# Analysis of national and local policy and protocols on the delivery of Needle Syringe Programme services to young people under 18

## Policy review and consensus development exercise

**Neil Hunt and Lucy Platt**

Centre for Research on Drugs and Health Behaviour
Faculty of Public Health and Policy
London School of Hygiene & Tropical Medicine

April 2013

## List of abbreviations

| | |
|---|---|
| AOD | Alcohol and other drugs |
| BBV | Blood borne virus |
| CAMHS | Child and Adolescent Mental Health Services |
| CG | Consensus Group |
| DANOS | Drug and Alcohol National Occupational Standards |
| DfES | Department for Education and Skills |
| DoE | Department for Education |
| HIV | Human Immunodeficiency Virus |
| HCV | Hepatitis C virus |
| ID | Identification document |
| LSCB | Local Safeguarding Boards |
| NSP | Needle and syringe programmes |
| PIED | Performance and image enhancing drugs |
| PWID | People who inject drugs |
| YOT | Youth Offending Team |
| YP | Young People |
| YP-NSP | Young Persons (under 18) needle syringe programes |
| NSP-YP | NSP policies with a sub-section on young people |
| YP-AOD-NSP | Policies focused on Young Persons' Alcohol and Other Drug Treatment with a sub-section on NSP |

## Notes on terminology

Safeguarding is an umbrella term that refers to the promotion of young people's welfare, the prevention of harms and 'child protection' i.e. activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Although it has been conventional to refer to such services as 'substance misuse' services in England there has been increasing criticism of the terms "misuse"/"misuser" within drug user organisations and among policy makers because of its implied value judgment, which can be alienating to the population services aim to work with. For this reason Australia and New Zealand have long adopted the more neutral term Alcohol and Other Drugs (AOD) as the overarching descriptor for the range of services responding to alcohol/drug use i.e. from universal prevention, through low-threshold harm reduction to structured treatment, pharmacological interventions and residential programmes. Engagement of the population emerges as an important theme within the findings of this report therefore AOD is used as a preferred, non-stigmatising term within this report.

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# Executive Summary

The aim of the project was to conduct a consensus development exercise using a Nominal Group Technique (NGT) and Delphi consultation with key experts to explore, develop and evaluate consensus on the optimal provision of NSP for young people who inject drugs (PWID) aged under 18 years. Alongside this, we also conducted a policy review to assess existing policies on the provision of NSP to young people aged under 18 .

## Methods

We conducted interviews with 12 experts working in the fields of Drug or Alcohol services for young people, child development and harm reduction of drug related harms with adults or young people. Interviews focused on how to deliver NSPs to young people and specifically the impact of age on how services are provided. Findings from the interviews were summarized as consensus statements on issues complicating service provision as well as statements on how these could be overcome. Consensus statements were discussed in a facilitated group discussion and prioritized into key statements that could inform policy. These statements were then circulated among a broader group of experts to assess levels of consensus and rated using a Likert scale. Interviews were also analysed thematically.

The policy review summarized eight NSP guidelines identified from England, Wales and Ireland. Quality was assessed drawing on the AGREE criteria relating to the development of policies including: i) scope and purpose; ii) stakeholder involvement; iii) rigour of development; iv) clarity and presentation; v) applicability; vi) editorial independence; and vii) relevance to the English policy context.

In addition quality was assessed according to content and the extent to which policies covered key topics identified as important in the consensus development exercise including: i). assessment of individuals in relation to capacity to consent and level of risk; ii) safeguarding young people; iii) multi-agency working; and iv) training of staff

## Findings

No international policy documents were identified with explicit guidelines on the provision of NSP to young people. The UK has a range of relevant policies that are largely founded on principles, which flow from a single, national programme of work dating back to 1999 and initiated by the Standing Conference on Drug Abuse and Children's Legal Centre (SCODA/CLC). (DrugScope 1999) Both explicitly and implicitly, these principles and the associated framework for practice have generally been accepted within England (See Appendix 8). Despite a broad, national consensus on governing principles and the framework for services, policies lack clarity about detailed aspects of practice that are critical for safe and effective practice and reflects the contemporary realities of injecting by young people in England.

*Safeguarding and assessment*

Findings from the interviews suggest that a key difficulty in providing NSP to young people is the conflict between fulfilling safeguarding duties and trying to engage a young person and provide them the harm reduction service they need. Assessment of young people is necessary in order to gauge vulnerability and what safeguarding procedures are necessary. The policy review provides clear guidelines on the content of an assessment and the need to assess a broad range of factors relating to an individual's social circumstances as well as risk behaviours relating to drug use. All guidelines recommend drawing on the Fraser Guidelines to assess

competence to consent. Guidance is less clear on how to conduct a comprehensive assessment while ensuring the young person is not deterred from attending the service. Findings from the interviews and consensus development exercise point towards a need to increase the emphasis on engaging the young person first, starting with an initial minimal number of questions to assess vulnerability and to provide some protection to the service provider, but first and foremost the emphasis should be to create a clearer environment in which competent practitioners can better apply their professional judgment about whether to provide young PWID NSP taking into account the complex problems they present with.

