

GUIDELINES FOR SERVICES PROVIDING INJECTING EQUIPMENT

BEST PRACTICE RECOMMENDATIONS FOR COMMISSIONERS AND
INJECTING EQUIPMENT PROVISION (IEP) SERVICES IN SCOTLAND

Table of contents

Glossary	ii
-----------------------	-----------

PART 1

1 Introduction	1
<i>Why does Scotland need guidelines for IEP services?</i>	1
<i>Aims of the guidelines</i>	3
<i>Who are these guidelines intended for?</i>	3
<i>The structure of this document</i>	3
2 How were these guidelines developed?	5
<i>Specifying the scope of the guidelines</i>	5
<i>Reviewing the evidence</i>	5
<i>Obtaining input from experts in the field</i>	6
<i>Undertaking wider consultation</i>	6
3 Models of service delivery	7
<i>Types of IEP services</i>	7
<i>Specialist IEP services</i>	8
<i>Pharmacy IEP services</i>	8
<i>Outreach services</i>	10
<i>Police custody suite / prison needle replacement schemes</i>	10
<i>In-prison IEP services</i>	11
<i>Secondary needle distribution</i>	12
<i>Peer-led distribution of injecting equipment</i>	13
<i>Needle dispensing machines</i>	13
<i>Hospital-based IEP services</i>	14

PART 2

The Guidelines – List of recommendations	18
Section 1: Developing an IEP programme	23
Section 2: Increasing distribution of injecting equipment	31
Section 3: Improving the effectiveness and consistency of IEP services	38
Section 4: Integrating injecting equipment provision with other services	48
Section 5: Health and safety of staff, clients and the community	53
References	57
Annex 1: Guidelines Development Group	63

Glossary

Terminology / abbreviations	Definition
HAV, HBV, HCV, HIV	Hepatitis A Virus, Hepatitis B Virus, Hepatitis C Virus, Human Immunodeficiency Virus
IEP services	Injecting Equipment Provision Services — This term will be used throughout this document to refer to all services that distribute injecting equipment – regardless of whether those services have the facilities to receive used injecting equipment.
Needle	In general, throughout this document, the word “needle” will be used to refer to both needles and syringes.
N/S	Needles and syringes — For the avoidance of doubt, in a small number of places in this document, this abbreviation is used to refer to both needles and syringes.
Fixed-site service	An IEP service which operates from the premises of a building, rather than through a mobile service or other form of outreach.

Part 1:

**Background
and context**

1 Introduction

This document contains guidelines on best practice for services providing injecting equipment (IEP) services. The development of these guidelines was an action arising from the *Hepatitis C Action Plan for Scotland: Phase II: May 2008 – March 2011*.¹

Action 14 of this plan states that “*national guidelines for services providing injection equipment to injecting drug users will be developed*” (p. 18 and p. 44) and Action 15 states that:

Services providing injection equipment (needles / syringes and other injection paraphernalia) will be improved in accordance with the guidelines.... Improvements will be made in terms of the quantity..., quality....and nature of provision (See p. 19 and p. 44).

The guidelines concern the provision of needles, syringes and other injecting paraphernalia to people who inject opioids (including heroin and methadone), stimulants and other illicit substances (for example, prescribed drugs injected illicitly). The guidelines do *not* cover the provision of injecting equipment to:

- Young people under 16 years of age
- People who use illicit drugs, but who do not inject
- People who inject prescribed drugs for a medical condition, such as diabetes.

NHS Boards and commissioners should consider how the guidelines may be applied to any populations not specifically covered by the guidance.

IEP services in Scotland deliver a wide range of interventions, including sexual health interventions, interventions which aim to prevent injecting, and those which encourage people to *cease* injecting. These interventions are extremely important and should continue to be provided. However, these interventions are not specifically addressed by these guidelines. Rather, the focus of these guidelines is on more effectively meeting the needs of people who are *current* injectors.

The Scottish Government has provided funding to all NHS Boards in Scotland to improve Hepatitis C services in their areas. Part of this funding includes additional funds to deliver expanded and improved IEP services.

Although these guidelines have been developed as an action under Scotland’s *Hepatitis C Action Plan, Phase II*, they also fit within the context of the principles outlined in the Scottish Government’s *Road to Recovery*.² For many injectors, engagement with an IEP service is a first step towards recovery.

Why does Scotland need guidelines for IEP services?

It has been estimated that there are approximately 24,000 injecting drug users in Scotland.³ There are a number of health risks associated with injecting drug use, including bacterial infections such as septicaemia and tetanus. Abscesses, cellulitis and collapsed veins can result from injecting with a blunt needle.⁴ Injectors are also susceptible to a range of blood-borne virus (BBV) infections, the most prevalent of which is Hepatitis C infection.

It is estimated that well over 90% of new Hepatitis C virus (HCV) infections in Scotland occur in people who have injected drugs.⁵

There is sufficient evidence from around the world to show that IEP services are effective in reducing injection risk behaviours among injecting drug users (in particular, self-reported sharing of needles and syringes, and frequency of injection) and there is some evidence that IEPs reduce HIV infection among injecting drug users.^{6,7,8,9} IEP services are also cost-effective when compared with the lifetime cost of treating HIV infection.^{6,7}

However, the picture with relation to Hepatitis C is less clear. There is currently insufficient review-level evidence to either support or discount the effectiveness of IEP programmes in reducing HCV transmission among injectors. However, this lack of evidence is mainly due to limitations in the studies reviewed.⁷ Some ecological studies have demonstrated stable or declining HCV prevalence in association with IEP programmes.^{7,10}

There is evidence to suggest that low levels of change in injecting risk behaviour may not be sufficient to reduce HCV transmission because of the large pool of infection in the injecting population,¹¹ and the high rate of transmission among new injectors.⁴ Therefore, there must be much greater reductions in needle sharing and much higher sterile needle / syringe coverage to reduce HCV prevalence in the injecting population.

At the same time, the literature is clear that the distribution of sterile needles and syringes alone is not sufficient to reduce the transmission of blood-borne viruses (especially, HCV) among injecting drug users.^{6,12} For example, injectors need to be educated not to reuse or share needles or other injecting paraphernalia.

In Scotland, despite reports of a decreasing trend in sharing needles, HCV prevalence remains high among injecting drug users. A recent study of prevalence among injectors attending IEP services in three Scottish Health Board areas found that overall, over half of the injectors surveyed had been infected with HCV.¹³ However, there was substantial regional variation in prevalence, ranging from 36% in NHS Lothian to 71% in NHS Greater Glasgow & Clyde. This same study also found similar variations in incidence among new injectors in this group.

Although there is some evidence of a decline in the frequency of sharing needles and syringes in Scotland since 2001, the sharing of other (non-needle) injecting equipment such as filters, spoons and water continues to be common.^{14,15,16,17,18}

At the same time, a national study of IEP services carried out in 2005 (referred to throughout this document as the National Needle Exchange Survey), found inconsistent and variable service delivery among services in Scotland.¹⁹ This research found widespread variation not only in the provision of injecting equipment, but also in staff training, and in the nature of interventions offered within IEP services. Particularly worrying was the finding that there were also very wide geographical variations in the average number of needles distributed per injector per year — ranging from 57 needles per injector per year in one area to 479 needles per injector per year in another. If it is estimated that injectors inject, on average, 2-3 times per day,^{20,21} the shortfall in the number of needles currently being distributed in Scotland can be estimated to be several million per year.

The HCV epidemic presents new challenges to IEP services. One of the challenges is to increase the uptake of sterile injecting equipment. In addition, to reduce sharing of injecting equipment, services need to seek ways of undertaking intensified interventions, without alienating service users. Some services may need to change what they are doing with injectors; others may need to do *more* of what they are already doing.

Aims of the guidelines

These guidelines aim to provide a consistent framework which can be used across Scotland to support the delivery of IEP services. The objectives of the guidelines are:

1. To promote good practice in relation to the planning and development of IEP services
2. To improve the accessibility of sterile needles, syringes and other injecting equipment to injecting drug users who are at risk of acquiring HCV and other BBVs
3. To improve the quality and consistency of IEP services
4. To promote integration between IEP services and other services for injecting drug users, including primary, secondary and social care services
5. To ensure that local areas are taking active steps to protect the health and safety of IEP service staff and clients, and the community in relation to the disposal of used injecting equipment.

Who are these guidelines intended for?

These guidelines have been written for people who have responsibility for the planning, commissioning and delivery of IEP services. This includes senior managers in NHS Boards, local authorities, the police and voluntary sector agencies who have a responsibility for developing and funding services in their local area. It also includes front-line service providers and their staff, both in the voluntary and statutory sectors (including NHS and social work staff, community pharmacists and pharmacy staff; and prison and police officers involved in the provision of needle replacement schemes).

It should be noted that the *Hepatitis C Action Plan, Phase II*, stipulates that HCV Prevention Leads will be responsible for ensuring the implementation of these guidelines in their area. The order in which individual recommendations are implemented and the overall timescales for implementation may be determined by local NHS Boards. However, the guidelines must be implemented in their entirety by March 2011. The Action Plan requires that service activity be audited against the guidelines, and that performance be measured against targets set by all NHS Boards in 2009.

The structure of this document

This document is in two parts. The first part contains three chapters:

- **Chapter 1** (the current chapter) sets out the background and context for developing IEP guidelines for Scotland.
- **Chapter 2** describes the process of developing these guidelines, discusses the nature of evidence available and how that evidence has been used in drafting the guidelines.
- **Chapter 3** describes and discusses the strengths and limitations of different IEP service models. Note that reference will be made to the information in this chapter throughout the guidelines.

The second part of the document contains the guidelines themselves, which have been grouped into five sections:

- **Section 1: Developing an IEP programme** – makes recommendations related to the process of developing and reviewing local IEP services.

- **Section 2: Increasing the distribution of injecting equipment** – focuses on increasing the quantity of injecting equipment (both sterile needles *and* other injecting paraphernalia) that IEP services give out.
- **Section 3: Improving the effectiveness and consistency of IEP services** – makes recommendations aimed at improving the quality of IEP services, particularly in relation to the way service providers interact with their clients.
- **Section 4: Integrating IEP services with other services** – aims to promote more integrated care for injecting drug users, particularly for those who are infected with HCV.
- **Section 5: Health and safety of staff, clients and the community** – makes recommendations which aim to protect the health and safety of staff and to promote safe disposal of used injecting equipment.

2 How were these guidelines developed?

This chapter describes the process by which these guidelines were developed. It is worth reiterating that these guidelines have been developed in response to an action within the *Hepatitis C Action Plan for Scotland, Phase II: May 2008 – March 2011*, and the timescales for the process were set by the Action Plan. These timescales allowed seven months in total to produce a set of draft guidelines, which would then be put out to consultation among stakeholders across Scotland. The aim was to publish the final guidelines by July 2009. However, publication was postponed to allow a review to be undertaken by the Crown Office of the Lord Advocate's Guidelines on needle and syringe distribution in Scotland.

Organisations such as the Scottish Intercollegiate Guidelines Network (SIGN) and the National Institute for Health and Clinical Excellence (NICE) have formal processes which they follow in developing clinical guidelines. These processes invariably involve drawing up and agreeing a detailed specification for the guidelines; undertaking a systematic review and critical appraisal of the relevant literature; obtaining input from a range of experts in the field; and undertaking wider consultation. In general, this process from start to finish can take up to two or even three years.

The development of guidelines for IEP services in Scotland used a similar, but truncated process, to fit within the much shorter timescales available.

Specifying the scope of the guidelines

The initial specification for the scope of the guidelines came from the *Hepatitis C Action Plan, Phase II*. This stated that improvements should be made in services that provide injecting equipment in terms of:

- The quantity of injecting equipment distributed
- The quality of the service delivered, and
- The nature of service provision.

This was a very broad and general remit, and one of the first tasks was to set out a specific set of objectives for the guidelines. This was done in consultation with a multi-disciplinary expert group (the Guidelines Development Group), which was gathered for this purpose.

Reviewing the evidence

These guidelines have been informed by evidence of effectiveness in relation to the prevention of BBVs (and HCV in particular) and regarding the prevention and reduction of injection risk behaviour. Evidence related to improving access to and uptake of IEP services, and in relation to improving the quality of IEP services was also considered.

A systematic review of the evidence was not specifically undertaken for these guidelines. Rather, the guidelines have been informed by systematic reviews undertaken by other organisations, including NICE,²² the World Health Organisation⁸ and the Australian Government.^{9,23} Reference has also been made to IEP guidelines and policies published in English-speaking countries including Australia,^{24,25} Canada^{26,27} and Wales.²⁸ Phase I of *Scotland's Hepatitis C Action Plan (September 2006 to March 2008)* involved a systematic gathering of evidence to inform the actions to be taken in Phase II and this evidence was also taken into account when developing the guidelines.²⁹

These guidelines, therefore, have been able to draw on a wealth of recent data on the nature and extent of current service provision and the needs for services in Scotland; review-level evidence on the impact of IEP services on a range of outcomes; as well as a substantial body of research which has been published by the Scottish Government since 2003 within its programme of research on HCV prevention.^{17,18,19, 30, 31}

Although there was a great deal of information available, it must be acknowledged that there was a dearth of systematic review-level evidence addressing the specific objectives set for these guidelines. Where review-level evidence existed, it has been used. However, where it was lacking, the guidelines have drawn on the findings of primary studies, some of which may have used less rigorous methods. In addition, where evidence was lacking altogether, the guidelines have drawn upon expert opinion.

Obtaining input from experts in the field

In addition to the information gathered through a review of evidence, a group of experts in the field were gathered to help assess the evidence and draft the guidelines. This group also had an important role in drafting guidelines on specific topics (for example, in relation to staff training) where it was felt a guideline was needed, but where evidence was generally lacking.

The members of the Guidelines Development Group comprised 18 experts from a range of disciplines. Members included representatives from IEP services; from NHS, voluntary and academic sectors; and from national bodies including the Scottish Government, the Scottish Prison Service, Health Protection Scotland, NHS Information Services Division, NHS Health Scotland and the Scottish Association of Alcohol and Drug Action Teams (SAADAT). The group was chaired by Professor Avril Taylor from the University of the West of Scotland, a recognised international expert in the area of harm reduction. A small research advisory group was also established to manage and oversee the process.

The Guidelines Development Group met three times during the course of drafting the guidelines. The first meeting took place in July 2008 and had the aim of outlining the scope and remit of the group. The second meeting was a three-day residential meeting at the end of August 2008, which involved reviewing and assessing the evidence and formulating an initial draft of the guidelines.

A third meeting took place in November 2008 to review, discuss and make changes to the draft guidelines where necessary, resulting in a set of “interim guidelines”.

Undertaking wider consultation

In Winter / Spring 2009, the interim guidelines were sent out for wide consultation to stakeholders in Scotland, including, *inter alia*, Drug and Alcohol Action Teams, HCV Executive Leads and HCV Prevention Teams in each NHS Board, public health consultants, IEP services in the NHS and voluntary sectors, and service user representatives. Service user representatives were also consulted at events held for that purpose. An analysis of consultation responses was undertaken and this is available upon request from the Scottish Government.

Review date

The guidelines will be reviewed after the end of the period covered by Phase II of Scotland’s Hepatitis C Action Plan — after March 2011.

3 Models of service delivery

Chapter 1 of this document discussed evidence on the effectiveness and cost-effectiveness of IEP services in general. However, the provision of injecting equipment can be undertaken using a wide range of service models. In other words, not all IEP services are alike.

One of the recommendations that will be made in the next section is that local areas should provide IEP services using a mixed-model approach. Therefore, this chapter looks in detail at the different models available, and provides information about their strengths and limitations, based on the findings of research. This information is intended to inform local decision-making about how best to structure service provision so that it meets the needs of local populations of injectors.

However, before going on to discuss the different models of IEP services, it is first necessary to describe a form of service classification that will be used at various points throughout this document.

