TORBAY YOUNG PEOPLE'S NEEDLE EXCHANGE POLICY

Commissioned by:

Safer Communities Torbay
Working with you for you

Torbay Drug and Alcohol Action Team

Service provider:

checkpoint

The Children's Society
With children, for children, with you

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Consultation:

This policy was sent for review by the following organisations/agencies:

- Torbay Local Safeguarding Children's Board (formerly the ACPC)
- Safer Communities Torbay Young Persons' Substance Misuse Group
- The Children's Society
- National Treatment Agency

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GLOSSARY OF TERMS USED

Terminology	Definition
needle exchange	The free and confidential provision of sterile injecting equipment to injecting drug users and the return and safe disposal of used injecting equipment.
safer injecting service	Offers a holistic approach in engaging injecting drug users in harm reduction interventions by utilising opportunities for health promotion and engagement with injectors who are unwilling or unable to stop using drugs immediately. Needle exchange is therefore only one component of a comprehensive safer injecting service.
young people	For the purposes of this policy, this term refers to those who are 17 years old and under. This may be abbreviated to *YP*. Particular age groups, such as *young people under 16* will be specifically referred to when required.
child in need/ child at risk	"a child or young person whose developmental needs cannot be met by their family or carers solely through the support of basic services" (Torbay Social Services definition).
IDU	Injecting drug use/injecting drug user.
BBV(s)	*Blood borne virus(es*) which include hepatitis B (HBV), hepatitis C (HCV) and the human immunodeficiency virus (HIV).
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency virus
service user	Young people utilising the safer injecting service. May also be referred to as *clients* by some services.
needle	When used in this document, *needle* refers to both needles and syringes (as the principal injecting equipment that is issued within safer injecting services.
injecting equipment	Other items of drug taking/preparing legal *paraphernalia*, which are legally permitted within the amended Misuse of Drug Act (MDA section 9a amended 2003) namely; citric/ascorbic acid, filters, pre-injection swabs, water for injection and spoons/cups/containers.
sharps	A generic term which refers to used/contaminated injecting equipment.

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1 INTRODUCTION

1.1 Scope of policy

This policy document relates to the needle exchange service, delivered as a key component of the safer injecting service provided by CheckPoint, 7 Victoria Road, Torquay (The Children's Society) and commissioned by Safer Communities Torbay.

1.2 Background to harm reduction

Needle exchange is an effective, evidence based harm reduction intervention which is strongly aligned to public health aims. In 1988, the Advisory Council on the Misuse of Drugs[1] advised; "*HIV is a greater threat to public and individual health than drug misuse…Abstinence remains the ultimate goal but efforts to bring it about in individual cases must not jeopardise any reduction in HIV risk behaviour which has already been achieved."* Nearly twenty years on, this statement still encapsulates the fundamental ethos and core harm reduction aims of needle exchange and safer injecting service delivery.

The reduction of drug related death and blood borne virus prevention are now key aspects to contemporary harm reduction objectives. National research into injecting drug users indicates that one third have recently shared needles with another injector. The frequent sharing of other injecting equipment is problematic and overall sharing rates are far from in decline. At least 40% injectors show evidence of hepatitis C infection, with transmission rates in new and young injectors rising. Around one fifth of injectors show evidence of HBV infection, with HIV rates at <1% outside London. Hepatitis A infections amongst this group are also increasing at a noticeable rate (HPA 2004[2], Hope *et al.* 2001[3], Rhodes 2004[4]).

1.3 Young people and injecting drug use

Young people are starting to use drugs at an increasingly early age and the age at which problematic drug use commences is also dropping. A small, but significant proportion of young people inject drugs although many may be 'hidden' from services until later in their drug using career.

One study indicates that sharing rates among young injectors are higher than that within equivalent adult populations (27% under age 20 compared with 16% of those 30 and over) (DoH 2002[5]). Sharing is more likely after the first year of injecting and there is an increasing number of young women injecting, of whom a high proportion are also engaging in other high risk behaviour such as unprotected sex (Mullen & Barry 2001[6]). Needle exchange can reduce the likelihood of a young person sharing injecting equipment (Guydish *et al.* 2000[7]), but there

[1] ACMD 1988, Report on treatment and Rehabilitation, 1988.
[2] Health Protection Agency [HPA], Health Protection Scotland, National Public Health Service for Wales, CDSC Northern Ireland, CRDHB, and the UASSG 2004. *Shooting Up; Infections among injecting drug users in the United Kingdom 2004.*
[3] Hope V, Judd A, Hickman M *et al.,* Prevalence of Hepatitis C Among Injection Drug Users in England and Wales: Is Harm Reduction Working*?* (American Journal of Public Health 39 January 2001, Vol. 91, No.1)
[4] Rhodes T.; Davis M.; Judd A. 2004. Hepatitis C and its risk management among drug injectors in London: renewing harm reduction in the context of uncertainty, Addiction, 99 [5].

[5] Cited by Lifeline. Occasional Paper 1: Needle Exchange for Young People. Available on: http://www.lifeline.org.uk/new_sitefiles/articles/20040811.html. Retrieved 24/10/04

[6] Mullen L. and Barry J. (2001) An analysis of 15-19 year old first attenders at the Dublin Needle Exchange. Addiction: 2001, 96 (2), p.251-258.
[7] Guydish J, Brown C, Edgington R, Edney H and Garcia D 2000. What are the impacts of needle exchange on young injectors? Aids and Behaviour: 4 (2), p.137-146

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is a brief window of opportunity to prevent blood borne virus infections, with new injectors acquiring these infections, in particular hepatitis C, increasingly early in their injecting careers (Hope *et al.* 2001, Judd *et al.* 2005[8], HPA *et al.* 2004). Accordingly, effective harm reduction interventions tailored for young people - such as needle exchange - are crucial preventative measures against blood borne virus transmission and other drug related harm.

1.4 Injecting drug use and young people – a local perspective

Within Torbay, injecting drug use among the under 18s is an infrequent phenomenon. Records from the adult needle exchange services (2004/05) indicate that no persons under 16 have accessed the service and six persons aged 16-17 used the service. Similarly, CheckPoint and Torbay YOT records for the same period show contact with six injecting drug users under 18.

The Torbay needle exchange service (adult provision) Service Level Agreement and policy/guidance requires for all young people accessing a needle exchange service to be referred or signposted to CheckPoint. In particular needles must never be issued to a young person sunder 16 in a pharmacy or an adult agency needle exchange setting. (Further information on adult needle exchange in Torbay can be found in appendix 5.)

It is important to note that given there has been no needle exchange or safer injecting service for young people under 18 within Torbay, it is anticipated that the development of this new service could mark a small increase in the numbers of young people presenting to this service. Coupled with the exponential rise in injectors accessing adult services, a moderate rise in service users would be marked as a factor of success in engaging with vulnerable and high risk young people.

1.5 Young peoples' safer injecting services – differing needs

> *"Injecting is a dangerous activity, every effort should be made to encourage all young injector to change their route of administration to a safer one, engage into treatment as urgently as possible and stop using drugs. The principle of reducing harm must not be lost when considering young drug misusers. However, additional harmful factors and the difference in legal status must be carefully considered and balanced." (*DrugScope/DoH 2001)[9].

Safer injecting interventions which reduce drug related harm may not necessarily reduce other risks. It is recognised that offering a safer injecting service to young people is very different to adult provision. In order that the young person's safer injecting provision operates in a competent and responsible manner, an appropriate balance must be struck between harm reduction and the worker's protective responsibilities to the young person.

Wherever possible, young people's drug services should be provided as specialist dedicated services which are separate and distinct from adult services (DrugScope/DoH 2001), as is the Torbay model for young people's drug services. In order that the service is young person focussed a regular frequency of contact is encouraged, with smaller quantities of injecting equipment issued at any one time which suit the needs of younger injectors. In addition, child protection and child welfare may impact on issues of consent and confidentiality.

[8] Judd A, Hickman M, Jones S, McDonald T, Parry JV, Stimson GV and Hall AJ. Incidence of hepatitis C virus and HIV among new injecting drug users in London: prospective cohort study. BMJ vol330 1 Jan 2005.
[9] DrugScope/DoH 2001. Making harm reduction work; Needle exchange for young people under 18 years old.

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2 AIMS AND OBJECTIVES

2.1 Aims

The provision of injecting equipment to young people, especially those under 16 years of age, is politically sensitive and legally complex. This policy aims to provide clear and comprehensive guidance for young peoples' drug workers and other professionals involved in their care, including comprehensive advice as to how, when and why injecting equipment might be provided to young people.

2.2 Objectives

CheckPoint will provide a safer injecting service in Torbay which has the express goals of reducing injecting drug related harm and protecting children in need and children at risk in the following objective areas:

2.2.1 *Blood borne virus transmission (BBVs)*
BBV transmission (HBV, HCV and HIV) via injecting drug use is a major public health problem which can be tackled by the provision of sterile injecting equipment.

2.2.2 *Reducing drug related death*
IDUs are at a significantly increased risk of premature death due to overdose. In the long term, deaths due to HCV transmission are likely to significantly exceed overdose fatalities.

2.2.3 *Community safety*
Inappropriately discarded needles (*sharps*) are a comparatively low risk to public health but pose a significant community safety problem. The young people's safer injecting service aims to achieve a sharps high return rate which does not compromise effective safer injecting interventions.

2.2.4 Monitoring
The safer injecting service enables workers to regularly monitor young people who inject drugs, thus engaging them in harm reduction interventions (offering safer injecting interventions, reducing the frequency of injecting and enabling them to cease injecting).

2.2.5 *Engagement with services*
A safer injecting assessment process aims to engage vulnerable young people into treatment or other care planned interventions. (See appendices 1 & 2; CheckPoint comprehensive safer injecting assessment form and operational guidelines).

2.2.6 *Child protection*
Any intervention with a young person will be considered within a child protection context and child protection procedures will always be complied with.

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3 GUIDING PRINCIPLES

3.1 Evidence based practice

This young peoples' safer injecting service is founded upon evidence based guiding principles which are outlined below.

3.2 Every child matters

Every child matters: Change for Children Young People and Drugs (HM Government, 2004)[10]. The Government's vision for children's services, was published in December 2004. It proposed a better integrated delivery of children's services to improve outcomes for children and young people:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

3.3 10 key policy principles

Needle exchange services for young people are developed in line with the following Ten Key Policy Principles (SCODA/The Children's Legal Centre, 1999)[11].

1 A child or young person is not an adult.
2 The overall welfare of the individual child or young person is of paramount importance.
3 The views of the young person are of central importance, and should always be sought and be considered.
4 Services need to respect parental responsibility when working with a young person.
5 Services should recognise the role of, and co-operate with, the local authority in carrying out its responsibilities towards children and young people.
6 A holistic approach is vital at all levels, as young people's problems tend to cross professional boundaries.
7 Services must be young person centred.
8 A comprehensive range of services should be provided.
9 Services must be competent to respond to the needs of the young person
10 Services should aim to operate, in all cases, according to the principles of good practice.

[10] HM Government, 2004. Every Child Matters: Change for Children Young People and Drugs.
[11] SCODA/The Children's Legal Centre, 1999. Ten Key Policy Principles.

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3.4 National guidelines and legal implications

3.4.1 The provision of injecting equipment to young people is legally complex. In delivering a Safer Injecting Service, the principles enshrined under the following documents will be adhered to:

- Children Act 1989[12]
- Working Together to Safeguard Children (DoH 1999)[13]
- Framework for the Assessment of Children in Need and their Families (DoH 2000)[14]
- Fraser Guidelines (Mental Health Act 1983 Code of Practice 1999)[15]
- Making Harm Reduction Work; Needle exchange for young people under 18 years old (DrugScope/DoH 2001).

3.4.2 It is also acknowledged that drug use is linked to illegal activities. The CheckPoint Safer Injecting Service will offer a holistic approach and aims to ensure that young people will understand the health, legal and social implications relating to illicit drug use.

3.5 Needs led

A specialist injecting assessment would be undertaken only with young people where injecting drug use is a feature of their presenting issues. This is illustrated in the Safer Injecting Assessment form (see appendix 1.)

3.6 Competency and consent

Safer injecting interventions with young people are a form of treatment and as such require consent. Gaining consent is different for young people than adults as additional legal, statutory and ethical considerations apply. Factors to be taken into consideration include the young person's age and their ability to consent to treatment in accordance with the Fraser guidelines (Mental Health Act 1983 Code of Practice 1999). This is outlined further in section 4.

[12] The Children's Act (1989)
[13] DoH 1999, Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.
[14] DoH 2000. Framework for the assessment of children in need and their families
[15] Fraser Guidelines (Mental Health Act 1983 Code of Practice, 1999)

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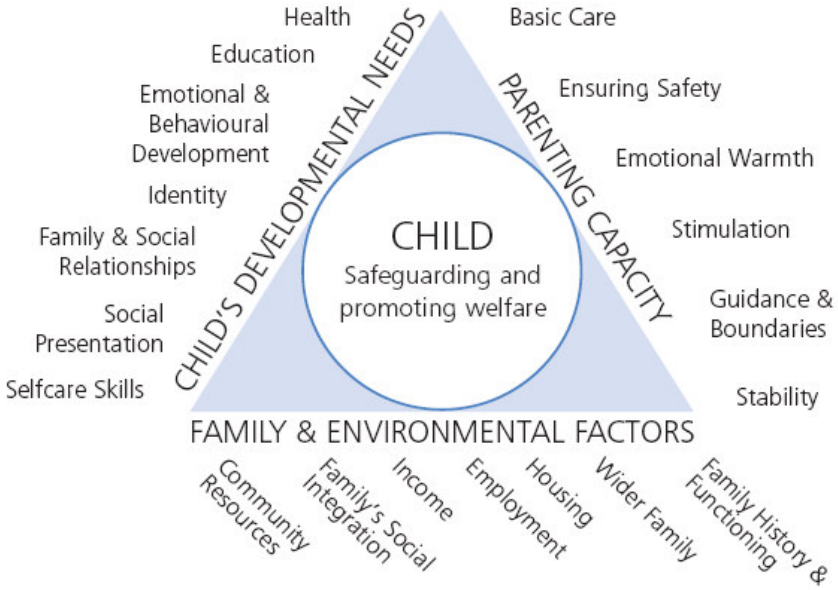
3.7 The framework for the assessment of children in need and their families

All assessments will be undertaken within the *Framework for Assessment of Children in Need and their Families* (DoH 2000), as illustrated below. It is acknowledged that there may be some changes to this in line with the Children's Assessment Framework during 2006.



3.8 A package of drug treatment

Needle exchange for a young person must be planned and delivered as part of a planned package of treatment. Independent anonymous needle exchange for young people is not good practice due to the different legal status of young people (DrugScope/DoH 2001).

CheckPoint (The Children's Society) will never offer needle exchange as a brief independent intervention independent of a structured, care planned intervention.

3.9 Harm reduction

Safer injecting services operate from a harm reduction approach to drug use which aims to reduce the reduce the health, social and economic harms of drug use which affect individuals, communities and society, often whilst the user continues to use drugs.

3.10 Safeguarding Board (formerly Torbay Area Child Protection Committee)

Torbay Safeguarding Board endorses the view that substance use/misuse alone does not indicate child protection concerns. This policy has been ratified by Torbay Safeguarding Board who will be consulted upon all future reviews of this policy. If a young person is thought to be at risk of significant harm either through their drug use or lifestyle factors, CheckPoint will inform Social Services according to Safeguarding Board guidelines. The young person may still need drug treatment whilst child protection assessments and interventions are being carried out and may still require support from CheckPoint.

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4 OPERATIONAL PROCESS

4.1 Young persons' safer injecting service operational policy

The young persons' safer injecting service adheres to a comprehensive operational policy which is detailed in appendix 2 and includes a care pathway which briefly outlines the processes involved.

4.2 Referral

Referrals to CheckPoint for any service are accepted by multiple methods including

- MASST[16] (Multi Agency Substance Screening Tool)
- telephone
- written
- self-referral (direct presentation by the young person)

The young person must always consent to the referral and express a willingness to engage with the service.