*Young person centred*

The principle of providing young person-centred services in a non-judgmental way is reflected in guidance for services. Our interviews with young people (although limited) suggest this is not always the experience of young people in practice. There is a need to fundamentally reappraise the way these ideas are translated into practice. No policy document was identified that demonstrated evidence that young PWID or their parents/carers had been meaningfully consulted in their development.

For young PWID, a potential concern will be whether their use of YP-NSP will result in unwanted involvement of authorities in their lives. Services need to communicate limits to confidentiality at the earliest possible point in the engagement process.

*Outreach and role of peers*

All interviewees stressed the importance of outreach as a way of engaging young people in services. However there was less consensus on this point in the Delphi exercise (see consensus statements A3). There are currently no guidelines on outreach for young PWID in existing NSP policies. Clear guidelines are needed on how outreach among young people can be used to engage young people and encourage them to use services.

Findings from the interviews suggested that peers (i.e. other, sometimes older, injectors) will often be the only people present when young people begin to inject. Although the possible risk that peers pose to vulnerable young people should not be neglected, if carefully managed, opportunities may exist for positive roles for peers that might substantially improve the protection and well-being of young PWID who are most vulnerable and beyond the immediate reach of services.

*Interagency working*

The policy review showed a general clarity about core staff competencies required for practitioners in young persons' AOD services, adult NSP and other treatment services in relation to working with young people, determining competence to consent and reducing injecting-related harms. The principle of multi-agency working is endorsed in broad terms but, in practice, many details that fundamentally affect the operation of services in the English context are lacking. Greater collaboration between services would provide opportunities for greater training.

The interviews highlighted how effective interagency working is critical within systems that support young PWID. A wide network of services will have contact with young PWID including alcohol or drug services for young people, specialist adult NSP or pharmacy NSP, as well as, Youth Offending Teams, Child and Adolescent Mental Health Services. All services need to better connect young people with the full range of services they need.

A key training need for professionals highlighted by the policy review and interviews is how to effectively communicate with young people in a non-judgemental way.

*Role of pharmacies*
Another area of contention that emerged in the Delphi exercise and interviews was the role of pharmacies in providing NSP to young people (see consensus statements G1-3). The policy review highlighted divergent policies on how NSP could be provided, with some guidelines specifying that pharmacies should only be used by those aged 16 or older. All guidelines clearly emphasized the need for pharmacies to collaborate closely with specialist young peoples' services.

The interviews highlighted how pharmacies will often be the first point of contact for young PWID and, in some localities, they provide the only available NSP. Pharmacists working with young people need to be trained in basic skills required for working with young people (including in communication skills, knowledge of safeguarding) as well as having clear links with young peoples' services. Schemes such as the C-Card scheme used for distribution of condoms to young people who have been previously assessed and judged competent to consent could be adapted to providing NSP and should be considered.

*Parents and carers*
The information needs for parents and carers with a young person receiving YP-NSP appear to be neglected.

*'Very young injectors'*
The near complete absence of consideration of 'very young injectors' (aged up to 14) may be a limitation to the applicability of the findings within this report.

# BACKGROUND

Since 1998, the young person's specialist substance misuse services respond to problems with both legal and illegal substance use in England. Their emphasis is on young people aged 18 or less although transitional care beyond that age is common. Monitoring data reveal that in practice, problems with heroin use or injecting are rare; in 2009 to 2010 only 2% of services users (n=23,355) reported using heroin or other opiates. (Manchester University National Drug Evidence Centre 2010)

Current policies on provision of harm reduction services among PWID aged 18 or less is unclear. Department of Health guidance enables access to a range of harm reduction services similar to adults, while recognising that the context and nature of their provision should differ and with an emphasis on specialist assessment and frequent review to prevent increasing risk. However, national commissioning guidance states that needle exchange services, advice and information on injecting practices, testing and treatment should take place separately from other services for adults in order to prevent young people coming to further harm. (National Treatment Agency for Substance Misuse 2007) The specific context of providing such services includes legislation on safeguarding children from harm. (HM Government 2006)

The recent 2011 Minimum Quality Standards in Drug Demand Reduction (EQUS) review tasked to review harm reduction standards across Europe identified little concrete guidance for those under 18 except to note that services have to be age appropriate, staff have to be trained to address clients needs according to their age and that there should be no age limits in harm reduction services. (Uchtenhagen and Schaub 2011) Frameworks for providing needle exchange to young people have been published, for example by DrugScope (2005) and considers multiple aspects of care including the assessment process, confidentiality and consent as well as competencies required by practitioners. There is an urgent need to gain consensus on best models of practice.

## Objectives

Accordingly, our objectives were to:

Objective 1: To conduct a consensus development exercise using nominal group technique and Delphi consultation to obtain consensus on the optimal provision of NSPs to young PWID.

Objective 2: To conduct a review of policy documents to assess existing policies on the provision of NSP to young people under 18 years.

# Consensus Development Exercise

## Aim

The aim of this component of the project was to conduct a consensus development exercise using a Nominal Group Technique (NGT) and Delphi consultation with key experts to explore, develop and evaluate consensus on the optimal provision of NSP for young people who inject drugs (PWID) aged under 18 years. [Gallagher, 1993; Murphy, 1998]

## Methods

We conducted a consensus development exercise incorporating three stages: 1) interviews with experts to identify key issues around provision of NSP to young people and options for service delivery; 2) a facilitated group discussion to gain consensus on issues and solutions; and 3) a Delphi exercise to gauge extent of agreement with a broader group of experts.

