

The background features a complex geometric design. It consists of several overlapping rectangular blocks in shades of teal, light green, and pink. The pink blocks are filled with a dense, intricate pattern of thin, wavy lines that resemble a wood grain or a topographical map. The teal and light green blocks are solid-colored. The overall composition is modern and layered.

INJECTING EQUIPMENT PROVISION IN SCOTLAND

GOOD PRACTICE GUIDANCE

This publication has been produced to offer guidance to local planners, commissioners, service providers and other stakeholders on how best injecting equipment provision and related harm reduction interventions may be developed and delivered in response to the local need and situation. October 2021 - Digital Edition

INJECTING EQUIPMENT PROVISION IN SCOTLAND

GOOD PRACTICE GUIDANCE

CONTENTS

Acronyms and Glossary	vii
-----------------------	-----

Foreword	ix
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Preface	xi
---------	----

1. Introduction

1.1	Aims of the guidance	1
1.2	Evidence	1
1.3	Who is this guidance intended for?	1

2. The current situation in Scotland

2.1.	Epidemiology of Injecting drug use in Scotland	3
2.2.	History of NSP/IEP in Scotland	4
2.3.	Evidence of IEP Effectiveness	5
2.4.	Legislation	7
2.5.	Policy	8
2.6.	Effectiveness of NSP/IEP policy	8

3. Implementing injecting equipment provision programmes

3.1.	Needs assessment	11
3.1.1.	Understanding need	11
3.1.2.	Who should undertake a needs assessment	12
3.1.3.	Frequency of needs assessment	12
3.1.4.	Approaches to needs assessment	13
3.1.5.	Identifying elements of the Needs Assessment	14
3.1.6.	Further reading and examples of Needs Assessment	17
3.2.	Planning and contracting or commissioning services	17
3.2.1	Stakeholder Consultation and Engagement	18
3.2.2.	Community empowerment	19
3.2.3.	Operational aspects of service delivery	19
3.2.4.	Staff training	19
3.2.5.	Communication strategy	20
3.2.6.	Monitoring and Evaluation	20
3.2.7.	Remote Communities	20

4. Models of service delivery

4.1.	Core and Enhanced IEP Interventions	23
4.2.	Models of Injecting Equipment Provision	24
4.2.1.	Community pharmacy IEP services	24
4.2.2.	Enhanced IEP Services	27
4.2.3.	Outreach services	28
4.2.4.	Police custody suite and prison IEP services	30
4.2.5.	Secondary distribution	32
4.2.6.	People with lived or living experience (peer-led services)	33
4.2.7.	Injecting equipment dispensing machines (unsupervised)	34
4.2.8.	Hospital-based IEP services	35
4.2.9.	Postal or delivery-only IEP services	36
4.2.10.	Supervised injection facilities (SIF)	37
4.3.	Groups requiring alternative approaches	41
4.3.1.	Homeless / roofless	41
4.3.2.	Adolescents or under 16	42
4.3.3.	Women	43
4.3.4.	Chemsex	43
4.3.5.	Use of Image and Performance Enhancing Drug (IPED)	44
4.4.	Improving the quality and integration of services	44

5. Equipment, paraphernalia and supporting services

5.1.	Key Points	47
5.2.	Equipment	48
5.2.1.	Non injecting methods of administration	48
5.2.2.	Hypodermic needles	49
5.2.3.	Syringes	49
5.2.4.	Low dead Space and needle reuse	50
5.2.5.	Syringe identification	51
5.2.6.	Cleaning injecting equipment	52
5.2.7.	Spoons	55
5.2.8.	Filters	55
5.2.9.	Acidifiers	55
5.2.10.	Pre-injection swabs	56
5.2.11.	Water for Injection	56
5.2.12.	Foil	58
5.2.13.	Sharps containers	58
5.2.14.	Packs	59
5.3.	Supporting services and interventions	59
5.3.1.	Wound care	59
5.3.2.	Assessment of injecting risk (AIR)	60

6. Training

Improving the quality and consistency of IEP services through education, training and awareness raising for service providers and people using IEP Services

6.1.	Minimum training required	63
6.2.	Training	63
6.3.	IEP Service Standards	68
6.3.1	Other support/training	68
6.4.	Data collection and management	68
6.4.1	Direct Entry at the point of transaction	69
6.5.	Creating the right environment	70
6.6.	Evaluation	70

Appendix 1: Needle Colour Coding Chart	72
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Appendix 2: Guidance Development Working Group	73
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References	74
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ACRONYMS AND GLOSSARY

ACMD	Advisory Council on the Misuse of Drugs
ADP	Alcohol and Drug Partnership
AIDS	Acquired Immune Deficiency Syndrome
AIR	Assessment of injecting risk
BBV	Blood-borne virus (including HIV and Hepatitis B and Hepatitis C)
DCR	Drug consumption room (see also SIF)
DHSS	Department for Health and Social Security
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
IE	Injecting equipment
IEP	Injecting equipment provision or injecting equipment providers
IPEDs	Image and performance enhancing drugs
ISD	Information Services Division
LDS	Low dead space (syringes and barrels)
MSM	Men who have sex with men
NES	NHS Education for Scotland
NESI	Needle Exchange Surveillance Initiative
NSP	Needle and syringe programme
ORT	Opioid replacement treatment, a form of medication assisted treatment for people with an opiate or opioid-based drug problem
PNSP	Prison needle and syringe programme – or, sometimes, a needle and syringe programme in another closed setting
POM	Prescription-only medicine

PWID	People who inject drugs
SDMD	Scottish Drug Misuse Database
SHPN	Scottish Health Protection Network
SIF	Supervised injecting facility (see also DCR)
SSTI	Skin and soft tissue infections
THIRD SECTOR	Charities, social enterprises, voluntary groups or other 'not for profit' organisations
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

FOREWORD

Currently Scotland has the highest per person mortality from drug-related deaths in Europe. In Greater Glasgow and Clyde, and several other health boards, there has been an ongoing outbreak of injecting-related HIV infections. There has also been an increase in injection-related injury and bacterial infections with outbreaks, such as the Lothian-centred cluster of Group A Streptococcal infections in 2016, causing significant morbidity and mortality. In the UK up to 10% of people who inject drugs who are hospitalised are admitted due to skin, soft tissue, and vascular infections¹. Nationally, there has been a rapid decrease in hepatitis C (HCV) chronic infections due to the impact of all oral treatments.

There is a direct link between this Guidance and the provision of what were then called needle exchange services in the first HIV epidemic in the 1980s. The first needle exchange in Scotland was opened in Edinburgh in 1987. Then, as now, IEP and associated harm reduction interventions are important public health measures that reduce the spread of blood-borne viral infections among people who inject drugs and can also serve as a vital link to other health and social care provision that can benefit a very marginalised population.

Delivery of low threshold, high quality IEP can ensure that people who inject drugs have access to services that can prevent and address health issues; averting new blood-borne virus (BBV) infections, allowing access to other primary health interventions such as woundcare or BBV testing and treatment and disseminating vital information regarding health and harm reduction to people who inject drugs.

Providers are often able to deliver a range of services that include the provision of injecting equipment but also education and information on reduction of drug-related harms, referral and signposting to drug treatment, medical care and legal and social services.

Integrated care for people who use drugs is an approach that seeks to combine and co-ordinate all the services required to meet the assessed needs of the individual person. Qualitative research carried out among people who inject drugs indicates they face a range of barriers when trying to access help from generic health and social care services²⁻³. These barriers include the burden of appointments, travel to services, stigma and negative staff attitudes, personal ill-health, lack of material resources and anxieties about accessing support.

All people accessing health and social care have the right to high quality service provision. The stigma related to injecting drug use can be a significant impediment to delivery of this care. It became evident during the consultation process in developing this Guidance that people value a service that treats them with respect and where there is active inquiry as to their needs and opinions.

The change to an outreach model in some areas during the COVID-19 pandemic again highlighted the effect an individual staff member's positive attitude can have on people using the service's satisfaction and personal health and sense of their worth.

The co-chairs and the members of the Scottish IEP Guidance Development Group have worked diligently to produce guidance that is relevant, comprehensive and evidence-based. This is essential reading for all involved in IEP in Scotland and the document provides a practice and training framework by means of which these vital services can be delivered effectively and be accessible for all.

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PREFACE

Since the launch of the Scottish Injecting Equipment Provision (IEP) guidelines¹ in 2010, there has been significant change in range of street drugs available; developments in treatments; best practice in harm reduction and in the evidence base.

The delivery of the original document, part of the Phase 2 Scottish Hepatitis C Action Plan, was one of a range of measures designed to improve Scotland's response to hepatitis C (HCV). Since then, there have been exciting developments in HCV treatments, with Scotland currently aiming to eliminate HCV as a public health threat by 2024. It is envisaged this Guidance can support the further development of injecting equipment provision services, with consequent positive impacts on mortality and morbidity.

Academic and peer-led research⁴ has shown that there remain some IEP services that do not adequately address the full range of need identified. Those delivering IEP also require updated guidance that reflects changing needs and health issues.

Research has shown patterns of drug use and injecting practice can change for various reasons including fluctuations in drug type, availability and purity. There is also evidence that services that are pragmatic and person centred are often the ones considered most valuable by the highly marginalised people who use them⁵.

The development of IEP guidance was part of the workplan of the Scottish Health Protection Network's SHBBV Prevention Leads (non-sexual transmission), a national group of public health experts. Members of the Guidance Development Working Group (Appendix 2) comprised experts from a range of disciplines. Members included representatives from IEP services; from NHS, third, and academic sectors; and from national bodies such as Health Protection Scotland (now part of Public Health Scotland). A two-month consultation process was undertaken. This included a launch webinar attended by over 150 participants, online workshops and an online consultation questionnaire. Individual consultation questionnaires were completed with 17 people who were currently injecting drugs.

John Campbell and James Shanley, Co-chairs, Scottish IEP Guidance Development Group

1 [Guidelines for services providing injecting equipment: Best practice recommendations for commissioners and injecting equipment provision \(IEP\) services in Scotland](#)

01

INTRODUCTION

1. INTRODUCTION

Aims of this guidance document

The aim of this guidance is to provide a framework which can be used to support the consistent delivery of high-quality IEP services across Scotland through:

1. Promoting good practice that improves the accessibility, quality and consistency of IEP services
2. Improving the accessibility of appropriate harm reduction equipment and advice to people who inject drugs and are at risk of BBV infection or other drug-related harm
3. Promoting joint work and partnership between IEP and other services for people who use drugs, including in the primary and secondary health sectors and social care and third sector services
4. Promoting a pragmatic, person-centred approach to improving the health of people who use drugs
5. Providing staff with a greater understanding of practical evidence-based interventions that help improve outcomes for people who inject drugs.

Evidence

This guidance has been informed by evidence of effectiveness in the prevention and reduction of injecting-related harm, including BBVs. Evidence related to improving access, uptake of IEP services and improving the quality of IEP services was also considered. A review of the evidence base was undertaken and completed in late 2019.

Who is this guidance intended for?

The guidance has been written for those who deliver, or those with responsibility for the delivery of, IEP services. This includes front-line services and their staff, including NHS and social work staff, community pharmacists and pharmacy staff and prison and police officers involved in the provision of needle replacement schemes. At a strategic level, it is also directed at NHS Boards, local authorities, Police Scotland, Scottish Prison Service and third sector agencies who have a responsibility for responding to need in their local area.



02

THE CURRENT
SITUATION IN
SCOTLAND

2. THE CURRENT SITUATION IN SCOTLAND

2.1. Epidemiology of injecting drug use in Scotland

People who inject drugs are at risk of a range of health harms including blood-borne viruses like hepatitis B (HBV), hepatitis C (HCV) and HIV, and bacterial infections such as botulism and tetanus.

In Scotland, there are an estimated 15,000–20,000 people who inject drugs^{6,7}. Heroin continues to be the most prevalent drug injected with over 90% of those interviewed in the 2017-18 Needle Exchange Surveillance Initiative (NESI) survey reporting injecting heroin in the past six months, similar to levels in previous NESI surveys.⁸ Reported injection of powder cocaine increased markedly from 9% in 2010 (n=217) to 29% (n=422) in 2017-18, with levels highest in the NHS Greater Glasgow and Clyde (NHSGGC) area (49%; n=286). Injection of 'legal highs' (i.e. novel psychoactive substances (NPS)) associated with increases in skin and soft tissue infections (SSTIs) and HCV in parts of Scotland in recent years,^{9,10} was rare within the 2017-18 survey, reported by less than 1% of participants.

People who inject image and performance enhancing drugs (IPEDs) such as steroids, growth hormone and tanning agents remain one of the largest sub-populations of people who inject drugs. National IPED injecting prevalence estimates are not available, however, unpublished data from services providing injecting equipment in NHSGGC suggests at least 3400 unique people who use IPEDs attended in 2018/19. Secondary distribution is more common within this group¹¹ than among other groups who use IEP services, suggesting many more people than those only accessing IEP may be injecting IPEDs.

Injecting drug use continues to be the most prominent risk factor for HCV infection in Scotland, accounting for over 90% of infections.¹² In Scotland, despite relatively low levels of reported needle and syringe sharing, HCV antibody prevalence remains high. The latest national estimates reported by NESI found that over half (57%) of those of those surveyed had ever been infected with HCV with rates highest in NHSGGC (68%). The prevalence of HCV antibodies has not changed substantially since the NESI study commenced in 2008. However, between 2015-16 and 2017-18, there was an 18% reduction in the prevalence of chronic HCV in Scotland overall, from 38% to 31%, with the largest falls observed in the NHS Tayside (NHST) area (from 29% to 18%). This decline in chronic prevalence is likely attributable to the increase in uptake of HCV treatment, which has been seen across all NHS Boards. The large decline in chronic prevalence seen in NHST is associated with efforts to increase HCV treatment among people who are actively injecting drugs by offering it in community settings such as Injecting Equipment Provision (IEP) sites.¹³ HCV prevalence in people who use IPEDs is generally low with greater antibody prevalence perhaps attributable to the group that used both opioids and IPED¹⁴.

In contrast to relatively modest levels of injecting equipment sharing, trends in reported personal

re-use of needles and syringes appear to be changing. The proportion of those interviewed reporting re-use of such equipment increased from 45% in 2011-12 to 58% in 2017-18, with rates particularly high amongst people injecting stimulants.

There is also emerging evidence of increasing engagement with foil (for smoking drugs) since it was rolled out nationally from September 2016. In 2017-18, 35% of respondents reported uptake of foil in the last six months, which is almost double what was reported in 2015-16 (18%). The lower rates in 2015-16 may be partly explained by the only partial roll-out of foil during the NESI survey that year.

The Global Health Sector Strategy (GHSS) on viral hepatitis and the draft action plan for the health sector response to viral hepatitis in the WHO European region¹⁵ call for a major global increase in provision of needles and syringes, from an estimated baseline of 20 needles and syringes per person who injects drugs per year to 200 by 2020 and 300 by 2030. However, these estimates do not account for individual differences in need. To better reflect the adequacy of needle and syringe provision, data from NESI are presented on self-reported adequacy of needle and syringe provision. In this metric, needle and syringe provision is considered 'adequate' when the reported number of needles received, met, or exceeded the number of times the individual injected. In 2017-18, the proportion of people who inject drugs reporting adequate provision of needles and syringes was suboptimal at 80%⁹.

HIV prevalence among people who inject drugs has been measured nationally from 2011-12 onwards and has increased over time from 0.3% in 2011-12 to 2.3% in 2017-18, driven by an outbreak of HIV infection in Glasgow strongly associated with cocaine injecting, homelessness and incarceration.¹⁶ In 2017-18, HIV prevalence in the NHSGGC area was 4.8% and 10.8% in Glasgow city centre; HIV cases were also detected in NHS Lothian, NHS Lanarkshire, NHS Tayside and NHS Fife areas, with prevalence rates ranging from 0.6% to 1.2%.