In the case of a professional working with a young person who is injecting but unwilling to engage with the young person's drug and alcohol worker, CheckPoint will offer a service by supporting the professional(s) involved with the young person, attending case conferences etc. in anticipation of the young person accessing the service in the future.

4.3 Assessment

The young peoples' drug and alcohol worker will undertake the core sections of a safer injecting assessment prior to any injecting equipment being issued. It is recognised that assessment is a comprehensive, ongoing process and that the needs of the service must be balanced against the immediate needs of the young person. A crucial part of the safer injecting assessment includes an assessment of competency to consent.

4.4 Confidentiality and child protection

CheckPoint confidentiality policy will be explained to the young person at the outset of all assessments (see appendix 6).

If a young person is deemed to be at risk of significant harm, a child protection referral will be made, however this will not preclude any ongoing safer injecting interventions from occurring. A full definition of the levels of risk in child protection and child in need can be found in appendix 4). Factors to consider for disclosure to social services or the police are detailed in the Safer Injecting Service operational guidelines (appendix 2).

Some young people may not be willing to divulge personal information, including their full identity at the first meeting and it may take time to build a relationship in order to give information for parental involvement and referral. In such instances, decisions will be made on a case by case basis and CheckPoint will ensure that all interventions are in the young

[16] HAS advises a multi agency screening to be used by "all youth orientated services offered by practitioners with some drug and alcohol experience and youth specialist knowledge" 2001:76 Health Advisory Service (2001) the substance of young needs: review 2001. London: Health Advisory service.

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person's best interest as opposed to colluding with their request for anonymity. In such cases workers' decisions would always be made in consultation with line management.

4.5 Competency (to consent to treatment)

4.5.1 There is no test of competence for young people accessing needle exchange; however this process should include an assessment of the young person's understanding of choice, consequences, risks and alternatives. All decisions made must be in the best interests of the young person and not the parents. In all cases, regardless of the young person's age, consent will be reviewed on an ongoing basis. The worker will continue to encourage the young person to involve their parents in their care where appropriate. Assessment of competency to consent to treatment is integral to the core sections of a safer injection assessment form. For further details, see appendix 2 (CheckPoint safer injecting service operational guidelines).

4.5.1 16 and 17 year olds

Although young people aged 16 and 17 are usually able to consent to treatment, an assessment of their competency to consent will still be undertaken. Child protection procedures still apply and still require consideration. CheckPoint will aim to involve parents in interventions with these young people wherever possible, however this should not be a bar to a young person aged 16 or 17 receiving a safer injecting interventions and sterile injecting equipment.

4.5.2 Under 16s

Young people under 16 cannot normally consent to their own treatment. Therefore consent should usually be gained from the parent/guardian before injecting equipment is issued. In instances where a parent/guardian is not present or the young person declines consent for their parents/guardian to be contacted, the competence of the young person to consent on their own behalf will be assessed by means of the Fraser guidelines (below) before any injecting equipment is issued.

4.5.3 Fraser guidelines (Mental Health Act 1983 Code of Practice 1999)

"Young people under 16 years of age have a right to confidential medical advice and treatment provided that:

- *The young person understands the advice and has the maturity to understand what is involved.*
- *The doctor/health professional cannot persuade the young person to inform parents/carers with parental responsibility, or allow the doctor to inform them.*
- *The young person's physical and/or mental health will suffer if they do not have treatment.*
- *It is in the young person's best interests to give such advice/treatment without parental consent.*
- *The young person will continue to put themselves at risk of harm if they do not have advice/treatment."*

Fraser guidelines within the context of this needle exchange policy have been specifically interpreted within the Safer Injecting Service operational guidelines (see appendix 6).

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4.6 Intervention/delivery of needle exchange

4.6.1 Care planning

A care plan will be produced to support the delivery of any safer injecting interventions, especially the issue of injecting equipment. The young person's needs will be reviewed on an ongoing basis and a formal care plan review will be undertaken at a frequency no longer than 4 weeks.

All safer injecting interventions will involve the worker making a professional judgement which will be discussed with line management/clinical supervisor or other relevant professionals. The worker's supervisor/line manager will countersign all care plans (see appendix 1).

4.6.2 Issue of injecting equipment

It is recognised that offering a needle exchange to young people is very different to adult provision. The issue of injecting equipment will normally occur in volumes which facilitate regular contact with the young person. Actual numbers of needles and injecting equipment issued will be considered on a person to person basis and will be dependant on a number of factors including drugs used, frequency of use, geography and accessibility.

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5 SUPPLIERS OF EQUIPMENT / PRACTICAL ARRANGEMENTS / FUNDING

The delivery of this service is funded by a Young Persons Substance Misuse Partnership Grant budget which includes set up costs and ongoing costs of injecting equipment and waste disposal.

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6 CARE GOVERNANCE

6.1 Definition

Care governance is defined as the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish according to the government. Essentially care governance relates to quality assurance at a local level, and includes education and training, managing risk and maintaining professional standards.

6.2 Competency of workers providing intervention

All young persons' drug and alcohol workers providing needle exchange assessments and interventions will be sufficiently competent to do so. CheckPoint recognises that needle exchange is a task which only competent experienced staff will undertake. These competencies include professional training in:

- Working with young people
- Child protection
- Drug and alcohol issues as they relate to young people
- Safer injecting including
    - Blood borne virus transmission and interventions
    - Overdose awareness
    - Peer injecting

Training that is substance use specific should be in line with relevant DANOS (Drug and Alcohol National Occupational Standards).

6.3 Monitoring/audit

The service governed by this policy will be monitored, especially within the first year of implementation, when a review of the service will be conducted after six months. Any required changes will be implemented as soon as possible unless these changes would significantly change the nature of the safer injecting service offered, in which case key stakeholders would first be consulted.

6.4 Policy review

This policy and related documentation is consistent with current national policy, guidance and legislation and will be reviewed annually to ensure that it reflects best practice. Key stakeholders and relevant organisations have been consulted upon in its development, including:

Torbay Local Safeguarding Children's Board
The Children's Society
Safer Communities Torbay
Torbay Care Trust

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Safer Communities Torbay
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Service provider:

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Appendix 1

CHECKPOINT YOUNG PEOPLE'S SERVICE
COMPREHENSIVE SAFER INJECTING ASSESSMENT

1 PERSONAL CIRCUMSTANCES

1.1 Personal details:

Client name:		**Date of birth:**		**Age:**	
Address:				**Gender:**	
Contact phone no.:		**Ok to leave message?**	Yes ❑ No ❑		

1.2 What kind of accommodation do you live in?

❑ Parents' house ❑ Friend's house ❑ Rough sleeper
❑ Foster carers' house ❑ Own accommodation ❑ Homeless
❑ Children's home ❑ Other (please state)

1.3 Who else lives there?

Parents	Yes ❑	No ❑		Yes ❑	No ❑
Foster carers	Yes ❑	No ❑	YP lives alone	Yes ❑	No ❑
Other children	Yes ❑	No ❑	Other adults	Yes ❑	No ❑

Indicate ages/details of all children below:

Indicate relationship between other adult(s) and YP below:

1.4 Does anyone else at home use drugs? Yes ❑ No ❑
If yes, record details and note whether any other injectors live at the YP's home
Comments:

1.5 Do your parents/carers know you use drugs/inject? **Explore whether parental consent is required/possible.**

Yes ❑ → **If yes could the YP's parents be approached to give consent?**

No ❑ → **If no, why not? Could the YP be encouraged to involve the parents in their care plan?**

1.6 Is this accommodation a safe place for you to live? **Explore any issues of abuse or vulnerability and the YP's awareness of personal safety.** Yes ❑ No ❑
Comments:

1.7 Are you at risk of losing your accommodation? **If yes, give details:** Yes ❑ No ❑

2 DRUG USE

2.1 Drugs used
List current/most frequent drugs first. Include alcohol/solvents/legal highs.

	Current use? y/n	**Route** (see code)	**Amount /cost**	**Freq. of use** (see code)	**Length of this episode**	**Past use?** y/n
Drug 1						
Drug 2						
Drug 3						
Drug 4						
Drug 5						

Summary of average daily/weekly use of problematic substance(s):

2.2 Are there any patterns to your drug use?
Explore time(s) of day when the YP uses, weekend/party/festival use. Consider any past patterns of use.

2.3 Why did you start injecting?
Explore the YP's attitudes/beliefs towards injecting and the options for alternative routes of administration.

2.4 Describe what happened when you had your first injection/hit?
Explore circumstances leading up to decision to inject/be injected, the YP's experience of this.

2.5 Do you plan to continue injecting? Why?
Explore what are YP's longer term views of their injecting drug use and the options for reducing injecting frequency.

3 INJECTING EQUIPMENT USED

3.1 **Do you currently use an adult needle exchange?** **Yes** ❑ **No** ❑
Explore how the YP accesses injecting equipment.

Comments:

Which exchanges?
Pharmacy ❑
Agency ❑
Other (state) ❑

Go to 3.2

3.2 **Do you get injecting equipment from other people?** **Explore how the YP accesses injecting equipment.** **Yes** ❑ **No** ❑
Comments:

Who?
Friends/peers ❑
Older injectors ❑
Non injectors ❑
Bought ❑
Other (state) ❑

Go to 3.3

3.3 **What needles/syringes do you use/have you used?**
Discuss sizes/volumes/products, reason for use.

3.4 **Injecting equipment used:**
Explore YP's understanding of injecting/equipment needed.

	Yes	No	Source? (where does YP get equipment from)	Previously used? Yes	Previously used? No	No. of people used with?
Needles/syringe	❑	❑	.....	❑	❑	.....
Spoon	❑	❑	.....	❑	❑	.....
Acidifiers	❑	❑	.....	❑	❑	.....
Filter	❑	❑	.....	❑	❑	.....
Water	❑	❑	.....	❑	❑	.....
Cups/glass/bottle	❑	❑	.....	❑	❑	.....
Pre-injection swabs	❑	❑	.....	❑	❑	.....
Tourniquet	❑	❑	.....	❑	❑	.....
Sharps container	❑	❑	.....	❑	❑	.....
Lighter/matches/candle/swabs	❑	❑	.....	❑	❑	.....
Box for keeping drugs/equipment	❑	❑	.....	❑	❑	.....
Other (state what)	❑	❑	.....	❑	❑	.....

3.5 **Do you ensure you have necessary injecting equipment prior to buying/acquiring drugs? How?**
Explore circumstances leading up to YP injecting – habitual/recreational/experimental use? Spontaneous use or planned?

4 PREPARING DRUGS FOR INJECTION

4.1 What do you understand by the term "sharing"?

Record in the YP's words & explain risks from any sharing activities identified.

4.2 What hygiene measures do you take before preparing drugs for injection?

	Yes	No	Comments/hygiene advice offered:
Wash hands before preparing?	❑	❑	
Wash/sterilise injection site(s)	❑	❑	
Clean work surface used to prepare	❑	❑	
Cover work surface used to prepare	❑	❑	
Other (state)	❑	❑	

4.3 How do you prepare drugs for injection (prepare a hit):

Summarise the process the YP undertakes. Consider water used, acidifiers [bulk/single use/other acidifiers], spoon for mixing, needle used to mix? Volume of water used, process for heating if relevant.

4.4 What sort of water do you normally use to mix your drugs for injection ('cook up')?

Explore the YP's understanding of hygiene, BBV and bacterial infection risks.

			Comments/harm reduction advice offered:
lower risk		Sterile water (from an ampoule)	❑	
		Boiled water (cooled down)	❑	
		Tap water	❑	
		Bottled/mineral water (e.g. Evian®)	❑	
		Water from toilet cistern/pan	❑	
high risk	↓	Other (please state)	❑	

Has the water or cup/receptacle it is in been used before? — **Comments/harm reduction advice offered:**

For flushing out own syringes?	❑
By another injector to flush or draw up?	❑
At the same time as another injector?	❑
For another purpose? (please state)	❑

Describe how/where you clean spoons and store them in between hits:

Summarise the YP's words and offer harm reduction advice, esp. considering risk of bacterial infections.

4.5 **Do you use an acidifier (e.g. citric/ascorbic acid [vit C]) when you dissolve your drugs ('cook up')?** ***NB heroin and crack cocaine injectors only.*** **Explore use of unsafe acidifiers and risk of endocarditis, fungal/bacterial, infections, BBV transmission.**

Yes ❑ **No/NA** ❑ → Go to question 4.6 below

What acidifier do you normally use?

Comments/harm reduction advice offered:

lower risk
- Citric/ascorbic acid single use sachet ❑
- Citric/ascorbic acid from bulk packet ❑
- Lemon juice ❑

high risk
- Vinegar ❑
- Other (describe) ❑

Has the acidifier been used before?

- By yourself? ❑
- By another injector? ❑
- At the same time as another injector? ❑

Describe how/where you store filters in between hits:
Summarise the YP's words and offer harm reduction advice.

4.6 **What sort of spoon/cooker do you normally use when you mix your drugs for injection ('cook up')?**
Explore use of spoons/cookers including infection risks from re-use and sharing.

Comments/harm reduction advice offered:

lower risk
- Sterile cooker eg Stericup® (purpose made) ❑
- Spoon ❑
- End of aluminium can ❑

High risk
- Other (describe) ❑

Has the spoon/cooker been used before?

- By yourself? ❑
- By another injector? ❑
- At the same time as another injector? ❑

Describe how/where you store filters in between hits:
Summarise the YP's words and offer harm reduction advice against re-use of filters.

4.7 Do you use a filter when you draw up your drugs into the syringe?
Explore use of filters including bacterial/viral infections risks and process of drawing up.

Yes ❑ **No** ❑ → Offer harm reduction advice re: undissolved particles/circulation problems.

What sort of filter do you normally use? **Comments/harm reduction advice offered:**

lower risk ↓ high risk

Sterile filter (purpose made)	❑
Cigarette filter (for hand rolling cigarettes)	❑
Cigarette filter (from pre-rolled cigarette)	❑
Cotton wool	❑
Other (describe)	❑

Has the filter been used before? ❑

By yourself?	❑
By another injector?	❑
At the same time as another injector?	❑
For smoking a cigarette first?	❑

Describe how/where you store filters in between hits:
Summarise the YP's words and offer harm reduction advice.

5 PEER INJECTION AND SOCIAL FACTORS

5.1 Do you inject yourself? **Yes** ❑ **No** ❑ **Sometimes** ❑
Explore the YP's knowledge and competence with the injecting process.

Comments:

5.2 Has someone else ever injected you (including your first ever hit)?
Explore YP's awareness of risks associated with giving and receiving peer injections.

Yes ❑ **No** ❑ → Offer harm reduction advice re: peer initiation/Break the Cycle. Go to 5.3

Who injects you? **Comments/harm reduction advice offered:**

	Often	Some-times	Never
Peer injector	❑	❑	❑
Partner/ex	❑	❑	❑
Dealer	❑	❑	❑
Older injector	❑	❑	❑
Non injector	❑	❑	❑
Other (state)	❑	❑	❑

Why does someone else inject you? **Comments/harm reduction advice offered:**

Don't know how to prepare a hit	❑
Poor injecting technique	❑
Can't access veins	❑
YP uses difficult to access sites (eg neck)	❑
Not allowed to inject self*	❑
YP prefers to be injected by someone else	❑
Other reason (state)	❑

* consider whether YP is vulnerable, and at risk of significant harm

5.3 **What risks do you think are involved with someone injecting you?** **Describe in the young person's words. Offer harm reduction advice on risks of giving and receiving peer injections (BBV, venous damage, overdose). Consider child protection issues.**

Comments:

5.4 **Could the YP move to a safer route of administration or take responsibility for injecting themselves with safer injecting advice?** **Yes** ❑ **No** ❑

Explore the YP's injecting ability & awareness of risk.

Comments:

5.5 **Do you inject anyone else?** **Yes** ❑ **No** ❑

Offer harm reduction/legal advice on peer initiation/peer injection.