Classification of IEP services

For the purposes of these guidelines, it is suggested that most (although not all) of the models discussed on the following pages can usefully be classified into one of three types as follows:

- **General IEP service** – provides a choice of needles and other injecting paraphernalia (usually through pack distribution), and basic advice and information about safer injecting practices. General services undertake a minimal assessment of clients' needs, and provide written and verbal information about other services (including other IEP services), signposting and referral. Examples of general services include: police custody and prison needle replacement schemes; and some community pharmacy and voluntary sector IEP services.
- **Enhanced IEP service** – provides needles and other injecting paraphernalia and access to in-depth advice and other harm reduction interventions. The latter may be delivered by staff employed within the service, or by a specialist coming into the service. It is expected that enhanced services undertake a more in-depth assessment of clients' needs, and provide consultations in relation to BBV interventions (testing, vaccination) and wound care. They should also provide written and verbal information about other services, signposting and referral. Some hospital-based services, community pharmacies and voluntary sector agencies provide enhanced services.
- **Specialist IEP service** – a service that provides needles and other injecting paraphernalia, in-depth advice and education, and a wide range of other interventions on-site or through outreach. Specialist services carry out in-depth assessments of clients' needs and provide access to other health and social care services either on-site and through referral. They may be delivered either within the statutory or voluntary sectors. Since specialist services may be considered to be a model of IEP service in their own right, they are described in more detail below, along with their strengths and limitations.

Models which are not covered by this classification system are those which are not delivered by professional staff — i.e., secondary needle distribution and dispensing machines. It is important to note that **this classification is not intended to represent a “tiered” classification**. Any injecting drug user should be able to have *direct* access to any of the three types of services. (In a tiered classification, higher-tiered services ordinarily require referral.)

The remainder of this chapter will now look in detail at the various models of IEP services.

Specialist IEP services

What are they?

As mentioned above, specialist IEP services may be either in the statutory or voluntary sector. These services provide injecting equipment, as well as other harm-reduction interventions, either through fixed-site or outreach services. In some cases, a specialist IEP service may be provided within a wider drug treatment or rehabilitation service. Historically, specialist services have been non-pharmacy services and much of the evidence available on specialist and pharmacy services makes a distinction between the two. However, there is now scope for community pharmacies to provide many of the interventions that have traditionally been available only through non-pharmacy specialist services. This potential development will be discussed further in the guidelines, later in this document.

The distinctive feature of a specialist IEP service is the level of interventions it provides. Many specialist services undertake in-depth assessments of their clients' needs, and offer access to a wide range of interventions, including BBV vaccination and testing, in response to those needs. In addition, the provision of needles and other injecting equipment can be tailored to suit the client's needs and preferences. Many specialist services also undertake motivational work with clients and are able to provide in-depth education and advice to reduce the risks associated with injecting.

There are examples throughout Scotland of specialist services offering BBV testing and vaccination, on-site access to primary care and dental clinics, training in overdose prevention, counselling, and other similar interventions. Specialist services are also often involved in providing training and support to other (non-specialist) service providers in their area.

Evidence

One of the important strengths of specialist services in Scotland is that they appear to be very successful in getting large numbers of needles out to their clients. The National Needle Exchange Survey found that, in the one year period between April 2004 and 2005, there were three times as many pharmacy services as specialist services in Scotland, and pharmacy services had twice as many transactions as specialist services. Nevertheless, in that year, the combined number of needles given out by all specialist services across Scotland substantially *exceeded* the combined total given out by all pharmacy services.¹⁹

A further strength is the quality of advice and information provided by specialist services. A review of qualitative evidence undertaken for NICE found that injecting drug users rated specialist IEP services based in drug agencies more highly than those in pharmacies for advice and information.³²

One of the limitations of specialist services is the lack of consistency in staff training and qualifications. The National Needle Exchange Survey found that there is currently no standard training for specialist IEP service staff across Scotland.¹⁹ Some services are delivered by highly-qualified staff with formal training in nursing or drug misuse. Others are delivered by unqualified staff who have only received in-house training.

Pharmacy IEP services

What are they?

Pharmacy IEP services are delivered within the premises of community pharmacies. They may be either general or enhanced, and as mentioned above, there is scope for some to become specialist services as well. There are many benefits to basing an IEP service within a pharmacy.

First, the use of community pharmacies can make IEP services more accessible to injecting drug users — both in large cities and in small towns — as the infrastructure is already in place. Providing injecting equipment within a community pharmacy also gives injectors on-site access to a qualified health care practitioner and a full range of NHS pharmaceutical services. The new Scottish pharmacy contract provides considerable opportunities for developing the care of drug users in a community pharmacy context. For example, the electronic Minor Ailments Service (eMAS) allows all patients who are exempt from prescription charges, to access a range of medications and dressings free of charge, directly from the pharmacist.

There are also other practical and cost benefits. The provision of injecting equipment within an existing pharmacy precludes the need to find and fit out new premises and hire staff, with all the expense that would entail. Furthermore, there is no need to obtain planning permission in order to deliver an IEP service within a pharmacy. At the same time, funding from the Scottish Government has allowed many pharmacies to construct consultation rooms that allow for greater confidentiality and privacy when speaking to customers.

In practice, however, community pharmacies are busy places which are used by members of the general public. There is often not the time, and in some pharmacies, there is not the space, to provide in-depth advice and education to injectors. Finally, in most pharmacy services, injecting equipment is provided in pre-packed bundles, and so the extent to which the service can be tailored to client needs and preferences is somewhat limited.

Evidence

A review undertaken for NICE found evidence that pharmacy-based programmes are popular with injectors and are generally rated more highly than drug-agency-based IEP services for accessibility (both location and opening hours).³² However, perceptions about staff attitudes and fear of exposure have led to negative feelings about pharmacy IEP services, particularly among women. This same review found evidence that injectors would like greater privacy when collecting needles from pharmacy services.

Some studies in Scotland have found significantly more positive attitudes towards drug users among pharmacists providing an IEP service than among those who do not.^{33, 34} However, others have found a wide range of attitudes (both positive and negative) among pharmacy IEP service providers.³¹

The National Needle Exchange Survey found that, in some areas of Scotland, IEP service provision is almost exclusively through community pharmacies.¹⁹ However, there can be barriers to pharmacy provision of injecting equipment services. Some of the difficulties include the size and suitability of the premises, a lack of separate consulting areas and a shortage of storage space.³⁵ In addition, pharmacists themselves may fear that the presence of drug users in the pharmacy will deter other customers – although there is evidence to show that these fears can be in contradiction to the views of customers who are often unaware that the pharmacy is providing drug services.

There are currently more than 1,000 community pharmacies in Scotland; however, only a small proportion (12%) are currently funded to provide injecting equipment services. Therefore, there is considerable potential to make greater use of the pharmacy network for injecting equipment provision, and there is evidence from primary research carried out in Scotland that active local recruitment can increase the participation of pharmacies in IEP service provision.³⁴ At the same time, consultation with service providers undertaken as part of the National Needle Exchange Survey suggested that it is essential to give on-going training and support to pharmacists and support staff involved in delivering an IEP service.¹⁹

Outreach services

What are they?

“Outreach” is a generic term which may cover a wide variety of IEP services. An outreach service may take the form of a mobile unit (van, bus, etc.), or a backpacking service on the street. Outreach may also be provided through home deliveries or a peripatetic service offered on the premises of another agency such as a health centre on certain days of the week for a few hours each day. Finally, the term outreach may also apply to an IEP service that is delivered out-of-hours to a particular target population, such as a night-time drop-in service for sex workers or a service for users of performance and image-enhancing drugs.

Outreach services are generally delivered by a specialist IEP service provider, and are often targeted at populations of injecting drug users that are difficult to reach through ordinary fixed-site services delivered during day-time working hours.

Evidence

An Australian review of evidence on effective harm reduction interventions reported that outreach programmes have been shown in that country to promote treatment entry and encourage some degree of change in levels of risk behaviour.³⁶ In addition, some US studies have indicated that outreach-based education programs were effective in reducing risk behaviours in injectors, including needle sharing and unsafe sex.³⁷

A review of research on mobile vans found that, compared to fixed site services, mobile vans can provide greater accessibility to injecting equipment over large geographical areas, and at times and in places where coverage is poor.³⁸ A roving site can also keep staff and clients relatively inconspicuous to neighbours, local businesses and the police. A review of the evidence carried out for NICE reported that mobile vans may attract younger injectors and injectors with higher risk profiles than pharmacy-based services.⁶ However, this evidence is based on studies that were all conducted in countries where injecting equipment was usually provided through the pharmacy sale of needles, rather than through free distribution. A review of qualitative evidence carried out for NICE found that mobile services were thought to increase accessibility for clients, but that they could not offer the full range of services available at some fixed site services.³²

There is a lack of published review-level evidence on the cost-effectiveness of outreach in preventing HCV transmission, as compared with other models of IEP services. However, a substantial programme of research on community-based outreach carried out by the US-based National Institute on Drug Abuse (NIDA) over 15 years, and involving more than 60,000 drug users in 52 communities, concluded that community-based outreach is an effective and cost-effective method for preventing transmission of HIV among out-of-treatment IDUs.³⁹ In Scotland, focus group participants who took part in the National Needle Exchange Survey suggested that outreach services were more successful than either community pharmacy or fixed-site specialist services in reaching hard-to-reach groups including women, sex workers and homeless injectors.¹⁹

Police custody suite / prison needle replacement schemes

What are they?

When taken into police custody, injecting drug users are required to dispose of any used injecting equipment found on their person. Needle replacement schemes involve providing replacement packs of sterile needles, and returning any sterile equipment to the injector when he / she leaves custody. At

the same time, injectors are informed of IEP services and drug treatment services available to them in the area.

Tayside Police in Dundee were the first to pilot needle replacement in Scotland in 2001-02. Following formal evaluation, it was recommended that the scheme be expanded to the whole of the Tayside region. The perceived success of the scheme resulted in similar schemes being rolled out to police forces across Scotland.

Following a successful pilot, the Scottish Prison Service also now provides a needle replacement scheme at reception in several prisons to support the schemes that exist in many police custody suites. This involves offering sterile needles to known injectors when they leave prison.

Evidence

There is some tentative evidence from Scotland to indicate that police custody suites may be able to reach a group of injectors who are not in contact with other services. An evaluation by Central Scotland police undertaken during the pilot of their own needle replacement scheme in 2003 showed that, within the first 10 months of the scheme, there were 127 needle replacement transactions. One quarter of arrestees who received sterile needles upon release from custody, had never used an IEP service before.⁴⁰

In-prison IEP services

What are they?

There are currently no prison-based IEP schemes in Scotland. However, under the *Hepatitis C Action Plan, Phase II*, there are plans to pilot an in-prison injecting equipment initiative in the Scottish Prison Service as one of a range of harm reduction measures to reduce the transmission of HCV. This initiative is due to be evaluated as part of the Action Plan and is currently in discussion between Government Ministers and prison unions. (See Action 17 of the *Hepatitis C Action Plan, Phase II*.)¹

The provision of injecting equipment to injectors in prison may be done through a dispensing machine or through a hand-to-hand exchange delivered by a doctor / nurse, a prison official or a harm reduction specialist.

A pilot study of injecting paraphernalia distribution (where prisoners had access to cookers and filters, but not needles and syringes) was carried out in HMP Aberdeen. Following the success of this pilot, it became Scottish Prison Service policy in 2007 to allow the provision of injecting paraphernalia throughout the prison estate, although some prisons have been slow to implement this policy.

Evidence

Addiction Prevalence Testing carried out by Scottish Prison Service in 2008 found that 64% of people entering prison in Scotland tested positive for illicit drugs, with 34% testing positive for opiate use.⁴¹ Annual prison surveys show that a small proportion (national average = 3%) continue to inject drugs while in prison.⁴² However, because of the lack of availability of sterile injecting equipment, the sharing and reuse of injecting equipment is common among this group.

A review undertaken on behalf of NICE found evidence that prison-based IEP programmes in six prisons all had positive results. These included no new cases of HIV, HCV or HBV; and stable or reduced drug use. The authors of this review concluded that prison-based injecting equipment provision was likely to be feasible in small prisons, but there was insufficient evidence to determine the effectiveness of these programmes in larger prisons.⁶

A review of qualitative research carried out for NICE found evidence that prison-based IEP services may find support, but also opposition, among both injectors and non-injectors.³² This review also found that anonymity was seen to be important by injectors in relation to prison-based IEP services.

The Scottish Prison Service carried out its own review of the literature on prison-based IEP services in 2005, and found that there have been 46 prisons in four European countries with IEP schemes in operation for around 10 years.⁴³ Evaluation of these schemes showed that they resulted in lower transmission rates of HIV and HCV, and no increase in drug use or injecting among prisoners. They also had not interfered with drug prevention strategies within the prison context, and there had been no attacks on staff or other prisoners with injecting equipment since the introduction of the schemes. Five of the schemes identified were no longer in operation at the time of the review. However, those that were discontinued had stopped, not because of problems or lack of success in implementation of the scheme, but rather due to the intervention of politicians. The discontinuation was universally opposed by the staff in those prisons — 85% of whom had initially opposed the introduction of the scheme.

Secondary needle distribution

What is it?

Secondary needle distribution involves the distribution of sterile injecting equipment to one service user, who then redistributes it to others in his / her social network.

The advantage of secondary distribution is that it increases the reach of the IEP service to injectors who might not otherwise access sterile injecting equipment. Services may use the opportunity of secondary exchange to provide in-depth advice and education to the secondary distributor. However, in practice, services have little control over the nature of the secondary transaction, or the advice given out by secondary distributors to others. Furthermore, the distributor may sell the equipment on to others, rather than distributing for free. Where the sale of equipment takes place, it is principally an indication of a lack of adequate service coverage, and the response of services should be to increase equipment availability and supply.

Evidence

The practice of secondary distribution is highly prevalent among injecting populations.^{18,44} Indeed, some injectors prefer secondary distribution. A review of qualitative research carried out for NICE, found that many injectors fear being caught and publicly exposed as drug users (to the police, neighbours or family) and that this can impact upon the use of IEP and other services.³² Anonymity, confidentiality and convenience are all very important to injectors, and some prefer secondary distribution for this reason — even if it means having to buy needles from another injector.

Women, in particular, can be reluctant to attend IEP services (particularly community pharmacy services) because of concerns about confidentiality and the perceived negative attitudes of staff.³² As a result, women are more likely than men to obtain injecting equipment through secondary distribution. Younger, or new injectors, also often obtain needles through peers, rather than through an IEP service.

As mentioned above, there are some disadvantages to secondary distribution. In particular, there is little control by IEP services over the advice and information given out by secondary distributors. This can lead to high-risk injecting practices among those taking part in secondary distribution. Some evidence for this comes from a study carried out in California (USA) which found that injecting risk behaviours were significantly more common among injectors who took part in secondary distribution (either as recipients or as distributors) than non-participants.⁴⁴

Peer-led services

What are they?

Peer-led distribution of injecting equipment is similar in some ways to secondary distribution, in that it involves one injector (or sometimes, a former injector) distributing sterile injecting equipment to other injectors. The difference is that the peer distributor has been formally trained (and may be formally employed) by an official IEP service provider, to provide accurate advice and information to other injectors.

The advantage of peer-led services is that they increase the reach of the IEP service to injectors not in contact with services, and they provide greater control over the nature of the secondary transactions. The disadvantage is that the training and supervision of peer distributors can be time intensive, and there may be a high turnover of personnel.