2.2. History of NSP/IEP in Scotland

Major outbreaks of HIV among people who inject drugs were identified in the early 1980s in the cities of Edinburgh¹⁷ and Dundee¹⁸. A key driver of these outbreaks was limited availability of sterile injecting equipment and, therefore, frequent equipment sharing between people who inject drugs. In response to widespread public concern about HIV and AIDS and the perceived threat to the general population, the UK Government sanctioned the opening of needle and syringe exchange services, more commonly now known as needle and syringe programmes (NSPs). Although NSPs had already been up and running in parts of the UK, they began officially operating in the UK in 1987 when the Department for Health and Social Security (DHSS) commissioned a pilot study to evaluate their effectiveness. In 1987, the DHSS set the following criteria for the pilot schemes; they should:

- Provide injecting equipment on an exchange basis to people already injecting and unwilling or unable to stop
- Provide assessment of and counselling for individuals' drug problems

- Provide advice on safer sex and offer counselling on HIV testing
- Collect information on people using the service and collaborate with a monitoring and evaluation project.

The evaluation¹⁹ which followed concluded that NSPs reached considerable numbers of people who injected drugs, many of whom were not in contact with any other services. As needle exchange was seen to be effective, did not outrage public opinion or cause other anticipated potential problems, the network of NSPs expanded rapidly across the country, alongside expansion in the substitute prescribing of methadone. The first NSPs in Scotland were established in Edinburgh, Dundee and Glasgow in 1987².

2.3. Evidence of IEP effectiveness

A large body of evidence supports the effectiveness of the provision of sterile injecting equipment through IEP services to reduce injection risk behaviours that can lead to blood-borne virus transmission and other drug-related harms^{20,21,22,23}.

IEP has progressed over the years to include a range of delivery models including the provision of equipment through:

- Community pharmacies
- Dedicated/fixed outlets
- Backpacking/outreach
- Mobile and home delivery services
- Peer-led services
- IE dispensing machines

These models are often delivered in partnership by a range of service providers including drug and alcohol services, homelessness services, prisons, hospitals, and many others²⁴ – see 4.2.

- The evidence for the effectiveness of the provision of injecting equipment alone in preventing HCV among people who inject drugs is mixed²⁵. While some systematic reviews conclude that there is insufficient evidence to support or discount its effectiveness for the prevention of HCV in people who inject drugs (particularly the effect of pharmacy-based IEP services on HCV prevalence)²⁶, other more recent studies have acknowledged reported decreases in HCV infections²⁷.

It has been acknowledged that the effectiveness of injecting equipment provision varies by geographical location, and that without also providing counselling education and drug treatment services (providing medication assisted treatment) IEP services alone are insufficient to reduce transmission of HIV and HCV in people who inject drugs²⁸.

² In Scotland from 2010 onwards, the term Injecting Equipment Provision (IEP) was adopted in place of the more internationally accepted Needle and Syringe Provision (NSP) to reflect the broad range of equipment provided by Scottish services such as water, filters, spoons etc. This term is used throughout this document to refer to all services that distribute injecting equipment – regardless of whether those services have the facilities to receive used injecting equipment.

Supervised injecting facilities (SIFs), in addition to providing sterile injecting equipment, have been identified as an environment which may also greatly reduce incidence of high-risk injection practices (i.e., syringe sharing, shared cleaning) that increase the likelihood of HCV infection²⁹ and other harms.

Examination of the heterogeneity of studies in this field – in terms of study design, inclusion criteria, definition of interventions, etc. – has established the need for further clarity in future community-level studies, particularly given the potential benefits of IEP services to reduce infectious diseases among people who inject drugs³⁰. Studies examining the impact of services in rural areas are particularly needed. Research is also needed to seek further understanding on how implementation of IEP, and other harm reduction services, can be scaled up and delivered more effectively to better respond to the health needs of people who inject drugs. This requires observational study designs³¹.

- There is moderate quality evidence that the provision of injecting equipment is effective in reducing HIV transmission and injecting risk behaviours among people who inject drugs⁶⁵.

IEP services have been identified as a structural intervention to reduce population level HIV infection (either with reported decreases in HIV prevalence or in HIV incidence)³².

The introduction of harm reduction services, and particularly the provision of injecting equipment, has been found to be cost-effective³³ and cost saving in some settings, particularly when future health outcomes and costs are considered (i.e., lifetime cost of HIV)³⁴.

A recent cost-effectiveness evaluation in three UK cities (including Dundee) has estimated that IEP services are cost-saving under the 100-year time horizon³⁵. This study estimated that by removing only IEP services from harm reduction interventions, regardless of setting, a large relative increase in the number of new HCV infections would be expected. The evaluation estimated a median increase in HCV infections in Dundee alone of 61%³⁶.

There remains limited evidence on the effectiveness or cost-effectiveness of IEP services for young people who inject drugs³⁷.

In terms of effectiveness in reducing the prevalence of injecting drug use in the community, ready access to sterile injecting equipment does not appear to prolong injecting drug use (i.e., it does not contribute to delayed cessation of injecting drug use)³⁸. In fact, some studies have indicated that the establishment of IEP services has led to a decrease in the number of people who inject drugs by bringing them into contact with treatment services earlier in their drug using careers³⁹.

This forms part of the large and growing body of research which highlights the impacts of IEP services on reducing injection risk behaviours (that can lead to HIV, HCV infections and other drug-related public health concerns). It is not surprising that the EU Drug Strategy for 2013–2020 – the first-ever strategic document on this level – has called for scaling-up and improving access to IEP services and other harm reduction interventions as an objective of EU's drug

policy⁴⁰, actions that are endorsed by this Scotland-specific guidance.

2.4. Legislation

At their inception in 1987, NSPs operated within the parameters laid out in two key pieces of legislation:

The Misuse of Drugs Act 1971 'section 9A'

- It was an offence for a person to supply any article - except a syringe or needle - in cases where 'the supplier believes it may be used by the recipient to administer an unlawful drug or prepare an unlawful drug for administration.'

The Medicines Act

- Water for injections was a prescription-only medicine (POM). This meant that, in practice, it could not be legally supplied by NSPs.

Outwith NSPs, section 9A exempted the provision of the following equipment (often referred to as paraphernalia) if they were dispensed by a doctor, a pharmacist or someone working lawfully within drug treatment services:

- Swabs
- Utensils for the preparation of a controlled drug
- Ascorbic acid or citric acid as an acidifier
- Filters
- Water for injection ampoules of up to 2ml

It was not until 2003 that additional amendments were made to section 9A following recommendations by the Advisory Council for the Misuse of Drugs (ACMD) on drug paraphernalia supply. From 1 August 2003, this permitted NSPs to supply people who use drugs with the items listed above, except for ascorbic acid (delayed until 2005).

Almost two years later Statutory Instrument (SI) 2005 No.1507 The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005 was published, with an amendment to Schedule 5 of the POM Order. The SI became law on 30th June 2005 and contained provisions for the supply, by drug workers, of water for injections to people who inject drugs (without any pack size restriction) and with a limit on the size of ampoule that could be supplied of 2ml. It is important to note that water for injections remains a POM and the exemption only applies to supplies made to people who use drugs. In the same year, ascorbic acid was added to the list of items that it is legal for NSPs to supply following further advice by the ACMD that was accepted by the UK Government.

In 2010, the ACMD wrote to the then Home Secretary and Health Secretary to deliver their latest report and to recommend that 'The ACMD consider that the balance of benefit favours exempting foil from Section 9A of the Misuse of Drugs Act 1971'⁴¹. Over the next few years, the

Home Office sought further information from the ACMD on the potential harms associated with smoking drugs⁴² and the role of foil in transitioning people away from problematic drug use.⁴³ Then, on 4th July 2013, the Home Office published a statement confirming their acceptance of ACMD advice on the lawful provision of foil by drug treatment providers in the context of a structured step to engage a person in a drug treatment plan, or as part of a person's drug treatment plan.. On 9th August 2014 it was announced that an SI would be laid before Parliament in September adding foil to the list of items exempt from section 9A. This was implemented on the 5th of September 2014.

At present, other equipment such as pipes (for the inhalation of drugs) are not exempt from section 9A and therefore supply remains technically illegal.

2.5. Policy

In 2008, the Scottish Government launched the Hepatitis C Action Plan for Scotland (Phase II), with one of its three main aims to prevent HCV transmission among people who inject drugs. In 2010 the National IEP Guidelines recommended⁴⁴ the provision of a set of new injection equipment for every injection, and dedicated additional funding to be awarded to NHS Boards to enable improvement of services in accordance with the Guidelines.³ Contemporaneously to the Action Plan, the Scottish Government's drug strategy, *The Road to Recovery*,⁴⁵ aimed to improve treatment services for those dependent on opioids.

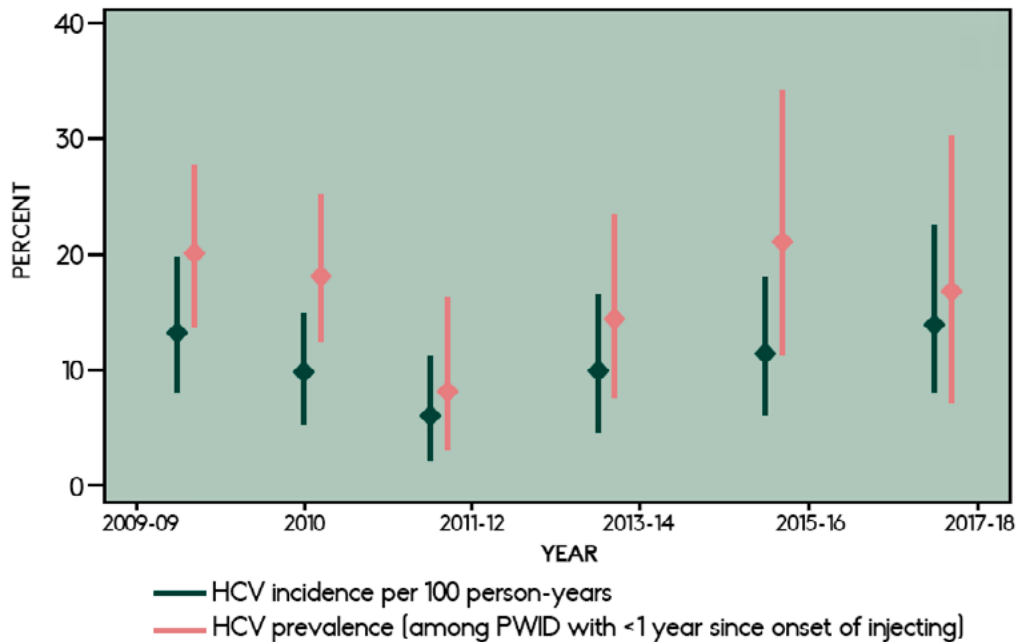
The Hepatitis C Action Plan for Scotland was superseded by the first Sexual Health and Blood-Borne Virus Framework in 2011.⁴⁶ The Framework brought together policy on sexual health and well-being, HIV and viral hepatitis for the first time and included an outcome aimed at achieving 'fewer newly acquired blood-borne virus infections.' The Framework was subsequently updated in 2015 to cover the period through to 2020⁴⁷ and included a commitment by the Scottish Government to provide funding to support a review and update of the IEP Guidelines, working with the Scottish Prevention Leads Network.

2.6. Effectiveness of NSP/IEP policy

An evaluation of the potential impact of the legislative and policy changes on HCV transmission among people who inject drugs in Scotland was carried out in 2014⁴⁸. Specifically, its aim was to determine the association between harm reduction interventions (IEP and opiate replacement treatment (ORT)) and the incidence of HCV infection among people who inject drugs in Scotland during 2008 to 2012. This study concluded that combined high coverage of needles and syringes and ORT were associated with reduced risk of recent HCV and that the combination of harm reduction interventions may have averted 1400 new HCV infections during 2008–2012. However, since this study was published, the declining trend in HCV incidence appears to have regressed and research has suggested that this may partly be due to the impact of NPS injecting in 2014-15⁴⁹. Further research is required to determine the impact on

averted infections between 2017 and 2018.

Figure 1. Indicators of recently acquired HCV infection among NESI respondents, 2008 to 2018. The method for calculating HCV incidence is described in Appendix 2 of the Needle Exchange Surveillance Initiative (NESI) 2008-09 to 2017-18 published in April 2019⁵⁰.



A more recent study has explored the association between harm reduction intervention uptake and skin and soft tissue infections (SSTIs) among people who inject drugs⁵¹. Specifically, it examined the associations between the uptake of IEP and ORT on SSTIs among people who inject drugs, and the injecting behaviours associated with having had an SSTI. The study concluded that IEP and ORT uptake may reduce the level of SSTIs among people who inject drugs suggesting increasing combined uptake may be beneficial. Nevertheless, a sizeable proportion of people who inject drugs with high harm reduction intervention uptake experienced SSTIs, suggesting the importance of other interventions such as wound care clinics.

The impact of the Scottish hepatitis B vaccination for all prisoners, a programme which commenced in 1999, was evaluated in another study⁵². This study aimed to compare rates of HBV vaccine uptake before and after implementation of the prison programme and to find the rates of ever/current HBV infection; and any association between vaccine uptake and ever / current HBV infection; and the determinants of vaccine uptake. The study found that vaccine uptake increased from 71% in 2008-09 to 77% in 2013-14 among all people who inject drugs (PWID) in Scotland and from 16% in 1993 to 59% in 2008-14 among recent-onset PWID in Glasgow; and was associated with incarceration. Vaccination was associated with reduced odds of ever and current Prevalence of HBV infection among people who inject drugs were low compared with other European countries.

03

**IMPLEMENTING
INJECTING
EQUIPMENT
PROVISION
PROGRAMMES**

3. IMPLEMENTING INJECTING EQUIPMENT PROVISION PROGRAMMES

This section aims to provide a framework for the planning and delivery of IEP services, to maintain and improve the provision of injecting equipment in Scotland and make that provision more accessible.

3.1. Needs assessment

Before implementing new or changing current injecting equipment provision programmes or services it is important to understand the needs of the people who will be using these services. Needs assessment provides a systematic method of doing this in a way that focuses on the needs of the target population rather than the service provider. It is a key step in planning and commissioning integrated services for people who use drugs⁵³.

3.1.1. Understanding need

“A health needs assessment is a systematic method of identifying unmet health and healthcare needs of a population (...) and making changes to meet these unmet needs”⁵⁴. Needs assessment has also been described as “a measure of how much of what is needed” or as “a process of ordering and prioritisation of community needs”⁵⁵.

The target population can be a group, or more specific subgroup, of the population. When considering people who inject drugs a needs assessment focussing on a group might look at all people who inject drugs whereas a subgroup needs assessment might focus on, for example: people who are roofless; women who inject drugs; people who live in a specific postcode area or people who use specific types of drugs such as image and performance enhancing drugs.

A useful definition of need is ‘the capacity to benefit from services’⁵⁶. This definition keeps the focus of needs assessment on interventions that can produce real benefits, and on identifying and understanding the needs of people who could benefit from receiving those interventions. It highlights the type and distribution of services and interventions that will bring the greatest benefit.

The needs of the target population are considered “when a benefit can be achieved from an intervention, and a measurable improvement can occur as a result of a change”⁵⁷.

A needs assessment should describe:

- The level of need for services

- The extent of unmet need
- The pattern of supply and effectiveness of current services
- How to work towards meeting unmet need
- How to use resources in the most effective and efficient way

3.1.2. Who should undertake a needs assessment?

To be effective needs assessment should be led by, or as a minimum informed by, someone with experience in the process. Each Health Board area in Scotland has a Public Health team which has a key role in ensuring that health needs assessment is undertaken and that Scottish Government health improvement policies are carried out. The local public health team is therefore the recommended point of contact for discussing and planning how needs assessment is taken forward. The local Sexual Health and BBV Managed Care Network should also be able to provide direction.

Joint planning partners, for example, Alcohol and Drug Partnership (ADP) partners also have an important role to play in planning and commissioning needs assessments in their area.

A collaborative approach should be used to bring together stakeholders and people from different backgrounds and organisations to get a full picture of service need, delivery, and priorities. It is especially important to involve the population whose needs are being assessed. A structured engagement and involvement of the target population should be planned and carried out as part of the needs assessment process.

A steering group should be set up to lead and review the process. It should include individuals with a range of skills and responsibilities, including data analysts, to ensure that the process is undertaken effectively, that it is completed within a reasonable timescale, and that the findings result in action.