*Interviews*

We conducted semi-structured telephone interviews with experts working in the following domains: i) child development, particularly relating to psychological and social development; ii) safeguarding children; iii) young persons' alcohol and other drug use; and iv) young persons' alcohol and other drug services. During the course of the interviews further experts were identified by interviewees including young people who had used NSPs and more experienced practitioners treatment providers. A list of individuals who were interviewed is included in Appendix 1.

Interviews elicited opinions on the delivery of NSP to young people and focused on the following key themes: changing implications of age and development; legal considerations; ethical considerations; and how service delivery should differ to those provided for older populations. A final section sought to identify further literature for inclusion in the linked systematic reviews. A copy of the interview guide is attached in Appendix 2.

The interviews were summarized thematically with reference to two categories of information: *issues* and a first draft of *consensus statements.* Issues described contextual features of young person NSP (YP-NSP) practice that are potentially germane to guidance and consensus statements addressed policy features that were the basis of a potential response to the issues. The summaries incorporated a combination of direct quotations or paraphrasing of the interviews with minimal initial interpretation. Interviewees were provided with a summary of their own interview and provided feedback prior to the consensus group meeting. A copy of the summary statements are attached in Appendix 4.

*Consensus group meeting and Delphi exercise*

Interview summaries were used to guide a facilitated group discussion with the same experts. During the meeting recommendations for service delivery were refined into consensus statements, which were subsequently distributed to a wider group of experts in a Delphi exercise to assess the level of approval using a Likert scale of 1 to 9.

***Analysis***

We estimated the mean, median and range of Likert scores assigned to each consensus statement collated through the Delphi exercise. Following the consensus group meeting and Delphi exercise we returned to the interview data to examine interviewees responses to points

where the least agreement had been met to provide a more detailed understanding of the different issues surrounding that aspect of policy.

*Ethics*

Informed consent was obtained from all participants of the interviews and consensus group meeting. The study received ethical approval from LSHTM's 'Observational / Interventions Research Ethics Committee' on Jan 25th, 2013 (Ref. 6346). A copy of the ethical approval, information sheet and consent form is attached in Appendix 3.

## Findings from the interviews

Box 1 below presents extracts from an interview with a young 18-year old man describing his experience of injecting drug use and use of drug treatment and needle/syringe programmes. This case study illustrates the complex circumstances in which injecting drug use may arise and the challenge for services that this presents. While obtaining sterile equipment was not generally a problem, on two early occasions he was refused access to services on account of his young age which led to him injecting with used equipment. Strategies to minimize risks associated with injecting were learnt informally from observing other people.

**Box 1: Case study**

*Well I was smoking crack from the age of 13, up until 14, and by the time I was 14 it got really really bad, I mean I'd been sent to prison by then, I was going out shoplifting all the time, I was committing a lot of crime, I was doing quite a lot of bad things, it was affecting my mental health so by the time I got to 15 and I was smoking it every day I was pacing around the garden and I was cutting myself and stuff like that and my dad said, "Look, try some of this," and he put it on the foil for me and ran it for me and I smoked it and it chilled me straight out and then from that point I always used to smoke heroin... When I got to abou14, 15, that was when I first started like properly injecting, do you know what I mean, by then I was properly injected [injecting] at 15, I didn't smoke heroin anymore, I would just inject it, I wouldn't smoke it at all anymore*

*I remember we always used clean works [needle/syringes] and that, it was never too much of a problem to get them and my friend normally had them or my dad normally had them so I only ever normally had to ask and they'd give me whatever I needed... Yeah, when I was about 16, 17, I had my own flat when I was 16 and yeah when I had that I lived in [town] I moved out of the way through Social Services and they got me a flat all the way in [town] and I couldn't register with any drug agencies up there and the adult agencies and I found it quite hard to get needles up there...And then I came to [town] and [service name] wouldn't do it either, [service], 'cos I was under 18 and they said it's an 18 only service and at that time I wasn't speaking to my dad and, you know, it was just moved to a new area and I didn't really know anybody that was doing that.*

*...by now I basically know, I think the way I inject there's not really anything wrong with the way I inject apart from sometimes if I haven't got any pins [needles] for any reason or something and then I use dirty pins sometimes then I will boil them up, but one that's been used before, I'll boil it up with bleach and stuff like that but it's still not great using a blunt pin and stuff, do you know what I mean?*

*[Where did you learn about different skills that have been valuable?]*

*Well mainly it's just watching my dad, like before I even started injecting I knew how to do it all from watching my dad, I'd watch him do it so I'd pretty much know how to do it, I knew how to do it all before, I just didn't know how to inject myself properly. So and I didn't know how to do it, but yeah that was something I picked up from him. And then just little techniques I've picked up along the way through friends and stuff like...getting it into the vein was the main thing, that's the main*