Evidence

A review of qualitative research carried out for NICE found that the use of peers as staff in IEP services increased engagement of clients with the service.³² However, the recruitment and training of peer staff was said to be time-consuming. Peer-led (and even peer-run) services have been widely used in Australia, particularly among the indigenous population, and are reported to be effective in reaching people who may not be reached by other means.^{45,46} An evaluation of an HIV peer-led education intervention in Maryland (USA) reported positive benefits for peer educators.⁴⁷

A review of the literature on educational interventions to prevent HCV found examples from around the world of highly effective incentive-based “peer-driven” schemes, where injectors are given rewards for passing on a specific body of information to members of their social network, and then recruiting those individuals to attend an IEP service where they are given further educational information.⁴⁸ A comparison of this intervention with a traditional outreach intervention in Connecticut (USA) found that both interventions produced significant reductions in self-reported HIV risk behaviours.⁴⁹ However, the peer-driven intervention outperformed the traditional intervention with respect to the number of injectors recruited, the ethnic and geographic representativeness of recruits, and the effectiveness of the HIV prevention education. In addition, the costs of recruiting injectors into the intervention and educating them about HIV in the community was only one-thirtieth as much in the peer-driven intervention as in the traditional intervention.

However, an evaluation of a peer-led HIV prevention intervention among gay men (steroid injectors) in London found that there was high turnover among peer educators (only 1 in 5 remained with the project throughout).⁵⁰ The intervention also required substantial input from the professional health promotion team — equivalent to one team member devoting 2.5 days a week to recruit, train and support peer educators over 18 months. The conclusion of this study was that peer education should not be viewed as a low-cost approach to prevention.

Needle dispensing machines

What are they?

Needle dispensing machines provide sterile needles and other injecting equipment through an automated machine. The machine may be operated free-of-charge or with a coin or token. If the machine is token-operated, the client is required to obtain tokens in advance from an IEP service.

The machine can be used to exchange new for used equipment, or it can be used to dispense equipment only, with a disposal bin located beside the machine. Dispensing machines can provide greater accessibility at times and places where coverage is poor.

Dispensing machines may be located near to, or on the premises of an existing IEP service to provide access to sterile injecting equipment when the staffed service is closed. Alternatively, they can be located in other areas. In Australia, for example, machines are located outside hospitals, community or sexual health centres and alcohol and drug services, in both urban and rural areas.³⁶

Evidence

There are currently no needle dispensing machines available in Scotland. However, dispensing machines have been used in Denmark, Norway, Switzerland, Germany, France, The Netherlands, Austria, Australia and New Zealand.³⁸

An international review of evidence on dispensing machines found no evidence to indicate that the availability of injecting equipment through dispensing machines led to an increase in drug use or injection frequency, and moreover, the sharing of needles was reduced significantly among individuals who used the machines.³⁸ This same review found that dispensing machines in France tended to attract younger injectors, those not in treatment and those who inject less frequently, and similarly, dispensing machine users in Berlin were more likely to report a shorter history of injection.

A more recent international review of qualitative research carried out by the same authors, found that dispensing machines increased access to sterile injecting equipment, reduced needle and syringe sharing, and were likely to be cost-efficient.⁵¹ They also complemented other modes of service delivery as they were used by injectors who were less likely to attend staffed IEPs.

Other evaluations of dispensing machines report similarly positive results. An evaluation of a 12-month trial of dispensing machines in one Australian city reported that the machines appeared to be serving both the clients of other IEP services and clients who were reluctant to use other IEP services or who find them inconvenient.⁵² A trial in Southampton (England) found that the installation of a dispensing machine outside the main IEP service in that city accounted for an increase of 7% in client transactions during the first four months of its operation.⁵³

Hospital-based IEP services

What are they?

Hospital-based IEP services are provided within a hospital building and are one way of providing 24-hour access to sterile injecting equipment.

Evidence

There was little evidence available on the use of hospital-based IEP services. The National Needle Exchange Survey found IEP services were delivered in the Emergency Departments of three hospitals in Scotland,¹⁹ and the use of hospital-based IEP services is common in some areas of Australia.²⁵

A review carried out for NICE found evidence to show that hospital-based IEP services may increase the accessibility to outpatient services among injectors attending these services.⁶

Summary

Table 1 below briefly summarises some of the key strengths and limitations of different IEP service models.

Table 1: Key strengths and limitations of different models of IEP services

Model	Strengths	Limitations
Specialist IEP services	<ul style="list-style-type: none"> ▪ In-depth education and advice ▪ Provision of injecting equipment can be tailored to individual client need ▪ Able to provide a wide range of interventions ▪ Option for locating other services on-site 	<ul style="list-style-type: none"> ▪ Hours of operation ▪ Lack of consistent training among staff
Community pharmacy IEP services	<ul style="list-style-type: none"> ▪ Longer (including weekend) hours of operation ▪ Multiple locations ▪ Less stigmatising / more anonymous ▪ Relatively inexpensive ▪ No planning permission required ▪ Access to a full range of NHS pharmaceutical services ▪ Access to qualified health care professional for general health advice 	<ul style="list-style-type: none"> ▪ Generally does not provide a full range of harm reduction interventions, in-depth advice and education (although these may be provided in enhanced services) ▪ Needles / syringes generally given out in pre-packed bundles rather than tailored to client need ▪ Can be difficulties with staff attitudes and lack of training / support
<p>Outreach IEP services, including:</p> <p><i>Mobile services (eg, bus or van)</i></p> <p><i>Home visits</i></p> <p><i>Peripatetic IEP services (provided as part of a wider service, for example, within a health centre or social work service)</i></p>	<ul style="list-style-type: none"> ▪ Increases accessibility (ie, the service goes to where the clients are) – particularly useful for covering a large geographic area ▪ More attractive than fixed-site services for certain hard-to-reach and high-risk groups of injectors ▪ Potential for in-depth education and advice to be made available ▪ Relatively inconspicuous to the public ▪ Able to reach hard-to-reach injectors (eg, women in particular) ▪ Better returns of used injecting equipment ▪ May attract different groups of injectors ▪ Improves accessibility in terms of location, time, culture and age group ▪ Peripatetic services delivered in health centres may improve injectors' access to other primary care services ▪ Relatively inexpensive 	<ul style="list-style-type: none"> ▪ Depending on the size of the vehicle, may have insufficient space for counselling sessions; arranging referrals; BBV testing; etc. ▪ If they operate for only a short time at each location, there is a high chance that they will be missed ▪ Cost and maintenance of the vehicle ▪ Safety for staff ▪ Potentially intrusive for clients ▪ Resource-intensive ▪ If they operate for only a short time in a particular location, there is a chance that they will be missed.

Model	Strengths	Limitations
Prison / custody suite needle replacement	<ul style="list-style-type: none"> ▪ Ensures that known injectors have access to sterile injecting equipment and information about local IEP services upon release from custody ▪ May reach some injectors who are not otherwise in contact with IEP services 	<ul style="list-style-type: none"> ▪ Little or no harm reduction advice given
Prison injecting equipment provision	<ul style="list-style-type: none"> ▪ Reduces sharing of needles, and other high-risk injecting practices among prisoners 	<ul style="list-style-type: none"> ▪ Can be opposition from politicians, prison staff and prisoners ▪ Concerns among injectors about anonymity
Secondary distribution	<ul style="list-style-type: none"> ▪ Improves reach to groups of injectors who will not (or cannot) use other forms of IEP services 	<ul style="list-style-type: none"> ▪ Lack of control over provision of, or accuracy of, harm reduction advice and information to recipients ▪ Continued high-risk injecting behaviour
Peer-led distribution	<ul style="list-style-type: none"> ▪ Peer knowledge of drugs and drug use ▪ Improves reach to groups of injectors who will not (or cannot) use other forms of IEP services ▪ May provide education, employment skills and income for peer distributors ▪ Convenient / accessible for clients ▪ Peers have credibility and can be important role models 	<ul style="list-style-type: none"> ▪ Training / supervising of peers can be costly ▪ Conflicting identities as peer worker and injector ▪ High turnover of peer workers
Dispensing machines	<ul style="list-style-type: none"> ▪ 24-hour access ▪ Anonymous ▪ Location can be wherever the need requires ▪ Convenient and easy to use ▪ Limited staffing required 	<ul style="list-style-type: none"> ▪ No face-to-face education or advice can be provided ▪ No way to regulate access to the machine (by under-16s for example), unless a token system is used ▪ Difficult to maintain anonymity when located in a public place ▪ Potential for public opposition
Hospital-based IEP services	<ul style="list-style-type: none"> ▪ 24-hour access 	<ul style="list-style-type: none"> ▪ Can be opposition from hospital staff

Part 2:

The guidelines

The Guidelines – List of recommendations

Section 1: Developing an IEP programme

Recommendation 1: Planning and developing IEP services

In planning and developing services that provide injecting equipment, NHS Boards, together with local partners, should undertake a number of tasks to ensure that services are able to meet the needs of their clients effectively. These include:

- Needs assessment
- Stakeholder consultation and engagement
- Staff training
- Advertising the service
- Monitoring and evaluation

Recommendation 2: Choosing appropriate models of delivery

NHS Boards and other service commissioners should ensure that a range of IEP services are provided using models of delivery appropriate to their injecting populations and the geography in their locality, based on an assessment of local needs.

In addition, it is recommended that:

- All clients should be able to access in-depth advice and information from a specialist IEP service.
- In large towns and cities (defined by the Scottish Government's urban-rural classification as settlements of 10,000 or more), there should be a balance between the use of specialist, enhanced and general services.
- Fixed-site services should be located in areas where there are clusters of injecting drug users.
- All NHS Board areas should have at least one fixed-site service.
- Fixed-site services should be located on, or within five minutes walk of, a public transportation route.
- When injectors live in areas where they cannot easily access a fixed-site service on foot or by public transportation, other models of distribution (for example, through outreach) should be used in preference.

Recommendation 3: Meeting the needs of sub-populations of injectors

In deciding which models of service provision to use, service commissioners and service providers should give special consideration to the specific needs of the following sub-populations of injectors, where these populations exist in their area:

- New injectors
- Women
- Sex workers
- Homeless injectors
- Users of performance and image-enhancing drugs (PIEDs)
- Minority ethnic groups
- People receiving opiate substitution therapy, or who have recently relapsed following treatment
- People in custody (both prison and police custody) or recently released from custody or court.

Recommendation 4: Opening times

IEP services should operate at times when injecting drug users are likely to need access to injecting equipment. There should be out-of-hours and weekend access within each NHS Board area corresponding to the needs of local injecting populations.

Section 2: Increasing distribution of injecting equipment

Recommendation 5: Provide one needle per injection

IEP services should provide, free of charge, as many needles as an individual client requires.

Services should continue to encourage clients to return used needles, and individual safe disposal bins should be provided for this purpose. However, the provision of sterile needles should **not** be dependent on the return of used needles. Services should aim at all times to ensure that all clients have a sterile needle for every injection.

NHS Boards should ensure that all IEP services in their area are actively encouraging their clients to take sufficient numbers of needles.

Recommendation 6: Provide other (non-needle) drug injecting equipment

IEP services should provide, free of charge:

- Acidifiers
- Cookers
- Filters
- Water for injections
- Pre-injection swabs

These items should be supplied in sufficient quantities to enable the use of one item each per injection.

Recommendation 7: Secondary distribution

Secondary distribution should not be discouraged. If a client states that he / she is supplying injecting equipment to others, it is acceptable to provide supplies for the purpose of secondary distribution.

However, those clients who supply equipment to others should be encouraged to bring the other injectors into the IEP service so that they can benefit from advice and information.

Recommendation 8: Provide methods for syringe identification

Injectors should always be encouraged to use a sterile needle and related paraphernalia for every injection. However, the reality is that some injectors may continue to reuse needles. Therefore, a method of equipment identification should be made available to clients who inject in the company of other injectors in order that they can identify their own equipment and avoid accidental sharing.

Section 3: Improving the effectiveness and consistency of IEP services

Recommendation 9: Training of IEP service staff

As a minimum, all individuals involved in the distribution of injecting equipment should receive appropriate training *prior* to providing a service or during induction in relation to:

- Understanding drug use
- How to engage with drug users
- Injecting risk behaviour
- Correct, single person use of injecting equipment
- Needs of different sub-populations of injectors, including those who are in treatment
- Prevention of HCV and other blood-borne viruses
- Overdose prevention and management
- Procedures regarding safe disposal of used injecting equipment
- Procedures for managing needle stick injury
- Contact details of other local relevant services

All staff involved in the provision of injecting equipment should have read and understood these guidelines. They should also be familiar with the Lord Advocate's Guidelines (issued in March 2010), and have basic training in child protection awareness. Pharmacists involved in the delivery of IEP services should complete the NHS Education Scotland (NES) distance learning package on "Pharmaceutical Care of the Substance User."

Staff training should include information about the importance of sensitivity and confidentiality in delivering an IEP service, and information about how best to liaise with other local services in relation to the needs of their clients.

On-going supervision should be provided and training should be updated at least annually.

NHS Boards should ensure that relevant training is made available to staff involved in the distribution of injecting equipment, including counter staff in community pharmacy services, and that these individuals are given all necessary support to attend the training.

Recommendation 10: Identifying and responding to the individual client's needs

All clients attending a service for the first time should be welcomed to the service and asked some basic information about their injecting practices in order that services are able to meet their needs. This initial discussion should be carried out in a private area, separate from the public, to ensure client confidentiality, and it should include the provision of both verbal and written information about safer injecting practices and about safe disposal of used injecting equipment.

As a **minimum**, IEP services should ask clients:

- How often they inject
- What they are injecting
- How often they (usually, or intend to) visit the IEP service, and
- Whether they are collecting supplies for anyone else.

This is to ensure that clients' equipment needs are addressed and that they leave the service with sufficient supplies to enable the use of one set of equipment per injection.

Recommendation 11: Service user education

When providing needles and injecting equipment, IEP services should educate clients about – as a **minimum**:

- Washing their hands with soap and water before injecting
- The correct use of each item of injecting equipment
- The risks of sharing injecting equipment
- The correct methods of disposing of used injecting equipment.

Recommendation 12: Getting client feedback

All IEP service providers should put in place mechanisms for identifying and responding to client feedback at regular intervals – at least annually.

NHS Boards should ensure that client feedback informs the on-going planning and development of local IEP services in their area.

Recommendation 13: Monitoring, evaluation and audit

IEP services should have systems for monitoring, evaluation and audit to enable on-going needs assessment at a local level.

In terms of monitoring, services should report to their local NHS Boards, and NHS Boards should participate in national data collection requirements. As a minimum, monitoring systems should allow NHS Boards to report on:

- The number of general, enhanced and specialist IEP services available in the area
- The number of needles distributed
- The number of items of other injecting paraphernalia distributed
- An estimate of the number of needles returned
- The number of transactions
- An estimate of the number of clients
- The proportion of male and female transactions / clients.

Section 4: Integrating IEP services with other services

Recommendation 14: BBV testing and vaccination for IEP clients

IEP services should encourage clients to be tested annually for HCV. In addition, wherever possible, all IEP services should make available vaccination (for HAV, HBV and tetanus), and testing (for HCV, HBV and HIV) **on-site** in a suitable private space.

Testing — including pre- and post-test discussion, sample collection, result-giving and onward referral — should always be delivered by appropriately trained staff. Where IEP services do not offer testing and vaccination facilities on-site, they should develop referral pathways that are user-friendly and accessible to injecting drug users.

Recommendation 15: Improving integration between IEP services and other services

All IEP services should be able to signpost or formally refer clients to treatment for drug misuse.

In addition, IEP services should be able to signpost or formally refer clients to other broader health and social support services, including:

- Well women, sexual health services and family planning advice
- Benefits advice
- Legal aid
- Social and mental health services
- Homelessness services
- Primary healthcare, including dressings, wound care and antibiotic prescribing
- Dental care
- Counselling
- Emergency department care

Wherever possible, IEP services should make any one or more of these broader support services (excepting emergency department care) available on-site. Where this is not possible, user-friendly and accessible referral pathways should be developed.

Section 5: Health and safety of staff, clients and the community

Recommendation 16: Ensuring the safe disposal of used injecting equipment

As part of wider risk assessment procedures, NHS Boards should ensure that all services in their area have robust policies and procedures in place in relation to the safe disposal of used injecting equipment.