Comments:

5.6 **Who else is around when you inject?** **Explore age/gender/relationship of injecting partner(s). Establish if the YP is vulnerable due to who he/she injects with, competency of injecting peers to manage overdose and other injecting risks, consider any child protection issues.**

	Often	Some-times	Never	Comments/harm reduction advice offered:
Alone	❑	❑	❑	
Non-injecting peers	❑	❑	❑	
Known injectors/friends/peers	❑	❑	❑	
Unknown injectors/others	❑	❑	❑	
Other (please state)	❑	❑	❑	

5.7 **Where do you inject? (geographical locations)**

Explore impact of surroundings on injecting risks (danger, overdose, BBVs/infections)

	Often	Some-times	Never	Comments/harm reduction advice offered:
Home (bedroom/bathroom?)	❑	❑	❑	
Someone else's home (known?)	❑	❑	❑	
Public toilet	❑	❑	❑	
Outside (park/street/alley?)	❑	❑	❑	
Dealer's house	❑	❑	❑	
Squat/disused building	❑	❑	❑	
Other (describe location)	❑	❑	❑	

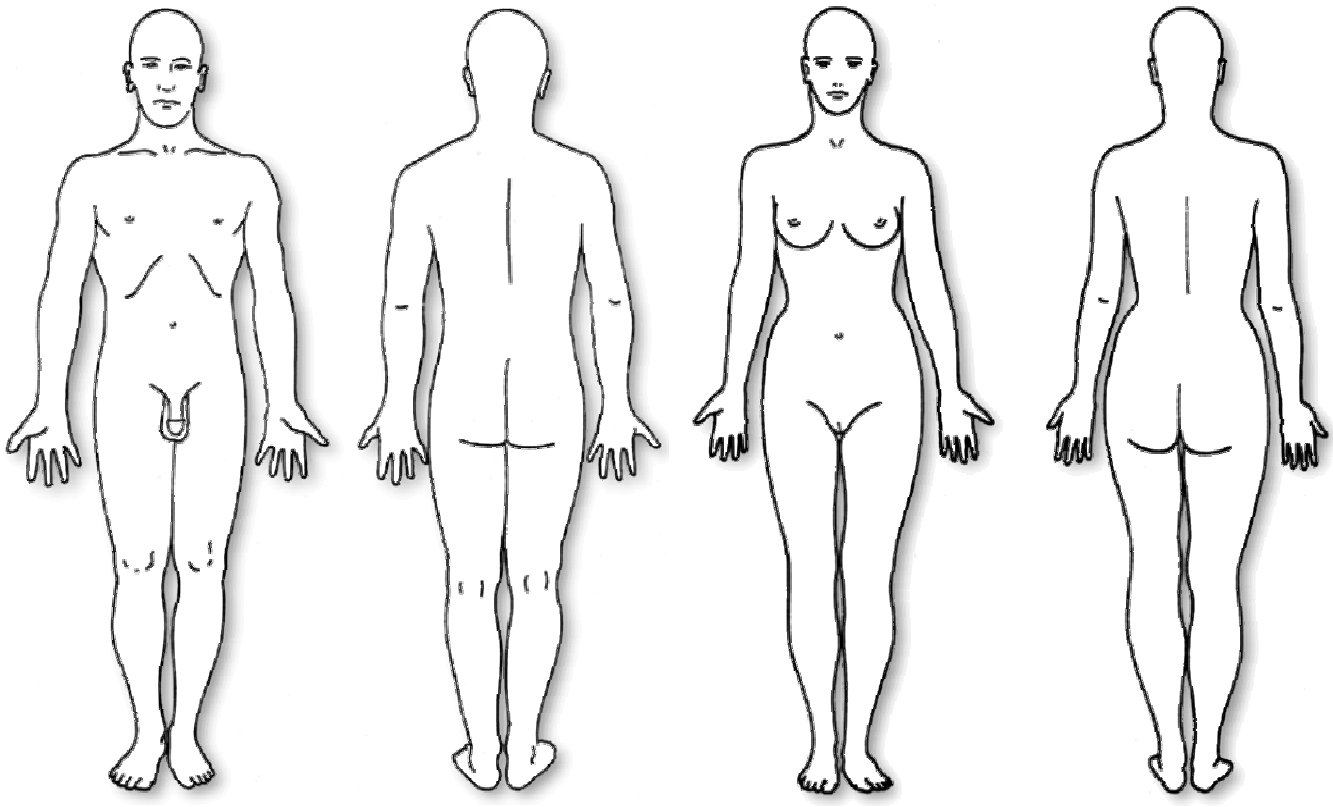
Comments:

6 VEIN CARE

6.1 Where in the body are you injecting?

Identify what sites the YP uses/has used on the diagram below. Differentiate between i/v, I/m or s/c if multiple routes are used.

Injecting route:	Yes	No
I/V (intravenous)	❑	❑
I/M (intramuscular)	❑	❑
S/C (Subcutaneous/ "skin popping")	❑	❑



6.2 Do you know that injecting in the groin, neck, penis, breasts is extremely dangerous?

Explore the YP's awareness of high risk injecting sites and give information.

Comments:

6.3 Worker's assessment of sites. **Note any bruising/tracking/scarring/current or past infections/cleanliness. If you have not observed injecting sites please state why.**

6.4 Does the YP require a medical referral/signposting due to injecting related damage?

Consider any infections/damage evident or reported by YP. **Yes** ❑ **No** ❑

If yes, who has the YP been referred/signposted to?

NB: No "intimate" injecting sites to be examined by YP drug worker (e.g. groin, breasts). Workers must only assess sites which can be viewed by rolling up sleeves/legs or removing outer clothing.

7 INJECTING PROCESS

Answer this section by summarising the YP's response in order that you explore their awareness of vein care issues. Record harm reduction advice given.

7.1 How do you choose a vein to inject in? **Explore selection of "bad/good" veins to inject into.**

7.2 Do you use the same vein each time or alternate? **Discuss site rotation.**

7.3 How do you raise a vein ("get a vein up")? **Explore risks of tourniquets & discuss alternatives – palpating veins, warming up, exercises – advise re: injecting in bath or other hazardous locations.**

7.4 How many attempts does it take you to hit a vein? **Explore any problems the YP experiences with vein access.**

7.5 Describe how you inject. **Record the YP's description of how the injecting process, particularly considering the following questions.**

Comments/harm reduction advice offered:

Do you lick/burn the needle before injecting?
Angle of needle when injecting?
Is the needle hole up or down?
Do you pull back to check you're in a vein first?
When do you release the tourniquet?
How slowly do you inject?

7.6	**If there are multiple attempts to hit a vein, do you re-load a syringe? If so how?** **Explore front/backloading, using blunt/barbed equipment.**
7.7	**Have you ever had a missed hit? If yes describe what happened.** **Discuss o/d risks if having 2nd hit, bacterial infections (e.g. tetanus, botulism), abscesses etc.**
7.8	**Have you ever accidentally injected into an artery by accident?** **Explain risks/artery awareness.**

8 AFTER INJECTING

8.1	**How do you clean your injecting site after injecting?** **Explore hygiene including inappropriate use of alcohol swabs.**
8.2	**How do you clear up any blood spills?** **Explore the YP's awareness and understanding of BBV risks/hygiene.**
8.3	**What equipment do you keep? Why?** **Explore the YP's understanding of safe storage especially if children are present in home. Explain dangers of re-using own equipment.**

8.4 **How do you dispose of your needles?**

Highlight dangers of unsafe disposal and drug related litter and offer appropriate advice.

Comments:

Item	Stored?	Where?	Disposed of?	Where?	Average no. of times used before disposal?
Needles/syringe	❑	.....	❑	.....	.....
Tourniquet	❑	.....	❑	.....	.....
Spoon/cooker	❑	.....	❑	.....	.....
Acidifiers	❑	.....	❑	.....	.....
Water	❑	.....	❑	.....	.....
Filter	❑	.....	❑	.....	.....
Pre-injection swabs	❑	.....	❑	.....	.....
Lighter/matches/candle	❑	.....	❑	.....	.....
Needles/syringe	❑	.....	❑	.....	.....
Tourniquet	❑	.....	❑	.....	.....
Other (state)	❑	.....	❑	.....	.....

NB Injecting equipment must <u>never</u> be withheld due to failure to return used equipment. The overriding harm reduction principle of needle exchange is to provide sterile injecting equipment and reduce the public health impact of blood borne virus transmission.

9 DRUG RELATED RISK

9.1 **Have you been immunised against Hepatitis B?** Complete one row only.

Full immunisation consists of 3 or 4 vaccinations (dependant upon schedule), plus a booster at 5 years. Anti-body testing is not obligatory with IDUs but is helpful if possible.

Yes ❑	Date of final vaccination:	Anti-body tested? Yes ❑ No ❑	Date booster due:
No ❑	Indicate reason for not being vaccinated:	Indicate vaccination arrangements:	
Partially ❑	Indicate no. vaccinations received:	Indicate no. vaccinations outstanding:	Indicate arrangements to complete course:
Unsure ❑	Liaise with GP	Result of liaison with GP:	

Comments:

9.2 Have you been tested for blood borne viruses?

	Not tested	Tested	Date tested	Result of test: Positive	Result of test: Negative	Unknown if tested
Hepatitis B	❑	❑	.....	❑	❑	❑
Hepatitis C	❑	❑	.....	❑	❑	❑
HIV	❑	❑	.....	❑	❑	❑

Comments:

9.3 How do you think you might be at risk of getting a blood borne virus?
Explore the YP's awareness of risk and knowledge of BBV issues.

9.4 Have you ever overdosed? **Accidentally** ❑ **Deliberately** ❑ **Never** ❑
Explore circumstances and setting of the o/d, what drugs were used and the YP's understanding of overdose risks.

9.5 Have you ever witnessed an overdose? What happened? **Yes** ❑ **No** ❑
Explore the YP's awareness of emergency first aid, 999 procedure.

10 SEXUAL HEALTH AND PREGNANCY

10.1 Are currently in a sexual relationship or sexually active? **Yes** ❑ **No** ❑
Explore with YP partner(s)/age/at risk sexual behaviour.

Comments:

Go to 8.3

10.2 What contraception methods do you use? Explore YP's awareness of safer sex.

None	❑
Condoms	❑
Contraceptive pill	❑
Other (please state)	❑

Comments:

10.3 Have you ever had sex without a condom? Yes ❑ No ❑

Explore any sexual health issues.

Comments:

Is a referral to GUM or family planning required?

10.4 Do you need a condom supply? Explore any contraceptive needs. Yes ❑ No ❑

Comments:

Ensure condom demonstration is given.

10.5 Are you pregnant, worried you could be, or trying to become pregnant? (female clients only) Yes ❑ No ❑

Explore YP's awareness of fertility issues and any plans for pregnancy.

Comments:

Is a pregnancy test or referral to specialist midwife required?

10.6 Do you have any problems/concerns about your sexual health? Yes ❑ No ❑

Comments:

Signpost for GUM appt. if required

NB: If detailed sexual health interventions are required ensure this is marked clearly in the care plan.

11 SUMMARY OF ASSESSMENT

11.1 **Summarise of the young person's presenting needs in respect of a safer injecting service:**

11.2 **Competency check list.** **Workers should aim to involve parents in the YP's assessment and care planning. If the YP is under 16, the following questions MUST be answered to enable consent from the YP them self.** **Competence to consent must be re-assessed with ever safer injecting intervention.**

Is parental consent being sought?

Yes ❑ **No** ❑ → **If yes, tick all which apply:**

- ❑ The value of gaining parental support has been discussed with the YP.
- ❑ YP is likely to continue injecting and be at risk of significant harm without injecting equipment/harm reduction advice being offered.
- ❑ YP's physical/mental health is likely to suffer without injecting equipment/harm reduction advice offered
- ❑ YP understands the nature and benefits of receiving injecting equipment/harm reduction advice
- ❑ Supply of injecting equipment/harm reduction advice without parental consent is in YP's best interest
- ❑ YP understands the nature and benefits of receiving injecting equipment and harm reduction advice

Comments:

If yes, who is consent being gained from?

Name:	**Relationship to YP:**

Ensure that the parent/carer signs the care plan BEFORE injecting equipment is given.

11.3 **As a worker, do you consider the YP to be "suffering or at risk of suffering significant harm"? (See appendix 2; Safer Injecting Service Guidelines).**

Consider all information gained during assessment, especially regarding the YP's maturity, understanding of harm reduction, injecting risks, peer injecting, association with other/older injectors, sexual exploitation, home circumstances and any chaotic drug user patterns.

Yes ❑ **If yes, discuss with line manager. Child Protection procedures MUST be followed.**

No ❑ → **Explain why:**

Indicate clearly why you consider the YP to be at risk:

Issues of significant risk/harm must be considered throughout the assessment process.

10. COMPLETION OF SAFER INJECTING ASSESSMENT

This form must be signed and dated when completed by the worker responsible. It must also be signed by the worker's manager/supervisor when the assessment has been discussed in supervision/team meeting.

Worker name:		**Worker signature:**		**Date of signature:**	
Manager name:		**Manager signature:**		**Date of signature:**	

SAFER INJECTING CARE PLAN

Needle exchange should only be provided as part of a planned package of intervention. The worker must evidence that not giving injecting equipment to the young person would be of greater risk to them than the risks posed by continued or increased injecting drug use.

Client name:				**Client date of birth:**		**Client's age:**	
Client gender:		**Date of plan:**		**Date for review:**		**Plan no:**	

Evidence of identified need *Summarise identified need*	**Intervention to meet need** *What is going to happen?*	**Responsible person(s)** *Who is doing what?*	**Anticipated outcome** *What result do you expect?*	**Timescales** *For completion*
Child protection/child in need	Referral to Social Services: ❑ Verbal referral (insert date) ❑ Written referral (insert date) ❑ Other intervention (state)	Name of Social Worker taking referral:	❑ SSD assessment of need ❑ Other outcome (state):	
Injecting related medical needs	*Referral to:* ❑ A & E/Minor injuries Unit ❑ GP surgery ❑ Walk in centre ❑ School nurse ❑ Drug & alcohol service ❑ Other intervention (state)		❑ Injecting site assessment /treatment ❑ BBV testing ❑ Hepatitis B/A immunisation ❑ Tetanus booster ❑ Drug treatment ❑ Other outcome (state):	

Injecting drug use needs	❑ Injecting equipment issued ❑ Inj. equipment not issued *Safer injecting advice given:* ❑ Leaflet ❑ Verbal ❑ Referral to drug treatment ❑ Other intervention (state)		❑ Reduced BBV risk ❑ Reduced overdose risk ❑ Reduced risk of vein damage ❑ Reduced risk of bacterial/other infections ❑ Enhanced safer injecting ❑ knowledge/techniques ❑ Reduced vulnerability re injecting environment ❑ Other outcome (state):	
Sexual health/BBV needs	❑ Safer sex advice given ❑ Condoms issued ❑ Condom demonstration ❑ Other intervention (state) Referral: ❑ Hep B vaccination (indicate who is vaccinating YP) ❑ GUM ❑ Family planning ❑ Specialist midwife ❑ YP sexual health clinic ❑ Other service (state)		❑ Reduced risk of STIs ❑ Reduced risk of unplanned pregnancy ❑ Multi-agency management of ❑ pregnancy ❑ Other outcome (state):	

THIS FORM MUST BE SIGNED AND DATED UPON COMPLETION OF SAFER INJECTING CARE PLAN

Plan completed by: (worker name)		**Worker signature:**		**Date:**	
Plan approved by: (supervisor name)		**Supervisor/manager signature:**		**Date:**	
Parent/carer: (parent/carer name) *		**Parent/carer signature ***		**Date:**	
* The parent/carer MUST sign the care plan unless it has been clearly demonstrated that the YP can consent for them self.		**YP signature:**		**Date:**	

RECORD OF SAFER INJECTING EQUIPMENT ISSUED AND RETURNED

Completed this form every time safer injecting equipment is issued/returned. The **YP's ID** (first and last **YP initials**, **date of birth** and **gender**) must be written in the **YP ID** box. Indicate the number of items issued/returned (**No**.) and the date (**Date**) in the boxes provided. The competency box **must** be initialed by the worker to confirm that competency has been re-assessed at **every** intervention where safer injecting equipment is issued.