*thing I've always had a problem with, injecting myself because when I used to smoke crack, I used to smoke it, I didn't like used to smoke it, I got to a point I got very paranoid so I stopped smoking it with people so I'd be on my own and smoke it and then afterwards I'd want to do the heroin but I'd be on my own so I'd spend a lot of time like making a mess of my arms that way. Do you know what I mean?*

*…. it didn't seem like my Drug Worker that I had at the time ever used to ask me about my injecting, he used to mainly focus on trying to avoid people and triggers and do you know what I mean, stuff like that, just trying to stay away from it, they didn't focus on the problem that I had, they were more focused on just trying to keep me away from it I think…they make you feel bad for doing it, "Oh you really should stop, it's really bad, you need to stop using it, it's not doing you any favours," you know, and it makes you feel really bad when you go there, that's not a good thing.*

*I went through, I was with like [project], Youth Offending Team, Social Services, mental health [and also residential rehab at the age of 15], I was with quite a lot, I've always had quite a lot of workers, and then I've had like ASBO Coordinators and Health Nurses and then I've had to see different doctors and yeah quite a lot of people, I've had probably, I've dealt with a lot of professionals in the last few years, dealt with a lot of different people and in prisons and…*

*…I felt like they were lecturing me a lot about using and they were, yeah, they didn't really talk about the things that they needed to talk about, how to inject properly and stuff like that.*

*At the minute it's all alright at the minute with my Drugs Worker, I tell her everything, it's alright, she speaks to me on a level and yeah tries to tell me, yeah, says things like, "Really good for smoking instead of injecting," she doesn't say, "Oh you shouldn't be injecting, you should be smoking it," so she's a really good Drugs Worker, I've no problems at the minute.*

### Changing implications of age and development

A key finding emerging from the interview data was that chronological maturity does not always equate with developmental maturity and that the age of 18 should not automatically be equated to capacity to consent.

> *it's that whole idea that just because somebody's 16 doesn't mean they're competent to make informed decisions in relation to their own welfare, so particularly if you're working with children who, you know, come from traumatic backgrounds, where there's been a level… you know, of bereavement or you know, big life events. Erm they may be young people who present as… I suppose for want of a better word, like really 'streetwise' but actually, developmentally or emotionally, they're potentially still about seven. And I…and I think this is a real difficulty generally in terms of assessing a young person's competency, i.e., in terms of how we do that in an informed way, erm which in a one-off intervention is actually quite difficult, it's quite… I think that's quite… quite a challenge to do.*

> *… it's far more complex to assess where a young person is developmentally as opposed to where they are chronologically. So that you need these kinds of legal guidelines or best practice in terms of don't give it to under-16 year olds without any parental consent or certainly inform your Social Services. 16 to 17, it's a bit greyer*

Service Manager

The development of young people encountered in NSPs was characterised as delayed in comparison to their older peers. There is a tendency for younger people to have shorter attention spans, which has implications for how much information can be obtained or conveyed during an encounter. This also has implications on the process of assessment: how to manage the detailed questions on social circumstances, injecting and other risk behaviours to ascertain competence to consent. The need for assessment was universally acknowledged, not only to gauge competency to consent and the needs of the young person but also to protect the person providing the service.

> *...it's that kind of erm duty that the worker would have to make those enquiries for somebody that they suspect was under-18. But then we can't then expect them to pull out a great big questionnaire which somebody then fills out with lots of information in, but there would be kind of a reasonable set of questions or a reasonable time spent on probing a bit more. That once that had been covered, if you then kind of get to the point where there's some horrible incident, you've… you're kind of covered because then that's really important for people, isn't it?*
>
> Service Manager

### Legal and ethical considerations

Legislation such as the Children's Act and safeguarding policies were described as both a barrier and facilitator to provision of NSPs to young people. The categorisation of a young person injecting as a 'child in need' can facilitate the provision of resources that enable more intensive support as the following quote illustrates:

> *Obviously, you know, working within the kind of framework around the Children's Act and erm I mean something that's been… I think one of the areas that we're working in XXX is… well, I know, they've kind of written some guides which would say, actually, if… if a young person is injecting, they should clearly be seen as 'child in need'. Erm which, you know, de facto, then leads somebody towards a certain set of services from Social Care…..*
>
> Service Manager

Concerns were expressed that on the one hand low-threshold services may promote risk behaviours that would otherwise not have occurred. However on the other hand, if initial contact triggers the implementation of safeguarding policies too easily, it will be harder to engage the young person and overly defensive policies can undermine professional practice. A key ethical and legal consideration expressed universally is that the lack of clear legislation and guidelines is potentially putting services providing NSP to people under 18, who are unaware of the age of their clients, at risk particularly if it results in an overdose or drug related death.