To prevent the transmission of BBVs through improperly discarded injecting equipment, IEP services should:

- Educate staff and clients to safely handle and dispose of used injecting equipment
- Provide multiple options and locations for safe disposal of used injecting equipment
- Inform staff and clients that they could be prosecuted if they are found disposing of used injecting equipment in a way that could put members of the public at risk.

Recommendation 17: Hepatitis B vaccination for staff

NHS Boards should work together with employers to facilitate vaccination for Hepatitis B, free of charge, for all staff who are responsible for delivering an IEP service.

Section 1: Developing an IEP programme

There are injecting populations in every part of Scotland, including rural and very remote communities.³ Local authorities, Health Boards and Community Health (and Care) Partnerships (CH(C)Ps) have a duty to respond to the needs of these populations, not only to reduce the significant risks of injecting to injectors themselves, but also to prevent the transmission of HCV and other BBVs within the general population.

Access to sterile injecting equipment should be available to whoever needs it, regardless of whether that individual's residence is rural or urban; island or mainland; or whether they are detained in prison or in police custody.

However, findings from the National Needle Exchange Survey have shown that, in many areas, there is far from sufficient distribution of needles to injecting drug users. In 2005, the Survey found that there were just 188 IEP services across the whole of Scotland, serving an estimated 19,000 injectors.¹⁹

There needs to be a significant increase in the overall provision of injecting equipment across Scotland. This increase in provision can come, both by providing more services on the ground, and also by making existing services more accessible (through, for example, expanded opening hours).

However, the expansion of IEP services in local areas needs to be done in a strategic way, giving full consideration to prevalence data and to evidence about the best way of meeting the needs of diverse, and often hidden, injecting populations.

These guidelines are intended to provide a framework for the planning and delivery of IEP services across Scotland. Many of the recommendations made in the following pages focus on **what** IEP services do and **how** they do it.

However, it is clear that, to implement these guidelines, services will need the support and commitment of colleagues who are responsible for service planning and commissioning activities. Before an IEP service can even open its doors to customers, decisions have to be taken about **where** and **when** the service will be delivered, **what form** the service will take, and **who** will staff it. These decisions will have a major impact on the accessibility and quality of services — and ultimately, the ability of services to meet the needs they were set up to meet.

Therefore, this section makes recommendations related to the process of planning and developing IEP services. These recommendations will be most relevant to those who have a strategic role in the planning and commissioning of services in their area, as well as those involved in managing and developing local IEP programmes.

The aim of the recommendations in this section is to increase the overall provision of injecting equipment and make that provision more accessible. Recommendations made later in this document will address ways that existing services can be improved.

Recommendation 1: Planning and developing IEP services

In planning and developing services that provide injecting equipment, NHS Boards, together with local partners, should undertake a number of tasks to ensure that services are able to meet the needs of their clients effectively. These include:

- Needs assessment
- Stakeholder consultation and engagement
- Staff training
- Advertising the service
- Monitoring and evaluation

Needs assessment

Needs assessment is a strategic process that involves identifying the extent and nature of the needs of a particular population so that services can be effectively planned and delivered to meet those needs. The outcome of needs assessment will be greater capacity within services and better access for service users, as well as improvements in the quality and range of service provision.

Needs assessment is not a one-off activity. Injecting populations, and their needs, may change over time, and so it is important to review needs assessment annually, and link the process of needs assessment to on-going monitoring and evaluation (described below).

Needs assessment is a complex task. However, there are a number of good practical guides which can assist with the process. Two of these are:

- Griesbach D, Hopkins V, Russell P & Rich C (2004) *Needs Assessment: A Practical Guide to Assessing Local Needs for Services for Drug Users*. Scottish Executive Effective Interventions Unit. Available at: www.scotland.gov.uk/Publications/2004/01/18783/32014.
- Cavanagh S & Chadwick K (2005) *Health needs assessment. A practical guide*. National Institute of Health and Clinical Excellence (NICE). Available at: www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf.

Stakeholder consultation and engagement

Planners and commissioners of IEP services need to take time to develop support among the diverse groups that will be affected by IEP services. These include: injecting drug users, treatment services, the police, public health, primary care and mental health services, and community representatives. One way of developing support is by establishing an advisory group comprising relevant stakeholders.

BBV Prevention Groups currently exist throughout Scotland, and generally these include representatives from agencies responsible for the commissioning and delivery of IEP services. To be truly effective, however, the planning of IEP services also needs to take into account the views of service users and community representatives. Local community drugs forums may provide one means of communicating with, and receiving input from, these groups.

In Scotland, planning regulations require formal public consultation prior to establishing a fixed-site IEP service. This is not required if the service is delivered within a pharmacy or other existing service,

or as an outreach, mobile or home-delivery service. However, even where formal public consultation is not required, future difficulties can be avoided if community representatives are actively involved in, and understand the benefits to the community, of IEP services. IEP services can often be victims of a “not-in-my-backyard” attitude. NHS Boards should be prepared to actively promote the benefits of IEP programmes to counter adverse media publicity and local opposition based on misinformation.

The police are also important stakeholders in relation to IEP services, and the drugs strategy of the Association of Chief Police Officers in Scotland (ACPOS) supports the principles of injecting equipment provision. Links to the police can be made through local community safety partnerships, and discussions with the police should take place before setting up any new service since police support can help to allay fears and combat local opposition. It may be helpful, in some circumstances, to establish a protocol with the police (and / or shop security staff), so that clients are not harassed when entering or leaving an IEP service, as this can discourage clients from attending.²⁶ Current good practice guidance from the UK Department of Environment, Food and Rural Affairs (DEFRA) suggests that such a protocol may also be helpful to avoid clients inappropriately discarding injecting equipment, since injectors may fear that if they are found by the police in possession of needles, they will be arrested and the needles used as evidence against them.⁵⁴

While it is crucial to engage with stakeholders in the early stages of setting up a new IEP service, it is also important to maintain that engagement over time, so that services can identify and respond to any issues that arise, and promote successes, for example, in reducing street-based injecting or drug litter.

Staff training

It is the responsibility of services to ensure that their staff are properly trained prior to delivering an IEP service. However, it is the responsibility of service planners and commissioners to ensure that suitable training is made available, and that staff are given all necessary support to be able to attend. In the case of pharmacy IEP services, this may involve providing locum costs. Recommendation 9 in Section 3 provides further information about the skills and knowledge that should be expected of all staff involved in the delivery of IEP services.

“Advertising” the service

Information about IEP services should, as much as possible, be targeted specifically at injecting drug users and agencies that work with them, not at the general population. This sort of communication strategy reduces the potential for inappropriate exposure that could lead to negative attention from the community and result in stigmatisation of clients attending services and practical difficulties for the service provider delivering the service.

Monitoring and evaluation

As discussed above, the process of needs assessment involves gathering information about the needs of a particular population. In many cases, a needs assessment exercise will result in change – either in the way existing services are provided, or in the introduction of new services or interventions. It is important to check that these changes are having the intended effect. For that reason monitoring and evaluation should be integral components of the process of needs assessment.

Monitoring is an ongoing process that involves the continuous or regular collection of key information to allow regular checks on whether an intervention is going to plan. However, monitoring does not provide information about the changes that could be made to improve outcomes for service users. For this latter task, evaluation is needed. The process of evaluation involves looking back to find out what difference an intervention has made. Evaluation can also be used to explore how and why something is working or not working.

Recommendation 2: Choosing appropriate models of delivery

NHS Boards and other service commissioners should ensure that a range of IEP services are provided using models of delivery appropriate to their local injecting populations and the geography in their locality, based on an assessment of local needs.

In addition, it is recommended that:

- All clients should be able to access in-depth advice and information from a specialist IEP service.
- In large towns and cities (defined by the Scottish Government's urban-rural classification as settlements of 10,000 or more), there should be a balance between the use of specialist, enhanced and general services.
- Fixed-site services should be located in areas where there are clusters of injecting drug users.
- All NHS Board areas should have at least one fixed-site service.
- Fixed-site services should be located on, or within five minutes walk of, a public transportation route.
- When injectors live in areas where they cannot easily access a fixed-site service on foot or by public transportation, other models of distribution (for example, through outreach) should be used in preference.

Chapter 3 of this document discussed the strengths and limitations of different models of IEP services. It is clear from the range of evidence presented that no one model of an IEP service can be considered better than another. Rather, the evidence suggests that some approaches may be more successful than others in reaching certain injecting populations, and that service users themselves may prefer, for a variety of reasons, to use one type of service over another. Therefore, IEP programmes delivered through **a combination of models** — with services at different venues tailored to meet the needs of different injecting populations — will be better than those delivered through a single model.

In considering which models to use, the aims must be:

- To maximise the distribution of sterile injecting equipment and remove barriers to access (discussed further in Section 2)
- To ensure that clients receive in-depth, user-friendly advice and education about how to reduce injecting-related risks (discussed further in Section 3)
- To offer clients access to a range of other services through IEP services (discussed further in Section 4)

Increasing pharmacy provision is one way of improving the accessibility of injecting equipment. At the same time, too much reliance on community pharmacy IEP services alone is problematic because of some of the limitations of pharmacy services discussed in Chapter 3 above. The National Needle Exchange Survey found that in some areas of Scotland, IEP service provision is almost exclusively through community pharmacies,¹⁹ which, at the time of the survey were mainly offering general IEP services. Therefore, it is recommended that in these areas, there should be a better balance between specialist, enhanced and general services. In addition, these different types of services should not all be provided in the same location; they should be *separate* services, to give service users a range of

options in how and where they access sterile injecting equipment. (For example, it may be useful to deliver a specialist service through outreach on the premises of an enhanced or general pharmacy service. However, this should not be the *only* route of access to a specialist service.)

To expand the distribution of sterile injecting equipment, both in remote and rural areas, and in built-up areas, there are some good arguments in favour of a greater use of outreach models. These services can be targeted to the needs of specific populations, can provide greater privacy and confidentiality, and can offer in-depth advice and education from a specialist harm reduction worker. However, there is a lack of evidence about the cost benefits of different forms of outreach. In remote and rural areas, peer distribution models may also be useful, and services should take sufficient time to educate peer distributors in safer injecting practices which they can pass on to others in their own social networks.

Service commissioners may also wish to give consideration to making injecting equipment more widely available through health centres, as this might also improve injectors' access to primary and secondary care. However, if the IEP service is only provided a few hours each week, there is a risk that clients will miss the service if they are unable to attend.

Although the use of dispensing machines is controversial, service commissioners may wish to consider the possible benefits of offering their injecting population 24-hour access to injecting equipment in this way.

In making the important decisions about where to locate a service, commissioners should take into account evidence which indicates that an injector's proximity to an IEP service can lead to greater utilisation of IEP services, and result in reduced syringe sharing.⁶ In addition, there is evidence from a number of studies to suggest that convenience (specifically opening hours, location and queues) of IEP services can influence decisions on whether to obtain injecting equipment from services, or from street sellers or through secondary distribution.³² Moreover, there is evidence to suggest that the immediate availability of injecting equipment is more important to injecting drug users than perceptions of risk associated with injecting behaviour.^{16, 32}

Recommendation 3: Meeting the needs of sub-populations of injectors

In deciding which models of service provision to use, service commissioners and service providers should give special consideration to the specific needs of the following sub-populations of injectors, where these populations exist in their area:

- New injectors
- Women
- Sex workers
- Homeless injectors
- Users of performance and image-enhancing drugs (PIEDs)
- Minority ethnic groups
- People receiving opiate substitution therapy, or who have recently relapsed following treatment
- People in custody (both prison and police custody) or recently released from custody or court.

People who inject drugs are not a homogenous group. Within the drug-injecting population, there are different cultures, and different groups with different needs. The groups listed above are often unwilling or unable, for a variety of reasons, to attend IEP services. Because of this, these groups are at high risk of acquiring HCV and other BBVs, and are at risk of other injecting-related harms resulting from unsafe injecting practices.

- **New injectors:** There is evidence from modelling studies to indicate that injectors are at greatest risk of being infected with HCV (and HBV) in their first year of injecting.⁵⁵ Experts are of the view that recent-onset injectors often do not use existing IEP services because they feel uncomfortable about disclosing their behaviour to individuals whom they perceive to be disapproving of them.
- **Women:** A review of qualitative evidence carried out by NICE has shown that female injectors are more vulnerable than men to unsafe injecting practices, due to incorrect beliefs about the risks of sharing equipment with a sexual partner, and increased fear of exposure. Women are also more likely to have negative feelings about using pharmacy-based IEP services and to obtain equipment by secondary distribution.³²
- **Sex workers:** A survey of health service use among female prostitutes found that sex workers are likely to have chaotic high-risk drug use and have multiple sexual partners. They are also likely to have poor use of health services, including IEP services.⁵⁶
- **Homeless injectors:** A review undertaken for NICE found evidence to suggest that homeless injectors have lower levels of syringe coverage than those who are not homeless.⁶ This is likely to put homeless injectors at greater risk of sharing and reusing injecting equipment. Homeless injectors are also more likely to report abscesses, open sores or wounds at an injecting site, and to be infected with HCV.⁴
- **Users of Performance and Image-enhancing drugs (PIEDs):** The nature of PIEDs and the way they are injected requires different injecting equipment (including larger barrels for syringes) and therefore a different form of safer injecting advice. IEP staff need additional training to be able to provide good-quality advice. Experts report that PIEDs users do not identify themselves with other injecting drug users, and as a result this group is often reluctant to access IEP schemes. At the same time, PIEDs users are often unaware of the risk of BBV transmission from

sharing needles. In planning services for PIEDs users, it should be noted that this group is often in employment and so may require evening services.

- **Minority ethnic groups:** Experts believe that this group of injectors, because of cultural differences, may not identify with other injecting drug users, and so may be reluctant to attend IEP services. There may also be language barriers in some cases.
- **People receiving opiate substitution therapy, or who have recently relapsed following treatment:** In the experience of experts, people on a methadone or other opiate substitution programme may face, or perceive barriers in accessing an IEP service, particularly if they are accessing needles through a pharmacy where they also are receiving methadone. This view was strongly confirmed by service user groups who were consulted on these guidelines. Both IEP services and treatment services should avoid punitive responses to injectors in this situation. Services should instead seek to discuss with the client whether changes need to be made in their prescription medication or dose, or whether other types of support are required, including the provision of injecting equipment.
- **People in or recently released from custody or court:** The most recent series of Hepatitis C prevalence studies in Scotland's prisons were undertaken in the mid-1990s. Overall, HCV prevalence was found to be 20.3%, which is substantially higher than HCV prevalence in the general population.⁵⁷ The high prevalence of HCV, combined with the illicit sharing of injecting equipment, make prisons a high-risk environment for the transmission of HCV.

In relation to police custody provision, a number of police custody suites in Scotland currently provide injecting equipment to people released from custody through needle replacement schemes, and there is tentative evidence that this model of IEP may be reaching people who are not otherwise in contact with IEP services.⁴⁰ Local areas may wish to consider the options for extending this type of service to people who are released directly from court after being held for a period in police custody.

The particular needs of these groups should be taken into consideration when deciding on the models and locations for IEP services and setting opening times. Some of these groups may require novel models of service delivery. In some cases, outreach models may be appropriate; in others, it may be enough to provide longer opening hours or night-time drop-in services.

Recommendation 4: Opening times

IEP services should operate at times when injecting drug users are likely to need access to injecting equipment. There should be out-of-hours and weekend access within each NHS Board area corresponding to the needs of local injecting populations.

As mentioned above in relation to Recommendation 2, convenience (specifically, opening hours, location and queues) of IEP services are very important to injectors and there is evidence that such factors can and do influence decisions on whether to obtain equipment from IEP services or from street sellers or secondary distribution.³²

IEP service commissioners and providers need to consider ways of improving access to sterile injecting equipment. One way of doing this is by making services available out of hours. Out-of-hours provision includes evenings, weekends and 24/7 provision.