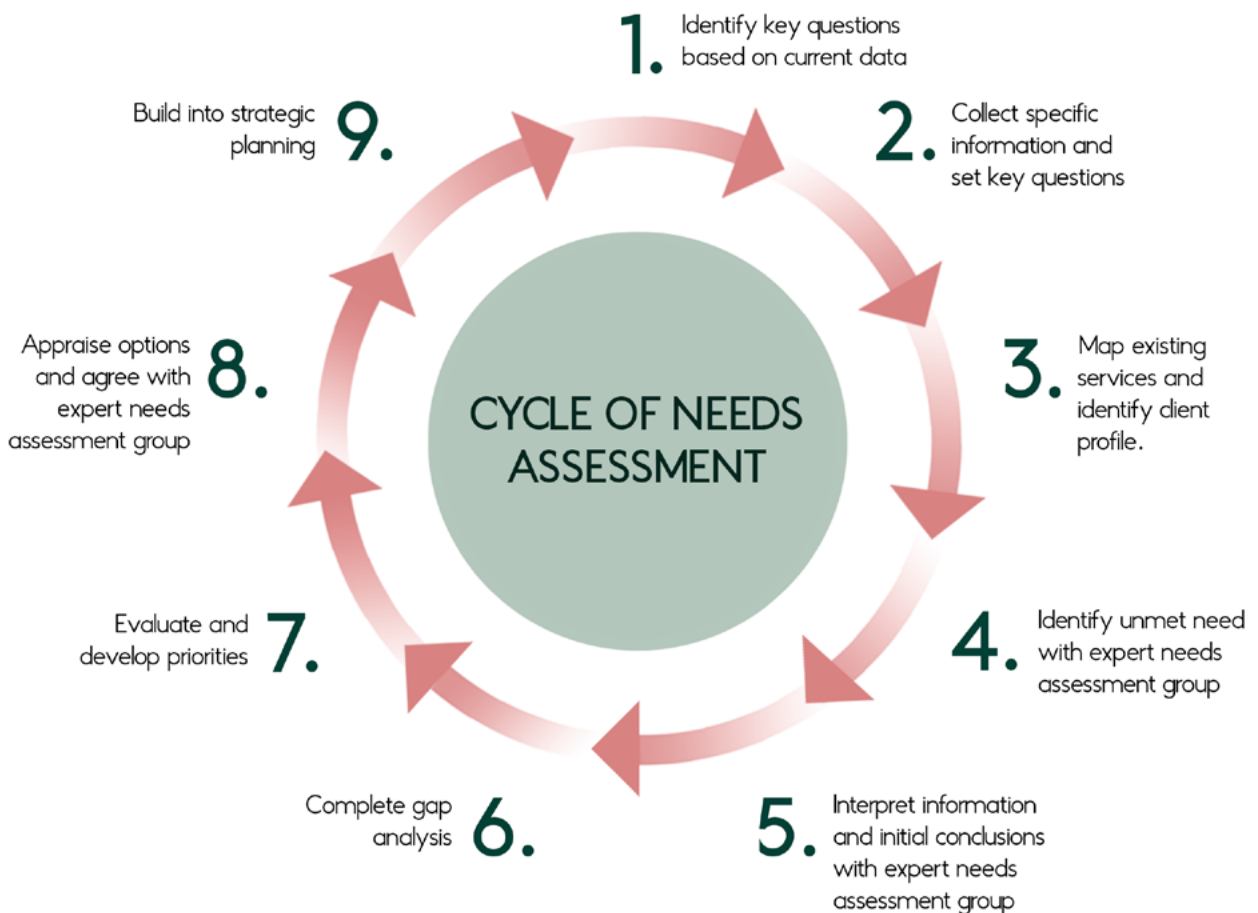
The Needs Assessment steering group membership should relate to the target population (i.e., service providers or practitioners, researchers); should represent them (i.e., family or carer groups and wider community); and should be able to make changes happen (i.e., managers of relevant agencies, service planners and commissioners)⁵⁸.

The steering group should establish a process to inform and drive the needs assessment.

3.1.3. Frequency of needs assessment

Needs assessment is an on-going process. It is anticipated that most systems will require a comprehensive needs assessment every three to five years. Needs may change over time therefore existing needs assessment(s) should be reviewed regularly through an annual refresh and/or by linking the process of needs assessment to on-going monitoring and evaluation.

Figure 2. Annual cycle of needs assessment. Adapted from NHS National Treatment Agency for Substance Misuse. Needs assessment guidance for adult drug treatment. July 2007⁵⁹



3.1.4. Approaches to needs assessment

Defining the objectives of a needs assessment is a priority at early stages of the process; clarifying that the methods used will be completely dependent upon the population targeted and what is to be measured.

There are two approaches to needs assessment, and they will determine the method used to carry out a needs assessment:

The first approach establishes the needs of the target population solely on the basis of consultation with people who use services and service providers, without any prior assumptions about what those needs might be.

Examples: How can this service better meet the needs of women who use drugs? Is there a need in this area for a service for teenagers who use drugs? How do the needs of people who use psychostimulants differ from those who primarily use opiates?

The second approach assumes, based on other available information, that there is a need.

Examples: What are the childcare needs of people who use this service? What is the best way of providing services for young people who use drugs problematically? What are the best ways of providing for the counselling needs of people who use psychostimulants?

Both approaches are useful, and it may be necessary to use either or both at different times.

3.1.5. Identifying elements of the needs assessment

Planning a needs assessment depends on the scope of the project and the population of interest. However, the following steps will be common to all:

- Identify the issue
- Identify the population
- Identify the sources of data available
- Identify the gap between need and supply

Key elements to consider while undertaking a needs assessment exercise:

- The needs of people who use services are the focus of the needs assessment
- Identifying the right people to be involved in the process and set up a steering group
- Identifying what needs to be measured and the target population
- Preparing focused and specific questions
- Agreeing the appropriate approach to carry out the needs assessment.

The process of needs assessment should ordinarily involve the following steps:

1. A review of the existing sources of information relevant to the target population
2. A profile of existing services and target population
3. A collation of the views of the target population
4. A collation of the views of relevant practitioners and service providers
5. An analysis and interpretation of the assessment to draw recommendations
6. A prioritisation of the identified needs, appraisal of the options for meeting those needs, and a plan of implementation, including allocation of resources
7. Monitoring and evaluation of how recommended actions have been implemented and the level of success in meeting the needs of the target population.

Step One: Sources of information

Needs assessment involves the collection of data from several sources. In some cases, the data will already exist in the form of routinely collected data sets, the results of local population surveys, and published or unpublished research papers. Other information will have to be collected through, for example, focus groups or one-to-one interviews with practitioners and members of the target population.

Information required about the target population may comprise population size and demographics (age, male/female rate, etc.); clinical history; patterns of drug use: drug-injecting behaviours; employment status; family and social dynamics; relationship with services; etc.

Effort should be spent in gathering enough information to build up a picture of the overall size and nature of the population's needs, not in gathering all the information that is available⁶⁰.

Step Two: Profiling existing services and target populations

The aim of constructing a service profile is to identify the range of needs currently being met by services, and the capacity and accessibility of those services.

An analysis of the gap between the needs of the target population and what is being provided will be the focus for future service planning.

It may be helpful to classify the needs of the target population into a small set of categories, such as: health-related; drug-related; accommodation-related; employment-related needs etc.

Step Three: Gathering the experiences and opinions of the target population

The target population should be at the very centre of needs assessment.

Before setting out, it is important to make it clear why you are seeking their views. A short, focused, set of questions and a clear explanation of why the views of the population are being asked can maximise engagement and influence developments without raising unrealistic expectations.

Further information about ways of engaging with your target population is available from the EIU Guide, 'Effective Engagement. A guide to principles and practice'⁶¹.

Step Four: Gathering the experiences and opinions of service providers and practitioners

Staff at all levels within the agencies providing services (including statutory, voluntary, and private sector agencies) are a crucial source of information about the needs of the target population.

Engagement with service providers should:

- Be supported by effective communication channels and undertaken on a regular basis
- Provide clarity about the purpose of the needs assessment
- Provide feedback to them throughout the process

Short surveys or face-to-face engagement (e.g., focus groups) might be a way to canvass the views of service providers and practitioners.

Step Five: Analysis, interpretation and communication of the assessment

The project team should include someone who is suitably qualified to analyse and interpret the available data from the outset. They will be required to work alongside those who are gathering the information to ensure that it is interpreted accurately. The findings produced from the analysis and interpretation of the data will be documented in a report, which should be drafted bearing in mind the target audiences and may include:

- A concise and clear summary of the main findings
- Infographics, graphs, charts, and tables to emphasise key findings
- A discussion of the key messages derived from the analysis and interpretation of the data, as well as identified gaps
- A set of proposed recommendations to provide a basis for discussion.

Step Six: Taking action

Decisions on appropriate actions will depend on several crucial and closely connected activities. These include:

- **Prioritisation:** a strategic process, undertaken by those responsible for the commissioning of services, in which the available needs and resources are ranked in some way to decide which needs will be met first and which will be met later.
- **Options appraisal:** There may be more than one way of meeting the needs identified⁶². Various options should be considered⁶³ and the evidence in favour of each approach should be considered carefully as well as recorded. Ultimately, the aim is to give priority to actions that will have the greatest positive impact on the target population, and which will require fewest additional resources.
- **Implementation:** When agreement has been reached about how the needs are to be met, an action plan (realistic, achievable, and adequately funded) and a timetable should be drawn up, which includes a plan for resource allocation.

Step Seven: Monitoring and evaluation

The purpose of monitoring and evaluation is to determine whether the changes made as result of the recommendations resulting from a needs assessment (either in the way existing services are provided, or in the introduction of new services or interventions) are having the desired impact. In the context of evaluating changes, it is helpful to use the following forms of evaluation:

- Process evaluation: which focuses on how an intervention is working and why; and
- Outcome evaluation: which aims find out whether the desired change has been achieved

3.1.6. Further reading and examples of needs assessment

The following are examples of needs assessment and further guidance to support services undertaking needs assessment. These have been identified to provide a framework which national or local groups might consider when developing their own needs assessment:

- **NHS Greater Glasgow & Clyde:**

Tweed E, Rodgers M, Priyadarshi S, Crighton E. (2018). “Taking away the chaos”: a health needs assessment for people who inject drugs in public places in Glasgow, Scotland. BMC Public Health 18, 829.

Available: <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-018-5718-9> [Accessed Sept 2021].

- **NHS Lothian:**

NHS Lothian (2017) Health Needs Assessment. NHS Lothian. Harm Reduction Team.

Available: <https://services.nhsllothian.scot/harmreductionteam/Pages/Health-Needs-Assessment----2017-.aspx> [Accessed Sept 2021].

- **Scottish Public Health Network (ScotPHN):**

Scottish Needs Assessment Programme (SNAP).

Available: <https://www.scotphn.net/resources/scottish-needs-assessment-programme-snap/introduction/> [Accessed Sept 2021].

- **NHS National Treatment Agency for Substance Misuse:**

NHS National Treatment Agency for Substance Misuse (2007) Needs assessment guidance for adult drug treatment.

Available: http://www.emcdda.europa.eu/attachements.cfm/att_231400_EN_UK45_Needs%20assessment%20guidance%20for%20adult%20drug%20treatment.pdf [Accessed Sept 2021].

- **Information Services Division (ISD)**

ISD. Population Needs Assessment for Health and Social Care Partnerships: guidance on the use of data sources.

Available: https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/docs/HSCP_NA_031014.pdf [Accessed Sept 2021].

3.2. Planning and contracting or commissioning services

Effective planning and commissioning are key to ensuring delivery of an effective injecting

equipment provision. This should cover the type, number and location of services required, the practicalities of service delivery and how this will be effectively communicated to maximise engagement. Undertaking needs assessment will give insight to many of these areas however the operational aspects of service delivery will require further consideration. This section aims to highlight the considerations which will inform the planning and commissioning process.

The diversity of IEP service models is intended to improve access in terms of time of day, geographic location and services offered. WHO, UNAIDS, and UNODC⁶⁴ recommend not providing injecting equipment in isolation but, instead, adopting a multidisciplinary approach which integrates various alternative and complementary models for delivery of injecting equipment and other harm reduction services. IEP services should therefore not operate in isolation but in the context of a comprehensive harm reduction strategy, which seems to be more beneficial⁶⁵.

3.2.1 Stakeholder consultation and engagement

SHBBV Managed Care Networks exist throughout Scotland, and generally these include representatives from agencies responsible for the commissioning and delivery of IEP services. To be truly effective, however, the planning of IEP services also needs to consider the views of people who use services and community representatives. This is also an opportunity to enhance local community knowledge and understanding on why the service is required and understanding the drivers of why people may use drugs problematically.

Planners and commissioners of IEP services need to develop support and awareness among the diverse groups that will be affected by IEP services. These include people who use drugs, familial and social networks, drug treatment and support services, the police, public health, primary care and mental health services, and community representatives. One way of developing support is by establishing an advisory group with a clear remit comprising relevant stakeholders. It should be noted that the capacity for involvement of people who may use IEP services in the activities of an advisory group – formal scheduled meetings, for example – may be limited. It may also be the case that a person ‘representing’ this stakeholder group has limited means to otherwise consult with a fair representation of the people they represent between meetings. For these reasons alternative or supplementary means to involve this essential stakeholder group will have to be adopted.

The police are important stakeholders in relation to IEP services. Links to the police can be made through local community safety partnerships and discussions with the police should take place before setting up any new service since police support can help to allay fears and combat local opposition. It may be helpful, in some circumstances, to establish a protocol with the police (or any private security providers)⁶⁶.

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

based injecting or drug litter. A protocol, developed locally in conjunction with people who use services, may also be helpful to avoid inappropriate discarding of injecting equipment⁶⁷.

3.2.2. Community empowerment

Introduction of new IEP services can raise anxiety within the proposed communities. NHS Boards and partners working in planning and commissioning structures, should be prepared to actively promote the benefits of IEP programmes to counter adverse media publicity and local opposition based on misinformation. In this they may work jointly with other partners including the local joint planning structures including the ADP; third sector partners and local police.

The United Nations Office on Drugs and Crime (UNODC), the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have coined the term “community empowerment” to refer to the process whereby people who use drugs are supported “to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services”⁶⁸. Community empowerment is, therefore, an essential approach that underlies all the interventions and programme components described in this guidance, and is essential for ensuring community-led planning, implementation, and monitoring of all aspects of prevention of the transmission of BBV infections^{69, 70, 71, 72, 73}.

At the local level, this means that organisations and networks of people who inject drugs are engaged by planning, funding, implementation and other relevant bodies. Connections with regional, national, and global networks of people who inject drugs are useful to exchange knowledge, experience, and support.

3.2.3. Operational aspects of service delivery

Needs assessment should highlight gaps in service provision and help identify what type of service(s) is/are needed in which location(s). Sections 4 of this document provides information on the types of services to guide discussion and information on recommended harm reduction interventions. Section 5 provides advice on the recommended injecting equipment and paraphernalia. Waste collection and disposal of these items will also be required. The safety of staff and people who use services and the confidentiality of people who use services should also be considered at this stage., For these reasons, consideration of issues such as location, size, and accessibility of premises should be made. When used in combination these factors will help plan operational delivery of the service and associated funding requirements. This in turn will inform the commissioning process.

3.2.4. Staff training

It is the responsibility of services to ensure that their staff are properly trained prior to delivering an IEP service. However, it is the responsibility of service planners and commissioners to ensure that suitable training is made available, and that staff are given all necessary support

to be able to attend. In the case of pharmacy IEP services, this may involve providing locum costs. Section 6 provides further information about the skills and knowledge that should be expected of all staff involved in the delivery of IEP services.

3.2.5 Communication strategy

Information about IEP services should, as much as possible, be targeted specifically at people who use drugs or who may have previously used drugs – e.g., BBV testing – and agencies that work with them. This strategy aims to reduce negative attention from the community, stigmatisation of people who use drugs attending services and practical difficulties for the service provider delivering the service.

3.2.6. Monitoring and evaluation

Monitoring and evaluation are key components of service planning and delivery. Monitoring is an ongoing process that involves the continuous or regular collection of key information to assess whether interventions are having the intended effect. The process of evaluation involves looking back to find out what difference an intervention has made. Evaluation can also be used to explore how and why something is working or not working.

It is recommended that a standardised electronic system of recording and information gathering is used to ensure compatibility and consistency of data nationally that allows comparison and evaluation of trends, developments and needs. To maximise data accuracy and capture complete demographic information, it is further recommended that data is input at the point of transaction in real time.

