each facility without the requisite knowledge, this implies 375 hours of needle exchange workers' time would be required altogether for training. The cost of this can be estimated using average hourly pay for drug workers, at £21[9]. The total transition cost is therefore estimated at around £7,900. This estimate is likely to be high as not all NSPs will offer foil (e.g. those who do not meet the conditionality), however there will also be staff within other specialist drug treatment providers who will provide foil and therefore may require training.

Cost of providing foil

26. There are no additional costs imposed from providing foil. The cost of providing foil is £72 per individual per year. This is less than the cost of providing needles and syringes (at £84 per individual per year), so there is a net reduction of costs (if all those who take up foil provision were previously using free needle and syringe provision).

BENEFITS

Benefits to individuals

Reduction of blood borne diseases in the drug misusing population

27. The use of foil will encourage substance misusers to shift from injecting to inhaling with a resulting effect that the risk of transfer of blood borne diseases may fall. This would have a positive effect on the health of this population.

28. Evidence from Holland suggests that the provision of foil by treatment organisations and awareness campaigns promoting foil use coincided with a significant reduction in HIV prevalence in Amsterdam. From 1986 to 1998, prevalence of intravenous drug use in Amsterdam fell from 66% of users to 36%. In 1986, HIV prevalence among drug injectors in Amsterdam was 8.5 incidences per 100 person-years. By 2000, this had fallen to zero incidences per 100 person-years[10].

Benefits to the public sector

Reduction in healthcare expenditure

29. A reduction in the risk and transfer of blood borne diseases will lead to reduced demand for healthcare provision amongst this population. This should lead to cost savings to the public sector. However, without figures as to how effective the policy would be at reducing disease prevalence, the corresponding savings cannot be quantified.

Reduction in cost from providing needles and syringes

30. The cost of providing needles and syringes is £84 per individual per year. Since foil costs £72 per individual per year, each drug user who switches from the needle and syringe provision to foil

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[8] National Needle Exchange Forum, http://www.nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf

[9] National Careers Service, https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/drugandalcoholworker.aspx

[10] Kools (2010), *From Fix to Foil,* http://www.ihra.net/files/2010/08/26/John-Peter_Kools.pdf

provision will result in a net saving of £12 per year. The total annual saving is therefore £12 multiplied by the number of needle exchange clients predicted to switch to foil.

Other benefits to the public

31. There are further non-monetised benefits from improved health of drug users, enabling individuals to live better lives and reduce the stress on their families and communities.

NET EFFECT

32. The net benefit per drug user switching from needle and syringe provision to foil provision is £12 per year. Multiplying this by the predicted number of needle exchange clients who will switch to foil provision yields estimates of the monetised net benefits;

Table 1 – Estimated Net Present Value (NPV) for Option 2

	Average annual net benefits (£m)	NPV (£m)
Lower bound	0.06	0.49
Upper bound	0.23	1.98
Best estimate	**0.14**	**1.23**

The best estimate of the net present value of Option 2 is £1.23 million discounted over 10 years. However, this does not include any of the non-monetised benefits described above which, if the policy is successful, are expected to be significant.

ONE-IN-TWO-OUT (OITO)

33. Programmes to provide foil will be run by a combination of voluntary and public sector organisations (those currently running needle exchange programmes). However, the programmes will be commissioned by the public sector and there is therefore no impact on business and civil society organisations. The policy is therefore out of scope of OITO.

OPTION 3: Enable the lawful provision of foil by drug services providers but with strict conditionality on service users being in treatment

COSTS

Costs to the public sector

Cost of training and staff

34. As with option 2, staffing costs for foil provision are therefore transferred costs.

35. As with option 2, 375 hours of needle exchange workers' time would be required training on the use of foil. Furthermore, all staff will need training on how to ensure that those receiving foil are entering into or already enrolled in a treatment plan. In total, therefore 1,875 hours of needle exchange workers' time would be required for training. The cost of this can be estimated using average hourly pay for drug workers, at £21[11]. The total transition cost is therefore estimated at around £39,400.

Cost of providing foil

[11] National Careers Service, https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/drugandalcoholworker.aspx

36. The cost of providing foil is £72 per individual per year. This is less than the cost of providing needles and syringes (at £84 per individual per year), so there is a net reduction of costs (if all those who take up foil provision were previously using free needle and syringe provision).

BENEFITS

Benefits to individuals

Reduction of blood borne diseases in the drug misusing population

37. As with option 2, the risk of transfer of blood borne diseases is expected to fall. However, the scale of the reduction in disease risk is expected to be lower than under option 2 due to the conditional nature of the foil provision.