YP ID (initials/dob/gender e.g. AA010190F)	**YP Initials**		**Date of birth**						**Gender**	**Indicate any unmet need for safer injecting equipment:**
	X	X	D	D	M	M	Y	Y	M/F	

Competency assessed?	**Initials:**		**Initials:**		**Initials:**		**Initials:**		**Initials:**		**Initials:**		
Returned equipment	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**Total**
.45L personal sharps bin													
Individual needles													
Equipment issued	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**No.**	**Date**	**Total**
.5ml insulin syringe													
1ml insulin syringe													
2ml syringe													
Grey 27g x 1/2" needle													
Brown 26g x ½" needle													
Orange 25g x 5/8" needle													
Orange 25g x 1" needle													
Blue 23g x 1" needle													
Blue 23g x 1 ¼" needle													
Green 21g x 1 ½" needle													
Pre-injecting swabs													
Citric acid sachets													
Vitamin C sachets													
Water for injection													
Stericups®													
Filters													
Condoms													

SAFER INJECTING INTERVENTIONS PLANNING SHEET

Client name:		**Client date of birth:**		**Client's age:**	
Worker name:				**Sheet no:**	

This form is to be completed every time the young person is seen for an appointment. It should detail the date and venue of the appointment and include who attended. The work planned should be detailed and ticked when completed. Other work completed should also be listed. Finally the worker must sign each entry on the log sheet.

This form provides and easy reference guide as to what interventions have occurred and provides evidence for the care plan review.
NB: It is not designed to replace case note recording – case note should be completed as per usual procedures.

Appt date	**Venue** *Where is the appointment taking place?*	**Attended by:** *List all who attend appointment*	**Work planned** *(If work is not completed in this session, defer it to future sessions)*	**Completed?** ☑	**Other work completed** *Indicate if other unplanned work occurred during session*	**Signature of worker**

Appt date	**Venue** *Where is the appointment taking place?*	**Attended by:** *List all who attend appointment*	**Work planned** *(If work is not completed in this session, defer it to future sessions)*	**Comp leted?** ☑	**Other work completed** *Indicate if other unplanned work occurred during session*	**Signature of worker**

APPENDIX 2

TORBAY YOUNG PEOPLE'S NEEDLE EXCHANGE

OPERATIONAL GUIDELINES FOR WORKERS

Commissioned by:

Safer Communities Torbay
Working with you for you

Torbay Drug and Alcohol Action Team

Service provider:

checkpoint

The Children's Society
With children, for children, with you

CheckPoint Under 18s Drug and Alcohol Service,
7 Victoria Road, Ellacombe, Torquay, TQ1 1HU.

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1. COMPREHENSIVE SAFER INJECTING ASSESSMENT

1.1 Context

Injecting equipment will never be issued to young people as a stand alone intervention and will always be part of a care planned intervention. However it is acknowledged that a young person may present to CheckPoint and their over-riding need may be regarding their injecting drug use. Therefore, safer injecting care plans will be informed by the comprehensive safer injecting assessment. This is an in-depth assessment tool specific to injecting drug use which may be completed over a series of sessions with the young person.

1.2 Initial assessment ('red' questions)

The sections of the form marked in red serve as an initial assessment to assist the worker in assessing the young person's give an early indication of the areas of risk that should be prioritised for future sessions. It is therefore important that the red sections are fully completed as early as possible and certainly before any safer injecting interventions occur, especially the issue of any injecting equipment. The red sections also assist the working in assessing the young person's competence to consent to treatment, should they not consent to parental involvement. (Further guidance on assessing competence can be found in section 2 below).

The safer injecting assessment will also establish that not giving injecting equipment to the young person will be of greater risk than the risks the face from continued or increased injecting drug use. The overall emphasis of safer injecting interventions will be to encourage young people to:

i. Inject more safely
ii. Change to a safer route of administration (see route transition interventions below)
iii. Engage in treatment (if indicated)
iv. Stop using drugs

1.3 Scope of comprehensive safer injecting assessment

In addition, to an over-arching assessment of competence to consent, the comprehensive assessment will encompass the areas detailed in the grid below. During assessment, any dangerous practices will be addressed by the worker who will offer harm reduction information and plan to deliver more detailed interventions specific to the risks identified with the young person if required.

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Scope of CheckPoint comprehensive safer injecting assessment form

1	*The young person's personal/home circumstances*	• Stability of accommodation/home life • Parental understanding of the YP's drug use
2	*Drug use*	• Drug history and current use • Patterns to drug use • Exploration of initial injecting experiences • The YP's future plans/wishes regarding injecting drug use
3	*Injecting equipment used*	• Where the YP sources injecting equipment • Initial assessment of injecting equipment is used • Initial assessment of sharing
4	*Preparing drugs for injection*	• Injecting hygiene • Process of preparing drugs for injection • Type of injecting equipment used and detailed assessment of sharing
5	*Peer injection and social factors*	• The YP's experience and understanding of peer injection • Assessment of risk of the YP due to possible peer injection • Social and geographical factors of the YP's injecting drug use
6	*Vein care*	• Injecting site assessment • Identification of any injecting related medical problems
7	*Injecting process*	• Selection and raising of veins • The injecting process • Missed hits • Veins and arteries
8	*After injecting*	• Hygiene and blood spills • Storing of injecting equipment • Safe disposal of injecting equipment • Re-use of injecting equipment
9	*Drug related risk*	• Hepatitis B vaccination • Blood borne virus testing • Overdose awareness and response
10	*Sexual health and pregnancy*	• Sexual activity • Condom use • Pregnancy • Sexual health
11	*Summary of assessment*	• Presenting needs • Competency check list • Child protection check list • Signatures

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2. COMPETENCE AND CONSENT

This section has been partly adapted from the BreakOut Under 18s Needle Exchange Policy (Derbyshire Mental Services NHS Trust)

2.1 Assessing competency – summary

The following key factors need to be considered when assessing competency to treatment:

- The younger the person is the less likely it is that s/he will be assessed as being competent to consent to treatment.
- Young people under the age of 13 are unlikely to be deemed competent to consent to treatment (i.e. medical *&* non medical forms of intervention).
- Young people under the age of 15 are unlikely to be deemed competent to consent to medical treatment.
- A young person can withdraw their consent at any time.
- Consent must be re-assessed at every intervention.

Although young people over 16 are generally deemed to be able to consent to their own treatment, CheckPoint will assess competency for any young person under 18 as a matter of good practice.

2.2 Factors and considerations in assessing competence

Competency will need to be determined individually for each and every young person. The following factors will be considered when assessing the competence of a young person to consent to treatment:

- The maturity of the young person. The younger the person, the less likely it is that they will be competent. Whilst each young person will need to be assessed individually, it is unlikely that those under the age of 13 would be deemed competent to consent to their treatment.
- The understanding the young person has of his or her actions.
- The understanding the young person has of the consequences of treatment or the capacity to deal with these without the support of his or her parents.
- The extent to which other factors which may affect the level of understanding are present, such as intoxication through drugs or alcohol, or learning disabilities.
- The nature and level of treatment. The more invasive the level of intervention proposed and the more problematic the substance use, the less likely it is that the young person will be found competent. Thus, competence for counselling is likely to be of a lesser standard than that required for invasive medical treatment.
- A young person's competence may fluctuate and should be under constant review

2.3 Fraser Guidelines (Mental Health Act 1983 Code of Practice, 1999)

Drawing on the Fraser Guidelines, the following five preconditions must be adhered to when assessing whether a young person is competent to give or withhold consent to the provision of confidential medical advice and treatment:

- That the young person is able to understand the service offered and has the maturity to understand what is involved.
- That their physical and/or mental health will suffer if they do not receive treatment;
- That the young person's best interests require the provision of treatment without parental consent.

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- That the young person will continue to put themselves at risk of harm if they do not receive treatment.
- That the young person cannot be persuaded to inform the parental responsibility holder(s), nor allow the staff to inform them.

2.4 Withdrawal of consent to treatment

- If a young person has been found competent, and has given consent to treatment, he or she can withdraw that consent at any time.
- If a parent consents to the young person being treated by the service, the parent may withdraw that consent at anytime, even if the parent has signed an agreement with the service for the young person to complete a course of treatment.
- Once consent has been withdrawn, treatment may not continue until such time as permission is obtained from the Courts or the young person is deemed competent and gives consent.

2.5 Parental responsibility

The law is clear on who has parental responsibility:

- The mother of the young person.
- The father of the young person where he was married to the mother at the time of the young person's-conception or birth or, where he was not married to the mother at the time of the conception or birth, has since married the mother.
- The unmarried father, if he has obtained a parental responsibility order through the Courts, or made and registered a parental responsibility agreement with the mother.
- Anyone who has a residence order in relation to the young person, or a legal guardian appointed under Section 5 of the Children Act 1989.
- The local authority, where the young person is the subject of a care order (but not where the young person is simply accommodated by the local authority).
- It is only necessary to obtain the consent of one person with parental responsibility to commence treatment with a young person where parental consent is required. There is no need to have the consent of every person who holds parental responsibility.
- One parental responsibility holder cannot veto the consent of another parental responsibility holder. The objecting parental responsibility holder could, however, seek a court order to prevent the treatment.

2.6 'Looked after' young people

- Where a young person is placed with foster parents, and the young person is not competent to consent to treatment, consent will need to be given by the parent or the local authority, depending on the legal status of the young person.
- Where the young person is accommodated under s.20 Children Act 1989 and is not competent to consent on his or her own behalf, the local authority must obtain consent from the parents, who retain parental responsibility. Where the parents refuse their consent for what the local authority regards as necessary treatment, the local authority may have to obtain an appropriate order from the Court to deal with this issue.
- The Children Act 1989 s.33(3) (b) permits local authorities to restrict a parent's exercise of parental responsibility where it is necessary to do so in order to safeguard or promote the young person's welfare. In exceptional cases, the local authority may seek a Court order for the treatment.

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2.7 Ten key policy principles (SCODA and The Children's Legal Centre, 1999)

1. A child or young person is not an adult.
2. The overall welfare of the individual child or young person is of paramount importance.
3. The views of the young person are of central importance, and should always be sought and be considered.
4. Services need to respect parental responsibility when working with a young person.
5. Services should recognise the role of, and co-operate with, the local authority in carrying out its responsibilities towards children and young people.
6. A holistic approach is vital at all levels, as young people's problems tend to cross professional boundaries.
7. Service must be young people centred.
8. A comprehensive range of services should be provided.
9. Services must be competent to respond to the needs of the young person.
10. Services should aim to operate, in all cases, according to the principles of good practice.

2.8 Factors to consider for disclosure

The following four parameters should be used as a guide by workers/managers when considering whether confidential information given by a young person should be disclosed to social services, the police or the NSPCC.

- **The age and the maturity of the child:** As a general rule, the younger the child, the more problematic it is to guarantee or maintain confidentiality. There is no age limit in law below which a child cannot enter into a confidential relationship, but given the problems of establishing competence to consent to treatment, it is difficult to envisage children being offered confidential treatment for drug misuse, without parental consent or parental involvement, much under the age of 13. Indeed, it is possible that a failure to inform parents that a young child is misusing drugs could lead to legal negligence action if the drug service or agency failed to take sufficient action to protect the child from harm as a result of that drug misuse.

- **The degree of seriousness of drug use:** The more serious the drug use, the more likely it is that disclosure of confidential information to other agencies (NSPCC, Social Services, Police) will have to be considered. In deciding whether to disclose, the drug service must take into account: the patterns and levels of drug taking; the risks of morbidity; mortality; and other risks such as involvement in crime and other behaviour linked with the substance misuse. The supply source of the child's drugs may also be important, particularly if the child is 'at risk' of exploitation or coercion.

- **Whether harm or risk is continuing or increasing:** Harm from drug taking needs to be assessed with consideration of past, present and potential future behaviour. If there is a clear risk to the child arising from present behaviour or evidence of an escalation of risk to an unacceptable level, it is important that a service takes steps to ensure the future safety of the child.

- **General context in which drug use is set:** If a child or young person has multiple problems, it is likely that other agencies or professionals will need to be involved to resolve these problems or reduce the child's vulnerability to risk of harm. Examples would be: a child who reveals abuse within their home or residential setting; the child who has fallen out with his or her parents and is homeless; the child who has absconded from care. In such cases, the child or

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young person needs to be encouraged to involve other agencies. The drug service will need to assess the child's circumstances and determine whether to disclose confidential information against the child's wishes.

Where there are concerns that a child or young person is 'suffering, or at risk of suffering, significant harm', and the professional or drug service decides that it is in the interests of the child's safety and welfare that there be disclosure of confidential information to Social Services or to the Police, the child or young person's consent should first be sought to the disclosure. The child or young person should also, where possible, be involved in the process of the referral. Where that consent is not given, the child or young person should be informed that the professional or drug service intends to disclose confidential information, and given the reason for this decision. He or she should also be informed of the likely outcome of the information being passed on to another service.

2.9 The need to know principle

It is recommended that information sharing policies be developed which distinguish between different types of information sharing.

- **Information shared for the purposes of monitoring evaluation and research:** Policies should state that any statistics and characteristics about clients used for the above purposes should be shared and stored in anonymous form to protect the identity of the clients. Information shared in this way which discloses the identity of a service user without his or her consent would be ***an unwarranted breach of confidentiality.***

- **Information shared with parents for onward referral and/or within joint case work arrangements:** If services need to work in partnership with parents and other agencies to meet the best interests of a child or young person, information sharing may be necessary. This can be done by encouraging the young person to give their consent to disclosure, unless there is a court order or a child protection imperative. In cases where young people are undergoing interventions as a result of a Court order or sentence, clear agreement must be reached at the outset on what information will have to be shared in order to monitor progress, and this should be explained clearly to the child or young person.

- **Information that must be shared in order to protect a child:** Practitioners who have concerns that a child or young person is 'suffering, or at risk of suffering, significant harm', must be supported in taking appropriated action to protect them, through agreed criteria and protocols, regardless of the young person's level of competence to consent to treatment and/or parental involvement. The young person's consent to, and involvement in, disclosure is still preferable, and any objections they have to disclosure should be seriously considered, but the authority, nevertheless, rests with responsible adults and services to assess the best course of action.

2.10 Assessment of competency during CheckPoint comprehensive safer injecting assessment

The CheckPoint comprehensive safer injecting assessment examines competency issues throughout. The obligatory questions (marked red on the assessment form) offer the worker an opportunity to assess competence. The role of these questions in assessing competency is detailed overleaf.

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2.11 Assessment of competency (CheckPoint comprehensive safer injecting assessment)

The following questions have been formulated to assess the requirements of the Fraser Guidelines in respect of competency.

Question		Purpose of question
1.1	Personal details	• Provides indicator of age to assist decision making regarding consent. • Provides contact details in case of onward referral for child protection assessment.
1.5	Do your parents/carers know you use drugs/inject?	• Identifies if parental consent can be obtained. • Explores why the YP may not want parents informed/involved in consent.
2.1	Drugs used	• Provides information on YP's current drug use patterns and level of drug related risk. • Confirms that YP is a drug user by extent of drug knowledge (i.e. not coerced by a peer/older injector to access injecting equipment on their behalf).
2.3	Why did you start injecting?	• Explores possibilities of YP stopping drug use or moving towards an alternative (safer) route of drug administration and YP's reasons for starting to inject.
2.5	Do you plan to continue injecting? Why?	• Explores whether YP plans to continue injecting. • Assesses whether YP is liable to continue injecting and be at increased harm if no intervention is given.
3.1	Do you currently use an adult needle exchange?	• Explores how the YP currently accesses injecting equipment and any risks in doing so.
3.2	Do you get injecting equipment from other people?	• Explores how the YP currently accesses injecting equipment. • Explores potential issues of exploitation/vulnerability.
3.3	What needles/syringes do you use/have you used?	• Explores types of equipment used and reason for use. • Confirms that YP is injector by extent of injecting knowledge.
4.1	What do you understand by the term "sharing"?	• Explores the YP's understanding of injecting related risk. • Explores YP ability to understand harm reduction messages.
4.2	What hygiene measures do you take before preparing drugs for injection?	• Explores the YP's understanding of injecting related risk. • Confirms that YP is a drug user by extent of drug knowledge (i.e. not coerced by a peer/older injector to access injecting equipment on their behalf).
4.3	How do you prepare drugs for injection (prepare a hit):	• Explores the YP's understanding of injecting related risk. • Confirms that YP is a drug user by extent of drug knowledge (i.e. not coerced by a peer/older injector to access injecting equipment on their behalf).
5.1	Do you inject yourself?	• Confirms that YP is a drug user by extent of drug knowledge (i.e. not coerced by a peer/older injector to access injecting equipment on their behalf).