In addition, it is recommended that health boards support NESI; a biennial, bio-behavioural, cross-section survey of people who inject drugs attending IEP services across mainland Scotland since 2008. NESI measures and monitors the prevalence of BBV and injecting risk behaviours among people who inject drugs in Scotland. The initiative was initially funded by the Scottish Government as part of the Hepatitis C Action Plan, which stated that efforts to prevent HCV in Scotland must focus on preventing transmission of the virus among people who inject drugs. Subsequently, the initiative has been funded under the auspices of the Scottish Government's Sexual Health and Blood Borne Virus Framework. NESI provides information to evaluate and better target interventions aimed at reducing the spread of infection amongst people who inject drugs.

3.2.7 Remote communities

A qualitative study⁷⁴ conducted in a remote, rural Scottish island brought together evidence from both people who inject drugs and service providers to explore the ethical paradigm as an important dimension which could enhance service engagement with people who use drugs. In

remote and rural locations there are challenges with IEP accessibility, preserving anonymity of people who use services, and collection and disposal of IE, especially out of hours. The study highlighted the concept of stigma linked with HCV, and double stigma in those who have been incarcerated. It also identified that IEP, the service provision available and community spirit is valuable in overcoming stigmatisation and the need for closer working of prison and local services to provide the opportunity for prisoners to have access to IEP, ORT and HCV treatment, either when imprisoned or on liberation.

The background is a complex composition of overlapping rectangular blocks. On the left, there is a vertical strip with a light pink background and a darker pink, wavy, wood-grain-like pattern. To its right is a solid dark green block. Further right is a light green block with a subtle gradient. Below these, there is a dark green block containing the text. To the right of the text block is a solid dark green block. At the bottom, there are two more blocks: a solid dark green one on the left and a light pink one with a darker pink wavy pattern on the right. The overall aesthetic is modern and layered.

04

MODELS OF
SERVICE DELIVERY

4. MODELS OF SERVICE DELIVERY

The provision of injecting equipment can be undertaken using a wide range of service models.

This section looks in detail at the different models available, and provides information about their strengths and limitations, based on research findings. This information is intended to inform local decision-making about how best to structure service provision so that it meets the needs of local populations of people who use drugs.

4.1. Core and enhanced IEP interventions

A wide range of interventions can be delivered by IEPs, as outlined in Table 1 (below). There is an expectation that all IEP services will be able to provide access to those interventions listed below as core at point of supply. The extended range of enhanced interventions may not be delivered by every site; however, commissioners should strive to make these available in their local area. All IEPs in the area should know which services offer these interventions and support people to access them.

Table 1. Injecting Equipment Provision (IEP) Interventions

Services and interventions offered	Type
Maintenance of records of people using the service on IEP database at time of transaction	Core
Provision of the agreed basic range of injecting equipment and disposal/returns	Core
Provision of basic safer injecting advice	Core
Provision of Naloxone	Core
Provision of advice on BBV testing and support people to access it	Core
Signposting to drug treatment and related services	Core
Provision of advice on wounds	Core
Provision of an extended range of injecting equipment	Enhanced
Provision of an assessment of injecting risk (AIR)	Enhanced
Provision of in-depth safer injecting advice	Enhanced
Provision of in-house BBV testing	Enhanced
Provision of in-house wound first aid	Enhanced
Provision of in-house access to wider interventions e.g., sexual health, contraception, blood testing and health checks for IPED use, etc.	Enhanced

4.2. Models of injecting equipment provision

A range of IEP models have operated in Scotland. In recent years, these have included dedicated injecting equipment services, community pharmacy IEP, IEP as a part of drug treatment services, mobile IEP from a vehicle, outreach on foot and in-reach, where the outlet operates in another organisation's premises. Other forms of provision, such as needle replacement schemes and domiciliary (where injecting equipment is taken to people's homes), continue to account for only a small number of IEP outlets operated by agencies. The models are described in more detail below, along with their strengths and limitations.

Evidence suggests it is difficult to draw conclusions on which services are most effective⁷⁵. It is recommended that a variety of services is therefore made available to meet the geographic and demographic needs of the area⁷⁶. Evidence supports an integrated, multi-disciplinary, multi-modal approach to delivering harm reduction interventions as opposed to IEP operating in isolation (see section 6).

Key elements to consider include:

- Accessibility, location, and transport
- Opening hours, including consideration of late opening/weekends
- Needs of specific subgroups – e.g., people who use image and performance enhancing drugs, prisoners, men who have sex with men
- Needs of specific environments – custody, hospital, prison

Scottish context

The total number outlets reporting IEP in Scotland has remained broadly similar since 2011/12 (292)⁷⁷. In 2016/17, 219 (78%) of the total 281 outlets were pharmacy-run and 62 outlets were agency-run.

A range of non-pharmacy agency IEP services have operated in Scotland over the past ten years. IEP as part of a broader drug treatment service, was the second most common form of non-pharmacy service (26%). This was followed by 'Mobile IEP' (16%), 'Street outreach' (15%) and 'Peripatetic outreach' (where the outlet operates in another organisation's premises) (13%). Biannual reports on IEP services can be found at <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/index.asp>.

4.2.1. Community pharmacy IEP services

Definition: IEP services delivered from community pharmacy premises by community pharmacy staff. This involves a mixture of staff including pharmacists, pharmacy technicians, dispensers and counter staff.

Scottish context

Service provision for people who use drugs is a core function of community pharmacy practice in Scotland⁷⁸.

- Pharmacies in Scotland are paid, via their NHS Board, to deliver IEP services through locally negotiated service level agreements.
- Pharmacy staff in Scotland have access to a range of training options⁷⁹, from professional distance learning packages to local seminars - most of which is free of charge and available through NHS Education for Scotland (NES), the Royal Pharmaceutical Society, national training providers (e.g., Scottish Drugs Forum) and local drug and alcohol services⁸⁰. By engaging in training activities, pharmacy staff across Scotland have, over time, developed a generally more positive attitude towards IEP programmes. Staff training has been recognised as an essential component of effective service delivery.
- Most Health Board areas in Scotland employ specialist drug and alcohol pharmacy teams. These roles promote and develop delivery of services such as IEP and may also have contributed to the scheme success in Scotland.

Expected benefits

- The use of community pharmacies can make IEP services more accessible as, typically, they are already established within communities in both urban and rural areas.
- Providing injecting equipment within a community pharmacy gives on-site access to a qualified healthcare practitioner and a full range of NHS pharmaceutical services.
- Convenience (location and opening hours), relative anonymity and increasingly positive interactions with staff, are positive factors identified in customers' experiences of pharmacy-based access to injecting equipment⁸¹.
- Community pharmacy is acknowledged as a resource for the delivery of effective healthcare, including encouraging activities to support BBV prevention⁸², testing and treatment. People accessing a pharmacy IEP may already have established relationships with pharmacy staff through accessing other services, such as ORT. This may reduce barriers to access through the establishment of trust. Research suggests that this is supported by non-judgemental and confidential delivery of the IEP service⁸³.
- Training has been identified as key to developing positive attitudes regarding IEP and making appropriate training available to all pharmacy staff has been seen as beneficial to service delivery⁸⁴.
- The provision of injecting equipment within an existing pharmacy precludes the need to find and fit out new premises and hire staff, with the expense that would entail.
- Most pharmacies have private areas or consultation rooms that allow for greater

confidentiality and privacy when speaking to customers.

- The Scottish pharmacy contract provides considerable opportunities for developing the care of people who use drugs in a community pharmacy context. For example, NHS Pharmacy First Scotland allows access to counselling on general health and the supply of a range of medications and dressings free of charge, directly from the pharmacist.
- Several innovative developments and research projects have been undertaken to improve access to BBV testing and treatment. Examples include dispensing of HIV and HCV medication. The SuperDot C Randomised Control Trial enabled pharmacists to undertake the testing, diagnosis and treatment of HCV removing the need for patients to travel to specialist centres with positive patient outcomes reported⁸⁵⁻⁸⁶⁻⁸⁷.

Potential challenges

Concerns about anonymity, associated stigma and recurrent anxiety are reported in all types of geographical areas and particularly in smaller towns and villages.

In all geographic areas, there may be fear of negative perception or response where people are attending a pharmacy for ORT and also require injecting equipment.

Community pharmacies are diverse services which are required to deliver a wide range of health interventions and services. Most pharmacy staff will not have the same level of in-depth knowledge as staff from dedicated harm reduction or drug and alcohol services, with regards to injecting drug and people who use drugs.

Delivery of face-to-face training to pharmacy staff can be challenging as it may require funding and the availability of appropriate to backfill for staff attending.

Key points

- Commissioners may consider the expansion of IEP through local community pharmacy as an easily accessible means for distribution of injecting equipment in local communities where a need is identified. This should be complemented by access to more intensive support available from enhanced IEPs.
- Collaboration, communication and integration with existing local or board-level drug treatment and support services should be encouraged.
- Medication-Assisted Treatment Standards require that treatment services themselves provide harm reduction services which includes the provision of injecting equipment.
- Access to general healthcare interventions available from community pharmacy should be advertised and offered to people accessing pharmacy IEP services.

- Commissioners should ensure that appropriate training is made available to all pharmacy staff, including pharmacy support staff, pharmacists, and pharmacy managers / owners^{77, 79, 88, 89, 90}. Pharmacy managers and owners should ensure that all staff involved in the delivery of IEP are supported to access the training⁹¹.

The availability of accessible information has been seen as a factor that facilitates dialogue and/or allows pharmacy staff to intervene in a more universal or broad-reaching manner with people who use drugs⁸⁸. Commissioners should ensure that suitable materials are made easily available for use within community pharmacy.

4.2.2. Enhanced IEP Services

Background and definition

Enhanced IEP describes IEP delivered by harm reduction workers with extensive knowledge and training in the field of drug use. They can be delivered in isolation as a dedicated IEP but are more commonly delivered as a key component of a wider range of interventions designed to support the needs of the person.

Enhanced IEPs should be staffed by people who have specific training, in depth knowledge and experience relating to drug use and provide a wide range of services including:

- Supply of a broad range of injecting equipment and paraphernalia which can be tailored to individuals' specific needs
- In depth assessment of injecting risk
- In depth safer injecting advice
- Activity promoting behavioural change
- Tailored interventions, including overdose awareness and naloxone training, wound first aid, BBV testing, treatment and vaccination, and sexual health services
- Links to wider services (onsite, by referral or signposting) such as treatment services, housing support and debt management

Scottish context

There are examples of well-developed enhanced IEP services in Scotland.

Since the 1990s, the busiest IEP in GGC has been Abbey Chemist in Glasgow City Centre. The people using this service often presented with a wide range of injecting complications which the pharmacy staff struggled to help with. In 2018 a joint initiative was launched between NHS GG&C and Abbey Chemist to employ a specialist harm reduction nurse. The idea was to provide low threshold access to a wide range of harm reduction interventions. Over 270 injecting-related wounds were identified and treated in the first year.

As well as woundcare, the nurse provided naloxone, injecting equipment, and safer injecting discussions. Due to the success of this intervention the nurse's role became incorporated with the NHS GG&C City Centre Outreach Team and the work continues embracing new initiatives such as WAND (Wound first aid, assessment of injection risk(AIR), naloxone and dry blood spot testing). The team continues to operate within the pharmacy five days per week.

A similar programme delivered in several pharmacies in Lothian achieved equivalent outcomes in terms of harm reduction.

Expected benefits

- Provides access to a wide range of services tailored to the needs of the individual
- Provides access to staff with specialist knowledge in all aspects of drug use
- Provides opportunities for collaborative working with wider services

Potential challenges

- May not be viable in areas with lower numbers of people which may limit access
- Individuals may not travel to access enhanced IEP services if not located in their local community or in an easily accessible location.

4.2.3. Outreach services

Background and definition

Outreach work can be described as frontline, low threshold work, to establish contact with people and to provide them with appropriate support⁹². Outreach services are often targeted at populations of people that do not routinely access other services. In Scotland they are generally delivered as an extension of enhanced IEPs thus providing access to the same level of staff knowledge, training and experience described in section 4.2.2. above. The range of interventions available will be determined by the mechanism of delivery.

Outreach is a generic term which may cover a wide variety of IEP services:

- Outreach (on foot) – backpacking, on-street, 'hot spot' locations
- Outreach (peripatetic) - on the premises of another agency, such as a health centre or homeless hostel e.g., on certain days of the week for a few hours each day
- Outreach (to home) – home delivery or home-based intervention
- Outreach (vehicular) – mobile unit (van, bus, etc.)

Five general aims of outreach work have been defined at national policy levels:

- To identify and contact target populations
- To support members of these populations to access existing care services

- To initiate activities aimed at prevention or reduction of harm
- To promote safer use of drugs
- To identify the needs and perceptions that people have with respect to existing services⁹³

Specific guidance on delivering outreach IEP can be found at the [United Nations Office on Drugs and Crime \(2012\) Outreach for injecting drug users](#)⁹⁴.

Services that may be provided through outreach include:

- A range of harm reduction interventions, education, advice and information specific to the individual or group
- Distribution of injecting equipment and paraphernalia
- Collection and disposal of used injecting equipment and paraphernalia (see section 5.2.12)
- Referral and signposting to appropriate healthcare and other agencies

Scottish context

Different models and outreach strategies have evolved over time in response to community needs, new knowledge, and the availability of resources.

Between 2014 and 2017 the Assertive Outreach team in Glasgow operated as a partnership between the Glasgow City Alcohol and Drug Partnership (ADP)⁹⁵, Turning Point Scotland and the Simon Community Glasgow. The Glasgow Assertive Outreach team consisted of four support workers who maintained a street presence distributing injecting equipment; providing harm reduction advice and training; and supporting individuals to engage with other services such as housing, social work, addictions, and specialist healthcare. Further details available at [Taking Away the Chaos. The Health Needs of People Who Inject Drugs in Public Places in Glasgow City Centre](#)⁹⁶.

In Aberdeen, the third sector service Alcohol and Drugs Action operates “Quay Services”. This is an outreach service aimed at providing support in the harbour area of Aberdeen specifically for women, many of whom work in the sex industry. The service provides access to a variety of items tailored to the person’s needs including access to sterile injecting equipment and paraphernalia, condoms, panic alarms and naloxone. This is delivered with accompanying advice, including, but not limited to, harm reduction advice; support and information relating to sex work, drugs, alcohol and related issues.

The service offers support aimed at achieving positive changes in their lives and links women to internal and external services including sexual health and local alcohol and drug services. The service staff are skilled workers and encourage women to engage with further one to one support where women can explore their substance use and any related issues in more depth.

Expected benefits

- Engage people who do not, or cannot, access other services.

- Engage specific target or high-risk groups
- Reduces injecting risk behaviour and exposure to BBV⁹⁷⁻⁹⁸.

Potential challenges

- The effectiveness of outreach interventions depends greatly on the skills of outreach workers, the flexibility of approach and the appropriateness and comprehensiveness of the services provided⁹⁹.
- The range of interventions available may be limited by environment and logistics
- Outreach work may be labour intensive due to additional travel requirements however this should be balanced against the expected benefits of delivering outreach services.
- Mobile outreach using vehicles are likely to require significant outlay to procure, fit out and maintain the vehicle(s).

Key points

- Outreach work may be a valuable component of BBV and bacterial infection prevention as an effective method for engaging with those not reached through other interventions¹⁰⁰⁻¹⁰¹.
- Outreach work should work in partnership with wider services to maximise the range of opportunities for people using services.
- Ongoing training, supervision and support are necessary⁹⁶.
- Outreach interventions should be assessed as appropriate to monitor effectiveness in fulfilling their aims and objectives¹⁰².