Where resources are limited, there is some evidence to show that having access to injecting equipment at the weekend is rated more highly than having access in the evening⁵⁸ and injectors often consider community pharmacy IEP services to be more accessible than drug agency-based services for that reason.³² Consultation with service user groups in Scotland indicated that some community pharmacies may restrict access to injecting equipment to certain hours of the day. NHS Boards should ensure that these restrictions are removed and that injectors have access to sterile injecting equipment at any time during the pharmacy's opening hours.

Where local injecting populations include certain hard-to-reach groups (as described in the previous recommendation), there may also be a need for some form of service in the evenings which is directly targeted at those groups.

The need for injectors to have 24-hr access to sterile injecting equipment should also be considered. This can be done either through increasing the number of 24/7 services, by making injecting equipment available through existing 24/7 services (e.g., hospitals), and / or by making sterile equipment available through other means, such as dispensing machines.

Finally, NHS Boards should ensure that accurate information is made available to service users about the locations and opening hours of all local IEP services. This can be done through a leaflet, or by printing the information on the bag that is given to service users to hold their injecting equipment. This information should be updated as necessary when opening hours are temporarily changed such as, during holiday periods for example.

Section 2: Increasing distribution of injecting equipment

The recommendations in the previous section focused on improving the accessibility of IEP services to injecting drug users. The recommendations in this section are about increasing the quantity of injecting equipment (both sterile needles and other injecting paraphernalia) that services give out. The aim of these recommendations is to make it possible for **every** injector to use a sterile set of injecting equipment for **every** injection. This principle should guide the distribution of injecting equipment in **all** IEP services in Scotland at all times.

Until recently, in Scotland there was a legal limit on the number of sterile needles that IEP services may give out to injecting drug users at any one time. These limits were set by Scotland's Lord Advocate in December 2002.⁵⁹ In recognition of the important public health imperative to encourage one needle per injection, the Lord Advocate has agreed to remove any requirement to limit needle and syringe provision, or the requirement to return used needles, and has issued new Guidelines to reflect this agreement in line with the publication of these Scottish Government guidelines for IEP services.

It is important to bear in mind that, although there was previously a legal limit on the number of needles and syringes that IEP services could give out to a client at any one time, there was also evidence from research to indicate that injecting drug users were not receiving anywhere near these numbers of needles when they attended IEP services. The reasons for this are discussed below under Recommendation 5.

Recommendation 5: Provide one needle / syringe per injection

IEP services should provide, free of charge, as many needles as an individual client requires.

Services should continue to encourage clients to return used needles, and individual safe disposal bins should be provided for this purpose. However, the provision of sterile needles should **not** be dependent on the return of used needles. Services should aim at all times to ensure that all clients have a sterile needle for every injection.

NHS Boards should ensure that all IEP services in their area are actively encouraging their clients to take sufficient numbers of needles.

A review of evidence carried out for NICE found that **higher** needle coverage is associated with **lower** levels of injection risk behaviours among injectors, including sharing needles, sharing cookers and syringe re-use.⁶ However, findings from the National Needle Exchange Survey showed that the number of needles currently given out to injecting drug users in Scotland falls far short of the number required to ensure one needle per injection. The short-fall is estimated to be in the millions.¹⁹

Statistical modelling studies have shown that there is a need to reduce needle sharing substantially to make a real difference to the incidence of HCV.¹¹ While there has been a slow decline over the past few years in the intentional sharing of used needles among injecting drug users,^{14,15} nevertheless, the re-use of previously used needles and unintentional sharing of needles continues to be common.^{16,17}

Until recently, there were legal limits set on the numbers of needles and syringes that could be distributed to injecting drug users in any one transaction. However, the findings of the National Needle Exchange Survey in 2005 showed that, within those limits, very few injectors were receiving their entitlement.¹⁹ This was due to a combination of factors. An evaluation of the impact of the Lord Advocate's Guidelines (as published in December 2002) found that injectors often did not ask for their entitlement — either because they did not know what it was, or because they felt they were already receiving sufficient needles for their injecting needs — despite re-using needles.³¹

At the same time, some IEP services in Scotland had distribution policies that were contrary to — and which placed greater restrictions on numbers — than the Lord Advocate's Guidelines.^{19, 31} In some cases, these policies were intended to “encourage” the client to return used injecting equipment to the IEP service. However, the unintended consequence was that some clients had to re-use or share needles.

The National Needle Exchange Survey also found massive variations between local areas in the numbers of needles distributed per injector in a one-year period — suggesting that the short-fall in distribution may be related to service configuration or local service policies.¹⁹

As of March 2010, there are **no** legal limits on the numbers of sterile needles and syringes that IEP services can give out to their clients. Therefore, any local policies that limit the distribution of sterile injecting equipment should be removed, and services should make every effort to ensure that all their clients are able to use a new needle and syringe for every injection.

As of March 2010, there is also no legal requirement for clients of IEP services to return used injecting equipment before new equipment can be distributed. Experts agree that it is poor practice to limit the

distribution of injecting equipment when clients do not bring back used equipment.⁶⁰ Nevertheless, it is good practice to encourage clients to return their used equipment. Furthermore, individuals can be prosecuted if they are found disposing of used injecting equipment in a way that could put members of the public at risk. It is suggested that service commissioners should explore new ways of maximising needle return, for example, through the provision of specially-designed public disposal bins and through home collections. At the same time, service providers should discuss with their clients how best to promote personal and civic responsibility among injectors in relation to this issue.

Above all, IEP services should develop strategies to actively increase needle distribution among injectors, and where there are barriers to increasing uptake (either from the service, or from the client), these should be removed. Clients visiting the IEP service should be encouraged to take *more* needles, and the message needs to be continually reinforced that individuals should use a sterile needle for every injection.

Recommendation 6: Provide other drug injecting paraphernalia

IEP services should provide, free of charge:

- Acidifiers
- Cookers
- Filters
- Water for injections
- Pre-injection swabs

These items should be supplied in sufficient quantities to enable the use of one item each per injection.

The sharing of injecting paraphernalia used in the drug preparation process — for example, cookers, filters and water — may present further opportunities for the transmission of BBVs. Evidence from a laboratory study which tested used paraphernalia from injecting drug users, found HCV on 67% of swabs, 40% of filters, 25% of spoons and 33% of water samples.⁶¹ There is insufficient evidence to indicate that the provision of sterile paraphernalia reduces injecting risk behaviour or the transmission of HCV because few studies have been undertaken.^{6,7} A review of epidemiological studies found evidence of a positive association between HCV incidence and sharing paraphernalia, although the studies were limited by methodological issues.⁶² HCV seroconversion has been particularly associated with sharing spoons and cotton filters.^{63,64} Given that the sharing of paraphernalia among injectors is highly prevalent,^{14,16,17,18} even among those who report never having shared needles, the potential for transmission via this route is great.

Therefore, these guidelines strongly recommend that IEP services distribute cookers, filters, water for injections and pre-injection swabs to service users, and that this provision should be free of charge. If the provision is *not* free of charge, it is likely that injectors will use their own “home made” supplies — which are not sterile, and which may be reused again and again — thus increasing the risk of HCV transmission. It is worth noting that recent studies have found that the provision of injecting paraphernalia by IEP services was seen as a high priority among service users themselves.^{18, 58}

Although the use of an acidifier does not contribute to the prevention of HCV or other BBVs, this recommendation includes the distribution of acidifiers — either citric acid or ascorbic acid (both available in sachets). An acidifier is necessary to make diamorphine soluble for injecting.⁶⁵ In addition, there has been some evidence at a local level which shows that the distribution of citric acid can attract people to services.⁶⁶ Moreover, if a sterile acidifier is not supplied free of charge, injectors are likely to make use of alternatives such as processed lemon juice or vinegar, which have both been associated with a greater incidence of eye problems in injectors.³⁰

All of the items recommended for distribution here are permitted under *The Misuse of Drugs (Amendment) (No.2) Regulation 2003* which came into force on 1 August 2003.⁶⁷ In addition, under the *Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005*, which came into force on 30th June 2005, the distribution of water for injections is permitted without a prescription so long as the water is supplied in 2ml quantities or less.⁶⁸

The distribution of injecting paraphernalia also needs to be accompanied by a discussion about the correct single-person use of each item of paraphernalia. Service user education is discussed further in Recommendation 11.

In providing a sterile set of injecting paraphernalia for every injection, it must be accepted that there may be some waste of equipment that service users either may not want or not need. For example, one ampoule of water for injections or one full citric acid sachet may be more than is required for one injection. Injectors should be advised to dispose of the remaining water / citric acid safely, rather than attempt to store it for later use. Homeless injectors may not be able to carry large packs of injecting equipment with them, and so where the only supply of sterile injecting equipment is through pre-packed bundles, these injectors are likely to dispose of the equipment they do not immediately need. This latter situation can be avoided through the use of a 'pick-and-mix' arrangement, whereby clients choose the equipment and paraphernalia they need. Furthermore, where injecting supplies are distributed in pre-packed bundles, it may be possible to reduce waste by offering service users a range of packs containing different sizes and numbers of needles / syringes, and involving clients in the design of the packs.

Recommendation 7: Secondary distribution

Secondary distribution should not be discouraged. If a client states that he / she is supplying injecting equipment to others, it is acceptable to provide supplies for the purpose of secondary distribution.

However, those clients who supply equipment to others should be encouraged to bring the other injectors into the IEP service so that they can benefit from advice and information.

Secondary distribution of injecting equipment is very common.^{18,32} Chapter 3 set out some of the advantages and disadvantages of secondary distribution in terms of preventing risk behaviour. The main advantage is that it can extend the reach of IEP services to injectors who may not be in contact with services and thus can get sterile injecting equipment to people who might not otherwise have it. The main disadvantage is that services have very little control over the information given to those who are the recipients of secondary distribution.

Where services are aware that secondary distribution is happening, IEP staff should ask the secondary supplier how many people he is supplying to, and whether there is any sharing of needles or other injecting paraphernalia. IEP staff should encourage the secondary supplier to bring those he supplies to into the service, and information should be provided about other IEP services offered in different localities and at different times.

Importantly, the secondary supplier should be asked to spend some time in the IEP service to discuss information about safer injecting practices, and the safe disposal of used injecting equipment, which he can pass on to those he supplies to. IEP services may find it helpful to have a supply of leaflets or other materials which they can talk through with the secondary supplier, and which he can pass on to others.

Where services have a good relationship with a secondary supplier, they should consider whether it might be appropriate to establish a more formal arrangement with this individual, for example, by developing a peer-led outreach service. As mentioned in Chapter 3, peer-led services have the same advantages as secondary distribution, but they also can be used to deliver better, more consistent harm reduction messages to members of the peer distributor's network.

There are examples from the literature of highly effective incentive-based peer-driven educational interventions, where injectors are given rewards for passing on a body of harm reduction information to their peers, and then recruiting those individuals to attend a harm reduction session in an IEP service. These were found to be significantly less expensive than traditional peer outreach interventions.⁴⁸

Recommendation 8: Provide methods for syringe identification

Injectors should always be encouraged to use a sterile needle and related paraphernalia for every injection. However, the reality is that some injectors may continue to reuse needles. Therefore, a method of equipment identification should be made available to clients who inject in the company of other injectors in order that they can identify their own equipment and avoid accidental sharing.

Despite the messages that service users are given about not re-using needles, many continue to do so, and where people inject in the company of others, it is possible that they may mix up their needles. An observational study among injectors in Glasgow highlighted the extent to which this situation can result in the accidental sharing of needles.¹⁷

Therefore, injectors need to have some method of distinguishing their own equipment from other people's. This may include, but is not limited to syringes with colour-coded plungers, coloured labels or tags. Different methods may be preferred by different people.

However, at the same time, it is crucial that the central message — *to always use a new needle / syringe for every injection* — should never be watered down or forgotten. The use of syringe identifiers simply recognises that it may not always be possible for injectors to use a sterile needle / syringe each time. Syringe identification methods can help reduce the risks of cross-infection by helping to prevent accidental sharing of used needles.

The inability to tell the difference between used syringes has been recognised as a significant cause of syringe sharing and BBV transmission.¹⁷ At the present time, there is no robust evidence on the most effective method of identifying / distinguishing syringes. However, it is likely that syringes that have difference built into the design will be more effective than methods that require injectors to mark or label their syringe.

Section 3: Improving the effectiveness and consistency of IEP services

A review of international research carried out for NICE found that there was a lack of evidence about the optimal provision of IEP services.⁶ The review therefore suggested that it was difficult to draw conclusions on ‘what works best’ within the range of harm reduction services available to injecting drugs users. Nevertheless, it was apparent from the literature that the distribution of sterile needles and syringes alone is **not sufficient** to reduce the transmission of blood-borne viruses among IDUs, especially the transmission of HCV.

This suggests that the effectiveness of an IEP service is likely to depend not only on **what** the service offers, but **how** it is offered.

The National Needle Exchange Survey found a lack of consistency between services in almost all aspects of service delivery in Scotland. Focus groups with service commissioners, service providers and pharmacy co-ordinators also identified a lack of consistent training among staff as one of the most significant barriers to good practice in IEP services.¹⁹

Therefore, this section makes recommendations that aim to improve the quality and consistency of IEP services. The focus is very much on improving the way services interact with their clients. To some extent, this requires improvements in staff training — so that staff can feel more knowledgeable and confident in speaking to clients. However, there is also a need, even after staff are trained, to find better ways of engaging with clients — not only to find out what the client’s needs are, but also to ensure that important messages are repeated to clients frequently and consistently across services.

Recommendation 9: Training of IEP service staff

As a minimum, all individuals involved in the distribution of injecting equipment should receive appropriate training *prior* to providing a service or during induction in relation to:

- Understanding drug use
- How to engage with drug users
- Injecting risk behaviour
- Correct, single person use of injecting equipment
- Needs of different sub-populations of injectors, including those who are in treatment
- Prevention of HCV and other blood-borne viruses
- Overdose prevention and management
- Procedures regarding safe disposal of used injecting equipment
- Procedures for managing needle stick injury
- Contact details of other local relevant services

All staff involved in the provision of injecting equipment should have read and understood these guidelines. They should also be familiar with the Lord Advocate's Guidelines (issued in March 2010), and have basic training in child protection awareness. Pharmacists involved in the delivery of IEP services should complete the NHS Education Scotland (NES) distance learning package on "Pharmaceutical Care of the Substance User."

Staff training should include information about the importance of sensitivity and confidentiality in delivering an IEP service, and information about how best to liaise with other local services in relation to the needs of their clients.

On-going supervision should be provided and training should be updated at least annually.

NHS Boards should ensure that relevant training is made available to staff involved in the distribution of injecting equipment, including counter staff in community pharmacy services, and that these individuals are given all necessary support to attend the training.

There is currently no standard training for people involved in the delivery of IEP services. Work is on-going by the Scottish Government to agree a national drug and alcohol workforce development strategy, and separate work is also being undertaken through the *Hepatitis C Action Plan, Phase 1*, to create a national HCV Learning and Workforce Development Framework, which will ensure that Scotland's HCV workforce is knowledgeable, skilled and confident in working with people who have, or who may be affected by, the HCV virus (Action 3, see page 41).¹

In the longer term, both these strands of work will lead to greater consistency and standardisation in training for staff involved in the delivery of IEP services. However, in the short term, NHS Boards still have a responsibility to ensure that IEP staff are adequately trained and skilled to be able to provide a high-quality service. In relation to this, it is worth noting that the National Quality Standards for Substance Misuse Services in Scotland require that:

Workers (paid and unpaid) will be appropriately trained and supervised (Quality Standard 8, point 3).

and that

*Services should employ and train their staff to treat clients with respect and dignity. (Quality Standard 3, point 2)*⁶⁹

Recommendation 9, above, specifically focuses on the knowledge and skills required by staff who are involved in face-to-face contact with clients. Experts are of the opinion that training in these areas is important to ensure that staff are delivering consistent messages and providing a consistent service.