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		• Assesses level of risk.
5.2	Has someone else ever injected you (including your first ever hit)?	• Assesses level of risk and vulnerability from peer injection.
5.3	What risks do you think are involved with someone injecting you?	• Explores the YP's understanding of injecting related risk. • Explores YP's awareness of possible abuse/exploitation occurring. • Identifies possible child protection issues. • Explores YP ability to understand harm reduction messages and ability to reduce their own risk.
5.4	Could the YP move to a safer route of administration or take responsibility for injecting themselves with safer injecting advice?	• Explores the YP's injecting ability & awareness of risk. • Explores whether it is likely that harm will continue to escalate if not treatment is received. • Explores maturity/competence of YP moving towards an alternative (safer) route of drug administration/taking responsibility for own injecting. • Explores YP ability to understand harm reduction messages and ability to reduce their own risk.
6.1	Where in the body are you injecting?	• Confirms that YP is injector by extent of injecting knowledge. • Explores the YP's understanding of injecting related risk.
6.2	Do you know that injecting in the groin, neck, penis, breasts is extremely dangerous?	• Explores the YP's understanding of injecting related risk. • Explores YP ability to understand harm reduction messages.
6.3	Worker's assessment of sites.	• Confirms that YP is injector by evidence of injecting sites • Assesses level of risk.
6.4	Does the YP require a medical referral/signposting due to injecting related damage?	• Assesses level of risk.
7.5	Describe how you inject.	• Confirms that YP is injector by extent of injecting knowledge. • Explores the YP's injecting ability. • Assesses level of risk.
8.4	How do you dispose of your needles?	• Explores YP's understanding of risk. • Explores YP ability to understand harm reduction messages.
9.3	How do you think you might be at risk of getting a blood borne virus?	• Explores YP's understanding of risk. • Explores YP ability to understand harm reduction messages.

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9.4	Have you ever overdosed?	• Assesses level of risk and vulnerability. • Explores YP's understanding of risk. • Explores YP ability to understand harm reduction messages.
10.5	Are you pregnant, worried you could be, or trying to become pregnant? (female clients only)	• Identifies possible child protection issues. • Identifies the need for drug treatment as a priority issue.
11.1	Summarise of the young person's presenting needs in respect of a safer injecting service:	• Identifies the YP's presenting needs.
11.2	Competency check list:	• Confirms that all aspects of competence has been assessed.
11.3	As a worker, do you consider the YP to be "suffering or at risk of suffering significant harm"?	• Identifies possible child protection issues.

'Red' questions are also designed to assess the young person's level of maturity and whether their ability to consent may be affected by levels of intoxication, learning difficulties or mental ill health.

These questions should be completed on the first contract with the young person before any safer injecting equipment is issued.

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3. ISSUE AND RETURN OF INJECTING EQUIPMENT

3.1 Frequency of contact for safer injecting interventions

Young people receiving a safer injecting service should be seen at least weekly. Contact may be more frequent if there are sufficient reasons to dictate this. Decisions to see the young person less than weekly and offer more than one week's supply of injecting equipment should be guided by:

- The level of risk
- Evidence that the young person has sufficiently reduced some of the risks associated with them injecting
- The young persons' age/ability to consent

3.2 Amount of injecting equipment offered

Interventions with young injectors differ from adult provision in that the aim is to maximise regular contact, and for this reason, a minimum of equipment will be issued at each intervention. The needs of individual injecting drug users vary considerably and it is difficult to specify the "average" requirement of the "average" injector. The following guidance should be considered when deciding a realistic amount of injecting equipment to offer a young person:

Frequency of injecting	• The number of days per week the young person injects • Then number of times per day the young person injects • In the case of an occasional/intermittent injector who is assessed as being likely to continue injecting infrequently, a small supply of injecting equipment may need to be provided.
Ability to inject	• The young person's ability to inject themselves - if there are multiple attempts, consideration to issuing additional equipment (alongside safer injecting advice and route transition interventions) must be given to avoid usage of blunt/barbed/blocked needles or sharing of contaminated equipment.
Day of week **Margin for error**	• Consideration of the day of the week – additional supplies may be required for weekend and bank holiday periods. • Injecting drug use is does not always go as planned, therefore a reasonable margin for error should always be allowed in case of the young person requiring more equipment than anticipated. However additional supplies given should not be so great that they reduce the young person's need for regular contact.

Professional judgement	• Overall workers, must demonstrate that they can strike a balance between
	  ○ encouraging the young person to regularly engage with the service and
	  ○ the risk of young person disengaging and continuing to access injecting equipment by other means (e.g. adult injectors) or using contaminated equipment because they feel that their needs will not be met by CheckPoint

3.3 Peer distribution of injecting equipment (secondary exchange)

Peer distribution is considered a valid method to increase access to injecting equipment amongst adult injectors. However it is unlikely that peer distribution amongst young people, especially those under 16, is likely to be in the child's best

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interests as the aim of the safer injecting service is to maximise contact with young injectors and deliver equipment as part of a care planned package.

Given that the CheckPoint Safer injecting service is a high threshold service, this reduces the likelihood of young people being exploited by adults who do not wish to access an adult needle exchange, although the possibility of this cannot be ruled out. There is however a real risk that the young person could be exploited by their peers, siblings etc who do not want to be identified as an injector and coerce the young person to access equipment on their behalf. The comprehensive safer injecting assessment offers a number of mechanisms to validate that the young person is an injecting drug user them self as opposed to being exploited by an adult or peer to access injecting equipment them self.

Any requests for additional injecting equipment for use by another injector should be very carefully weighed up by the worker.

3.4 Needle disposal

It is important that the return of injecting equipment is maximised. Inappropriately discarded needles and syringes are a major concern to local communities. This can result in negative publicity for drug services and undermine public confidence in the important public health role needle exchanges play in terms of reducing blood borne virus infections.

Workers must always ask the young person whether they have any equipment to return at the outset before issuing further injecting equipment. Engaging injectors in regular discussion about the way their injecting equipment is disposed of keeps the importance of returning injecting equipment an open discussion point.

The young person should always be issued with a personal sharps bin which meets their needs and instructions on how to use/lock it may need to be given. It is acknowledged that many injectors are reluctant to carry injecting equipment any further than is necessary, may return used injecting equipment in bulk on an intermittent basis or make use of other sharps disposal facilities within the locality. For these reasons it is not realistic to work on the principle of issuing the same number of needles/syringes as are returned.

When a young person is issued with injecting equipment for the first time, the worker should explain the importance of returning used injecting equipment to and the hazards associated with inappropriate sharps disposal and inappropriate storage of injecting equipment. This is especially important if there are other (younger) children in the household and consideration of child protection procedures must be made.

Advice on sharps safety is found in appendix 3 of the Checkpoint Safer Injecting Service Policy.

3.5 Issue of needles and syringes

There can be no definitive guidance on what type of needles and syringes should be issued to a young injector. This will vary according to the following:

- the type of drug(s) used
- frequency of injecting
- injecting site
- injecting route
- personal choice

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3.6 Best practice

Best harm reduction practice is to encourage injectors to use the smallest possible needle/syringe as this generally reduces risk. However needles and syringe issued must be suitable for the site, route of administration, and drug solution injected (e.g. large needles should not be used for superficial veins and small needles should not be used for deeper veins, viscous substances should not be injected with narrow gauge needles). A summary of the range of needle and syringes and their suitability of injecting is detailed in the grid overleaf.

In the case of YPs preferring to use other needles/syringes and the worker assessing that these are not this most ideal injecting equipment, the worker will seek to encourage the YP to move over to using more suitable needle but continue to offer the YP their preferred equipment of choice alongside insulin syringes. The worker should continue to positively encourage the YP to change a more suitable product and could do so by offering a small supply of this product to "try" in addition to the young person's usual equipment of choice.

The YP's choice of needles/syringes will only be declined if the worker assesses that the by issuing the equipment requested, the YP is likely to sustain more harm than if this equipment was not issued.

3.7 Type of needles and syringes

Insulin syringe (with a fine needle attached):
The majority of needles issued to injecting drug users are the "all in one" 1mL insulin syringes, with a fine needle attached. This product is likely to be the most commonly issued needle/syringe unless assessment indicates that this equipment does not meet the YP's needs or they cannot be encouraged to switch to more suitable injecting equipment.

1mL syringes:
The issue of a 1mL syringe suitable for attaching a needle would be indicated in instances where:

- The YP prefers to change the needle after drawing up
- The YP has difficulty accessing veins causing the needle to blunt/barb/block after more than one attempt (and the drug solution is needed to be re-loaded)
- The YP finds the use of insulin syringes with a needle attached difficult

2mL syringes:
It is unlikely that a 2mL syringe would best meet a young person's needs as this may encourage them inject larger volumes of a drug solution and may also reduce the level of control over the speed of the actual injecting process. These syringes should only be issued if there are clear grounds to do so, *or* if the YP cannot be encouraged to use a smaller syringe and would be at increased risk if 2mL syringes were declined.

5mL syringes:
There are unlikely to be harm reduction grounds for issuing a young person with a 5mL syringe and this item will not be stocked by the CheckPoint Safer Injecting Service. Any request for a 5mL syringe should be discussed in detail with the young person as use of this item is usually for a very high risk injecting practice.

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Types of needles and syringes (Adapted from Derricott *et al.*, 1999[1])

Needle	Used for:	Unsuitable for:
.5mL insulin syringe (with needle)	☑ Superficial/finer veins. (This is the preferred needle/syringe of issue to YP.) ☑ Subcutaneous injection*	☒ Deeper veins. ☒ Intramuscular injection.
1mL insulin syringe (with needle)	☑ Superficial/finer veins. (This is the preferred needle/syringe of issue when YP decline a .5ml syringe). ☑ Subcutaneous injection*	
Grey needle 28g x ½"	☑ Superficial/finer veins or subcutaneous injection when YPs are issued with detachable syringes. ☑ Subcutaneous injection*	
Brown needle 26g x ½"	☑ Superficial/finer veins or subcutaneous injection when YPs are issued with detachable syringes and decline a grey needle	
Orange needle 25g x ⅝"	☑ Superficial veins when a grey or brown needle is refused by the YP	☒ Deeper veins ☒ Very fine veins ☒ Intramuscular injection
Orange needle 25g x 1"	☑ Deeper veins when the YP cannot be encouraged to use superficial veins	☒ Intramuscular injection
Blue needle 23g x 1" 23g x 1¼"	☑ Deeper veins (esp. groin)* when the YP cannot be encouraged use superficial veins ☑ Intramuscular injection* when the YP cannot be encouraged to cease intramuscular injection	☒ Superficial/finer veins.
Green needle 21g x 1.5"	☑ Intramuscular injection* when the YP cannot be encouraged to cease intramuscular injection	☒ Intravenous injection
1mL syringe	☑ Intravenous injection ☑ Intramuscular injection* ☑ Subcutaneous injection*	
2mL syringe	☑ Intravenous injection ☑ Intramuscular injection*	☑ Subcutaneous injection
High risks: (denoted above * in red)	✗ Subcutaneous injection of illicit drugs ✗ Intramuscular injection of illicit drugs ✗ Groin (femoral) injecting	✗ Use of performance enhancing drugs (steroids) by YPs ✗ Use of growth hormones/insulin (alongside steroids) by YPs

[1] Derricott, J., Preston, A. and Hunt, N. (1999) The safer injecting briefing.

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4 ISSUE OF OTHER INJECTING EQUIPMENT ('PARAPHERNALIA')

4.1 Legal considerations

In accordance with the Misuse of Drugs Act 1971 and subsequent amendments, it is legal for the following items only to be issued to injecting drug users for harm reduction purposes by drug serve/needle exchange workers:

- Needles/syringes
- Citric acid
- Ascorbic acid (vitamin C)
- "Cookers" (for preparing drug for injection in)
- Pre injection wipes ("swabs")
- Water for injection
- Filters

However, just because an item is legal for issue, this does not negate the need for the worker to demonstrate their duty of care by ensuring that the any injecting equipment is given alongside harm reduction advice which meets the person's needs. The onus is further extended to workers engaging with young people who must also consider that issue of any safer injecting equipment is in the young person/child's best interests.

All other equipment, such as tourniquets, crack pipes, snorting straws or tin foil (for smoking heroin) are illegal to issue to drug users. Any consideration of issuing these items should be based upon the harm reduction benefits and must be supported by a "letter of comfort" from the local Base Command Unit of Devon & Cornwall Police.

4.2 Isopropyl pre-injection wipes ('swabs')

To swab or not to swab..? Medical studies suggest that pre-injection swabbing to disinfect the skin before vaccination or venapuncture is unnecessary (Sutton *et al.*1999[2], Dann 1969[3]).

Some needle exchange services do not issue swabs for these reasons. It should be noted however that there may be a vast difference between a clinical environment and the injection of unsterile drug solutions. Whilst swabs may offer little medical advantage, many drug users inject in unsanitary conditions and those vulnerably housed, homeless, or having no 'safe' place at home to inject may make frequent use of public toilets or other unsanitary areas where access to washing facilities is limited or absent. Overall, there is a limited evidence base to support this, although a study by Murphy *et al.* (2001)[4] indicated that cleaning the skin with alcohol before injection has a protective effect against abscesses in injecting drug users.

Street drugs are unsterile and swabbing cannot ensure a fully sterile injecting process. Injectors should be encouraged to wash their hands and injecting sites thoroughly before preparing drugs for injection for infection control purposes. One harm reduction source suggests that swabbing may "be better than nothing in injecting drug users in that they at least convey a message about the desirability of cleanliness" (Derricott, 2005 in print[5]). Injectors should also be strongly encouraged to ensure all surfaces used for preparing a drugs are washed clean beforehand or at least covered with something suitable (kitchen towels), to reduce infection risks.

[2] Sutton CD, White SA, Edwards R, Lewis MH. (1999). A prospective controlled trial of the efficacy of isopropyl alcohol wipes before venesection in surgical patients. *Annals of the Royal College of Surgeons England* **81(3)**: 183-6.
[3] Dann TC. (1969). Routine skin preparation before injection: an unnecessary procedure. *Lancet* **2(7611)**: 96-8.
[4] Murphy *et al.*, 1999. Risk factors for skin and soft tissue abscess among injection drug users: a case-control study. Clin Infect Dis 2001; 33:35-40.
[5] Derricott *et al.* 2005, The Safer Injecting Briefing, in print.

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Swabs are frequently used incorrectly and injectors need clear guidance on appropriate use. Swabs should be used to wipe across the injection site once (rather than around and around which may move the bacteria around) *prior* to injecting and *wait* until the alcohol has dried (30-60 seconds) *before injecting* to ensure best results.

Unfortunately, swabs also have some inappropriate uses which workers should aim to minimise by harm reduction education:

- Being used after injection (may encourage further bleeding and delay in clotting/scab to form).
- Being ignited to provide heat to dissolve drugs for injection (a fire risk).
- Being used as a filter to draw up drugs into the syringe through (there may be a danger of particles breaking off the swab and the alcohol solution in the swab being injected).
- Being used to cleanse the face or other areas of the body (excessive use of swabs may harden and dry out the skin).
- Being used to "sterilise" injecting equipment (this will not effectively sterilise needles and syringes and there is no guarantee that blood borne viruses will be inactivated by swabbing equipment).