> *In terms of its adult syringe exchange where, you know, we have had a couple of examples where we know under-18s have been dispensed with pins [needles] because they have just turned up and they look about 20-odd and nobody's thought to ask them. And it uh kind of transpired over time that actually this young person is 17 so actually, we shouldn't have done that but in terms of an adult… you know, an adult exchange worker doing the right thing, because essentially, all… what do we ask adult exchange workers to do? We don't ask people to bring in identification to access services and there's the whole… you know, and if we started doing that, isn't that a huge barrier to bring people into services? So it's… I've… I've no idea but I think there's something about, like you said, kind of how… how do you kind of establish that an agency is working within*

*good faith and what are those… so what… what is it that an agency needs to be doing that if that incident happens where a 16 year old is dispensed needles, the adult worker is going 'well, do you know what, I'm still working within my agency protocols and guidelines and that's kind of good enough for me not to be hauled over the coals for dispensing to a child who, heaven forbid, then ODs' [overdoses] and, you know, there's a horrendous incident and you then get into the realms of local authorities running serious case reviews and where does it all lie?. But actually, none of this is… you know, there's no precedence in law for any of this and so that's the challenge, the precedent usually tends to come when something fucks up, doesn't it?*

Service Manager

## Key aspects of service delivery for young PWID

*Assessing need*

One identified problem confronting service delivery for young PWID in England is the lack of basic data on levels of injecting among young people and risk behviours in order to assess levels and need. The ethical and practical complexities of providing services generates a perverse incentive for services to conceal work with young injectors, which may lead to systematic under-estimation of the size of the population using services within England. Nevertheless, the following quote illustrates one potential way that routinely collected data might inform our understanding of need:

*I think people are hindered. I think practice as a result is compromised…people turned a blind eye. "I knew they were under age but it kind of gets a bit complicated to ask". Over recent years I think people just don't engage. I think there's a culture, my sense is the culture is don't engage people who are under 18, there have been one or two areas where it happens but you just don't talk about it. Now my concern about it is that we don't really know how many young, under 18s are injecting. I did do a trawl several years ago in our own service to look at the number of people who presented for assessment within the previous year period who reported injecting under 18 [I can't remember the exact number] but these are people who come to the service. We know 40% of the people we are working with at any one time started using heroin before they were 18...it's reasonable to presume in an area like I work in where injecting is embedded and smoking actually is a very rare occurrence a significant proportion of those were injecting before they were 18. I'm not talking massive numbers…I'm fairly confident that if you went into most treatment services and asked them to investigate just that, a notable number of people would say "yeah I was injecting before I was 18" they're not contacting services and young people services I've worked with say "Well no cos young injectors learn for themselves, young injectors are not going to venture into a drug treatment service."*

Service Manager/Policy specialist

A recently introduced national harm reduction database for Wales emerged as a beacon of good practice and illustrates ways that such a system can potentially provide real-time monitoring of trends in injecting by young people that supports locally targeted responses. Besides the capacity to analyze need with reference to an assortment of demographic and drug variables, a parallel national Naloxone database also enables monitoring of 'take home naloxone' uptake by young PWID. Although some corresponding data is available through the NTA the data are not immediately available and therefore are less able to inform a rapid response. Currently the database has information on 159 PWID under 18, with the youngest aged 12.

*We have a national database for needle exchange in our statutory and voluntary services where we have 46 of those [services] and I have 159 under 18 injectors on this system who are actively, this is just for last year's data…I'll have a look at it now [comments are reading off from the database while being interviewed] the youngest at 12, I have three at 13, six at 14, three at 15, five at 16 and 13 at 17 and then, sorry, 63 who are now 18 so we have currently, injectors who are registered and actively using needle exchange from 12to 17 years old…..We'll be rolling this out to pharmacies although obviously I'm not expecting to get huge numbers of young injectors at pharmacies but at least we'll…be able to access information with regards to these young people…it's extremely important because it enables me to identify if there's anywhere, if a new site opens up,. We had a new centre open up between a town centre and a school and we had an increase in young steroid injectors under the age of 18 so we were immediately able to identify that, go down and talk about what they might need…*

*NH – [so what is in the dataset?]*

*We have age, gender, unique identifier but we do specify it does not have to be your accurate initials and date of birth however "Please use the same every time and use your accurate year of birth"…first part of post code. Data is not 100% complete but it's pretty good, housing status, employment where it's appropriate, ethnicity, source of referral, and then we have substance use both injecting and non-injecting, we have route of injecting, frequency of use whether it's their primary secondary or other, then some information about health you know and onward referral…we have a separate database for Naloxone provision which is right across Wales it's a national service and I'm central administrator for that too and because it's prescription only I have more full details of location , age, gender, training provision.*

Academic/policy specialist

*Juggling duty of care with engagement*

The desire to fulfill a duty of care and do no harm results in obstacles that potentially deter the engagement young PWID most at risk. The two young PWID who were interviewed found it virtually impossible to obtain NSP services when they were under the age of 16, despite the fact that they had each been injecting for two years by this age. The key obstacles include the detailed, highly intrusive assessment requirements as well as requirements to provide NSP through specialist agencies other than those likely to be used by young people (i.e pharmacy and adult NSP services).