Useful links:

- NHS Greater Glasgow and Clyde (2016) [Taking Away the Chaos. The Health Needs of People Who Inject Drugs in Public Places in Glasgow City Centre](#)⁹⁶.
- WHO (2004) [Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users](#)¹⁰³.
- WHO (2004) [Training guide for HIV prevention outreach to injecting drug users: workshop manual](#)¹⁰⁴.
- UNAIDS (2007) [Practical guidelines for intensifying HIV prevention](#)¹⁰⁵.
- Outreach Best Practices: Harm Reduction Coalition website: <https://harmreduction.org/issues/syringe-access/tools-best-practices/manuals-and-best-practice-documents/additional-best-practice-documents/outreach-best-practices/>

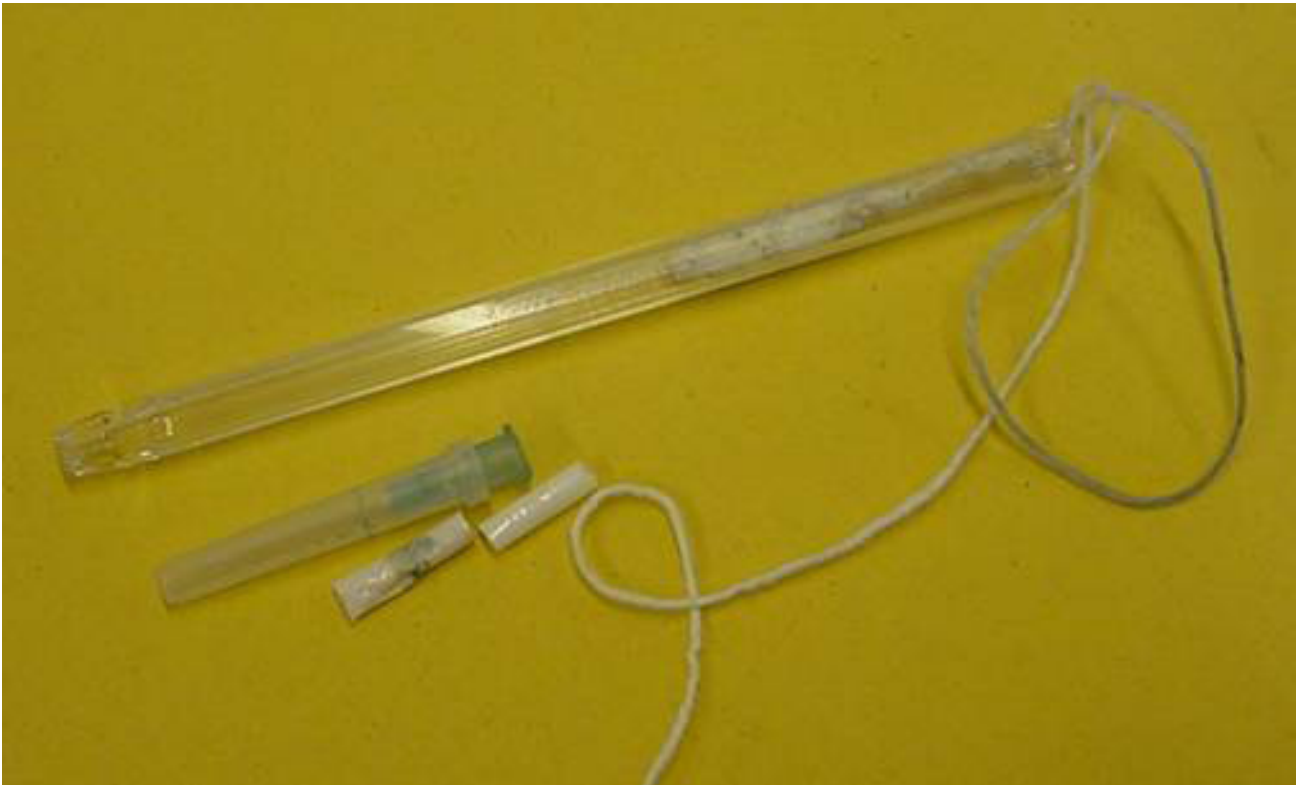
4.2.4. Police custody suite and prison IEP services

Background and definitions

Police custody suites: When a person is taken into police custody their injecting equipment is generally removed for disposal. Police custody needle replacement schemes provide replacement equipment when leaving custody.

Prison-based IEPs: These provide injecting equipment to people in prison.

Figure 3: Homemade syringe handed in to Scottish prison staff (2003).



The risk of acquiring BBVs via injecting drug use in prison is well established^{106, 107, 108}.

The WHO, UNODC, and the UNAIDS have recommended the implementation of harm reduction initiatives in prisons and other places of detention as an essential public health measure and have developed international guidelines on how to do this¹⁰⁹. Prison-based IEP may have a role in reducing BBV transmission where this is identified as an issue.^{110,111}

Scottish context

There are currently no prison-based IEP schemes in Scotland. There have been efforts to pilot in-prison injecting equipment provision in the Scottish Prison Service, however, where available, this has been limited to paraphernalia. The Scottish Prison Service provides a needle replacement scheme on liberation in several prisons.

The NESI study (2019) which surveyed people who inject drugs found that of those who had ever been incarcerated, 7.4% reported ever injecting drugs in prison¹¹².

Since the introduction of ORT in Scottish prisons, HCV incidence has been reduced among people in prison¹¹³. Current evidence, however, indicates that the risk of hepatitis C transmission is elevated immediately following liberation from prison¹¹⁴ and that the scale-up of prison interventions could be an important part of comprehensive harm reduction programmes.

Access to injecting equipment on release from police custody suites is available in several NHS Health Board areas in Scotland. Police custody suites may be able to reach people who are not in contact with other services. An evaluation by Central Scotland Police undertaken during the pilot of their own needle replacement scheme in 2003, reported that, within the first 10 months of the scheme, there were 127 needle replacement transactions. One quarter of people who were arrested and received injecting equipment on release from custody had never used an IEP service before¹¹⁵.

Expected benefits

- Reductions in sharing and reuse of equipment, high-risk injection practices and HIV and HCV transmission¹¹⁶
- Decreased HIV and HCV prevalence among prisoners 126¹¹⁷,
- Increased awareness of HIV, HCV and risk behaviours among people in prison and prison staff, as well as a reduction in stigma and discrimination¹¹⁸.

Potential challenges

- Providing equipment may prolong injecting activity among people who may otherwise cease injecting on account of injecting equipment not being provided in the UK prison setting¹¹³.

Key points

- People in prison should have access to an equivalent standard of healthcare as anyone in the community¹¹⁹
- Providing injecting equipment remains an essential public health intervention, regardless of setting
- Previous Scottish IEP guidance made recommendations to introduce IEP within Scottish Prisons^{120_121}. This has not been introduced and it seems unlikely to happen in the short term. This may change in the event of significant incidence of BBVs within the prison population or if another injecting-related outbreak occur. Monitoring of incidence in prison populations should be undertaken on a regular basis.
- People in prison should have access to information, education and support from trained personnel regarding safer drug use and harm reduction¹²².
- Prisons should provide easy and confidential information regarding local IEP and drug treatment services available on liberation as part of standard harm reduction practice¹²³.

4.2.5. Secondary distribution

Definition and context

Secondary needle distribution refers to a range of formal and informal practices whereby a community member acquires and redistributes injecting equipment to peers within social networks.

The practice of secondary distribution is prevalent among injecting populations¹²⁴. For people who are younger and less experienced, secondary distribution has typically been identified as their primary source of new equipment¹²⁵. Qualitative research and recent epidemiological evidence also indicate that secondary distribution is common among networks of people who use IPEDs¹²⁶⁻¹²⁷.

Expected benefits

- Secondary distribution facilitates access to injecting equipment (including foil) for a greater number of people who may not otherwise access it¹²⁸
- Opportunities provided during secondary distribution can facilitate harm reduction discussions and promote engagement with services.

Potential challenges

- Secondary distributors cannot be expected to effectively pass on key safer injecting and harm reduction messages.¹²⁹

Key points

- While IEP services should actively encourage secondary distribution, they should also encourage others to personally attend IEP services for wider harm reduction interventions¹³⁰
- Information on secondary distribution should be recorded on the national database.

4.2.6. People with lived or living experience (peer-led services)

Definition and context

Peer-led services refer to the model that relies on the involvement of a peer (or person with lived or living experience of substance use) in the distribution of injecting equipment.

Peers should be supported in this role through the provision of training, education and individual supervision.

Expected benefits

- People with lived or living experience may more readily gain trust and may have a deeper understanding of drug use and associated issues⁹¹
- Use of peer distributors to disseminate key messages around harm reduction may be an effective intervention, particularly because these messages have greater validity when delivered by someone who has had comparable experiences to the recipient.

Potential challenges

- Peer distribution requires a high degree of support including effective funding, recruitment, training and regular supervision¹³¹.

Key points

- Supporting the development of local peer-led networks may increase overall capacity and effectiveness of IEP programmes

4.2.7. Injecting equipment dispensing machines (unsupervised)

Background and definition.

IEP via dispensing machines provides injecting equipment through an automated machine and can reach populations and geographical areas where other services are not easily accessible or when other IEP is unavailable.¹³²

Dispensing machines have been described as a supplement to standard IEP services^{133_134} and should be seen as an adjunct and not a stand-alone option. They can be used to actively exchange new for used equipment or to dispense equipment only. Disposal facilities may be attached. Dispensing machines may require coins or tokens to limit inappropriate access. The convenient nature of this provision may appeal to certain people.

Scottish context

The use of vending machines is not common in Scotland. Though there is some evidence that dispensing machines can reach the target population, stakeholders across Scotland have often expressed that their preferred option to provide injecting equipment during evenings and weekends is by extending the hours of staffed IEP services, to maximise opportunities for harm reduction interventions¹³⁵. Where provision remains limited or challenging, dispensing machines may go some way to providing a workable solution.

Expected benefits

- Increased access to IEP where current services are insufficient
- May address local concerns about IEP service availability and location.¹³⁶

- May offer anonymous, private and non-stigmatised access to injecting equipment¹³⁷.
- May reach people who do not normally access other IEP services^{149 138}.
- The use of these machines has shown minimal impact on the local community in terms of increased crime or other potential, unintended consequences¹³⁹.

Potential challenges

- Dispensing machines have very limited efficacy on providing IEP functions beyond provision and disposal of injecting equipment
- Stock management, disposal of waste, maintenance and repairs incur costs and present logistical difficulties
- Ensuring continuity of service
- The type of machine used may require specific materials not supplied under local provisioning
- Community opposition may pose a barrier to the implementation and use of dispensing machines.¹⁴⁰

Key points

The use of dispensing machines may supplement other harm reduction interventions to support underserved populations, cover gaps in IEP and reduce unsafe injection behaviour.

4.2.8. Hospital-based IEP services

Background and definition

Hospital-based (or healthcare facility) IEP services may allow for 24-hour access to injecting equipment.

Given the health complications of drug use, hospitals (and particularly emergency departments) regularly engage with people who use drugs. Hospitals and health facilities can link people to community-based IEP services, infection-control systems and various health and social care treatment services through informal as well as formal referral mechanisms¹⁴¹.

Scottish context

Acute Drug and Alcohol Liaison teams are available in some acute hospitals and aim to provide people with substance use issues a bridge between acute inpatient healthcare services and community drug and alcohol services¹⁵².

Expected benefits

- May improve access to IE, support and engagement with other health services and IEPs¹⁴².
- May provide opportunistic access to IE when other services are unavailable.

Potential challenges

- Attitudinal challenges (opposition, discrimination, stigma) and safety concerns of hospital staff and fellow patients may arise in healthcare settings where IEP services are being implemented.
- Workload pressure in acute settings may demand that critical services are prioritised over hospital IEP.

4.2.9. Postal or delivery-only IEP services

Background and definition

Postal or delivered IEP provides access to injecting equipment delivered directly to the person's home via a courier, postal service or uninvolved third-party. Contact is usually by phone or online. Following discussion with an IEP worker the agreed type and quantity of injecting equipment will be dispatched to the individual. Telephone or online contact provides opportunity to discuss harm reduction along with advice on how and where to dispose of the equipment allowing some interaction.

Such a model of supply allows only limited opportunities for care intervention or education and requires alternative arrangements for disposal of waste (classified as hazardous waste, once used).

In recent years, in the UK, people requiring injecting equipment have been able to purchase online from commercial suppliers with subsequent postal delivery. This lacks the opportunity for harm reduction or support available from an IEP service. Providing a commissioned postal or delivery IEP service may overcome this.

Scottish context

COVID-19 and its associated lockdown required innovation and service development to maintain service provision. This included development of postal options for injecting equipment and naloxone supply in several Health Board areas. Harm reduction discussions are undertaken remotely by phone or online chat which informs equipment selection including sharps containers. These are subsequently posted. To date numbers have been relatively low and some barriers have been identified for example the size of package means it is too large to go through the letterbox which poses issues if the person is not at home. It does, however, provide a starting point for evaluation and refinement to determine whether this is a useful addition in the longer term. In Grampian this has led to further interventions such as BBV testing kits being trialled using the postal system.

Potential benefits

- The ability to provide injecting equipment across a very wide geography utilising established processes which are typically cost-effective
- A better alternative to commercial online IEP as it allows for provision of other harm reduction or support
- Public health emergencies, e.g., a pandemic or any circumstance which leads to the restriction of free movement, may favour this model.

Potential challenges

- Providing a robust route for facilitating remote safe disposal of injecting equipment
- Arranging postal supply or delivery may involve significant staff-time burden with potential for travel-time and mileage costs. This may be a particular challenge in remote and rural areas
- Lack of opportunity for a face-to-face assessment.

4.2.10. Supervised injection facilities (SIF)

Background and definition

Supervised injection facilities (SIF) (also referred to as drug consumption rooms (DCR)) offer a safe and hygienic environment for people to inject their own drugs under the care and supervision of trained staff. SIFs can reduce a range of complications associated with injecting drugs and the environmental risks such as presence of discarded needles in public places. It may also improve people's engagement with health and social care services, including other IEP and harm reduction services¹⁴³.

SIFs provide a safe environment for more hygienic drug consumption that is protected from public scrutiny.

SIF can provide injecting equipment; advice and support before, during and after drug consumption; emergency care in the event of an overdose; primary medical care and the opportunity for referral to appropriate social healthcare and treatment services.

The first SIF was opened in Switzerland in 1986. More than 120 supervised injection facilities are currently in operation in Australia, Canada, and in Europe. including in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, and France¹⁴⁴.

Scottish context

NHS Greater Glasgow and Clyde⁹⁵ has proposed a pilot SIF in Glasgow city centre, to address the range of harms caused by a growing incidence of public injecting and in response to the increasing numbers of injecting-related HIV diagnoses. A recent study showed prevalence of

public injecting was 16% overall in Scotland and 47% in Glasgow city centre. Public injecting was associated with an increased risk of HIV infection, current HCV infection, overdose and SSTI¹⁴⁵.

Such a facility would be established through collaboration and co-operation between key local agencies and the wider community, carefully integrated with existing services. The proposal includes a robust, prospective evaluation – including an economic component – that would confirm whether the benefits observed in other cities are transferable to the local context.

Expected benefits

- Positively influence injecting practice and reduce injecting-related-harms.
- Reduce public preparation and injection of drugs
- Reduction in discarded injection equipment
- Engagement with people who are not in contact with other services^{146,147}
- Provides opportunities for a wider range of public health interventions.

Potential challenges

- Current interpretation of UK legislation suggests that the delivery of SIFs would most likely require cooperation and agreement between Government, the Crown and police as well as those providing the service
- The introduction of SIF may generate local public opposition^{148,149} and requires skilful management, community liaison and cooperation between agencies

Table 2: Summary of the expected benefits and potential challenges of the different models of IEP services

Model	Expected Benefits	Potential Challenges
<p>Community pharmacy IEP services</p>	<ul style="list-style-type: none"> • Accessibility and convenience: multiple locations and longer (including weekend) hours of operation • Access to qualified healthcare professional for general health advice and to a full range of NHS pharmaceutical services • Less stigmatising / more anonymous • Relatively inexpensive 	<ul style="list-style-type: none"> • Generally, it does not provide a full range of harm reduction interventions, in-depth advice, and education (although these may be complemented by enhanced services) • Needles / syringes generally given out in pre-packed bundles rather than tailored to individual's need • There can be difficulties with staff attitudes and lack of training / support
<p>Enhanced IEP services</p>	<ul style="list-style-type: none"> • In-depth education and advice • Provision of injecting equipment can be tailored to individual need • Able to provide a wide range of interventions • Option for locating other services on-site 	<ul style="list-style-type: none"> • May not be viable in areas with low numbers of people who inject drugs • May require travel to access • Hours of operation
<p>Outreach services including mobile services; home visits; peripatetic IEP services (provided as part of a wider service)</p>	<ul style="list-style-type: none"> • Increases accessibility – particularly useful for covering a large geographic area • May engage people who have not engaged with other services, including some key subgroups such as women • Potential for in-depth education and advice to be made available • Relatively inconspicuous to the public • Better returns of used injecting equipment • Improves accessibility in terms of location, time, culture, and age group • Peripatetic services delivered in health centers may improve access to other primary care services • Peripatetic services can be cost effective when delivered from existing premises 	<ul style="list-style-type: none"> • Vehicles may have insufficient space for counselling sessions; arranging referrals; BBV testing; etc. • If they operate for only a short time at each location, there is a chance that they will be missed • Cost and maintenance of the vehicle • Safety for staff • Potentially intrusive for people who the service seeks to serve • Some, e.g. vehicles, may be very cost intensive.