Staff training is not a one-off action. On-going training is necessary to ensure that staff are able to learn about innovations and new approaches to working with clients. Staff also need remain up-to-date with new information on HCV and other blood-borne viruses — treatment, prevention and vaccination procedures.

It is often the case that staff employed in specialist harm reduction services have previous experience of working directly with injectors prior to starting work in the IEP service. However, this may not be the case for service providers in other types of services.³⁵ It is suggested, therefore, that training for all IEP staff should be multi-disciplinary (that is, pharmacists, custody suite officers and specialist IEP providers should ideally receive training *together*, rather than *separately*), and training might usefully include brief work experience within a well-run IEP service.

Having the right knowledge and skills is important in providing an IEP service. However, the personal qualities of staff are also important in maintaining the quality of IEP services. In focus groups with service commissioners, service providers and pharmacists undertaken as part of the National Needle Exchange Survey, it was reported that negative staff attitudes — perceived to be linked to inadequate staff training and support — were identified as two of the biggest barriers to good practice in IEP services.¹⁹ And indeed, there is evidence from qualitative research among injectors in the UK to indicate that negative and judgemental staff can act as a barrier to clients accessing services.⁷⁰ In contrast, friendly, approachable staff can encourage the use of the service.⁵⁸

Finally, it is not enough to simply make training available to IEP service staff. The training must be offered in a way that allows staff to attend. This may have implications particularly, for example, for pharmacists, and may require the employment of locums or that training be delivered in the evenings. Local commissioners should ensure that services are given support to enable staff to attend training. In any case, while it is the responsibility of local service commissioners and planners to make relevant training available, it is the responsibility of service *providers* to ensure that all staff involved in the provision of injecting equipment are trained *prior* to delivering a service.

Recommendation 10: Identifying and responding to the individual client's needs

All clients attending a service for the first time should be welcomed to the service and asked some basic information about their injecting practices in order that services are able to meet their needs. This initial discussion should be carried out in a private area, separate from the public, to ensure client confidentiality, and it should include the provision of both verbal and written information about safer injecting practices and about safe disposal of used injecting equipment.

As a **minimum**, IEP services should ask clients:

- How often they inject
- What they are injecting
- How often they (usually, or intend to) visit the IEP service, and
- Whether they are collecting supplies for anyone else.

This is to ensure that clients' equipment needs are addressed and that they leave the service with sufficient supplies to enable the use of one set of equipment per injection.

Many clients value speed and convenience in an IEP service. However, to meet a client's injecting needs appropriately, services will need to take some time, at least initially, to find out what those needs are. The *National Quality Standards for Substance Misuse Services* (Standard 4) requires that services undertake an assessment of the client's needs, and that the client should be involved in this process.⁶⁹

In the context of an IEP service, the term "assessment" simply refers to a very basic discussion which should take place with **all** clients the first time they attend the service. The questions listed above should form the basis for this discussion. (Service providers should also ask these questions of all their *existing* clients if they have not previously done so.) The main purpose of this discussion is to ensure that clients receive sufficient injecting equipment (needles, filters, cookers, etc.) for their injecting needs — i.e., to enable the use of one set of injecting equipment per injection. The responses to these questions do not need to be recorded by the service, but it is recognised that if they are not recorded, services may find it easier to ask the questions each time a client attends the service.

This initial discussion should also be used to educate the client about safer injecting practices and safe disposal procedures, and to provide information about other (types of) IEP services in the area. This is particularly important for young, or new injectors, who may have had little or no previous accurate advice or information. Some service providers may find it helpful to use a leaflet or other written resources to guide this discussion. However, it is *not* recommended that services give clients a leaflet without going through the leaflet with them first. (The reason for this will be discussed in relation to Recommendation 11 which addresses service user education in more detail.)

As has been mentioned earlier in this document, injecting drug users place great value on confidentiality and privacy in using IEP services, and some may avoid attending services for fear of being exposed.³² Therefore, wherever possible, services should find ways to conduct IEP service transactions and have discussions with clients in a private space, away from other customers. In a community pharmacy setting, a consultation room can be used for this purpose.

To allay any fears or concerns that clients may have in relation to being asked about their injecting practices, service providers should clearly explain to clients that this is being done *only* so that they can be provided with a better service, and the information will be kept confidential.

Once IEP service staff have established a relationship with a client, it is suggested that these questions should be repeated from time to time, to ensure that the client's injecting needs are still being met. In addition, service providers should ask their clients at frequent intervals if they are having any difficulties with the use of their injecting equipment, or if they have any questions about its use. Services should at all times put the client at the centre of the service, and treat clients with respect and dignity as required by the *National Quality Standards* (Standard 3).⁶⁹

The recommendation above relates to a basic assessment which should be undertaken by all IEP services. However, it is recognised that specialist and enhanced IEP services may be able to undertake a fuller assessment of a client's needs. Where this *is* possible, the assessment should additionally include questions about:

- Where clients are injecting (ie, what part of the body)
- BBV status
- Current or previous experience of treatment for drug misuse

When responding to clients' *needs*, IEP services should also take into account that different clients may have different *preferences*, for example, in relation to the size of needles and syringes they use. Services, including those that distribute needles / syringes through pre-packed bundles, should offer clients a choice of needles / syringes.

Recommendation 11: Service user education

As a **minimum**, when providing needles and injecting equipment, IEP services should educate clients about:

- Washing their hands with soap and water before injecting
- The correct use of each item of injecting equipment
- The risks of sharing injecting equipment
- The correct methods of disposing of used injecting equipment.

Recommendation 10 touched on the importance of IEP services providing information to their clients on safer injecting practices. This recommendation considers this issue in more depth.

As discussed in Chapter 1 of this document, there is evidence to show that the sharing of needles among injecting drug users in Scotland is declining.^{14,15} However, the reuse of needles and the sharing of other injecting paraphernalia (cookers, filters and water) continues to be highly prevalent.^{14,16,16,18} The practices of *frontloading* (drawing up a drug solution into a 'donor' syringe and then measuring out appropriate amounts into one or more other syringes) and *backloading* (removing the plunger from a recipient syringe and squirting the drug solution into the syringe through the back opening) are also common.^{17, 71} In addition, some studies have found that injectors often do not understand how sharing cookers, filters and water can result in HCV transmission.^{18,16, 72} This evidence suggests that IEP services may need to take a more active role in educating injectors, and / or to find new ways of providing advice and information about safer injecting practices.

As mentioned in Chapter 3 of this document, the level of information and advice available through IEP services will depend to some extent on the knowledge and expertise of the staff. It is expected that staff in specialist IEP services will be able to provide in-depth information and take on more of an educational role with clients than staff in general IEP services. However, staff in *all* services should be able to give clients basic information (both verbal and written) about how to reduce the risks associated with injecting.

The content of this information should include, as a minimum, the points listed above. The first three points are recommended on the basis of research which examined the theoretical benefits and risks associated with different items of injecting paraphernalia (eg, acidifiers, cookers, filters, sterile water) and different injection preparation methods.¹⁸

The distribution of injecting paraphernalia should initially be accompanied by a discussion about the correct single-person use of each item of paraphernalia. In relation to the use of acidifiers, it should be explained to clients that although the use of a sterile acidifier is safer than using non-sterile alternatives (e.g., lemon juice or vinegar),³⁰ the use of a sterile acidifier is not entirely without risk. An acidifier can irritate or cause acid burns during injection. Unfortunately, it is not possible to recommend precisely how much acidifier should be used during the injection process without knowing the purity and thus the concentration of diamorphine in street heroin.¹⁸ Therefore, when supplying acidifiers, IEP services should advise service users to add acidifier in small amounts, a little at a time until all the drug has been dissolved. In some cases, an entire sachet of citric acid or ascorbic acid will not be needed, and the remaining acidifier should be disposed of safely.

Services should discuss these issues with **all** clients attending the IEP service for the *first time or after a period of absence*, even if the client may have been attending another IEP service. As mentioned in

relation to Recommendation 10, this discussion should take place in a private space or separate room to ensure client confidentiality. In addition, *every time* a client attends an IEP service, staff should remind him / her of the following key messages:

- Clients should wash their hands before injecting
- Clients should always use a sterile needle for every injection — *do not reuse needles*.

When providing information to clients, service providers should try as much as possible to avoid the use of jargon. For example, the word, “paraphernalia,” may not be understood.¹⁸ In addition, there is evidence suggesting that leaflets are not the most effective method of communicating important messages to injecting drug users since some may have literacy problems.³¹ Therefore, verbal communication is an important method for educating service users. Where printed materials are used, it is suggested that they use visual / graphic methods of communicating messages, rather than relying heavily on written text.

In planning IEP services, local NHS Boards should be aware that, for a variety of reasons, some injectors may prefer not to attend fixed-site services to obtain their injecting equipment. These individuals need to receive educational input through other means, and it is suggested that outreach or peer-led services may be suitable for this purpose.

Recommendation 12: Getting client feedback

All IEP service providers should put in place mechanisms for obtaining and responding to client feedback at regular intervals — at least annually.

NHS Boards should ensure that client feedback informs the on-going planning and development of local IEP services in their area.

Any attempt to improve the quality of IEP services in Scotland must take into account the views and preferences of the people who use those services. The *National Quality Standards for Substance Misuse Services* in Scotland state that the perspectives of service users must play a central role in service delivery and development, and that service users should be asked at least once a year for their views and ideas on the service. (See Quality Standard 11.)⁶⁹

However, the findings of the National Needle Exchange Survey suggested that service users views currently appear to play little part in IEP service provision.¹⁹ This recommendation seeks to change this situation.

Client satisfaction is an important aspect of service effectiveness, and it is suggested that services could benefit by asking their clients for their views more often. The process of finding out the views of clients needs not be time-consuming or expensive. However, a little time will be needed to analyse and report the results.

There may be some benefits in having client feedback collected consistently across services within a local area and it is suggested that NHS Boards assist with this. Agreeing a consistent method is more likely to result in services collecting the information — whereas if it is left to each service to decide what information to collect and when to collect it, the task may not be prioritised. In addition, some services may require assistance in deciding what to ask clients and how to record and analyse the information.

Recommendation 13: Monitoring, evaluation and audit

IEP services should have systems for monitoring, evaluation and audit to enable on-going needs assessment at a local level.

In terms of monitoring, services should report to their local NHS Boards, and NHS Boards should participate in national data collection requirements. As a minimum, monitoring systems should allow NHS Boards to report on:

- The number of general, enhanced and specialist IEP services available in the area
- The number of needles distributed
- The number of items of other injecting paraphernalia distributed
- An estimate of the number of needles returned
- The number of transactions
- An estimate of the number of clients
- The proportion of male and female transactions and clients.

This guideline introduces a requirement by NHS Boards to participate in the national monitoring of IEP service activity through collection of a minimum data set. The development of a national minimum data set is an action under the *Hepatitis C Action Plan for Scotland, Phase II* (see Action 21).¹ The purpose of national monitoring is to allow the Scottish Government to determine whether NHS Boards are distributing sufficient injecting equipment to meet the needs of their local injecting populations.

However, the data items listed above are recommended not only to facilitate monitoring at a national level, but also at a local level. Data collected through monitoring provides the basis for on-going needs assessment and future service development. In relation to this point, it is suggested that local areas may also find it useful to collect additional data on:

- Drugs injected
- Frequency of injecting
- Client BBV status
- Postcode sector of residence (this is the first half of the postcode plus the first digit of the second half, eg, EH12 6 or DD3 7)

These latter four items will **not** be included in the national minimum data set, but they are nevertheless very important for planning services at a local level.

To provide an estimate of the number of clients attending IEP services, it will be necessary for services to assign a unique identifier to each of their individual clients. Examples of a unique identifier could include, for example, a combination of the client's initials and date of birth. Clients may also be asked to provide their own unique identifier, for example, a nickname, or a number which has significance for them. Services are *not* required to record their clients' names.

In some cases, clients will be collecting injecting equipment for other injectors. If possible, services should attempt to capture information about the number of other injectors for whom the client is collecting supplies. It is recognised that this will not provide a precise estimate of the number of injectors in a particular area.

Traditionally, IEP services have been completely anonymous. However, with an increasing emphasis on evidence-based practice and measurable outcomes, IEP services need to move away from complete anonymity for the sake of improving the quality and accessibility of services.

As discussed in relation to Recommendation 10, some clients may feel worried or suspicious about the shift away from a fully anonymous IEP service. Service providers should anticipate these fears, and explain to clients that new guidelines have been introduced across Scotland to improve services, and that to be able to provide a good quality service, local areas need better information about the number of injectors living in their area. IEP services should continue to operate on a confidential basis.

The national minimum data set will also require an estimate of the number of needles returned. The inclusion of this data is not for the purposes of determining whether sufficient injecting equipment is being distributed, but rather for evaluating the effectiveness of educating clients about safe disposal. It is accepted that data on returns is significantly flawed and can only be based on a rough estimate: IEP service staff should **never** open returned disposal bins to count the contents. Furthermore, clients might dispose of equipment safely through a variety of IEP outlets or through public sharps disposal bins.

However, NHS Boards should work together with local authority Environmental Health Departments to monitor sharps and injecting paraphernalia discarded in public places. The routine collection and analysis of this data can be used to good effect in planning the locations of sharps disposal bins (discussed further in relation to Recommendation 16).

Finally, although service monitoring is very important, monitoring of the data outlined above does not provide information about service outcomes or adherence to these guidelines. Therefore, NHS Boards should undertake service evaluation, and ensure that robust audit procedures are in place at a local level, to assess whether local IEP services are implementing these guidelines. Obtaining and acting upon client feedback (as discussed in Recommendation 12) should form an integral part of this process.

Section 4: Integrating injecting equipment provision with other services

IEP services have traditionally been seen as ‘low-threshold’ services. However, the intention has always been that IEP services should provide a route into treatment for injecting drug users. More recently specialist and enhanced IEP services in Scotland have begun to provide their clients with far more than just a route into drug treatment. These services give their clients access to a wide range of primary care and social care interventions, by providing regularly-scheduled “clinics” or consultations on the premises of the IEP service.

There is also a growing trend by specialist and enhanced services to offer a range of BBV interventions on-site. For example, at the time of the National Needle Exchange Survey in 2005, 40% of specialist IEP services in Scotland provided HCV testing facilities on-site.¹⁹

There is also evidence from qualitative research carried out among injectors in the UK which indicates that injectors can face a range of barriers when trying to access help from generic health and social care services.⁷³ These barriers include the burden of appointments, travel to services, stigma and negative staff attitudes, personal ill-health, lack of material resources and anxieties about accessing support.

Therefore, any move towards providing these more generic services within the premises of an IEP service is to be encouraged and strongly supported. Such a development is very much in line with the principles of integrated care as set out in the Effective Interventions Unit publication, *Integrated care for drug users – principles and practice*:

*Integrated care for drug users is an approach that seeks to **combine and co-ordinate** all the services required to meet the assessed needs of the individual. It requires:*

- *Treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug users*
- *The service response to be needs-led and not limited by organisational or administrative practices*
- *Collaborative working between agencies and service providers at each stage in the progress of the individual.*⁷⁴

IEP services are well-placed to play a major role in bringing about better, more integrated care for injecting drug users, and the recommendations in this section focus on improving integration between IEP services and other types of services. This includes services which aim to identify those who are infected with HCV, and which link them into clinical care and social support.

Recommendation 14: BBV testing and vaccination for IEP clients

IEP services should encourage clients to be tested annually for HCV. In addition, wherever possible, all IEP services should make available vaccination (for HAV, HBV and tetanus) and testing (for HCV, HBV and HIV) **on-site** in a suitable private space.

Testing — including pre- and post-test discussion, sample collection, result-giving and onward referral — should always be delivered by appropriately trained staff. Where IEP services do not offer testing and vaccination facilities on-site, they should develop referral pathways that are user-friendly and accessible to injecting drug users.