As a rule, a minimum of one swab per needle/syringe should be issued though it is should be noted that swabs are frequently used for other purposes in the injecting process – any requests for considerably more swabs should be investigated as they may be indicative of inappropriate use.

4.3 Citric/ascorbic acid

Brown heroin and crack cocaine is alkaline and an acidifier is required in order to dissolve it for injection. Cocaine, amphetamine, or white heroin (rare in the UK) do not require an acidifier. Some acidifiers commonly used (such as lemon juice [fresh or bottled] or vinegar) present significant dangers. Occasionally more dangerous substances containing an acidifier (e.g. kettle de-scaler) may be used. Single use citric acid sachets have been evaluated as being successful in reducing the risk of Candida endophthalmitis (fungal) infections, which can cause eye infections and blindness due to use of unsterile acidifers such as lemon juice[6].

All acids are ascorbic and will damage the body's tissues - guidance on using the smallest amount as possible must be offered (it is possible to add more acid to a solution but not to take some away). A serious risk of acidifier burns is that they may degenerate the tissues and provide the right conditions for which anaerobic bacterial infections. These include clostridium novyi, tetanus or botulism which may develop if the drugs contain these bacterium and subcutaneous, intramuscular injecting or 'missed hits' occur.

Injectors should be encouraged to only use the single use sachets of acidifiers supplied by the safer injecting service. One opened, a sachet should be thrown away as bacteria may develop which could cause serious infections. The use of bulk packets of acidifiers should be strongly discouraged as these may not be manufactured as sterile and will certainly not be sterile, especially once opened. Packets or sachets of acidifiers' should never be shared by more than one injector as this is a blood borne virus risk.

[6] Garden J, Roberts K, Taylor A, Robinson D. January.2003. Evaluation of the provision of single use citric acid sachets to injecting drug users. Effective Interventions Unit.

Please do not reproduce without an acknowledgment.

Citric acid is stronger than ascorbic acid so less is needed, but there is no evidence to suggest that neither acid is better or worse than each other. As it is weaker, more ascorbic acid powder is required to dissolve drugs for injection and it offer some advantages over citric acid given that there is more margin for error if a pinch too much is added (resulting in less serious damage to the body).

The safest acidifiers to use for dissolving drugs for injection are citric acid or ascorbic acid (vitamin C). A very small pinch of acidifier should be added to a drug solution and then more if this is insufficient. A minimum of one sachet of acidifier per needle/syringe should be issued.

4.4 "Cookers"/ spoons

Spoons for preparing drug solutions in are frequently re-used or shared by more than one injector. It is good practice to encourage injectors to use single use "cookers" which are difficult to re-use or share. Other items, such as the end of a drinks can are also used to prepare drug solutions in, which may pose health risks (due to them not being sterile or being coated on the outside with toxic substances). Injectors may require some instruction correct usage of cookers as they are less robust than a spoon and there is a risk of the drug solution being spilt and the injector being deterred from using them.

As a rule, a minimum of one cooker per needle/syringe should be issued.

4.5 Filters

Filters are needed to filter out impurities when drawing up the drug solution into the syringe through the needle. The most appropriate filter for use is a medical filter attached to the needle; however these may not fit all brands/sizes of needle. Tobacconist filters (for rolling hand made cigarettes) are issued by some services, and although these are not sterile, they offer some advantage over the use of filters from pre-rolled cigarettes (especially if they have been already used for smoking). There is a strong risk that filters will be re-used as they harbour an active drug solution. However this risk should not negate their distribution as the use of other items, such as cotton wool or pre-injection swabs as fibres may break off and be injected into the body. Stored filters provide the right conditions to incubate serious anaerobic bacterial infections such as tetanus or botulism and harm reduction advice must be given to strongly discourage this practice.

As a rule, a minimum of one filter per needle/syringe should be issued.

4.6 Water for injection

All water used to dissolve drugs, except sterile water for injection may be contaminated by bacteria or blood borne viruses. If sterile water for injection ampoules are not available, the injector should be encouraged to consider the following "hierarchy" of water:

1. Cooled down tap water that has been boiled for five minutes in a covered saucepan.
2. Cooled down tap water that has been boiled in a kettle.
3. Cold water straight from the tap.
4. Bottled or distilled water (this is more likely to contain bacteria as it may have been kept warm or if it has been opened may have been exposed to the air).

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It is known for injectors who prepare and inject drugs in public toilets to use water from toilet cisterns or pans which presents significant infection risks and should be strongly discouraged.

Drawing up water from a shared container (cup/bowl/glass/bottle) is a blood borne virus transmission risk if another injector's needle/syringe has come into contact with the water or vessel – even if there is no blood visible to the naked eye. Water which has been used by another injector to rinse or clean a syringe/needle must not be used for the same reasons. Sharing of water or water containers should be strongly discouraged. Water for ampoules contain a small amount of water and are therefore unlikely to be shared or retained for later use.

As a rule, one ampoule of water per needle/syringe should be issued.

4.7 Tourniquets (NB: this item is not permitted to be issued by the Misuse of Drugs Act)

Home made tourniquets are frequently used by injectors to assist in raising veins. A young injector is less likely to require a tourniquet to raise superficial veins (unless they have been injecting for some time, considerable damage to the veins has occurred or venous access is generally poor, especially in females).

Tourniquets should only be used if they are really needed as they come with noticeable dangers. Injectors who can be persuaded to desist from using a tourniquet should be offered the following advice to help raise a vein:

- Making a fist (opening and closing the hand).
- Moving their arm around from the shoulder in a circle (like a windmill) or other vigorous exercise.
- Putting their arm in warm water (* extreme caution re: bath – see below).
- Being in a warm location (this may present challenges to injectors who inject in public locations, especially in winter).
- 'Slapping' the vein vigorously (*Trainspotting* style) is ineffective.

***Injecting in the bath is very dangerous** - if overdose occurs, drowning is possible. If the young person uses a bath to raise their veins ensure that they get out of the bath first and inject in a safer location.

If the young person is unlikely to desist from using a tourniquet the following advice should be given:

- Any tourniquet used must be "quick release" (knots or buckles should never be used).
- Tourniquets must never be shared as there is a risk of them becoming contaminated with blood and transmitting blood borne viruses.
- A tourniquet is dangerous (and less effective) if used in any other part of the body than the upper arm (especially leg or neck).
- Tourniquets must not be pulled too tight.
- A tourniquet should not be left on the arm for more than one minute.
- A tourniquet must be released *before* injection occurs otherwise serious damage to the veins can occur. If the person overdoses, circulation damage/loss of limb is possible (if the young person experiences frequent missed hits, check that they are releasing the tourniquet before injecting).

Tourniquets are not specifically exempt from the Misuse of Drugs Act and remain illegal to be given out for harm reduction purposes. (See section 4.1).

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5. HIGH RISK INJECTING PRACTICES

5.1 Injecting drug user risk assessment

Injecting is a dangerous activity and many of the risks can be minimised by good harm reduction interventions. The injecting drug user risk assessment grid overleaf summarises some of the key issues which are explored in more detail in this section. This section is not exhaustive and the worker may wish to refer to a comprehensive text book (e.g. Derricott et al. 1999) for more detailed information. In all cases, consideration should be given as to whether the young person is at significant risk of harm.

5.2 High risk injecting sites

All injecting sites, other than the upper limbs, present higher risks. Arms should be the first site of choice for injecting, however this does not infer that injecting into the arms is "safe". "Site rotation" (not using the same site continuously and giving veins a chance to heal) is crucial to minimise the risk of collapsed veins and local infections. Workers should educate injectors who are unable to desist from injecting how to find and raise appropriate veins for injecting.

Hands: Young people may avoid injecting in the hands as evidence that they have injected is difficult to hide. Hands contain a number of visible but often small and delicate veins Injectors should be discouraged from using these as damage to them may result in severe problems. Injectors who inject in their fingers must remove any rings first as if the finger swells the ring will obstruct the blood flow.

Leg/feet: The use of the legs or feet for injecting comes with added risks as they are more prone to infection and healing may be slower. Veins on the sole of the feet should never be used for injection. Injecting into the feet and legs should be done as slowly as possible to prevent vein damage and towards the heart (upwards).

Groin (femoral vein): There is an apparent rise in the use of the femoral vein for injecting. A young person is very unlikely to have no suitable veins in their upper limbs and therefore if they are a femoral injector this is likely to be because they wish to hide the fact that they are injecting and/or because they have been encouraged/shown how to inject in the femoral vein by another (older) injector. The young person may also be injected in the femoral vein by another injector.

Femoral injecting is high risk because it is a deep vein which is located by feel and not sight and is also close to a major artery and nerve which increases the potential for major injecting related injury. There is some evidence that use of the femoral vein is more likely in circumstances where visibility is poor, such as public toilets with UV lights (although use of this lighting have been ceased by Torbay Council). This is an intimate site which heals slowly and may be harder to keep sterile. Frequent femoral injectors develop a sinus (hole) which remains open for some time.

Femoral injectors will require a longer needle – ideally a blue 23g x1" or 23g x1½". Green needles should not be given unless the young person cannot reach their femoral vein with a blue needle or cannot be persuaded to use a blue needle. Smaller needles, especially long grey needles, should NEVER be used for femoral injecting as they are too thin for deep veins and there is a danger of them breaking – even if the young person is of slight build.

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INJECTING DRUG USER ASSESSMENT

There is no safe way to inject illicit drugs. Risks from injecting drug use are dependant on a number of variables.

Site assessment

1. Where in body? (v= very common, c=common, u=uncommon)

Lower risk sites	Higher risk sites	Very high risk sites
Arms (v)	Hands c) Legs (c) Feet (c)	* Femoral (c) * Neck (c) * Armpit (u) * Breasts (u) * Penis (u)

All sites other than **upper** & **lower** limbs are likely to be **very high risk sites.**

Femoral injecting (groin) increasingly common for cosmetic reasons. Femoral injectors rely upon 'feel' to locate deep femoral vein - proximity to femoral artery & sciatic nerve presents substantial risk. DVT a likely outcome of persistent femoral injecting.

Sinuses (a 'hole' failing to heal over properly) common with persistent femoral injecting.

2. Condition of site?

'Common' conditions

- Localised tissue/vein damage
- Lumps/bumps
- Abscesses

Complications:

- Ulcers
- Bacterial infections
- Septicaemia
- Collapsed veins
- DVT

3. Likely injecting route specific infections

i/v

BBVs (hepatitis B, hepatitis C, HIV)

i/m

- **Bacterial infections** (eg tetanus, wound botulism, clostridium novyi)
- **BBVs**
- **Missed hits** result in inadvertent i/m or s/c injecting.

NB: these injecting routes more common for females.

s/c

Sharing assessment

Ensure the term 'sharing' is not used as jargon and that you and the client are talking about the same behaviour. Sharing any injecting equipment is a high blood borne virus transmission risk.

1. Sharing as "borrowing and lending"

It is a process of process of both ***giving out*** and ***receiving*** used injecting equipment. Use terms such as ***borrowing and lending*** or ***giving and receiving*** to explore this process.

2. Who with?

Sharing means the use of injecting equipment by more than one person. This includes:

- sexual partner(s)
- (close) friends
- relatives

Injectors may not classify sharing with those close to them as such. This is especially so in sexual relationships involving trust dynamics.

3. What? (Direct and indirect sharing)

'Direct' sharing - Use of needle and/or syringe by more than one person.

'Indirect' sharing - Paraphernalia/equipment used for either drug administration or preparation by more than one person.

Equipment shared includes:

- spoons
- water/cups
- filters
- swabs
- citric acid/vit c
- tourniquets/belts

4. When? Consider historical element

- Ask client about recent and past episodes of sharing/drug use.
- Consider 'window period' (up to 6m).

Hepatitis C infections in particular may be asymptomatic for several years

5. Where?

Consider situational factors like imprisonment, public injecting and access to clean equipment.

Drug assessment

- **No street drugs are sterile.**
- **They are not designed for injecting.**
- **There is no "safe" way to inject.**

1. Risks associated with

- ***Heroin*** - overdose risk increased if injected, especially if used in combination with other depressants (alcohol, benzodiazepines, other opiates).
- ***Amphetamines*** - can result in regular binge use and increased vein damage.
- ***Anabolic steroids*** - counterfeit/fake drugs commonplace which may not be sterile or contain what is stated on packaging. Poss. developmental damage in adolescents.

2. 'high risk' substances when injected

- ***Cocaine/crack*** - local anaesthetic properties of cocaine deadens pain at injection sites resulting in substantial injury (esp. in femoral injectors).
- ***'Snow/speedballing'*** - concomitant cocaine/crack & heroin injection. Risks as above, plus increased overdose risk with binge use.
- Any ***tablet*** can be crushed up for injection. Especially sedatives and opiates. Chalk/ silicate bases cause circulatory problems. ***Diconal*** especially harmful when injected.
- ***Oral solutions*** (additives can cause major circulatory problems). Methadone mixture uncommonly injected but causes substantial circulatory problems.
- ***Acidifiers*** – heroin & crack cocaine require acidifier to make water soluble drug solution. Non sterile acidifiers (lemon juice, vinegar, kettle de-scaler) cause numerous health problems including candida/eye infections, heart conditions. Acidifier damage linked to bacterial infections.

Advice to any femoral injector must in the first instance be that it is very dangerous with the intention of discouraging them from continuing. If the young person is unlikely to desist from infecting in the femoral vein, safer injecting advice and equipment may be given, however it is of paramount importance that the over-arching message is positive discouragement as this is such a high risk practice.

Neck injecting: This is a very dangerous activity as the vein is close to arteries, veins, tendons and nerve which could cause very serious damage if accidentally hit. Many neck injectors rely on another to inject them, else they will have to use a mirror which requires a degree of skill (injecting "back to front"). Neck injecting is less common and any interventions about how the risks can be reduced must not exclude the central message that it is extremely dangerous.

It is arguable that there is little or no safer injecting advice which can be given to neck injectors, other than to use an alternative injecting site.

Penis, breasts, forehead These sites are occasionally used and come with significant risks. It is arguable that there is also minimal safer injecting advice which can be given regarding these sites, other than to use alternative sites. Specific advice can be obtained in The Safer Injecting Briefing (Dericott et al, 1999).

5.3 High risk injecting routes

Subcutaneous injection
Subcutaneous injection ('skin popping') used to be advocated as a safer alternative to intravenous drug use both to give veins a rest and because it offers the slowest rate of absorption (which may slightly reduce overdose risks). However this advice has been revised particularly in the light of anaerobic bacterial infections in injectors (Clostridium novyi, tetanus, botulism). If the drugs are contaminated with such bacterium (likely when drug batches have been contaminated when stored in the ground etc) there is a high risk of these infections developing in subcutaneous tissues. Failing this, subcutaneous injecting makes absorption of solutions slow and this can cause severe localised infections. It is advisable to discuss in detail an injectors practice as some injectors may believe they are skin popping when in fact they are injecting intramuscularly (or vice versa). Some injectors will inadvertently inject subcutaneously if the experience missed hits (fail to inject into the vein) and the risks are the same.

Some substances (growth hormones, insulin) used alongside anabolic steroids are designed for subcutaneous use. If the young person cannot be dissuaded from using performance enhancing drugs (due to the serious risks to their normal physical development/bone growth) advice may need to be given on correct subcutaneous injecting techniques (see Derricott *et al.* p68).

Skin popping should be strongly discouraged. If this technique is being used because the young person has exhausted their veins, the emphasis on harm reduction advice should be strongly towards them giving up injecting

Intramuscular injection
Intramuscular injection is not ideal for injecting illicit drugs for many of the reasons cited above. It is also likely to cause localised stiffness, soreness if done frequently. Most anabolic steroids are designed for intramuscular injection. If the young person cannot be dissuaded from using anabolic steroids (due to the serious risks to their normal physical development/bone growth) advice may need to be given on correct intramuscular injecting techniques (see Dericott *et al.* p68).