Increased number of people entering treatment

38. It is assumed that the provision of foil conditional on tackling dependence will incentivise people to enter into treatment and therefore aid recovery. Improved health of individuals and recovery from their dependence would enable them to live better lives and reduce the stresses on their families and communities. Recovery from dependence is also likely to enable individuals to take on work and to contribute fully to society.

39. As no policy of this kind has been implemented before, no data is available on which to base an estimate of how many drug misusers will enter treatment relative to the status quo or to Option 2.

Benefits to the public sector

Reduction in healthcare expenditure

40. As with option 2, the reduced risk of disease is expected to reduce public healthcare costs. However, the scale of the reduction in disease risk is expected to be lower than under option 2 due to the incentives created by the conditional nature of the foil provision.

Reduction in cost from providing needles and syringes

41. The cost of providing foil is £72 per individual per year. This is less than the cost of providing needles and syringes (at £84 per individual per year), so there is a net reduction of costs (if all those who take up foil provision were previously using free needle and syringe provision). The scale of this saving is expected to be lower than under option 2 due to the conditional nature of the foil provision.

Other benefits to the public

42. For each additional drug user whom the policy encourages to enter into treatment, a net benefit to society of around £6,500 is expected[12] (after accounting for the cost of the treatment to the public sector, the reduced number of offences committed and the reduced need for health and social care services). There are further non-monetised benefits from improved health of drug users, enabling individuals to live better lives and reduce the stress on their families and communities.

NET EFFECT

43. The net benefit per drug user switching from needle and syringe provision to foil provision is £12 per year. It would be expected that fewer people would take up foil use once the conditionality is attached than under option 2. The net benefit from any additional drug misuser entering treatment as a result of the free foil is expected to be £6,500.

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[12] The Drug Treatment Outcomes Research Study (2009), http://www.dtors.org.uk/reports/DTORS_CostEffect_Main.pdf

44. Multiplying the net benefit per drug user by the predicted number of drug users who will switch to foil provision would yield estimates of the net benefits. However, as no policy of this kind has been implemented before, no data is available on which to base an estimate of how many drug users will switch to foil and how many additional drug users will enter treatment.

45. The net benefit of option 3 relative to option 2, after accounting for both monetised and non-monetised impacts, will depend on whether the lower number of people expected to switch to foil use due to the conditional nature of the foil provision is compensated for by an increased number entering treatment and recovering from drug addiction. As the net benefits associated with the latter effect far outweigh those associated with the former, it would only require a minor increase in the number of drug users entering treatment in order for the net present value of Option 3 to outweigh that of Option 2.

ONE-IN-TWO-OUT (OITO)

46. Programmes to provide foil will be run by a combination of voluntary and public sector organisations that provide needle exchange facilities (this includes facilities in pharmacies and specialist drug treatment services and those in custody suites and A&E departments). However, the programmes will be commissioned by the public sector and there is therefore no impact on business and civil society organisations. The policy is therefore out of scope of OITO.

F. Risks

OPTION 2: Enable the lawful provision of foil by drug services providers with no conditionality

47. Providing foil without conditionality can lead to individuals being provided foil for the rest of their lives. There will be no encouragement to enter into treatment and recover from their dependence under this option. Providing foil over such a long period of time is likely to have some harmful effects to the individual.

48. There is a risk that enabling the lawful supply of foil can lead to people taking up the use of drugs through this medium.

49. There is also a risk that those who are not currently needle exchange clients could take up foil, thereby imposing additional costs on drug services providers.

50. However, the ACMD review did not find any evidence of harmful effects from the provision of foil or any indication that the intervention encourages the use of illegal drugs.

OPTION 3: Enable the lawful provision of foil by drug services providers but with strict conditionality

51. There is a risk that the conditionality applied to this option will deter people from choosing inhaling over injecting. This will limit the maximum benefit of the policy being achieved within the substance misuse population.

52. Enabling the lawful provision of foil under this option can also increase the risk of people taking up the use of drugs through this medium. However, any risks from long term provision under option 2 of an increase in the number of people misusing drugs are minimised by the short term nature of provision and the conditionality of treatment and recovery; foil will only be provided to those who have a documented treatment plan, and not to new users.

53. There is a risk that those who are not currently needle exchange clients could take up foil, thereby imposing additional costs on drug services providers. Although as detailed above, the ACMD did not find any harmful effects from the provision of foil.

G. Enforcement

54. Enforcement of the proposed policy will be undertaken by health regulatory bodies, Accountable Officers, professional bodies, police and other relevant governmental agencies responsible for the provision of healthcare and management of medicines in England and the Devolved Assemblies.

H. Summary and Recommendations

The table below outlines the costs and benefits of the proposed changes.