The 2007 Needle Exchange Surveillance Initiative (NESI) found that a large proportion of injecting drug users attending IEP services in Scotland are not only infected with HCV, but are unaware that they are infected.¹³ If this situation remains unchanged, it is expected that the number of injectors who go on to develop HCV-related decompensated cirrhosis in Scotland will double between 2000 and 2020.⁷⁵ Guidance issued by the Royal College of General Practitioners points out that unless testing and early treatment is made more widely available, HCV is likely to cost the NHS across the UK up to £8 billion over the next 30 years as increasing numbers of people will require treatment for cirrhosis, liver failure and liver cancers.⁷⁶

Given the high prevalence, and incidence, of HCV among injecting drug users, frequent testing must be recommended. However, the aim is not only to reduce the number of undiagnosed infections among injecting drug users, but also to promote better integration between IEP services and specialist hepatitis services — so that those who are infected can receive the treatment they need.

Research undertaken during Phase I of the *Hepatitis C Action Plan for Scotland (September 2006 – March 2008)*, found that there was a lack of integration among primary care, specialist hepatitis services, addiction, prison and social care services. This resulted in many HCV-infected persons not obtaining the anti-retroviral treatment and care they needed.⁷⁷ This same study found that there were also often lengthy delays between having blood taken, and receiving a test result. Injecting drug users, in particular, often fail to return to their GP to learn of their HCV status following a test.

Action 10 of the *Hepatitis C Action Plan, Phase II* requires that NHS Boards work together with Community Health Partnerships (CHPs) to develop and implement innovative approaches to improve HCV testing and referral activities by GPs and practitioners in other community settings.¹ The recommendation made here – that testing facilities be made available through IEP services — may be considered to be one such innovative approach, and would result in making testing more accessible to injecting drug users.

When offering testing to injecting drug users, it is important to keep in mind that many injectors do not perceive HCV with the same level of concern as they do HIV, nor do they necessarily understand the significance of a positive HCV test result.^{18,17, 72} Injectors must be made aware of the implications of both a positive and a negative result so that they are able to give informed consent to be tested. Explaining this may take time, and should be done by suitably trained staff in a way which respects the individual's privacy and confidentiality. There is SIGN guidance available, as well as the guidance issued by the RCGP (mentioned above), which should provide the basis for pre- and post-test discussions carried out with clients in IEP services.⁷⁸

In relation to Hepatitis A, Hepatitis B and tetanus, these guidelines recommend vaccination of injecting drug users on the basis of current Department of Health guidelines, *Immunisation against Infectious Diseases 2006 (The Green Book)*.⁷⁹ (See Chapter 17, page 150; Chapter 18, pages 168-169; and Chapter 30, page 372.)

Recommendation 15: Improving integration between IEP services and other services

All IEP services should be able to signpost, and where possible, formally refer clients to treatment for drug misuse.

In addition, IEP services should be able to signpost, and where possible, formally refer clients to other broader health and social support services, including:

- Well women, sexual health services and family planning advice
- Benefits advice
- Legal aid
- Social and mental health services
- Training and employability services
- Homelessness services
- Primary healthcare, including dressings, wound care and antibiotic prescribing
- Dental care
- Counselling
- BBV treatment and support services
- Emergency department care

Wherever possible, IEP services should make any one or more of these broader support services (excepting emergency department care) available **on-site**. Where this is not possible, user-friendly and accessible referral pathways should be developed.

An international review of qualitative research carried out for NICE found evidence to suggest that a range of harm reduction interventions (including referrals to drug treatment and other services; BBV testing; and medical care), in addition to IEP services, were accessed and valued by injecting drug users.³² These findings are supported by a study from Scotland which sought to identify and rank client preferences in relation to the development of IEP services. This study found that access to dressings for wounds and sores and antibiotic prescribing were considered to be particularly important, since injectors can be reluctant to visit their GPs for these problems.⁵⁸

Just as there may be some benefits to providing a range of other services within the premises of an IEP service, so there may also be benefits from providing injecting equipment on the premises of *other* services. For example, a review carried out for NICE found evidence to show that hospital-based IEP services may increase the accessibility to outpatient services among injectors attending these services.⁶ This same review also found that the provision of injecting equipment through health care services may decrease emergency department use by injectors.

IEP services should not prevent injectors from being referred for treatment for HCV (or other BBV) infection on the basis that they are still injecting. SIGN Guideline 92 on the *Management of hepatitis C*, states that:

*Current injecting drug users infected with HCV should not be excluded from consideration for HCV clinical management, including antiviral therapy, on the basis of their injecting status.*⁷⁸

IEP service providers should also be aware that it is not uncommon for drug users to continue to inject even after entering a programme of substitute prescribing treatment. For example, an observational

study carried out in Scotland found that half of the 30 injectors who took part in the study were receiving methadone treatment, but were still injecting.¹⁷ Similarly, the 2007 Needle Exchange Surveillance Initiative (NESI) found that between 70-77% of IEP service clients in Glasgow, Edinburgh and Lanarkshire reported receiving methadone treatment in the last six months.¹³

NICE reviewers found evidence to suggest that the combination of methadone maintenance therapy and full participation in an IEP programme reduces the incidence of HIV and HCV among drug users.⁶ Therefore, IEP services should not discourage injectors from accessing sterile needles and other injecting equipment on the basis of receiving treatment for drug misuse.

Section 5: Health and safety of staff, clients and the community

This final section makes recommendations about health and safety issues. It is assumed that NHS Boards have carried out a detailed risk assessment for all IEP services in their area, and that procedures are in place, not only to protect staff, but also clients and members of the public.

The two recommendations made in this section aim specifically to reduce the risk of transmission of BBVs among staff, clients and the general public.

Recommendation 16: Ensuring the safe disposal of used injecting equipment

As part of wider risk assessment procedures, NHS Boards should ensure that all services in their area have robust policies and procedures in place in relation to the safe disposal of used injecting equipment.

To prevent the transmission of BBVs through improperly discarded injecting equipment, IEP services should:

- Educate staff and clients to safely handle and dispose of used injecting equipment
- Provide multiple options and locations for safe disposal of used injecting equipment
- Inform staff and clients that they could be prosecuted if they are found disposing of used injecting equipment in a way that could put members of the public at risk.

An Australian review of the international evidence on needle and syringe programmes found no evidence from numerous studies that these programmes increase the number of needles discarded in public.²³ In addition, the risk of a member of the public acquiring a BBV through an accidental needlestick injury appears to be low. This same Australian review reported that to-date, there is only one published case in the world of Hepatitis C transmission after an injury from a discarded used needle in the community.⁸⁰ In Scotland, there are no published cases of a member of the public acquiring a blood-borne virus through a needlestick injury received from an inappropriately discarded needle.⁸¹

Nevertheless, as the Department for Environment, Food and Rural Affairs (DEFRA) points out in their guidance on reducing drug-related litter, whatever the *actual* health risks, it is clear that the public *perceives* those risks to be much higher.⁵⁴ This perception can lead to public opposition to IEP services. Therefore, services should remind clients at regular intervals to dispose of used injecting equipment safely. Clients can also be encouraged to educate their peers about safe disposal — particularly if they are involved in a secondary distribution network.

The DEFRA guidance recommends the following actions be undertaken to educate and motivate clients to dispose of used injecting equipment safely:

- *Users accessing needle exchanges or any other type of drug treatment service, should be given information that encourages them to think responsibly about needles and other drug litter. Where necessary and appropriate, the dangers of unsafe disposal of needles should be explained, including explicitly outlining the facts that it can increase negative attitudes to all users in the community and in extreme cases may result in closure of facilities.*
- *Homeless, new and younger users should be especially targeted for this type of information, with clear information on safe disposal.*
- *Drug service (including needle exchange) premises should have posters or written material that carries safe disposal messages. Written material of this type should be distributed to other places where users may go – including police stations, drop-ins for homeless people and so on. Leaflets can be put in bags containing supplies that are given out. Safe disposal stickers could be placed on sharps bins. Regularly changing this material helps motivate users to look at it each time.*
- *Service users should always be encouraged to take away sharps bins from a range that suits their needs, from small and discreet bins to those suitable for larger quantities. They should also be*

encouraged both to use them and return them.... Services should invite comments from users about the type and availability of bins and adjust their range as necessary.

One possible barrier to appropriate disposal of used injecting equipment by injectors is the lack of facilities, particularly outside the hours during which IEP services operate. Public sharps bins provide one means of removing that barrier, and DEFRA recommends that local partnerships fully explore the potential for public sharps bins, liaising closely with drug users and services to ensure the siting and promotion of bins is as effective as possible. In relation to this, GIS software can be a useful tool, as it can be used to map “hot-spots” where drug-related litter is currently found. (This assumes, of course, that Environmental Health Departments are recording this information.)

Other options are to locate return bins outside the premises of IEP services to allow injectors to return needles when the services are shut, or to negotiate with staff from other agencies (hostels, for example) to locate bins on their premises. By providing multiple options and locations for the return of used equipment, it may be possible to increase return rates and reduce drug-related litter. If public sharps disposal bins are available locally, IEP service staff should know the locations of these bins, and provide this information to clients.

It is suggested that local NHS Board risk management staff should be consulted for advice on the appropriate choice of public and individual safe disposal bins.

In order to educate clients, staff need to be educated themselves about the safe handling of injecting equipment and the safe disposal of used injecting equipment. Robust procedures should also be in place to protect IEP service staff from accidental needlestick injury. For example, when estimating the number of returned needles in the bins (for monitoring purposes), disposal bins can be weighed or shaken to determine how full they are. Alternatively, clients can be asked how many needles they are returning.

Recommendation 17: Hepatitis B vaccination for staff

NHS Boards should work together with employers to facilitate vaccination for Hepatitis B, free of charge, for all staff who are responsible for delivering an IEP service.

Chapter 18 of the Department of Health guidelines, *Immunisation against Infectious Diseases 2006 (The Green Book)* recommends that immunisation against Hepatitis B is provided to individuals who are at increased risk of infection because of their lifestyle, occupation or other factors such as “close contact with a case or carrier”.⁷⁹

Hepatitis B vaccination is recommended for healthcare workers who may have direct contact with patients' blood or blood-stained body fluids. This includes any staff who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten by patients.

The *Control of Substances Hazardous to Health (COSHH) Regulations 2002* require employers to assess the risks from exposure to hazardous substances, including pathogens (called biological agents in COSHH), to bring into effect measures necessary to protect workers and others who may be exposed from those risks, as far as is reasonably practicable.⁸² Therefore, the provision of Hepatitis B vaccination for IEP service staff is the responsibility of the individuals' employer, and NHS Boards should work with employers to facilitate this.

References

- ¹ Scottish Government (2008) *Hepatitis C Action Plan for Scotland Phase II: May 2008 – March 2011*. Available from: www.scotland.gov.uk/Publications/2008/05/13103055/0.
- ² Scottish Government (2008) *The road to recovery. A new approach to tackling Scotland's drug problem*. Available at: www.scotland.gov.uk/Publications/2008/05/22161610/0.
- ³ Hay G, Gannon M, Casey J, McKeganey N (2009) *Estimating the national and local prevalence of problem drug misuse in Scotland. Executive report*. Centre for Drug Misuse Research, University of Glasgow. Available at: www.drugmisuse.isdscotland.org/publications/local/Prevalence_2009.pdf.
- ⁴ Health Protection Agency, Health Protection Scotland, National Public Health Service for Wales, CDSC Northern Ireland, and the CRDHB (2008). *Shooting Up: Infections among injecting drug users in the United Kingdom 2007*. London: Health Protection Agency. Available at: www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1224833091550.
- ⁵ Roy KM, Hutchinson SJ, Wadd S, Taylor A, Cameron SO, Burns S, Molyneaux P, McIntyre PG & Goldberg DJ (2007) Hepatitis C virus infection among injecting drug users in Scotland: a review of prevalence and incidence data and the methods used to generate them. *Epidemiology and Infection*, 135(3): 433-442.
- ⁶ Jones L, Pickering L, Sumnall H, McVeigh J & Bellis MA (2008) *A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users. Final full report — revised Oct 2008*. Available at: www.nice.org.uk/guidance/index.jsp?action=download&o=42477.
- ⁷ Palmateer N, Kimber J, Hickman M, Hutchinson S, Rhodes T & Goldberg D (2008) *Evidence for the effectiveness of harm reduction interventions in preventing Hepatitis C transmission among injecting drug users: a review of reviews*. Health Protection Scotland.
- ⁸ World Health Organisation (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*. Available at: <http://www.who.int/hiv/pub/idu/pubidu/en/index.html>.
- ⁹ Loxley W, Toumbourou J, Stockwell T, Haines B, Scott K, Godfrey C, Waters E, Patton G, Fordham R, Gray D, Marshall J, Ryder D, Siggers S, Sand L & Williams J (2004) *The prevention of substance use, risk and harm in Australia: a review of the evidence*. National Drug Research Institute, Commonwealth Department of Health and Ageing, Government of Australia. Available from <http://espace.library.curtin.edu.au/>. (See Chapter 14: Harm Reduction).
- ¹⁰ Commonwealth Department of Health and Ageing (2002). *Return on investment in needle and syringe programs in Australia: Summary report*. Commonwealth of Australia. Available from www.drugpolicy.org/docuploads/roifinal.pdf.
- ¹¹ Vickerman P, Hickman M and Judd A (2007) Modelling the impact on Hepatitis C transmission of reducing syringe sharing: London case study. *International Journal of Epidemiology*, 36: 396-405.
- ¹² Patrick DM, Tyndall MW, Cornelisse PG, Li K, Sherlock CH, Rekart M, Strathdee SA, Currie SL, Schechter MT, O'Shaughnessy MV (2001) Incidence of hepatitis C virus infection among injection drug users during an outbreak of HIV infection. *Canadian Medical Association Journal*, 65(7): 889-895.
- ¹³ Health Protection Scotland and the University of the West of Scotland (2008). *The Needle Exchange Surveillance Initiative (NESI): Prevalence of HCV, HIV and injecting risk behaviours among injecting drug users attending needle exchanges in Scotland, 2007*. Glasgow: Health Protection Scotland. Available at: www.hps.scot.nhs.uk/bbvsti/publicationsdetail.aspx?id=38071.