*I was quite shocked about to be honest, the fact that at 16 like I was a full-time injector, do you know what I mean, I had my own place, I was injecting, I was living quite a bad lifestyle and I was doing everything, committing crime, going to prison but I couldn't get needles, do you know what I mean, it was quite frustrating to be honest and I think that it's not good because people start using dirty pins [needles] and stuff like that.*

Young PWID (male)

Interviewees discussed the urgent nature of many NSP transactions. Simply stated, when someone has obtained heroin or other drugs that they intend to inject – quite possibly to avoid withdrawal - there is sometimes a profound constraint on how much bureaucracy a person is willing to accept before deciding that it is preferable to obtain injecting equipment from somewhere other than an NSP. Some common scenarios also challenge best practice, in particular requests for NSP at weekends or close to 5pm when many services are closing and specialist practitioners are unavailable. These ethical dilemmas force difficult decisions and tough choices for practitioners who wish to protect young PWID from harm while at the same time complying with policies.

*Young person-centred and non-judgemental*

The provision of 'young person-centred services' is discussed as a fundamental principle within English guidance for young persons' AOD services. And being 'non-judgmental' is widely regarded as a basic precept within treatment and care, yet this was the exception rather than the rule within the experience of a Consensus Group participant described above in the case study (Box 1). He describes how the concern to deter injecting across services resulted in a focus on goals that did not accurately reflect his own, an increased sense of stigmatisation and missed opportunities to communicate harm reduction advice and information. In contrast, the participant's current drugs worker is discussed as a rare exception to the more paternalistic approach of numerous previous services. The extract illustrates the way that quite subtle differences in language can make the difference between communications that are perceived as either supportive or judgmental.

In cases where workers had previously been injectors themselves was also described as an aid to authentic communication, because of the way it provides a common experiential understanding of the realties and of the realities life for a young injector. The interviews with practitioners emphasised skills that might be thought of as 'basic', but may also be absent or inadequate in services provided by poorly skilled or inexperienced personnel, notably:

- providing a warm, personal welcome;
- maintaining good eye contact;
- skilled use of body language;
- conducting assessments using a conversational style rather checklists;
- and, acknowledging injecting within the young person's lifestyle choices, irrespective of the professional concern and ethical concerns that this inevitably raises.

The high level of skills required to undertake all this proficiently, coupled with the relatively rare opportunities to develop them with young PWID were noted by several practitioners and led to suggestions that alongside the core competencies all practitioners required some level of role specialization was likely to be necessary to ensure high quality service provision, in which an identified lead person can support colleagues regarding young NSP.

*Outreach*

All interviewees described the importance of 'outreach' which identifies and connects with young PWID as a vital element of effective practice. Outreach was also described as a potential route for maintaining young people in services and as way or reminding them of appointments.

> *….keep a hold of them so that they remain in treatment and erm, and that sometimes means without hassling young people, reminding them of appointments and being very proactive, and eh, all that sort of stuff, so young people's services need to be erm, accessible, and I don't just mean by, I mean it's clearly difficult in XXX, we're a very rural community, there are you know, pockets where erm, you know, there aren't even buses, and it is very difficult for young people to access services, and so we need to do outreach services, we need to deliver the needles, we need to be doing home visits, erm, all those things that are going to keep people within the service.*
>
> Service Manager

> *And, and I think there would need to be outreach. I think you might make the initial contact in outreach but you, the aim is to bring them in the service to secure their full engagement with what you're trying to do with them.*
>
> Academic

*Um, you need to go to them, rather than expect them to, to come to you because, err, kids are quite reluctant to, to come forward in the first place…*

Academic

The following quote from a young PWID illustrates how outreach services are not identifying young people in time to provide necessary advice about safe injecting practices.

*…..Yeah, there's three pharmacies in town where you can get needles from and there is a service called an 'outreach' service where they come out and they drop needles to you and see how your injecting sites are but I didn't know about them until I was nearly turning 17…….And let them know what the risks are, ask to see their injecting sites because the time that I got with the outreach service, my arms were battered, basically, my veins and my arms were ridiculous, I had basically none left where my ex had completely battered my arm, so when it comes to the point where I was having to inject myself, I was sort of stuck, I didn't know where to start, do you know what I mean, I didn't have no one there to tell me "Oh yeah, this is how you do it."*

Young PWID (male)

*Opportunities for peer based interventions*

Questions about the role of peers (other PWID) arose in many ways. The possibility that a young person could be vulnerable and adversely affected by *some* peers was generally accepted and is treated as an uncontroversial fact here, but opinion was more nuanced about possible benefits that might be missed if the potentially positive role of peers is neglected. The introduction to injecting typically arises within friendship networks, which may sometimes also include a lover, siblings or even a parent i.e. relationships predicated on some level of compassion or care. Although interviewees were cautious about the risks of involving peers, there was also some recognition that they constitute a potential asset, and one that could operate to protect young PWID at the crucial early phase of injecting where the young person has no contact whatsoever with professionals who can provide harm reduction advice and information and is most at risk. The following example illustrates a view that there might be scope to work through older injectors, who were construed as rational, intelligent and capable of using good judgment in such circumstances if such work operated under controlled, monitored circumstances:

*[Regarding peer involvement in which older PWID could potentially coach young PWID with whom they are associating in self-protection skills]*