Intramuscular injection should be strongly discouraged. If this technique is being used because the young person has exhausted their veins, the emphasis on harm reduction advice should be strongly towards them giving up injecting

5.4 Substance specific injecting risks

There are no "safe" drugs to inject. The major substance-specific risks are indicated below. (This information is not exhaustive.)

Heroin injection: The chief risk from heroin use is overdose which is likely to be fatal if medical assistance is not given. This is further detailed below (6.4). In recent years, there has been a reported increase in clostidial-type bacterial infections (eg clostsridium novyi, tetanus) in heroin injectors which are thought to be linked to contaminated drug supplies.

Stimulant injection: A chief risk form cocaine/crack injection is vein damage – cocaine acts as a local anaesthetic which may result in more injection damage than usual if more than one injecting is administered in close succession (as pain cannot be felt once the area is numbed). Recurrent injecting is especially risky for groin injectors of cocaine/crack as the femoral vein is deep and located by feel and not sight. Any damage sustained will take longer to heal and is prone to infection. It is not uncommon for stimulant injectors to use in "binge" cycles which adds to this risk and increases the chances of multiple injecting injuries.

Weight loss and loss of appetite and malnutrition are common results of stimulant use and may also be linked with eating disorders (in males as well as females). Underlying mental ill health may be triggered or exacerbated by stimulant use and temporary psychosis is strongly associated with heavy and prolonged stimulant use, for which medical treatment and hospitalisation may be required.

Tablets/capsules: Tablets and capsules come with added dangers when dissolved for injection due to undissolved particles and bulking agents, such as silicate and chalk which can cause significant circulatory problems. The injection of Diconal (Dipipanone) is especially hazardous; however access to this drug is unusual due to improved prescribing practices.

Methadone mixture: The prescribing of injectable methadone is uncommon within Torbay and rarely clinically indicated and young people are unlikely to access this preparation. The injection of oral methadone is known but this is managed by an effective supervised consumption regime. The injection of oral methadone is extremely dangerous due to the ingredients of oral methadone and the sheer amount of liquid injected to get a 'hit' and there is little, if any, harm reduction advice that can be offered other than to cease this practice.

Contaminated/strong drugs: It is a common misconception that drug dealers routinely add dangerous cutting agents to illegal drug supplies (such as brick dust, rat poison, Ajax® etc). Whilst this is possible it is widely felt to be an anti-drug myth which is validated by analysis of seized street drugs. The majority of bulking agents are relatively harmless and may also assist in the quality of the drug effect (eg paracetamol, caffeine, dextrose).

This being said some drug batches do contain harmful pathogens, dangerous combinations of drugs or harmful bulking agents which is more likely to have occurred by accident than by design (it would make no economical sense to kill off one's customers).

Evidence indicates that overdose due to unusually strong drug batches is uncommon and more commonly linked to poly drug use or reduced tolerance. Whilst the risk of strong batches cannot be ruled out, the chief overdose prevention messages must be regarding poly drug use and drops in tolerance – this is further explored in the overdose section below.

Safer Communities Torbay participates in an emergency drug alert cascade protocol which aims to deliver credible, accurate, verifiable and consistent emergency messages to drug users. Any reports of contaminated/dangerous/strong drug batches should be reported to the lead officer with in Safer Communities Torbay for investigation and dissemination of an official alert.

5.5 Overdose

The chief causes of overdose (intentional or non-intentional) are:

- Poly drug use as the use of more than one substance potentiates (enhances) the effects of another as well as doubling the amount of drugs used.
- Reduced tolerance (especially opiates and post release from care/prison).
- Injecting/taking drugs alone (there is no way of the casualty summoning help if they become unconscious).
- Excessive consumption – e.g. doubling up on a dose because the previous one was thought to be ineffective or due to a "bad hit".

Strong or contaminated drug supplies:
Evidence indicates that heroin overdoses do not commonly occur due to strong or contaminated drug supplies (Hall 1996[7], Darke & Zador 1996[8]). It is vital that the central messages of overdose prevention are not diluted by the myth that overdoses are usually caused by strong/contaminated drugs, when there are few proven instances of this occurring.

Nonetheless, it is good practice to remind drug users that the content, strength or purity of illicit drug preparations can never be determined and that all drug taking therefore comes with risk – but this should not detract from the core overdose risk messages.

Overdose is a frequent and dangerous outcome of drug use, especially injecting. Evidence suggests that many injectors have, or will, experience overdose either directly or by witnessing a peer. All injectors should be offered overdose awareness information and clear instructions on how to respond to an overdose. The basic message all drug users should be given regarding overdose response is as follows:

- Stay calm.
- If the person is unconscious (wont wake up) check they are breathing ok.
- Put them in the recovery position.
- Dial 999 immediately and ask for an ambulance. Don't hide that the person has used drugs - this information is needed to help save their life.
- Keep checking that the person is breathing ok. Stay on the line to the operator who will talk you through what to do if the person stops breathing.

[7] Hall W, 1996. How we can reduce heroin overdose death. Medical Journal of Australia 164, 197-198.
[8] Darke S, Zaldor D. 1996. Fatal heroin 'overdose': a review. *Addiction*; 61:123-128.

Stimulant overdose:
Many drug users do not realise that stimulant overdose is possible. A stimulant overdose casualty may require emergency medical attention if:

- They are over-heating (very hot/sweaty/clammy).
- They have a fast or erratic pulse.
- They are experiencing convulsions.
- The are panicky and act irrationally, putting themselves or other people at risk, and it is not possible to calm them down.
- They are displaying the symptoms of heart attack or stroke.

WestCountry Ambulance overdose protocol:
WestCountry Ambulance will normally treat overdose as a confidential matter and will not involve the police unless:

- Somebody has died or a death is likely (the casualty has not responded to treatment).
- A vulnerable adult or a child is at risk (this will include young people under 16).
- There is a possibility of threats or violence towards the ambulance crew (including past history associated with the person/address).

Depressant overdose:
Depressant combinations (opiates, alcohol and/or sedatives such as benzodiazepines, hypnotics or anti-depressants) are especially risky. Depressant overdose depresses respiratory functioning any the casualty may stop breathing without medical assistance. Naloxone (an opiate reversal agent) is routinely carried by Devon & Cornwall Paramedic crews and is usually very effective in preventing opiate overdose death if administered quickly enough.

Stimulant and depressant combinations:
Stimulant/depressant mixes still have a potentiation effect and this risk is increased by a frequent misconception that using these two different groups of drugs will cancel each other out. As well as combined use the use of a depressant drug to "come down" from a stimulant is common – more dangerous mixes include:

Speedballing (injection of heroin and cocaine together) results in increased injecting and use of higher amounts of substances. The "up" effect of the cocaine may mask the "down" effect of the heroin and result in more heroin being used than normal, leading to overdose, especially if used in binge cycles. Potentiation also occurs (heroin and cocaine increase each others effects).

Stimulant overdose:
Frequent injecting or high usage of amphetamines or crack/cocaine can result in stimulant overdose. Many drug users are aware of depressant overdose risks but less aware of the risk of stimulant overdose. Serious and fatal adverse effects of stimulant overdose include convulsions, heatstroke, stroke, and heart attacks all of which require urgent medical attention.

There are many other risks of combined drug use which do not relate to injecting drug use which should be discussed with an at risk young person if relevant. These include:

- Using heroin to come down from crack
- Using benzodiazepines, cannabis or (occasionally) heroin to come down from ecstasy or hallucinogens

- Drinking alcohol whilst using amphetamines or cocaine (especially cocoethylene with cocaine/alcohol use).

5.6 Sharing and re-use of injecting equipment

Sharing relates to the use of any injecting equipment previously used by another in the processes of preparing and/or injecting drugs. Amongst researchers, sharing is defined as *direct* (needles and syringes) or *indirect* (injecting paraphernalia and methods used to divide doses of drugs such as front- or back-loading). Terms such as *borrowing, lending, passing on and receiving* may also be used.

Despite the success of needle exchange harm reduction initiatives in averting an HIV epidemic in the UK amongst British injectors, sharing remains frequent, especially indirect sharing (Rhodes *et al.* 2004)[9]. Indirect sharing is an established transmission route for hepatitis C (Hagan et al. 2001)[10] and hepatitis B and the risks of HIV transmission should not be ruled out, given that recent evidence suggests a rise in HIV incidence amongst injectors (HPA 2005)[11]. Hygiene and general blood awareness is also paramount.

Data from needle exchange surveillance in 1997 extrapolated that in England an injector has access to one needle every 1-2 days. Although slightly dated, the general findings suggest that needle availability is still inadequate. Research has suggested that primary reasons for sharing include needle availability, craving, with secondary reasons including naivety, bereavement, laziness, a tendency towards short-term thinking and homelessness (Kelaher and Ross 1999, Taylor et al. 2004). Injectors not engaged with any treatment agencies may have a limited awareness of the risk behaviours in which they engage (Sheridan 1998) and therefore it is vital that the workers address this gap when engaging with young people who are injecting drugs.

Discussions pertaining to sharing terminology may contain implicit assumptions and both drug users and those professionals working with them may not fully understand the complexity of sharing behaviour. It may be helpful to unpick this terminology, using words such as '*giving and receiving'* or '*borrowing and lending'* so that the young person fully understands what is meant by sharing. With whom, what equipment, when it is shared and where sharing takes place are all crucial aspects of a comprehensive sharing assessment. This is summarised injecting drug user risk assessment above.

[9] Rhodes T.; Davis M.; Judd A. 2004. Hepatitis C and its risk management among drug injectors in London: renewing harm reduction in the context of uncertainty, Addiction, 99 [5].
[10] Hagan H, Thiede H, Weiss NS, Hopkins SG, Duchin JS & Alexander ER, Sharing of drug preparation equipment as a risk factor for hepatitis C. American Journal of Public Health, 2001 91 (1).
[11] HPA 2005, Shooting up.

5.7 Peer injection

Many drug users progress onto an injecting route after having used drugs via another route and are likely to be initiated by a peer, i.e. receive their first injection(s) from an experienced injector (Hunt et al. 2001)[12]. An increased risk of overdose and blood borne virus infection comes with peer injecting, as the recipient has less control over the drug preparation/injecting process. Blood stained hands which administer peer injections also present a blood borne transmission risk. A young person who is being injected by an older peer in particular may be vulnerable and at risk of significant harm and child protection procedures may need to be followed. Peer injection occurs for a number of reasons including:

- the YP does not know how to prepare drugs for injection.
- the YP has poor injecting technique.
- their venous access is poor.
- the YP uses sites which are difficult to access eg back of knee, neck.
- the YP is not allowed to inject them self.
- The YP prefers to be injected by a peer.

If a young person who is being peer injected cannot be persuaded to discontinue with injecting, it may be in their best interests for them to develop their own injecting technique in order that they can take responsibility for their own injecting. The worker must however ensure that the safer injecting advice given does not encourage or incite injecting drug use, is risk specific and aimed at reducing drug related harm.

Whilst harm reduction interventions with existing injecting drug users are crucial, effective interventions to limit the onset of new injectors must be considered. It is important therefore that peer initiation is discussed with the young person to discourage them from initiating other young people into injecting drug use. Useful techniques, tools and resources regarding this intervention are available from the *Break the cycle* campaign[13].

5.8 Route transition interventions (RTIs)

A route transition intervention is a temporary or permanent transition in the way that a drug is administered. RTIs are a vital component of the young person safer injecting delivered as part of a planned package of care. The underlying philosophy of the service should always be that there are safer alternatives to injecting drugs.

RTIs include:

- prevention of drug users beginning to inject drugs they are using
    - *Break the cycle* (peer initiation cessation – see above)
    - Awareness/education campaigns
    - Substitute prescribing with at risk drug users likely to progress to injecting
- encourage people to switch from injecting to a safer route
    - substitute prescribing
    - promoting heroin smoking
    - promoting sniffing of drugs
    - promotion of rectal administration where appropriate (see www.hit.org for the UYB campaign)
    - awareness/education campaigns

[12] Exchange Campaigns / Department of Health 2001. Preventing initiation into injecting. Hunt N, Derricott J, Preston A Stillwell G.
[13] Details of the B*reak the cycle* campaign available from www.exchangesupplies.org

6 REFERRAL FOR BLOOD BORNE VIRUS TESTING AND VACCINATION

6.1 Hepatitis B vaccination

Given that IDUs may acquire an infection prior to accessing any formal drug treatment, attention needs to be given to vaccinating drug users as early as possible in their drug using careers. NHS policy (NHS executive 1999)[14] is to target high risk drug users for hepatitis B vaccination which includes:

- present/occasional injectors
- close contacts of injectors
- those likely to progress to injecting (particularly non injecting heroin and stimulant users)

There is currently no clear care pathway for the vaccination of young people under 18 and decisions will be made on a case by case basis. GPs may be well placed to vaccinate young drug users earlier in their drug using career. Alternatively vaccination may occur via GUM or the treatment provider service.

6.2 Blood borne virus testing

Any young person who has shared any injecting equipment (even only once) may be at risk of blood borne virus transmission, in which case HIV and hepatitis B/C testing is indicated. Pre and post test discussions should take place with all antibody testing for blood borne viruses. Testing can be provided by the GUM department who offer a confidential service which will not record testing or results on the individuals medical records. DoH[15] guidelines now also advice that hepatitis C testing can be provided by GPs.

In all cases, regardless of where the YP receives blood borne testing, the young person's drug and alcohol worker can provide a valuable role in preparing the young person for blood borne virus testing and ensuring that comprehensive pre and post test discussions occur.

[14] NHS executive 1999 .Health Service Circular (HSC) 1999/036.
[15] DoH 2003. Hepatitis C Essential information for professionals and guidance on testing. Crown Copyright.

APPENDIX 3: SHARPS SAFETY GUIDELINES

SHARPS SAFETY GUIDELINES
TORBAY YOUNG PEOPLE'S NEEDLE EXCHANGE

1. SERVICE SAFETY

1.1 The needle exchange operational guidelines have been designed so that there should be no health risk to the staff involved in the scheme. Adherence to these guidelines ensures that staff never have direct contact with contaminated needles and/or syringes.

1.2 As a precautionary measure, all staff should be instructed about the risk of needle stick injuries, infection and surface contamination and the procedure for responding to a needle stick injury clearly displayed at an appropriate place in the building in order that it is immediately accessible in the case of needle stick injury.

1.3 The circumstances below illustrate how staff involved in the safer injecting service could be vulnerable to blood borne virus infection (BBV). For the purposes of this document, the term BBV refers to hepatitis B (HBV), hepatitis C (HCV) and the human immunodeficiency virus (HIV).

1.3.1 Needle stick injury
1.3.2 Open cuts/abrasions/sores to hands/lower arms not being covered with waterproof dressings when handling sharps/blood products
1.3.3 Staff clearing up blood spills without the use of protective gloves/aprons
1.3.4 Staff picking up discarded needles without adhering to safety protocols
1.3.5 Contamination of conjunctivae or mucous membranes by blood or bloodstained fluids.

1.4 It is vital that staff involved in the safer injecting service are fully immunised against hepatitis B as per the CheckPoint safer injecting service SLA (service level agreement).

2. KNOWN RISKS OF BBV INFECTION FROM NEEDLE STICK INJURIES

2.1 Intravenous drug users are frequently infected with hepatitis B and/or hepatitis C, and occasionally HIV. The risk of BBV transmission from a needle stick injury *when the donor is a known to be infected with the virus* is as follows[16]:

HIV	1:300
Hepatitis C	1:30
Hepatitis B	1:3

2.2 It is also noted by researchers that the risks of BBV transmission from a discarded needle ('sharp') is significantly lower than the statistical risk normally quoted within a clinical setting (i.e. for nurses etc).

2.3 This reduced risk in a non-clinical setting is because:

- usually smaller amounts of dried blood products are present,
- injuries often being more superficial (e.g. through a shoe or clothing).