- ¹⁴ Information Services Division Scotland (2008). *Drug Misuse Statistics Scotland 2008*. Tables A1.29 and A1.31. Available from www.drugmisuse.isdscotland.org/publications/08dmss/08dmss-000.htm.
- ¹⁵ Information Services Division Scotland (2006). *Drug Misuse Statistics Scotland 2006*. Tables A1.34 and A1.37. Available from: www.drugmisuse.isdscotland.org/publications/06dmss/06dmssb.htm.
- ¹⁶ Rhodes T, Davis M, Judd A (2004) Hepatitis C and its risk management among injectors in London: Renewing harm reduction in the context of uncertainty. *Addiction*, 99: 621-633.
- ¹⁷ Taylor A, Fleming A, Rutherford J & Goldberg D (2004) *Examining the injecting practices of injecting drug users in Scotland*. Scottish Executive Effective Interventions Unit. Available from: <http://www.scotland.gov.uk/Publications/2004/02/18871/32890>.
- ¹⁸ Scott J (2008) *Safety, risks and outcomes from the use of injecting paraphernalia*. Scottish Government. Available from: <http://www.scotland.gov.uk/Publications/2008/03/14133736/0>.
- ¹⁹ Griesbach D, Abdulrahim D, Gordon D & Dowell K (2006) *Needle exchange provision in Scotland. A report of the National Needle Exchange Survey*. Scottish Executive. Available at: <http://www.scotland.gov.uk/Publications/2006/06/16110001/0>.
- ²⁰ Tempalski B, Cooper HL, Friedman SR, Des Jarlais DC, Brady J, Gostnell K (2008) Correlates of syringe coverage for heroin injection in 35 large metropolitan areas in the US in which heroin is the dominant injected drug. *International Journal of Drug Policy*, 19 Suppl 1:S47-58.
- ²¹ Heller DI, Paone D, Siegler A & Karpati A (2009) The syringe gap: An assessment of sterile syringe need and acquisition among syringe exchange program participants in New York City. *Harm Reduction Journal*, 6:1. January.
- ²² Several reviews undertaken as part of the process of developing needle exchange guidelines for England are available from NICE at: www.nice.org.uk/guidance/index.jsp?action=byID&o=11829.
- ²³ Dolan K, MacDonald M, Silins E & Topp L (2005) *Needle and syringe programs: A review of the evidence*. Canberra: Australian Government Department of Health and Ageing. Available at: www.hepatitisc.org.au/resources/documents/nspreviewofevidence.pdf.
- ²⁴ Queensland Needle and Syringe Program (2007) *Queensland needle and syringe program policy. Revised 2007*. Available at: www.health.qld.gov.au/qnsp/pdf/QNSP_Policy.pdf.
- ²⁵ Victorian Department of Human Services (2001) *Victorian needle and syringe program. Operating policy and guidelines*. Health Protection Services Unit, Public Health. Available at: www.health.vic.gov.au/drugservices/pubs/needle.htm.
- ²⁶ Strike C, Leonard L, Millson M, Anstice S, Berkeley N, Medd E (2006) *Ontario needle exchange programs: Best practice recommendations*. Available at: http://www.ohntn.on.ca/compass/Best_Practices_Report.pdf.
- ²⁷ British Columbia Centre for Disease Control (2004) *Harm reduction supply services policy and guidelines*. Available at: <http://www.bccdc.org/download.php?item=1040>.
- ²⁸ Welsh Assembly Government (2005) *IEP service framework*. Available at: wales.gov.uk/dsjlg/publications/communitysafety/submisusetreatframework/needleexchange.pdf?lang=en
- ²⁹ Health Protection Scotland (2007) *Scotland's action plan for Hepatitis C Phase I, September 2006 – August 2008: First year progress report*. Available from www.hepcscotland.co.uk/action-plan.html.
- ³⁰ Garden J, Roberts K, Taylor A & Robinson D (2003) *Evaluation of the provision of single use citric acid sachets to injecting drug users*. Scottish Executive Effective Interventions Unit. Available from: http://www.drugmisuse.isdscotland.org/eiu/pdfs/citric_acid_full.pdf.

- ³¹ Taylor A, Allen E, Hutchinson S, Roy K, Goldberg D, Ahmed S & Roberts K (2005) *An evaluation of the Lord Advocate's Guidance on needle exchange*. Scottish Executive Drug Misuse Research Programme. Available from: <http://www.scotland.gov.uk/Publications/2005/05/18114615/46165>.
- ³² Cattan M, Bagnall A-M, Akhionbare K & Burrell K (2008) *Injecting equipment schemes for injecting drug users. Qualitative evidence review. Final full report — revised Aug 2008*. Available at: <http://www.nice.org.uk/guidance/index.jsp?action=download&o=42476>.
- ³³ Matheson C, Bond CM, Mollison J (1999) Attitudinal factors associated with community pharmacists' involvement in services for drug misusers. *Addiction*, 94(9): 1349-59.
- ³⁴ Matheson C, Bond CM & Tinelli M (2007) Community pharmacy harm reduction services for drug misusers: national service delivery and professional attitude development over a decade. *Journal of Public Health Medicine*, 29: 350-357.
- ³⁵ Hall S & Matheson C (2008) Barriers to the provision of needle-exchange services: A qualitative study in community pharmacies. *International journal of pharmacy practice*, 16: 11-16.
- ³⁶ Gowing LR, Proudfoot H, Henry-Edwards SM, Teesson M (2001) *Evidence Supporting Treatment. The Effectiveness of Interventions for Illicit Drug Use*. Woden: Australian National Council on Drugs.
- ³⁷ Coyle SL, Needle RH, Normand J (1998) Outreach-based HIV prevention for injecting drug users: A review of published outcome data. *Public Health Reports*, 113(Supplement 1):19–30.
- ³⁸ Islam MM & Conigrave KM (2007) Assessing the role of syringe dispensing machines and mobile van outlets in reaching hard-to-reach and high-risk groups of IDUs: A review. *Harm reduction journal*, 4(14).
- ³⁹ National Institute on Drug Abuse (2000) *A Manual to Conduct Community-based Outreach. A manual to reduce the risk of HIV and other blood-borne infections in drug users*. Available at: www.drugabuse.gov/CBOM/index.html.
- ⁴⁰ Forth Valley Substance Action Team (2004) Central Scotland Police needle replacement scheme for prisoners, Falkirk Police Station. In *Substance*, vol. 1(1), p. 2. Available at: www.drugmisuse.isdscotland.org/dat/forthvalley/substance1.pdf.
- ⁴¹ Information Services Division Scotland (2008). *Drug Misuse Statistics Scotland 2008*. Table C3.1. Available from www.drugmisuse.isdscotland.org/publications/08dmss/08dmss-000.htm.
- ⁴² Scottish Prison Service (2008) *Prisoner Survey 2008. Eleventh survey bulletin*. Available at: www.sps.gov.uk/MultimediaGallery/8bb1f9db-4681-440d-ba30-5f07ed8d09a7.pdf.
- ⁴³ Heller-Murphy S (2005) *The direction of harm reduction in the SPS: From chaotic drug use to abstinence*. Scottish Prison Service. Available at: www.sps.gov.uk/MultimediaGallery/dcac7216-c6a7-4531-a674-b2c004e58737.pdf.
- ⁴⁴ Lorvick J, Bluthenthal RN, Scott, A, Gilbert ML, Riehman KS, Anderson RL, Flynn NM & Kral AH (2006) Secondary syringe exchange among users of 23 California syringe exchange programs. *Substance Use & Misuse*, 41: 865-882.
- ⁴⁵ Carruthers S (2007) The organization of a community: Community-based prevention of prevention of injecting drug use-related health problems. *Substance use & misuse*, 42(12-13): 1971-1977.
- ⁴⁶ Australia Injecting and Illicit Drug Users' League (2006) *A framework for peer education by drug-user organisations*. Canberra. Available at: www.aivl.org.au/files/FrameworkforPeerEducation.pdf.
- ⁴⁷ Latkin CA (1998) Outreach in natural settings: the use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports*, 113 Suppl 1: 151-159.

- ⁴⁸ Griesbach D and Taylor A (2009) *Educational interventions to prevent hepatitis C: A review of the literature and expert opinion*, NHS Health Scotland. Available at: www.healthscotland.com/uploads/documents/10433-Hep_C_Report.pdf.
- ⁴⁹ Broadhead RS, Heckathorn DD, Weakliem DL, Anthony DL, Madray H, Mills RJ & Hughes J (1998). Harnessing peer networks as an instrument for AIDs prevention: results from a peer-driven intervention. *Public Health Reports*, 113 Suppl 1: 42-57.
- ⁵⁰ Elford J, Sherr L, Bolding G, Serie F & Maguire M (2002) Peer-led HIV prevention among gay men in London: process evaluation. *AIDS Care*, 14(3): 351-60.
- ⁵¹ Islam M, Wodak A & Conigrave KM (2008) The effectiveness and safety of syringe vending machines as a component of needle syringe programmes in community settings. *International Journal of Drug Policy*, 19(6): 436-41.
- ⁵² McDonald D (2008) The evaluation of a trial of syringe vending machines in Canberra, Australia. *International Journal of Drug Policy*, September 12.
- ⁵³ Tudor M & Gordon D (2008) Interim research into the efficacy of an out-of-hours needle exchange vending machine at The Bridge, Southampton. Presentation at the 2008 National Conference on Injecting Drug Use. Available at: www.exchangesupplies.org/conferences/ncidu/2008_NCIDU/speakers/david_gordon.html.
- ⁵⁴ Department for Environment, Food and Rural Affairs (DEFRA) (2005). *Tackling drug-related litter. Guidance and good practice*. At: www.defra.gov.uk/environment/localenv/litter/pdf/drugrelatedlitter.pdf.
- ⁵⁵ Sutton AJ, Gay NJ, Edmunds WJ, Hope VD, Gill ON, Hickman M (2006) Modelling the force of infection for hepatitis B and hepatitis C in injecting drug users in England and Wales. *BMC Infectious Diseases*, 8(6): 93.
- ⁵⁶ Jeal N & Salisbury C (2004) Self-reported experiences of health services among female street-based prostitutes: a cross-sectional survey. *British Journal of General Practice*, 54(504): 515-519.
- ⁵⁷ Gore SM, Bird AG, Cameron SO, Hutchinson SJ, Burns SM, Goldberg DJ (1999) Prevalence of hepatitis C in prisons: WASH-C surveillance linked to self-reported risk behaviours. *QJM: An international journal of medicine*, 92(1): 25-32.
- ⁵⁸ Matheson C, Anthony GB, Bond C, Rossi MK (2008) Assessing and prioritising the preferences of injecting drug users in needle and syringe exchange service development. *Journal of Public Health*, 30(2): 133-138.
- ⁵⁹ Scottish Executive (2002) *Needle and syringe exchange schemes*. NHS Health Department Letter (HDL) (2002) 90. Available at: http://www.sehd.scot.nhs.uk/mels/hdl2002_90.pdf.
- ⁶⁰ National Needle Exchange Forum, UK Harm Reduction Alliance & Exchange Supplies (2006) *Reducing injecting related harm: Consensus statement on best practice*. Available from: www.ukhra.org/statements/consensus_statement_on_best_practice.html.
- ⁶¹ Crofts N, Caruana S, Bowden S & Kerger M (2000) Minimising harm from hepatitis C virus needs better strategies. *BMJ*, 321: 899. (October 7).
- ⁶² De P, Roy E, Boivin JF, Cox J, Morissette C (2008) Risk of HCV transmission through drug preparation equipment: a systematic and methodological review. *Journal of viral hepatitis*, 15(4): 279-292.
- ⁶³ LE Thorpe, Ouellet LJ, Hershov R, Bailey SL, Williams IT, Williamson J, Monterroso ER, Garfein RS (2002) Risk of hepatitis C virus infection among young adult injection drug users who share injection equipment. *American journal of epidemiology*, 155(7): 645-653.

- ⁶⁴ H Hagan, Thiede H, Weiss NS, Hopkins SG, Duchin JS, Alexander ER (2001) Sharing of drug preparation equipment as a risk factor for hepatitis C. *American journal of public health*, 91(1): 42-46.
- ⁶⁵ Jenny Scott, Winfield A, Kennedy E, Bond C (2000) Laboratory study of the effects of citric acid and ascorbic acid on injections prepared with brown heroin. *International journal of drug policy*, 11(6): 417-422.
- ⁶⁶ Personal communication, Glasgow Drugs Crisis Centre.
- ⁶⁷ *The Misuse of Drugs (Amendment) (No.2) Regulation 2003* (Statutory Instrument No. 2003, No. 1653). See regulation 6A. Available at: www.opsi.gov.uk/si/si2003/20031653.htm.
- ⁶⁸ *The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005* (Statutory Instrument No. 2005, No. 1507). See part 3. Available at: www.opsi.gov.uk/si/si2005/20051507.htm.
- ⁶⁹ Scottish Executive (2006) National quality standards for substance misuse services. Available at: <http://www.scotland.gov.uk/Publications/2006/09/25092710/0>.
- ⁷⁰ Neale J, Sheard L & Tompkins CN (2007) Factors that help injecting drug users to access and benefit from services: A qualitative study. *Substance abuse treatment, prevention and policy*, 2: 31.
- ⁷¹ Rhodes T, Briggs D, Holloway G, Jones S & Kimber J (2006) *Visual assessments of injecting drug use*. Research briefing 13. National Treatment Agency for Substance Misuse, London. Available at: www.nta.nhs.uk/publications/documents/nta_visual_assessments_injecting_drug_use_2006_rb13.pdf.
- ⁷² Latka M, Hagan H, Kapadia F, Golub ET, Bonner S, Campbell JV, Coady MH, Garfein RS, Pu M, Thomas DL, Thiel TK, Strathdee SA (2008) A randomised intervention trial to reduce the lending of used injection equipment among injection drug users infected with Hepatitis C. *American Journal of Public Health*, 98(5): 853-861.
- ⁷³ Neale J, Tompkins C & Sheard L (2008) Barriers to accessing generic health and social care services: a qualitative study of injecting drug users. *Health and Social Care in the Community*, 16(2):147-54.
- ⁷⁴ Effective Interventions Unit (2002) *Integrated care for drug users. Principles and practice*. Scottish Executive. Available at: www.sehd.scot.nhs.uk/publications/icdu/icdu-00.htm.
- ⁷⁵ Hutchinson SJ, Bird SM & Goldberg DJ (2005) Modeling the current and future disease burden of Hepatitis C among injection drug users in Scotland. *Hepatology*, 42: 711-723.
- ⁷⁶ Royal College of General Practitioners (2007) *Guidance for the prevention, testing, treatment and management of hepatitis C in primary care*. At: www.smmgp.org.uk/download/guidance/guidance003.pdf.
- ⁷⁷ Cullen BL, Hutchinson SJ, Roy KM, Schofield J, Hawkins G, McDonald S, Weir A, McLeod A, Goldberg D (2008) Needs assessment of Hepatitis C testing, treatment, care and support services in Scotland: Overview report. Glasgow: Health Protection Scotland. Available from: HPSHCVAActionPlan@nhs.net.
- ⁷⁸ Scottish Intercollegiate Guidelines Network (SIGN) (2006) *Management of hepatitis C. SIGN Guideline 92*. Available at: www.sign.ac.uk/guidelines/fulltext/92/index.html.
- ⁷⁹ Department of Health (2006) *Immunisation against infectious diseases (The Green Book)*. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917. See Chapter 18 (Hepatitis B).
- ⁸⁰ Dolan K *et al* (2005) *Needle and syringe programs: A review of the evidence*. Citing Libois A, Fumero E, Castro P, Nomdedeu M, Cruceta A, Gatell J-M and Garcia F (2005) Transmission of hepatitis C virus by discarded-needle injury. *Clinical Infectious Diseases Journal* 41: 129-130.

⁸¹ Personal communication, Health Protection Scotland.

⁸² See *Control of Substances Hazardous to Health (COSHH) Regulations 2002*. Available at: www.opsi.gov.uk/si/si2002/20022677.htm.

Annex 1: Guidelines Development Group

Chair

Professor Avril Taylor (University of the West of Scotland)

Members

Paul Arbuckle (NHS Information Services Division)
Gareth Brown (Scottish Government, Public Health Division)
Lee Davis (NHS Information Services Division)
Frances Donachie (NHS Ayrshire & Arran)
James Egan (Scottish Drugs Forum)
Stephen Heller-Murphy (Scottish Prison Service)
George Howie (NHS Health Scotland)
Carole Hunter (NHS Greater Glasgow & Clyde)
George Hunter (Turning Point, Glasgow)
Catriona Matheson (University of Aberdeen)
Senga McDonald (Drugs Action, Aberdeen)
Norah Palmateer (Health Protection Scotland)
Kirsty Roy (Health Protection Scotland)
Justin Schofield (NHS Greater Glasgow and Clyde)
James Shanley (Edinburgh Harm Reduction Service)
Linda Tweddle (NHS Dumfries & Galloway)
Maureen Woods (Lanarkshire Harm Reduction Service)
Leon Wylie (Scottish Association of Drug & Alcohol Action Teams)

Attender / Editor

Dawn Griesbach (Griesbach & Associates)

Research Advisory Group

(Responsible for managing the process of developing the guidelines)

Professor Avril Taylor (University of the West of Scotland)
Leon Wylie (Scottish Association of Drug & Alcohol Action Teams)



© Crown copyright 2010

ISBN: 978-0-7559-7856-4

Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by RR Donnelley B64077

Published by the Scottish Government, March 2010

ISBN 978-0-7559-7856-4



9 780755 978564