*NH: Thinking of working with the older injector?*

*That's the one. That's the one. That's a big one yeah.*

*NH: So there are opportunities there?*

*Also in controlled environments, monitored safe environments. It's not for everybody Neil but you know? ['Recovery Champions' whose experiences can be distant from those of young injectors aren't always appropriate] If it's gonna work it's gonna work in a controlled environment in terms of appropriateness. Our adult injecting population are not stupid. Really you know they're only human and shouldn't be judged. They're more than capable of being able to educate without that becoming skewed in terms of what they're doing themselves or what their beliefs are. I know they're few and far between, people that believe this, but the only difference, the only definition is that they choose to do something with their life which is socially unacceptable and damaging, but a lot of that is down to the fact of how they have to go about getting the drugs.*

Service Manager

*NSP through pharmacies*

One of the main challenges for NSP provision within pharmacy settings is the problem of assessing Gillick competence and uncertainty about the opportunities and skills for doing so. Two interviewees with extensive practitioner experience mentioned that a potentially useful reference point is the C-Card scheme for providing condoms to young people, which has many participating pharmacies nationally. The system has two levels of access to free condoms, one for those aged 13-15 year olds and another for 16 or over. For 13-15 year olds, a C-Card is provided following assessment of Gillick competence[1] according to the same principles that underpin existing NSP guidance. Although the parallels between NSP and condom provision are not complete, it was nevertheless thought that pharmacists who assess competence for locally delivered C-Card schemes could have useful potential as professionals who are already conversant with the applicable principles and who work in settings where young PWID sometimes present for the first time looking for NSP.

Another solution to the problem of assessment presented was the use of a private room in pharmacies in which to assess the young person's competency to consent. This would require the pharmacist to be trained in young persons' needs, the Fraser guidelines and appropriate legislation. Another concern was that pharmacies did not have the necessary resources or staff to address the broader social and health needs of the young person and any pharmacy NSP be should be tied in closely to young people's services who can provide this support.

> *I think, well I think it's quite difficult. I think, you know, in a… in an ideal scenario you might say on an exceptional basis, providing that the pharmacist understands about children's safeguarding, could speak to them in a private room, would make sure that they, um, had the competence to consent, ensure that they're directed to the right service, etcetera, my feelings (sighs) generally are that that really wouldn't happen though in practice, um, just... You know, obviously there are some very good pharmacists out there but there's, you know, my feeling is that, um, generally while pharmacists provide a range of services for drug users, they tend to just want them in and out very quickly...*
>
> Commissioning Manager

> *Erm yeah, I suppose could there be an expectation for pharmacists to do that, [give out needles/syringes] they'd then have to bring the young person's service in on the back of that, it seems a bit disjoined, whereas if it, you know, a young person goes straight through a needle… a young person's specialist service, they're already aware of delivering needle exchange in the context of a broader treatment environment. Because, you know, this… this… this is what guidance is telling us, it's not a… it's not a one-off, the focus has to be very clearly about bringing the young person into treatment and maybe*

[1] Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The Gillick case involved a health departmental circular advising doctors on the contraception of minors (for this purpose, under 16s) The House of Lords focussed on the issue of consent rather than a notion of 'parental rights' or parental powers. In fact, the court held that 'parental rights' did not exist, other than to safeguard the best interests of a minor. The majority held that in some circumstances a minor could consent to treatment, and that in these circumstances a parent had no power to veto treatment. Lord Scarman and Lord Fraser proposed slightly different tests. Lord Scarman's test is generally considered to be the test of 'Gillick competency', "As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed." Confusion sometimes arises between Gillick competency, which identifies under-16s with the capacity to consent to their own treatment, and the Fraser guidelines see Box 4, which are concerned only with contraception and focus on the desirability of parental involvement and the risks of unprotected sex in that area.

*that's best managed by a young person's service rather than breaking it… breaking interventions up.*

Service Manager

*well, we don't work particularly closely with pharmacies around this in terms of being very… maybe they are very clear, I don't know, but are pharmacies clear that actually they should not be dispensing pins [needles] to under-18s, I don't know who is telling them that. Erm if they were to do that, obviously pharmacies with their little consulting rooms that they have, erm maybe that's something pharmacists could be supported to do, but obviously, that would be the kind of training around young people's needs, the legal framework, Fraser guidelines erm so you're either saying actually, pharmacies are somewhere or… well, pharmacies could do needle exchange to under-18s if they kind of met the competencies. Or they need to be better aware of where to send the young person to because they have to say "No, I'm not… I'm not doing it" but I… you know, we're not great at working with pharmacies around that at all.*

Service Manager

*Scope for improving inter-agency working*

As the case study of the young PWID illustrates, someone who begins injecting aged 14 can encounter many professionals: youth offending teams (YOT), social services, mental health, residential treatment, anti-social behavioural orders (ASBO)coordinators, health nurses and in various medical settings (e.g. within an Accident and Emergency service that provided treatment for an abscess). Yet for a young PWID who is intent on injecting, these can all miss early, critical opportunities to deliver basic, harm reduction work that can help protect a young PWID's safety and well-being, if they focus exclusively on stopping injecting.