Table 2 (continued). Summary of the expected benefits and potential challenges of the different models of IEP services

Model	Expected Benefits	Potential Challenges
<p>Police custody suite and prison IEP services</p>	<ul style="list-style-type: none"> • Ensures that people have access to sterile injecting equipment and information about local IEP services upon liberation from custody • May reach people who are not otherwise in contact with IEP services 	<ul style="list-style-type: none"> • Little or no harm reduction advice given • May be opposition from staff
<p>Prison-based IEP schemes (Not currently in Scotland)</p>	<ul style="list-style-type: none"> • Reduces sharing of needles, and other high-risk injecting practices among prisoners 	<ul style="list-style-type: none"> • Can be opposition from politicians, prison staff and prisoners • Concerns among prisoners about anonymity • May reduce incentive to move away from injecting for some people
<p>Secondary distribution</p>	<ul style="list-style-type: none"> • Improves reach to people who will not (or cannot) use other forms of IEP services 	<ul style="list-style-type: none"> • Lack of control over provision of, or accuracy of, harm reduction advice and information to recipients • Continued high-risk injecting behaviour
<p>People with lived or living experience (peer-led services)</p>	<ul style="list-style-type: none"> • Peer knowledge of drugs and drug use • Improves reach to people who will not (or cannot) use other forms of IEP services • May provide education, employment skills and income for peer distributors • Convenience / accessibility • Peers have credibility and can be important role models 	<ul style="list-style-type: none"> • Training, support and supervising of peers can be labour intensive • Potential conflicting identity as someone who both uses drugs but also provides support as a peer worker • High turnover of peer workers

Needles and syringes dispensing (unsupervised) machines	<ul style="list-style-type: none"> • 24-hour access • Anonymous • Location can be wherever the need requires • Convenient and easy to use • Limited staffing required 	<ul style="list-style-type: none"> • No face-to-face education or advice can be provided • No way to regulate access to the machine (by under-16s for example), unless a token system is used • Difficult to maintain anonymity when located in a public place • Potential for public opposition • Require upkeep, e.g. stocking, fixing if broken etc.
Supervised injection facilities (SIF)	<ul style="list-style-type: none"> • Attract hard-to-reach populations of people who use drugs, particularly marginalised groups 	<ul style="list-style-type: none"> • UK legislation does not currently support the operation of SIFs • Potentially generate local public opposition
Postal service	<ul style="list-style-type: none"> • Potentially reaching wide geographical areas • Wide access to harm reduction advice by phone or online • Convenience 	<ul style="list-style-type: none"> • Not having a face-to-face assessment • Delivery can be a challenge for large parcels • Needs pre-planning – not spontaneous • Disposal of returns

4.3. Groups requiring alternative approaches

Some groups may need further and particular consideration when planning and implementing IEP programmes.

4.3.1. Homeless/roofless

Homeless populations experience significant health inequalities¹⁵⁰. A strong association between homelessness/unstable housing and public injecting has also been a consistent finding in recent evidence.

Substance use (particularly alcohol and polydrug use involving heroin, in Scotland) among homeless people is a complex phenomenon, strongly associated with economic marginalisation, social isolation, alienation and, in particular, mental health problems¹⁵¹. Although evidence supports homelessness and problematic use of substances as mutually reinforcing, substance use, is generally not a necessary or sufficient condition for homelessness to occur, as other factors also appear to be necessarily involved¹⁵².

It has been suggested that integrating IEP services, and other harm reduction programmes, into wider strategies to end homelessness, requires an appropriate and realistic policy framework that contributes to the creation of safer environments.¹⁵³ Four key areas for action are recommended: developing policies of social inclusion; ensuring adequate housing; providing harm reduction services “on demand” and securing organisational infrastructure¹⁵⁴.

4.3.2. Adolescents or under 16

Young people who inject drugs have specific developmental, social, and environmental vulnerabilities¹⁵⁵. They are less likely than adults to use harm reduction and treatment services and may be less informed about risks and their rights¹⁵⁶.

Early onset of injecting and being new to injecting are associated with increased risks of HIV and HCV transmission. Specific groups of young people, especially those that are injecting in public places, are at considerably higher risk. Harm reduction (IEP and ORT) services for this age group and the interventions required may differ in their delivery than for older people who inject drugs¹⁵⁷.

The legal status of being a minor raises additional challenges for the development of targeted harm reduction interventions. These include issues such as informed and parental consent. While these challenges exist, they should not be a barrier to the provision of IEP services to some people under the age of 16.

IEP services and other harm reduction interventions should be tailored to meet the needs of young people facing a variety of issues¹⁵⁸, including the needs of sexually exploited children and young people.¹⁵⁹ Recent studies confirm how adolescents and young people require significant support beyond the typical package of IEP services, with clear linkages to other sectors, social services, education, and employment. For IEP and other harm reduction services to be effective for young people, it must be informed by their own experiences to ensure that adopted approaches are relatable and meaningful to them¹⁶⁰.

Services for young people should:¹⁶¹:

- Be developed and implemented to meet the needs of different groups of people under 16 years of age who use drugs
- Provide advice on harm reduction
- Consider the implications of refusing service based on age
- Be connected to local information and service availability
- Be aware of, and responsive to, the needs of young people in the local area

4.3.3. Women

Women who use drugs are consistently reported to have less access to harm reduction services and to be at higher risk of HIV and hepatitis C infection than men who use drugs¹⁶².

Women may be reluctant to engage with IEP services. This reluctance may be caused by issues involving gender-based violence; pregnancy and parenting; criminalisation; sex work stigma and discrimination¹⁶³.

Gender should be taken into account in the design and delivery of IEP services and women who use drugs should be involved in the design and implementation of programmes.

IEP services should provide options to improve and expand care for women who inject drugs.¹⁶⁴ Some of the following might be considered:

- Taking steps to acknowledge, address and prevent stigma, discrimination, violence, exploitation and abuse including through access to justice¹⁶⁵
- Developing more accessible services including, for example, mobile services or non-traditional hours of services
- Improving access to other services (including childcare, sexual and reproductive health) and joint work or integration with other services
- Enhancing outreach and case management to reach women whom services otherwise cannot engage

4.3.4 Chemsex

Chemsex involves the use, by men who have sex with men, of drugs (commonly referred to as “chems”), during sexual activity.

Mephedrone, gamma-hydroxybutyrate (GHB) / gamma-butyrolactone (GBL) and methamphetamine are commonly used substances¹⁶⁶. Some people inject drugs intravenously, which is referred to as ‘slamming’. Combining substance use and sex can result in increased risk-taking around both sex and drug use, which can lead to higher rates of STIs and BBVs.^{167,168}

Chemsex has been a growing or emerging trend in Scotland for some time. There are gaps in knowledge of chemsex, and some staff have low confidence in their abilities to provide support or even identify sensitive issues.¹⁶⁹ Some IEP services may not have the knowledge base to be able to meet the needs or to provide support to men engaging in chemsex. IEP services may not be accessible or approachable for some men who have sex with men.

Where there is identified need, areas should assess current IEP provision, including considering the equipment and information resources supplied, the training needs of staff and the availability of, or signposting to, IEP within sexual health services used by men who have sex with men.¹⁷⁰

4.3.5 Use of Image and Performance Enhancing Drugs (IPED)

There are a wide range of IPEDs currently used including anabolic androgenic steroids, human growth hormone and injectable tanning agents. These substances are used by a diverse group of individuals¹⁷¹

People who use IPEDs often report that they do not perceive IEP services as a useful source of information or think IEP service providers do not understand IPED use¹⁷². They may therefore use other sources believed to be more credible, such as peers and particularly online forums, although these may be more product than health focussed¹⁷³. Stigma also exists around IPED use which may lead to individuals concealing their use or being deterred from seeking help.

Generic IEP services may require better understanding of IPED use to provide appropriate support. Due to infrequent or no contact with people who use IPEDs, IEP service staff may not fully understand the motivations, prevalence, modes and patterns of use and any resulting complications associated with IPED use. All IEPs could benefit from training on injecting practice technique for people who use IPEDs. This would bring a better understanding of terminology used, benefits as well as the harms, including injecting-related injuries and what harm reduction strategies/resources and services are available for support.

4.4. Improving the quality and integration of services

The approach adopted in this document focuses on improving integration between IEP and related services and improving the way services interact with people.

Evidence indicates that people who inject drugs can face a range of barriers when trying to access help from generic health and social care services¹⁷⁴⁻¹⁷⁵. These barriers include the burden of appointments, travel to services, stigma and negative staff attitudes, personal ill-health, lack of material resources and anxieties about accessing support.

Integrated care is an approach that seeks to facilitate availability of, or access to, all the services required to meet the assessed needs of the individual. This may be co-located or via referral / signposting.

Some IEP services in Scotland provide access to a wider range of primary and social care interventions, for example BBV interventions at point of IEP.

Scottish Context

The NHS Greater Glasgow and Clyde 'WAND' initiative focuses on four key interventions: Wound care, Assessment of injecting risk (using the AIR tool, an in-depth questionnaire focussing on injecting behaviour), Naloxone and dry blood spot (DBS) testing. It was designed to address some of the health issues facing people injecting drugs within Glasgow city centre face, including drug-related death, injecting-related complications and BBVs.

A stamp is made on a paper card to record when each component of the assessment has been completed. Interventions are also recorded on an electronic database. When all interventions are completed, the person is provided with a cash-equivalent voucher which can be taken to any shop to exchange for cash. This incentive can be accessed every three months.¹⁷⁶ The preliminary results of the WAND campaign have been very encouraging. In the month of September 2020, there were 403 wounds checked, 403 assessments of injecting risk, 467 naloxone kits supplied, and 380 DBS BBV tests completed.

05

EQUIPMENT
PARAPHERNALIA &
SUPPORTING
SERVICES

5. EQUIPMENT, PARAPHERNALIA AND SUPPORTING SERVICES

5.1. Key Points

IEP services should ensure:

- They offer a full range of injecting equipment including needles; syringes; spoons; filters; water for injection; acidifiers; pre-injection swabs; foil (as an alternative to injecting) and naloxone.
- The use of low dead space fixed syringes is encouraged where possible
- An appropriate range and size of needles, syringes and equipment is available so the correct equipment is used for each injection, according to drug, injecting site and individual preference.
- Every IEP outlet also offers naloxone to those at risk of opioid overdose and those who may witness an opioid overdose.
- A supply of naloxone is available within the IEP for emergency use
- People accessing IEP are encouraged to take sufficient equipment so that they always have new equipment for every injecting episode.
- At least one needle is provided per syringe, where separate syringes and needles are provided.
- People who take injecting equipment are offered an appropriately sized sharps container and encouraged to return used equipment for safe disposal.
- Supply of injecting equipment is not subject to limits or in any way linked to volume or frequency of returned used equipment.
- Secondary distribution of equipment is encouraged, and supported, whilst at the same time making every effort to make services are attractive to those who receive IEP this way.
- Information and advice which is relevant to the type of drug being injected, the anatomical point of injection and the location the drugs will be prepared and injected is provided at every opportunity.
- Staff providing the IEP service and delivering advice are appropriately trained
- A visual means of identification of injecting equipment to help prevent accidental sharing of syringes is encouraged.
- They record demographic and transactional data as directed by the national data collection system⁴.
- Where possible, a basic assessment of injecting risk is conducted at first registration by an appropriately trained member of staff.
- All people using an IEP service are made aware of how they can access a specialist Assessment of Injecting Risk (AIR).
- People have access to BBV testing and vaccination and are informed about what services provide this in their area.

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Currently, neo360[®] is the approved IT system for IEP services

- People are made aware of any local and national issues, such as outbreaks, bacterial infections or blood-borne viruses.

5.2. Equipment

The drug market in Scotland has never been more diverse with a wide range of drugs injected. Currently the main drugs of injection are heroin, cocaine and image and performance enhancing drugs (IPEDs). With this in mind the range of equipment IEP services offer should meet the needs of all of these groups and the likely injecting methods they will use.

All injecting equipment should be manufactured to the applicable medical standards, all paraphernalia supplied should be fit for purpose and comply with relevant regulations and/or standards.

In Scotland, a national IEP supplier is commissioned by tender through NHS Scotland's national procurement process. This should be used by all health boards to deliver a consistent and cost-effective service.

In addition to needles and syringes, in order to reduce infection risk, additional paraphernalia is provided including spoons; filters; water for injection; acidifiers; pre-injection swabs and foil (provided as an alternative to injecting).

A Scottish cross-sectional study¹⁷⁷ based on a voluntary anonymous survey of people who inject drugs examined the factors associated with paraphernalia sharing. The results indicate that uptake of paraphernalia is associated with safer injecting practice.

5.2.1. Non-injecting methods of drug administration

The introduction of foil (see section 5.2.11) as an alternative to injecting has proven to be very popular with high uptake in some areas¹⁷⁸. Foil provides a useful tool for frontline staff to promote route transition or breaks from more harmful injecting¹⁷⁹. It is possible that, as new drugs emerge, methods of administration will change also. Services should be aware and responsive to this.

Many of the items provided from IEPs have been specifically developed to facilitate the preparation and injection of 'street drugs' in the safest manner possible. However, no assumption should be made that people will know how to use these items properly or most effectively. Therefore, people need to be shown how to use these correctly through demonstrations, written or verbal instructions.

- It should be noted that injecting any 'street drug' comes with significant risk
- All equipment should be promoted as single use with sharing or reuse discouraged

- Consideration should be given to providing equipment (beyond the provision of foil) which would support non-injecting methods of drug use should legislation allow. An example of this would be consideration of the provision of filters with a compatible device for inhalation of drugs. As with the provision of foil, this would provide an opportunity for route transition strategies to be promoted to help individuals break the cycle of injecting. This would also allow for the elimination of the harms associated with individuals' use of homemade, high risk, smoking equipment including the transmission of viruses such as COVID, or blood-borne viruses, when shared with other people.

5.2.2. Hypodermic needles

All hypodermic needles supplied should be registered medical devices, supplied in individual packaging, sterile and marked 'single use'.

Hypodermic needles are single use, and should be safely disposed of after use, in an appropriate sharps container.

People should be encouraged to use the most appropriate size needle for the drug being injected and anatomical location. Choosing the right size of needle for the planned injection is essential if harms and complications are to be minimised. As a general rule of thumb, the smallest, thinnest needle, which comfortably reaches the target vein or muscle, should be first choice.

All detachable needles are marked by both length and gauge (thickness). It is important to know that the higher the gauge the finer the needle. There is also a colour-code system to help quickly identify sizes. See Appendix 1

- All IEPs should supply a range of needles which are suitable for subcutaneous injections, superficial intravenous injections, deep vein injections and intramuscular injections
- Needles should be single use and disposed of immediately after use (in the sharps container provided).
- Sharing needles with others is high risk for transmission of blood-borne viruses (BBV)
- Reusing needles increases the risk of bacterial infection, vein and site damage.

5.2.3. Syringes

All syringes provided should be of medical standard. They should be presented in individual, sterile, sealed packaging and clearly marked as 'single use'.

There are 2 types of syringes available: syringes with a fixed needle or syringes which are designed to accept a separate, detachable needle.

- Syringe with fixed needle

This one-piece unit is manufactured with the needle permanently attached to the end of the syringe. This ensures the volume of blood left behind after injection is minimal, making it the lowest 'dead space' option available. The needle attached is fine needle, of a high gauge (27g-30g), so is less likely to cause harm, if used properly. When appropriate for the type of injection this should be the first choice for anyone injecting 'street drugs'.