[16] UKCC (2001). UK guidance on best practice in vaccine administration

2.4 One report states that specific follow up studies, although limited, have indicated that no cases have been published of a member of the public becoming infected with HIV, HBV or HCV as a result of needlestick injury from discarded sharps.[17] Whilst this is reassuring information, it does not mean that staff should not be vigilant. Any blood spills or loose sharps should be presumed to be a potential BBV risk.

3. OPERATING PROCEDURES FOR RECEIVING RETURNED INJECTING EQUIPMENT IN THE SAFER INJECTING SERVICE

3.1 All items of used injecting equipment (sharps) are potentially contaminated and should be treated as such.

3.2 As soon as a clinical waste bin is full, it is the responsibility of the staff member to close the lid into a locked position immediately. Over full bins pose a health and safety risk and licensed waste collectors are unable to transport clinical waste which is incorrectly sealed.

3.3 Returned personal sharps containers must to be stored in the supplied clinical waste bins which display the biohazard logo and conform to legal requirements. Clinical waste bins are collected by a licensed waste collector and must not be transported by road or rail by any other personnel as it is a criminal offence to do so without the appropriate licence.

3.4 All sharps should be returned to the safer injecting service in the personal sharps bin issued (sometimes known as a 'cin bin'). Personal sharps bins should be sealed properly by the client before being returned.

3.5 It is advisable that clients handle their own personal sharps bins and always place these in the clinical waste bin themselves.

3.6 In order that staff avoid the handling of personal sharps bins, a clinical waste bin must be kept in a readily accessible place which is secure and out of a public area so that it can be quickly accessed for returned needles.

3.7 Under no circumstances should staff handle any sharps which are not in a personal sharps bin. In the event of clients wishing to returning loose sharps, the client must be given a personal sharps bin and instructed to put their own needles/syringes in it, close it themselves, and place it in the clinical waste bin. In the event of a loose sharp being discarded in the building, the guidelines laid out in section 4 of this document below (operating procedures for handling loose/discarded sharps) must be followed.

3.8 If it is not possible for the client to handle the personal sharps bin themselves (i.e. the client has left the bin without waiting), the following precautions should be taken:

3.8.1 If you have cuts to your hands or lower arms, you must cover these with a waterproof adhesive dressing before handling personal sharps bins.
3.8.2 Wear latex gloves whenever possible if you handle sharps bins. This is essential if the bins are contaminated with blood and/or you have cuts on your hands.
3.8.3 Before handling, observe wither the personal sharps bin is:
a. correctly closed
b. not broken/split

[17] Derricott *et al.*, 1999. The Safer Injecting Briefing.

c. not contaminated with blood stains
d. has sharps sticking out of the aperture

3.8.4 If latex gloves have been used to handle the personal sharps bin, discard these in the clinical waste bin as well.

3.8.5 Wash you hands with soap and water after handling sharps bins.

3.9 In the event of a client returning a larger quantity of loose sharps, the client must place these sharps directly into a clinical waste bin them self. Request that they also place the receptacle (e.g. carrier bag or container) in the clinical waste bin. Do not under any circumstances request that the client counts the number of sharps returned as the handling of loose sharps increases the risk of needle stick injury. The number of sharps can be estimated for recording purposes.

3.10 In the event of a client returning a carrier bag full of personal sharps bins, the client must place these into a clinical waste bin themselves as explained above. Carrier bags/bin liners etc full of personal sharps bins must never be handled by staff due to the possibility of loose sharps being contained amongst them which could cause injury.

3.11 Under no circumstances should any clinical waste or returned personal sharps bins be opened, or hands/fingers/limbs placed inside.

3.12 Any unused personal sharps bins returned to the safer injecting service should not be re-issued as they may be contaminated and must be placed in the clinical waste bin.

3.13 Always remember to record returned sharps on the safer injecting service record sheet.

4. OPERATING PROCEDURES FOR HANDLING LOOSE/DISCARDED SHARPS IN THE SAFER INJECTING SERVICE

4.1 Rigorous adherence to safety procedures means that it is highly unusual for staff to need to handle loose sharps. In such an event, the following procedures should be rigorously adhered to. Always assume that any sharp is potentially contaminated.

4.2 Arrangements can be made for discarded sharps to be removed via the local Council's waste department, who will charge a fee to your business if the sharp not in a public area. There may also be a delay before the council is able to attend to the sharp. This is not a task that can be done by the licensed waste collectors who collect clinical waste bins.

4.3 Staff should avoid handling loose needles wherever possible and encourage clients to dispose of their own injecting equipment in a personal sharps bin.

4.4 It is advisable that staff never handle loose sharps unless they have had specific training in handling loose sharps and have use of a sharps collection kit.

4.5 The following advice should be considered if staff move a discarded sharp with a sharps collection kit:

4.5.1 ALWAYS wear protective gloves when handling contaminated equipment. It is important to note that whilst latex gloves protect from blood spills, these still leave staff vulnerable to a needle stick injury.

4.5.2 Do not kick the sharp – needle stick injuries can still occur to the foot!

4.5.3 NEVER attempt to re-sheath a used needle (i.e. put the cap on the needle) – many needle stick injuries occur in this way.
4.5.4 Spray sharp and surrounding area with disinfectant spray in sharps collection kit.
4.5.5 Use tweezers/tongs to pick up sharp and place directly into sharps bin. Do not pick up the sharp with the hands.
4.5.6 Never carry a discarded sharp, ensure that you have a clinical waste container with a large aperture next to the sharp so that you can place the sharp in it immediately.
4.5.7 Dispose of gloves/tongs etc used in the sharps bin after use.

5 NEEDLE STICK INJURIES

5.1 Encourage the wound to bleed (this should never be done in cases of major wounds) by holding it under cold running water. Do NOT suck the wound. Squeezing it is also no longer advised.

5.2 Wash the affected area thoroughly with soap and water. Cover the wound if possible with a dry dressing.

5.3 Do not retain the sharp as this serves no purpose. Ensure that the sharp is disposed of safely in a clinical waste bin to avoid any further injury.

5.4 Contact the nearest hospital Accident & Emergency department immediately and ensure that the injured person attends within an hour of the injury. If possible, someone else should telephone to warn the A&E department of the situation. The A & E department may require the following information:

a. Date of incident
b. Time of incident
c. Description of incident
d. Hepatitis B immunisation status of injured person

5.5 The incident must be reported to the responsible pharmacist or pharmacist in charge as soon as possible and formally reported in the accident book.

5.6 The manager must complete an incident report form as soon as possible (within 1 working day of the incident).

5.7 Should a needle stick injury occur to either yourself or your colleague, you will be required to act immediately. Valuable time could be wasted by searching for information on the right thing to do. Therefore it is very important that you familiarise yourself with the first aid required for such injuries and are aware of where the following flow chart is placed within your workplace.

NEEDLESTICK AND SHARPS INJURY FIRST AID

Step 1: Immediately encourage wound to bleed by holding the wound under COLD running water

DO NOT SUCK THE WOUND

Step 2: Wash the wound and affected area thoroughly with soap and water

Cover the wound with a sterile dry dressing

Step 3: Attend your local accident and emergency department within 1 hour of the injury occurring.

Your nearest Accident and Emergency Department is:

Torbay Hospital
Lawes Bridge
Torquay
TQ2 7AA

Telephone: (01803) 654003

- Do not 'save' the sharp; ensure that it is disposed of safely so to avoid further injury.
- Report the incident to your line manager as soon as possible and ensure it is recorded in your accident book.
- Complete an incident report form and forward it to your PCT Clinical Governance Lead.

PLEASE ENSURE THAT THIS NOTICE IS DISPLAYED IN AN ACCESSIBLE STAFF AREA AT ALL TIMES

APPENDIX 4: DECISION MAKING PROCEDURES WHERE THERE ARE CHILD PROTECTION CONCERNS AND DEFINITIONS OF CHILD PROTECTION AND CHILD IN NEED.

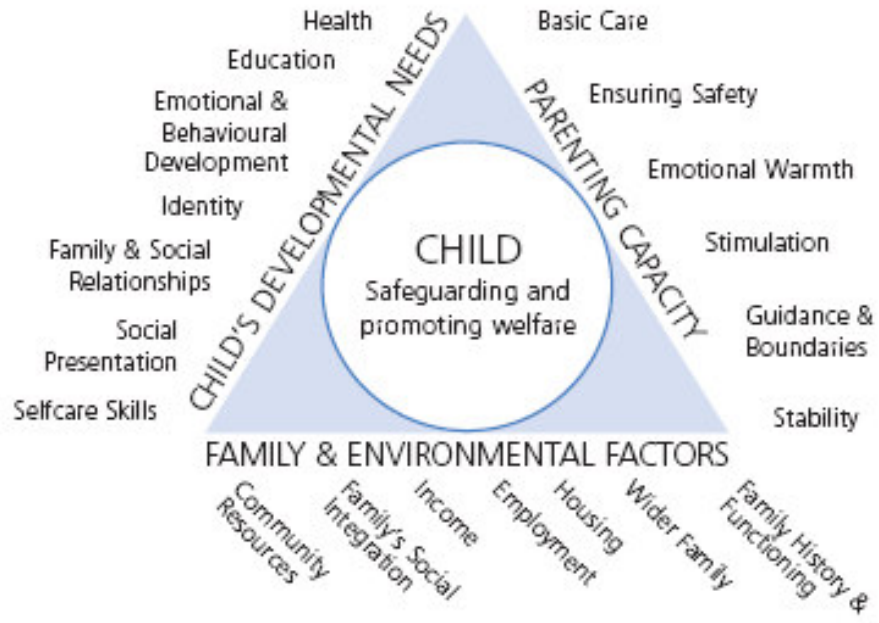
From:
MASST; Multi Agency Substance Screening Tool (Developed for Multi-agency workers in Torbay and Devon, December 2004). Pp 27-29.

Decision making procedures where there are child protection concerns-

- It is recognised by Checkpoint, The Youth Offending Team and by Torbay Social Services, Children and Families Division that substance use/misuse alone does not indicate child protection concerns.
- Where an agency and/or worker have identified a young person that may be presenting with possible child protection concerns relating to their substance misuse, the worker must contact Checkpoint, The Youth Offending Team or Social Services immediately.

In addition to complying with your agency child protection policies YOT and Checkpoint can be used as a consultancy to help assess if a referral should be made to Social Services.

- If the identified child protection issue is felt by the Specialist YP Drug Services be of a great enough concern, then Specialist YP Drug Services will inform the agency to refer direct to Socail Services.
- The case will be discussed fully without giving the full names or any identifying details, and if after this discussion it is felt that a child protection investigation is required, then immediate contact will be made with the young person to inform them that a child protection referral has been completed.
- When considering child protection concerns it may be useful to assess substance misuse issues as part of 'The Framework for the Assessment of Children in Need and Their Families'.



- Please also refer to the multi-agency guidance on information sharing and assessment.

- The following are the Multi Agency Guidelines for what to do if you are concerned about a child or young person. These guidelines are for any child protection issue and not specific to substance misuse, but the principles are the same.

  It is essential that there is a match between what are the assessed needs of a child / young person and the service provided. We must assume that there will always be a combination of individual needs that may require a range of interventions, possibly through a number of services, to meet the desired short and long tern outcomes for children.

  The decision on 'what service' must be based on as much information as possible about the needs of a family, their strengths and difficulties. The Needs Planning Matrix will support workers / community members to come to a decision as to whether there is a need for some preventative input through universal services or whether the difficulty has developed to such a level that emergency or specialist support is required. People in the community, in families and within the universal services will often be those who are making this assessment and decision.

  The needs matrix will provide a framework for exploring difficulties and noting the key areas of focus and levels of concern. Once considered this should be used to decide which agency / service would be best placed to co-ordinate a package of support and if appropriate a referral should be made.
  A copy of the full needs planning matrix is available, details from the young peoples substance misuse co-ordinator, Torbay Drug Action Team (tel. 01803 841440).

- The matrix has 4 agreed levels of risk in child protection. The following outlines how these fit in with substance misuse.

The agreed levels of risk in Child Protection

	Level 4	Level 3	Level 2	Level 1
	Children living with multiple risk factors and high levels of vulnerability	**Vulnerable children, who require a specialist and time planned response.**	**Vulnerable children who require further assessment of their needs.**	**Potentially vulnerable children, who require access to services to prevent the development of problems.**
At risk of harm	Child has suffered and continues to suffer significant harm. Parent abusing not protecting / denial of risk to child / severely inhibiting development Child unprotected by extended family/ community/ agencies.	Incident of abuse, self-harm or rapid deterioration of neglect. Parental behaviour is not sufficient to protect or provide for the child. Inadequate response to the child from family / communities / agencies. To refer to children and families team is not sufficient in itself. Other agencies need to be proactive in providing family and child support.	Accumulating indicators of abuse and / or neglect / child has needs in the aftermath of abuse. Parents unaware of the risks or passive towards safety issues/ parents are known to be at risk. Families / agencies / services are not working to a co-ordinated plan to address issues of possible harm.	Elements of the child's universal needs unrecognised or unmet. Parents at risk / or parents who have unmet needs arising out the abuse they have suffered or are suffering. Environmental not focussed on the needs / protection of the child. Children's voices not readily heard. Child protection / children's rights not in the forefront of everyone's minds.
Substance misuse	Child / young person has suffered or continues to suffer significant harm due to their own or parents substance misuse.	Child / young person at risk of significant harm due to parents / own substance misuse.	Child / young person is vulnerable due to own / parents misuse. Difficulty in accessing services.	Child / young person is potentially vulnerable due to own / parents substance misuse. Parent / young person not accessing / unable to access services.

APPENDIX 5: TORBAY PHARMACY NEEDLE EXCHANGE SCHEME SERVICE LEVEL AGREEMENT

PROVISION OF NEEDLE EXCHANGE FOR YOUNG PERSONS AGED UNDER 16 IN TORBAY

1. Needle exchange records require that the date of birth of all clients is recorded on each visit. In instances where staff think a client may be aged under 16, the date of birth should be requested prior to issuing any needle exchange equipment. Staff should be prudent to quickly ascertain a young person's age from their quoted date of birth.

2. Pharmacy staff must ask for authentic photo card identification in all cases where it is suspected that a client may be under the age of 16 but insists otherwise. Should staff doubt the authenticity of the identification provided, they should refuse the client a needle exchange service.

3. Clients under the age of 16 requesting a needle exchange service may be referred to their local young person's service (see below), who are the specialist service commissioned to work with under 16 year olds who are drug users.

4. Clients who are, or who appear to be under the age of 16 cannot under any circumstances receive a pharmacy needle exchange service. It is recognised that needle exchange provision to under 16s is a legal quagmire and national guidelines indicate that a comprehensive assessment by a specialist young person's drug worker should precede all needle exchange interventions with young people under the age of 16.

5. Ideally, clients aged between 16 and 17 years who are accessing pharmacy needle exchange should also be signposted to their local young person's drug service. Needle exchange staff should aim to encourage young people to access these services, which offer specialist services for the needs of young people who are drug users (see below for details of specialist young persons drug services in Torbay).

Torbay Young Persons Drug Service:	**CheckPoint** 7 Victoria Road Ellacombe Torquay TQ1 1HU	Contact: Tel:	Under 18's drug and alcohol worker 01803 200 100
Counselling for Young People in Torbay may also be provided at:	**YOT** (Youth Offending Team) Commerce House Abbey Road Torquay	Tel:	01803 201 655

CONFIDENTIALITY

The information you give at Check Point will be treated in confidence.

We aim to earn your trust and respect and believe in your ability to make choices and decisions.

However, your safety is of great concern.

There are three situations where we **might** have to pass information on. These are:

- **PHYSICAL HARM** - If you or someone else is in physical danger
- **SEXUAL ABUSE** - If someone under the age of 18 is being sexually abused
- **EMOTIONAL ABUSE / NEGLECT** - If someone under the age of 18 is being emotionally abused or neglected.

IT IS YOUR CHOICE WHAT INFORMATION YOU GIVE US.
WE WILL TALK TO YOU BEFORE WE TAKE ANY ACTION.