Table H.1 Costs and Benefits

Option	Costs	Benefits
2	***Monetised***	***Monetised***
	Expected transition cost of £0.01m for training	Expected net benefit of £1.23m saved from providing foil rather than needles to existing needle exchange clients
	Non-monetised	***Non-monetised***
		Reduced prevalence of blood borne disease, leading to health benefits to drug users, reduced public healthcare costs and increased ability for drug users to contribute to society
3	***Monetised***	***Monetised***
	Expected transition cost of £0.04m for training	Expected benefit to society of £6,500 from any additional drug user entering into treatment
		£12 annual saving per user switching from needle provision to foil provision- expected to be smaller than under option 2 due to conditional nature of foil provision
	Non-monetised	***Non-monetised***
		Reduced prevalence of blood borne disease, leading to health benefits to drug users, reduced public healthcare costs and increased ability for drug users to contribute to society- expected to be smaller than under option 2 due to conditional nature of foil provision

55. Option 3 is the preferred option. It enables the Government to support individuals willing to enter into treatment to rid themselves of their dependency in order to live drug free lives. Lawful provision of foil with strict conditionality is in line with the aims of the 2010 Drug Strategy.

56. Option 3 would be expected to lead to a lower take-up of the foil provision than option 2 due to the conditionality on entering into treatment. This would limit the benefits to be realised from the reduced cost of foil provision (relative to needle and syringe provision) and the reduced prevalence of blood borne diseases. However, there is potential for the conditionality element to increase the number of people entering drug treatment. This would lead to significant benefits to society. As such, there is a trade-off between the potential benefits of more foil users under option 2 and the potential benefits of more drug users entering treatment under option 3. The outcome of the trade-off depends on the extent to which option 3 would limit the use of foil or, alternatively, the extent to which it would encourage drug users into treatment.

57. The Government prefers option 3 due to the potential for the conditionality element to increase the number of people entering drug treatment, in line with the aims of the 2010 Drug Strategy. If this potential is realised, the benefits under option 3 could be significantly higher than under option 2 (because the net benefit of entering treatment is so large).

58. Enabling the provision of foil without strict conditionality would be inconsistent with the aims of the 2010 Drug Strategy and will not encourage individuals to enter into treatment or assist them in their recovery from drug misuse.

59. Any risks arising out of the lawful provision of foil are limited by the imposition of the conditionality under which foil is supplied and are therefore minimal compared to when provision is enabled without conditionality.

I. Implementation

60. The Government plans to implement these changes in September 2014.

J. Monitoring and Evaluation

61. Mechanisms will be put in place to carefully monitor the take-up, implementation and adherence to the conditionality over the next year.

K. Feedback

62. Feedback on the proposed changes will be sought from Public Health England, the Department of Health, and patient representative bodies.

Appendix A

Estimation of the monetised impact of foil provision

Table A.1 – Relevant data, estimates and sources

Number of actual needle exchange clients in England (2005)		**39,178**[13]
England population (2005)		**50,466,000**[14]
England, Scotland & Wales population (2005)		**58,510,000**[15]
Estimated number of needle exchange clients in England, Scotland & Wales (2005)		**45,428**[16]
England, Scotland & Wales population (2013)		**61,900,000**[17]
Estimated number of needle exchange clients in England, Scotland & Wales (2013)		**48,060**[18]
Proportion expected to take up foil use on ongoing basis under option 2	*Lower*	**10%**[19]
	Upper	**40%**
	Best	**25%**
Number expected to take up foil use on ongoing basis under option 2	*Lower*	**4,806**
	Upper	**19,224**
	Best	**12,015**
Unit cost of foil provision (annual)		**72**[20]
Unit cost of needle and syringe provision (annual)		**84**[21]
Average hourly pay for drug worker		**£21.00**[22]
Estimated hours of training required (total)		**375**[23]

13 http://www.nta.nhs.uk/uploads/nta_nes1_needle_exchange_survey.pdf
14 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-213624
15 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-213624
16 Scaled up with population
17 http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2011-and-mid-2012/index.html
18 Scaled up with population growth
19 http://www.nnef.org.uk/nnef_statements/resources/2009-03_NNEF_Survey_Report_ACMD_TC.pdf. Response to "The distribution of foil by needle and syringe programmes will encourage a significant proportion of injecting drug users to move away from injecting on ongoing basis": 50.3% 'Agree' or 'Strongly Agree'
20 Public Health England
21 Public Health England
22 https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/drugandalcoholworker.aspx
23 http://www.nta.nhs.uk/uploads/nta_nes1_needle_exchange_survey.pdf: around 1500 needle exchange facilities in England, Scotland and Wales, 75% of staff already have necessary knowledge.