- **Separate syringe and needle**
Syringes come in a range of sizes (including 1ml, 2.5ml and 5ml). The most common syringe to be used for the injection of 'street drugs' is either a 1ml or 2.5ml syringe. For anabolic steroids the choice is usually 2.5ml. This is sufficient fluid volume for most people to inject and for this reason 5ml syringes or larger should be discouraged.
- Sharing syringes with others increases risk of transmitting blood-borne viruses. Sharing may occur when people prepare and or administer drugs together or in the re-use of other people's injecting equipment.
- Syringes should be single use and disposed of immediately after use (people should be encouraged to use the sharps container provided).
- Syringe reuse (i.e. when a person re-uses injecting equipment they themselves have previously used) is associated with tissue damage, and local and systemic bacterial infections.

5.2.4. Low dead space and needle reuse

People should be encouraged to plan ahead and have sufficient new injecting equipment for each injecting episode. However, there are times or situations where this may not be possible. This is particularly true if the living environment prohibits injecting and the possession equipment – i.e. prisons, supported accommodation or night shelters. There may also be circumstances where injecting equipment has been removed from its secure wrapping and left unsupervised by the person it belongs to. If this does arise, the needle, syringe and paraphernalia should be treated as compromised (potentially used without knowledge) and properly sterilised before use. It is important that equipment that can reduce the risk of inadvertent or direct sharing is used. See section 5.2.6.

In 2012, the WHO recommended that needle and syringe programmes (NSPs) offer low dead space (LDS) syringes¹⁸⁰⁻¹⁸¹, which may reduce the survival of HIV and HCV in syringes¹⁸²⁻¹⁸³⁻¹⁸⁴, as well as reduce transmission risk¹⁸⁵⁻¹⁸⁶⁻¹⁸⁷. This recommendation was based on syringes with permanently attached needles. Research has shown that exclusive use of low dead space syringes (with needle attached) is associated with lower prevalence of HCV, particularly among those who started injecting recently, suggesting LDS syringe use is protective against HCV¹⁸⁸.

The difference between high and low dead space syringes is determined by the amount of blood/fluid that is left in the syringe post-injection. The higher the dead space the greater the

risk of transmission of blood-borne viruses if shared with other people¹⁸⁹.

A number of syringes and needles have been specifically designed to reduce dead space and potentially reduce some of the risks associated with sharing¹⁹⁰.

- By design, fixed needle syringes are the lowest dead space products available and should be promoted as best choice when suitable.
- Care should be taken when ordering low dead space equipment to ensure the separate components fit together e.g. low dead space needles will not fit on a low dead space syringe.

Although the use of LDS is recommended, the importance of syringe sterilisation should also be emphasised for injecting situations where:

- Sterile syringes are not available
- The syringe has been left unwrapped and unsupervised by the person who is to use it and should therefore be regarded as potentially compromised

This should minimise the possible risk of BBV transmission, while maximising the protective benefit of using low dead space syringes.

The key messages for promoting better practice are:

- Always take sufficient equipment for every injection
- Reusing equipment increases risk of damaging veins and transmission of blood-borne viruses
- Sterilisation, if reuse of syringes is unavoidable

LDS syringes and needles should be presented in a sterile, sealed packet and clearly marked as single use.

5.2.5. Syringe identification

The rationale behind syringe identifiers is to reduce the likelihood of accidental sharing which can occur when people are using drugs in the same location and put down their unwrapped injecting equipment and leave it unsupervised and may, even inadvertently, pick up another person's equipment. If compromised equipment must be used, it should be properly sterilised before use (see section 5.2.6).

The main methods of identification currently available are colour-coded syringes or 'scratch panels' containing letters and numbers. It is important that this does not suggest that identification reduces all risk of BBV transmission. People should be advised that if they lose sight of their needle and/or syringe they should treat this as compromised (potentially used

without knowledge) and use a new needle and/or syringe.

- Syringe identifiers do not guarantee that the needle and syringe will not have been used by another person
- The key message of “use new injecting equipment for every injection and share nothing” should continually be promoted.

If reuse of syringes is unavoidable, sterilisation should take place.

5.2.6. Cleaning injecting equipment

All IEPs should provide information regarding cleaning injecting equipment.

People should be encouraged to plan ahead and have sufficient new injecting equipment for each injecting episode. However, there are times or situations where this may not be possible. This is particularly true if the living environment prohibits injecting and the possession equipment – i.e. prisons, supported accommodation or night shelters. There may also be circumstances where injecting equipment has been removed from its secure wrapping and left unsupervised. If this does arise, the needle, syringe and paraphernalia should be treated as compromised (potentially used without knowledge) and properly sterilised before use. It is therefore important that equipment that can reduce the risk of inadvertent or direct sharing is used. See section 5.2.6.

- Smoking may be a practical option than sterilising until new injecting equipment can be accessed. For example, it may be easier to carry a small pack of foil than carry all the equipment needed for sterilising. People should be encouraged to carry spare foil with them at all times.
- If the syringe is to be reused water is often drawn into the syringe to flush it out. Although this does not guarantee sterility or reduction of BBV risk. It is likely to be better than doing nothing.
- Sterilising needles and syringes using clean water and bleach is often referred to as ‘bleaching’. This process requires two 5ml ampoules of water for injection (WFI) or clean cold water and thin bleach. Bleaching is an effective way of destroying BBVs and reduces the likelihood of transmission. It should not be assumed that thin bleach or clean water will be available where drugs are prepared and injected.
- Regardless of the syringe sterilising method used, there is a still significant risk associated with the sharing of paraphernalia (e.g. spoons, filters and water) as BBVs and bacteria have the potential to survive on this equipment.
- Where needles, syringes or paraphernalia are reused a significant bacterial infection risk

remains.

- Using the larger ampoules of WFI (2x5ml) for any flushing and bleaching will ensure enough water is available for all syringe sizes to be flushed out properly. Therefore, spare WFI should be carried at all times.
- While the central message of “always use new and sterile injecting equipment” prevails, it is important to ensure that people know how to sterilise needles and syringes with the use of bleach¹⁹¹. This acknowledges the fact that people may not have sufficient needles and syringes with them and therefore need to sterilise.

The following steps should be recommended to use bleach to sterilise syringes:

- Find a clean and level surface
- Wash your hands
- Open two 5ml ampoules of water for injection or alternatively fill two clean containers with cold tap water
- Part-fill third container with **thin household bleach**

STEP 1

Draw water into the syringe from the first water ampoule or first water container until the barrel is full, then flush the contents down the sink. Also pour the water from the first water ampoule or the first water container down the sink

STEP 2

Draw up the bleach into the syringe until the barrel is full and flush contents down the sink. Also pour the bleach from the container down the sink

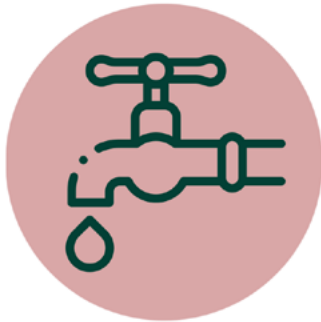
STEP 3

Draw water into the syringe from the second water ampoule or second container until the barrel is full, then flush the contents down the sink. Also pour the water from the second water ampoule or the second water container down the sink

Chlorine disinfectant tablets may be dissolved and used in place of bleach.

Figure 4. Recommended steps if using thin household bleach to sterilise syringes

IF YOU CAN, ALWAYS USE A NEW, STERILE SYRINGE
SET UP 3 CUPS OR OTHER CLEAN CONTAINERS



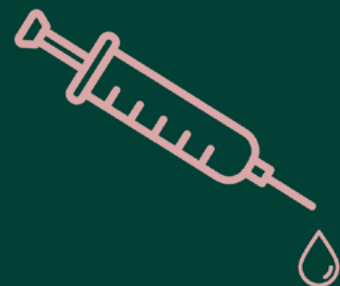
1.
Fill the first
cup with cold
water and
flush



2.
Fill the second
cup with thin
household
bleach and
flush



3.
Fill the third
cup with cold
water and
flush



5.2.7. Spoons

All IEPs should provide these.

Spoons should be presented in individual, sterile sealed packaging and clearly marked as 'single use'.

Spoons (sometimes called cookers) are used to dissolve drugs in water to create an injectable solution. Some drugs, such as heroin, also require other steps such as addition of an acidifier and/or heating of the solution. Heating is usually by holding a flame e.g. from a lighter, underneath the spoon.

- Sharing and/or using non-sterile spoons other than those provided by the IEP may increase the risk of bacterial infections.

5.2.8. Filters

All IEPs should provide these.

Sterile filters should be presented in an individual, sterile, sealed packet and clearly marked for 'single use'. There are a number of filter types available ranging in effectiveness by design or material^{192,193}.

In order to remove particles or impurities (such as cutting agents or plant matter), drugs being prepared for injection are commonly filtered before injection. Injecting-related complications can arise if this matter is not removed due to a failure to filter the solution or from poor filtration; these include infections, abscesses and emboli. The sharing of filters is common and creates a risk of bacterial infection and transmission of blood-borne viruses. The reuse of filters poses a high risk of bacterial infection. The storage and reuse of filters which is sometimes undertaken to use any residual drug held within the filter likewise is a high risk of bacterial infection and should be discouraged.

The most common filters are small 'cigarette-type' filters or the specialist filter built in to the cap of a syringe. The use of all other filters, such as cotton wool or bits of gauze should be discouraged.

- Filters which trap the smallest spore or particle size should be first choice
- Filters should be single use and disposed of immediately after use (in the sharps container provided).

5.2.9. Acidifiers

All IEPs should provide these.

The acidifiers provided should be presented in a sterile, sealed sachet and appropriately packaged in small quantities.

Most heroin, crack cocaine and freebase cocaine all require an acidifier TO BE ADDED during the preparation process to help 'break the drug down' so that it is soluble. There are two main acidifiers provided through IEP to prepare these drugs for injection, citric acid and vitamin C (ascorbic acid). Both acidifiers are very effective in the preparation of these drugs for injection.

- Citric acid can be seen as more effective; however, it is easy to add too much and the solution become too acidic and cause vein damage^{194,195}.
 - Vitamin C (ascorbic acid) is less acidic which may result in less vein damage.
 - It should be noted that when compared, more Vitamin C than citric acid must be added to dissolve the same amount of drug.
- Regardless of which acidifier is being used, they should be used in the smallest amounts required to dissolve the drug, as overuse can cause vein damage and make it harder for injecting sites to heal.
 - Once the acidifier sachet is opened, any leftover should be discarded, so that it does not become contaminated and cause an infection.
 - Household materials sometimes used as acidifiers, such as lemon juice or vinegar, are non-sterile and carry a high risk of infection or injury. Their use should be discouraged.

5.2.10. Pre-injection Swabs

All IEPs should provide these.

Pre-injection swabs should be of the highest quality, and appropriate for cleaning the target injecting site. They should be presented in an individual, sterile sealed packet which requires opening.

Pre-injection swabs are used to clean the injecting site prior to injecting. Swabs should not be placed on the injection site after injecting to stop bleeding as alcohol may stop healing and encourage bleeding and bruising.

- It is important that swabs are not seen as a substitute for washing hands and injecting sites.

5.2.11. Water for injection (WFI)

All IEPs should provide this. Water for injection (WFI) should be of medical standard and clearly marked 'water for injection'. These are provided in a sterile, single-use ampoule.

Water for injection is a specially prepared, cleaned and purified form of water which contains no chemicals or bacteria. It is available in either a 2ml glass or 5ml plastic ampoule. The design of

the plastic 5ml ampoule allows for needles or syringes to be easily attached to the end and water drawn up without spillage. Plastic ampoules are more resistant to breakage and most areas have chosen to provide these.

Supply of water for injections by 'practitioners, pharmacists and persons employed or engaged in the lawful provision of drug treatment services' is permitted under Section 9A of the Misuse of Drugs Act 1971, providing it is in accordance with the Medicines Act (link). The Humans Medicines Regulations, that restricted supply to 2ml ampoules, were amended in 2012 to allow the supply of 5ml water ampoules (link).

- Regardless of the size of ampoule, they are single use and should never be shared
- All sources of water, if shared, may pose a risk of transmitting blood-borne viruses
- Non-sterile sources of water (including reuse of sterile water) carry a risk of bacterial infection if injected.

It is crucial that water for injection is made easily available. In the absence of water for injection people will revert to alternative sources of water. Harm reduction messages should cover the risks associated with different water sources as outlined below. ¹⁹⁶.

Figure 5: Water Hierarchy: Relative risks of bacterial infection from water sources.



5.2.12. Foil

All IEPs should provide this.

The most common drug to be smoked from foil is heroin. It is widely agreed that the most harmful way to administer heroin is to inject. Drugs other than heroin can also be smoked using foil.

If appropriate, people should be encouraged to move from injecting to smoking^{197,198}. This is called route transition. Experienced staff should discuss all methods of use with people accessing the service.

Foil should be provided in sealed packs containing sheets of foil which have been specifically manufactured for the smoking of 'street drugs.' Unlike foil manufactured for catering purposes, this foil is free from oils.

Smoking, rather than injecting, can:

- Prevent blood-borne virus transmission
- Prevent injecting-related complications
- Reduce the risk of death through overdose
- Eliminate the need to obtain, carry and store injecting equipment

While smoking is regarded as a safer alternative, there are inherent risks associated with smoking any drug which should be highlighted.

5.2.13. Sharp Containers

All IEPs should provide these.

The sharps disposal containers provided should be secure, lockable, fit for purpose and comply with relevant regulations and/or standards.

A range of sizes will help people dispose of their injecting equipment and return them for appropriate disposal.

All people accessing IEP should be encouraged to take sharps containers with their injecting equipment.

When providing sharps containers, information should be provided to the effect that:

- Syringes and needles should be placed into the sharps container immediately after use
- All injecting paraphernalia can be placed in these containers; however, this will reduce the containers capacity

- The person can close and lock the lid mechanism
- Sharps containers should never be filled above the “fill line”, where marked
- Safe storage, disposal and return procedures

5.2.14 Packs

Packs should contain all of the equipment needed to prepare drugs for injection. Pack contents will vary according to the intended use or drug injected.

Some areas provide large packs of 20 or more needles and associated paraphernalia whilst others work solely with a range of single use packs. Packs should be tailored to individual needs – i.e. those people injecting outdoors or homeless are unlikely to be able to store large packs. For people who inject anabolic steroids large quantities of packs may be more beneficial.

- The equipment in all packs should be designed for single use only. Nothing in these packs should be shared or reused.
- Injecting powder cocaine, NPS or hormones will not require an acidifier which may be included in the pack. This should be made clear to the recipient.
- People who inject anabolic steroids will not require the spoon, filter or acidifier included in some packs and should be directed to access an appropriate pack or individual items.

5.3. Supporting services and interventions

5.3.1. Wound care

Many people who inject drugs experience a range of associated problems. This ranges from simple pain at point of injection to serious life-threatening conditions such as botulism or anthrax. Early identification of these complications and wounds and provision of related harm reduction advice is essential as it can reduce and prevent people’s suffering and limit the further medical response required.

Wherever possible wound and infection identification and first aid should be a low threshold service. Many people are not fully engaged with drug services and may not have access to regular health checks. Information regarding serious injecting-related complications should be available to all people who use the service.

Due to the wide range of presentations and serious complications if left untreated or misdiagnosed, it is important that those services providing IEP can identify injecting-related complications at point of transaction. This allows them to either treat onsite or refer to a specialist service or hospital for treatment as appropriate. Staff should be able to access training and resources to enhance knowledge in both people using the service and staff. Scottish national guidance for wound-care for injecting-related complications will be published in 2021 and

commissioners must also take these into consideration when assessing IEP needs.

The launch of 'NHS Pharmacy First Scotland' promotes pharmacy as the first port of call for minor ailments and includes a small range of basic dressings. This provides opportunity to engage people, treat where appropriate and link in with services such as primary care where further assessment is required. The role of the pharmacy in identifying and addressing this, often hidden, harm should be considered. It is possible that larger pharmacy IEPs may make space available for specialist services to run woundcare clinics at key times or days.

Assessment

All people using an IEP service should have access to a basic assessment which is designed to record:

- Drugs injected
- Frequency
- Needle and paraphernalia sharing
- Needle and paraphernalia reuse
- Anatomical injection sites
- Geographic location where drugs are prepared and injected

Technical opportunities for identifying veins for injection may be used at safer injecting facilities and at heroin assisted treatment provision clinics. These hand-held scanners can prevent unnecessary trauma and vein damage by illuminating and identifying accessible veins in areas of the body that can be less risky than sites such as the groin. Currently there are a limited number of IEP services trialling the use of these devices in Scotland¹⁹⁹. It is likely that in time the price of these devices will be reduced, and they will be more widely available.

5.3.2. Assessment of injecting risk (AIR)

People should be encouraged to take part in a specialist Assessment of Injecting Risk (AIR) which would be carried out by trained staff in enhanced services. There is currently an AIR tool available through the national data collection system (currently neo360) which helps and guides staff through the assessment process. This tool is more advanced in nature and designed to cover the following topics:

- All drugs used and methods and routes of administration
- Overdose risk and Naloxone
- Needle choice
- Hand and site cleaning
- Use of acidifier, water and paraphernalia
- Injecting site health
- Complications and harms
- Batch preparation

- BBV testing and vaccination.

The development of the AIR tool has allowed further innovation through use of IT. This has supported frontline staff to improve the quality and efficacy of face-to-face interventions. For example, WAND initiative as described in section 4.4.

The background is composed of several overlapping rectangular blocks. On the left, there is a dark grey block with a white, intricate, maze-like pattern. To its right is a light pink block with a darker pink, wavy, organic pattern. Further right is a solid dark teal block. Below the dark grey block is a solid dark teal block. Below the light pink block is a solid light green block. At the bottom left, there is a light beige block with a white, maze-like pattern, and to its right is a solid red block with a darker red, wavy, organic pattern. The text '06 TRAINING' is centered on the dark teal block in the middle of the page.

06

TRAINING

6. TRAINING

High quality staff training is essential to increase the skills and competence of the workforce and provide people with the best possible service. There is now a wide range of drugs injected by very diverse groups, all of whom require specific information relating to the drugs they are injecting, the injecting method and known risks and harms.

The National Needle Exchange Surveillance Initiative (NESI) and more recently an evaluation of IEP services in Tayside found a lack of consistency in services as well as gaps in staff knowledge and training^{200_201}.

Training is encouraged prior to staff undertaking any duties relating to IEP to ensure quality and consistency of IEP services across the county.

6.1. Minimum training required

As a minimum, all staff involved in IEP should receive appropriate training prior to providing a service, which covers:

- Understanding drug use
- How to engage with people who use drugs
- Risk associated with injecting practice
- Correct use injecting equipment
- Needs of different sub-populations
- Reducing transmission of BBVs
- Identification of injecting-related complications
- BBV testing and/or referral to specialist treatment
- Overdose prevention and response (including naloxone)
- Procedures regarding safe disposal of used injecting equipment
- Procedures for managing needle stick injury
- Contact details of other local relevant services
- Use of the approved electronic recording tool and the need for direct entry of data

On-going supervision should be provided, and training should be updated as required.

6.2 Training

Training may be required:

- When setting up a new IEP service
- For new staff involved in IEP delivery
- Where there are ongoing updates or changes in trends and equipment
- As needed to maintain knowledge and expertise

Those responsible for the management of IEP services should make relevant training available

to staff. This should include staff in community pharmacy services. This can be delivered through a variety of methods, for example:

- Vernacare online e-learning www.harmreduction.co.uk/solutions/elearning/
- IPEDs safer injecting resource (www.ipedinfo.co.uk)
- Scottish Drugs Forum (<https://www.sdftraining.org.uk/online-learning>)
- Training should be delivered in formats that are accessible and based on the principles of adult learning
- Training needs analysis will assist in identifying the training needs of staff
- Training should be matched to both the service type and the role of the staff member (See diagram below)

Table 4: Training topics and content for all IEP staff

Topic	Core training required for all IEP staff	Additional Training for Enhanced IEP Activities	Training Content
DATA COLLECTION			
IEP Data Collection	✓		<ul style="list-style-type: none"> • Overview of data collection system • The importance of direct entry at point of transaction • Using the system to its full potential • Using data to evaluate and improve the service
INJECTING EQUIPMENT PROVISION (IEP), SAFER INJECTING, ASSESSMENT & WOUND CARE			
Basic Principles of Injecting Equipment Provision (IEP)	✓		<ul style="list-style-type: none"> • Rationale for using a harm reduction approach • Understanding why people inject • Understanding and reducing stigma • National policies and guidance • How to deliver IEP safely • An overview of all the equipment provided • What equipment is provided for different drugs • Importance of confidentiality, anonymity, and sensitivity

Basic Principles of Safer Injecting Practise	✓		<ul style="list-style-type: none"> • The circulatory system (veins and arteries) • Types of injections – IV., IM and subcutaneous • Accessing a suitable vein (including tourniquet) • Associated risks with different anatomical injecting sites • Associated risks of different types of drugs • Preparing different types of drugs for injection • Importance of hygiene, think of the environment, hand washing and injecting sites • Environmental risk factors • Choosing the right size of needle and equipment appropriate to the injecting site and substance injected • Injecting-related complications and bacterial infections • Assessment of individual's injecting practise and technique and how to promote safer injecting practise
Assessment of Injecting Risk (AIR)		✓	<ul style="list-style-type: none"> • AIR is designed to assist enhanced IEP staff to assess injecting risk. This assessment should be used in an interactive way to promote discussion and engagement. Staff should have training on the use of the tool and feel competent on its application.
Wound First Aid		✓	<ul style="list-style-type: none"> • Overview of the anatomy/structure of skin and tissue • Common injecting-related wounds • How to properly check injecting sites • How to identify and monitor wounds and infections and understand when to refer • Appropriate dressings and treatment, including venous disease • The need to encourage retention with specialist services • Advice on minimising wounds

DRUGS, HARM REDUCTION & OVERDOSE AWARENESS			
Basic Drugs and Harm Reduction Awareness and other relevant service provision	✓		<ul style="list-style-type: none"> • Range of drugs used, their effects, adverse effects, and rationale for use • The wide range of harm reduction interventions available and when and how to use them e.g., behaviour change models, alternatives to injecting etc • Awareness of local alcohol and drug treatment services, advocacy services and how to refer individuals to these services
Overdose awareness and naloxone	✓		<ul style="list-style-type: none"> • Rationale for Naloxone provision • Understanding signs and symptoms of overdose • Responding to overdose and administering Naloxone • Skills and knowledge to provide Naloxone
Image and Performance Enhancing Drugs (IPEDs)		✓	<ul style="list-style-type: none"> • Overview and prevalence • Motivations for use • Understanding how people access information • Promoting use of validated sources e.g., Specialist clinics, www.ipedinfo.co.uk • Range of IPEDs used and injecting equipment required • Encouraging people who use IPEDs into services • Risks and harms • Reducing harms • IPED specific injecting advice

BLOOD BORNE VIRUSES, SEXUAL HEALTH AND CONTRACEPTION

Key facts about Blood Borne Viruses (BBVs)	✓		<ul style="list-style-type: none"> • Overview of key BBVs associated with injecting • Transmission risks • Window periods • Encouraging regular testing • Basic understanding of treatment options
BBV testing. How to test, support, signpost and refer for treatment		✓	<ul style="list-style-type: none"> • Offering the Blood Borne Virus (BBV) test and initial discussion • How to conduct a BBV test • Overview of current prevention and treatment options • Encouraging regular testing • How to offer support and signposting
Sexual Health and Contraception		✓	<ul style="list-style-type: none"> • Importance of condoms as protection against Sexually Transmitted Infections(s) • Provision of appropriate contraception • Offering sexual health tests with discussion • How to conduct sexual health test(s) • Overview of current prevention and treatment options • Encouraging regular testing • How to offer support and signposting

6.3. IEP service standards

There is currently no standard training programme for people involved in the delivery of IEP services however there are published standards that can support the IEP workforce to ensure they are knowledgeable, skilled, and confident in working with people who use IEP services. NHS Boards and those delivering IEP services have a responsibility to ensure that IEP staff are adequately trained and skilled to be able to provide a high-quality service. In relation to this, it is worth noting that the National Quality Standards for Substance Misuse Services in Scotland require that:

- Workers (paid and unpaid) will be appropriately trained and supervised (Quality Standard 8, point 3)
- Services should employ and train their staff to treat people with respect and dignity (Quality Standard 3, point 2)

Standards to be aware of:

- National Quality Standards for Substance Misuse Services in Scotland
- The National Occupational Standard 'AH32014 Supply injecting and other relevant equipment to individuals who use substances and facilitate safe disposal'
- NHS Education for Scotland (NES) – Hepatitis C Workforce Education Development: An Outline of Requirements
- NES National Trauma Training Programme

Whilst local commissioners should ensure that services are given support to enable staff to attend training and to make relevant training available, it is the responsibility of service providers to ensure that all staff involved in the provision of injecting equipment are trained prior to delivering a service.

6.3.1 Other Support/Training

- Scottish Needle Exchange Workers Forum
- SDF online training²⁰²
- NHS Education Scotland (NES) pharmacy "Substance misuse: core module" ²⁰³.
- Child protection awareness
- Blood borne viruses and bacterial infection awareness
- Trauma informed practice (NES)²⁰⁴.

6.4. Data collection and management

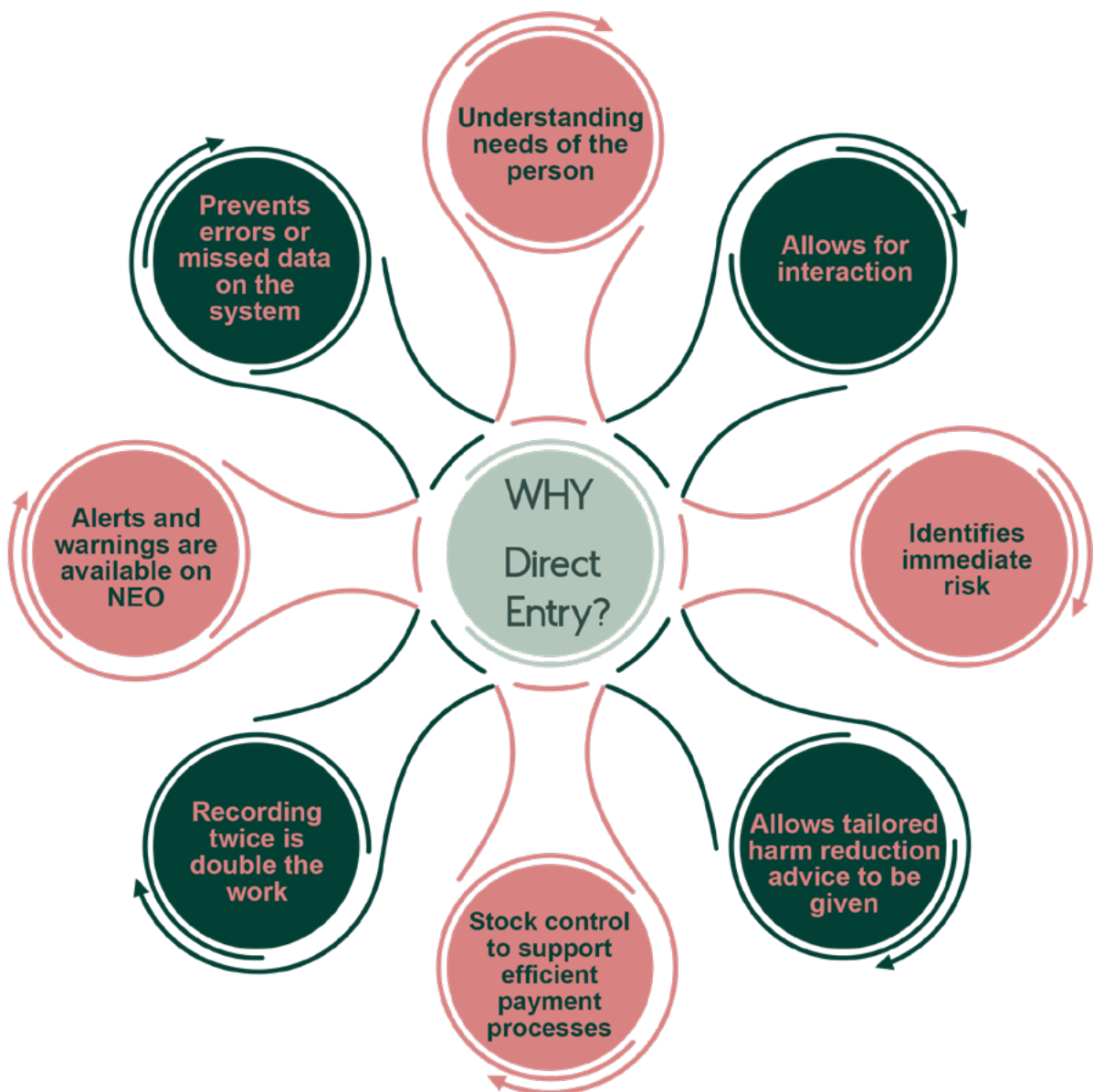
In Scotland, people can access IEPs anonymously. This is intended to reduce barriers such as fear of personal disclosure. However, non-identifiable core data is essential in supporting service delivery, development and improvement at service, local and national level. It helps

ensure that we respond effectively to meet the needs of people who use drugs in Scotland. It is therefore critical that this information is properly recorded and updated.

Some methods of data collection, such as paper forms or batch submission of information, is shown to offer limited data quality, much of which cannot be used meaningfully. Furthermore, analysis of data is labour intensive using manual methods.

6.4.1 Direct Entry at the point of transaction

Figure 6. Direct Entry at the point of transaction



6.5. Creating the right environment

There are often challenges for people who use IEP services, including stigma and lack of access to healthcare. Whilst having the right knowledge and skills is important so are the attitudes of staff and the environment they create.

In focus groups with service commissioners, service providers and pharmacists, undertaken as part of the National Needle Exchange Survey, it was reported that negative staff attitudes — perceived to be linked to inadequate staff training and support — were identified as two of the biggest barriers to good practice in IEP services. There is evidence which suggests that negative and judgemental staff can act as a barrier to individuals accessing services.⁷⁰

Staff training should include information and the importance of sensitivity and confidentiality in delivering IEP services. Training to increase an empathetic approach and understanding with people accessing services may also be beneficial.

Services should consider the impact that their processes and premises may have on the overall experience and perceptions of people who might use an IEP service whether these impacts are intended or not. This might include privacy during transactions; requesting the service; use of different entrances or areas which may have both positive and negative connotations.

- People accessing IEP services must be treated with dignity and respect
- Staff should be aware of practices which result in stigma and discrimination

6.6. Evaluation

Views from people accessing services can be used to inform and improve service delivery.

Service providers and commissioners should consider the opportunities that involvement of people who use the service have to offer in delivering and taking part in local training alongside IEP staff. This joint working may help with engagement, enhance the knowledge of staff and help create an environment where people are and feel valued and listened to.

Evaluation should be a regular activity to ensure services are responding to the needs of people, to identify gaps in staff knowledge and to continually improve the service provided. Satisfaction surveys and mystery shopping are useful tools that can support an ongoing quality improvement approach to service development and provision.

APPENDICES

APPENDIX 1

Needle Colour Coding Chart

Colour	Gauge Size	Length	Suitability for	Drugs usually injected by needle
Green	21g (0.8mm)	1½" (38mm)	Drawing oil based steroids Intramuscular (IM) injection of steroids (buttocks)	Oil Based Steroids
Blue	23g (0.6mm)	1¼" (32mm)	Intramuscular (IM) injection (buttocks) of steroids Femoral (groin) injection (IV)	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).
Blue	23g (0.6mm)	1" (25mm)	Intramuscular (IM) injection (buttock, thighs and shoulders) of steroids Femoral (groin) injection (IV)	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).
Orange	25g (0.5mm)	1" (25mm)	Femoral (groin) injection (IV). Slightly deeper veins when the needle is prone to blocking.	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).
Orange	25g (0.5mm)	5/8" (25mm)	Slightly deeper veins when the needle is prone to blocking	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).
1ML Fixed (LOW DEAD SPACE)	27g- 29g	½" (13mm)	Superficial veins such as arms, hands, feet and legs (IV) Subcutaneous injection of some hormones	Heroin, Cocaine, Amphetamine and NPS. IPEDS such as growth hormone, tanning agents and peptides.

APPENDIX 2

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