Although it is proper for such services to work together and aspire to discourage injecting entirely, if they collectively fail to take harm reduction opportunities that are highly relevant to the young PWID's circumstances, this seems like a failure of inter-agency working. All agencies should provide a pathway to YP-NSP (with its associated support) and a clearer, improved understanding of the role of NSP as part of a package of services around the young person. By missing such opportunities, well-intended efforts to enable young people to stop injecting may fail them when such attempts are unsuccessful. For example in the case of residential treatment failing or following a custodial sentence, the first thing the young person may do is resume injecting:

*NH …and then you went back into prison, were there any occasions when you did inject through that sort of episode, I'm thinking about sort of occasions when somebody, yeah, so you…*

*Yeah, the day that I ran away sort of thing from the rehab [required as part of a court order], I left that guy, before I left the rehab I'd already decided when I was in this house that I was going to run away from him, I was sick of it and I just wanted to get away from them, I'd already rang my drug dealer because I left the rehab and asked me if he had anything, 'cos I had like a minute, I think I had about £400 in the bank so yeah I came straight back, caught the train from where I was, and scored before I came back and injected and smoked some crack and came home.*

Young PWID (male)

*Parents and carers*

Beyond discussion of their involvement when competence to consent is determined, parents and carers' needs appear to have received little consideration. Their perspective is also largely absent within the policy review. Interventions rarely appear to reflect parents/carers' needs in any way and few, if any, materials exist that address the concerns they may have when a young person receives YP-NSP. Often, they had difficulty understanding why an intervention that may be perceived as 'enabling' might be offered. One service that had a specialist parent support worker appeared to offer an example of good practice to meet these needs.

> *for just a few months we had a, erm, a pilot scheme of a parent support worker and we had this woman and she didn't have anything to do with the actual young people in treatment who were receiving needle exchange, but she just went round and spoke to the parents and supported them, because they were finding things completely difficult, they didn't understand some of them why their children were getting needles..*
>
> Former Service Manager.

*Very young injectors*

The phenomenon of 'very young injectors' (aged up to 14) has rarely been documented or considered in the UK. Nevertheless, in 2005 Donmall and Jones identified over 2000 people who began injecting between the ages of 10-14 within a treatment sample of 140,000 English drug users (Donmall M and A 2005). More recently, secondary analysis of a Welsh injecting needs assessment undertaken in 2006 reported 28/157 people who began injecting between the ages of 9 – 14 and a new Welsh harm reduction database identifies six people accessing NSP aged 13-14 during 2012 (personal correspondence, Josie Smith). It should also be noted that the 18 year old participant in our Consensus Group began injecting at 14. Injecting by very young people has also been reported consistently in Central and Eastern Europe – most strikingly among street children in Russia and Ukraine (EHRN 2009; UNICEF 2010). Remarks in the interviews and consensus development process were, however, largely geared towards those older young people (aged 15-17) who are more likely to be encountered within services. Beyond confirmation that injecting by such very young people arises, the specific practice challenges of protecting and responding to this population has received scant consideration in the literature. This may also be a limitation to the applicability of the findings within this report.

## Findings from the consensus group meeting

A total of 12 participants attended the consensus group meeting. With the exception of one person, all had taken part in the interviews and included representatives from: research and policy (4); NSP service delivery (3); one young PWID; and a parent/carer. It was not feasible to identify an eligible parent/carer for inclusion within the interviews. However, the young person who attended the consensus group meeting requested that his mother accompany him for support. This provided a welcome opportunity to directly include the perspective of a parent in the discussion. The process involved discussion of each person's justifications for the statements, and the discussion worked through each statement thematically.

Following discussion it was agreed that eight areas were key to the provision of NSP to young PWID that are outlined below. Statements were summarised under these eight areas and are described in Box 2 below.

**Box 2 Summary statements**

1. Engagement of a young person

This included policies related to how to encourage young people in need to use NSPs, and once initial contact has been made, how to maintain that engagement.

2. Assessment
This section included statements on what kind of assessment should be undertaken with a young person, when and how it should be done.

3.Balancing safeguarding and engagement
This section suggested an approach to balancing safeguarding and engaging the young person in the service.

4. Competencies of staff
This section outlines key competencies and skills needed by staff working with young people in NSPs.

5. Organisation of services
This section refers to the physical organisation of services as well as the role of young people in making decisions on care pathways.

6. Parental/carer involvement
This section outlines how the involvement of parents and/or carers should be managed to ensure their involvement in planning care pathways if appropriate.

7. Pharmacies
This section outlines the role of pharmacies in providing needle/syringes to young people and advice on when this might be appropriate.

8. Governance
This final statement emphasises the need for good governance by obtaining approval of any policy by Drug Action Teams and Local Safeguarding Boards.

## Findings from the Delphi exercise

The consensus statements were circulated to a total of 30 experts working in the field of drug treatment across the United Kingdom as well as selected European countries in order to assess levels of agreement on the consensus statements. A copy of the participants contacted is attached in Appendix 5 below. A total of 20 responses were received and these responses are summarised in Table 1 below.

There was a high level of consensus in the majority of statements with a mean score of 8 or 9 on the Likert scale. Statements that led to the least agreement were concentrated in the section on engagement of a young person. The statement asserting the need for mobile outreach to engage young people into NSP (A3) as well as the use of peer-based approaches to facilitate young people into services (A4) had a mean score of 7 (range 3-9) and the statement (A6) on the need to provide opportunities for young PWID to learn from peers or ex users had a mean score of 6 (range=1-9).

Other statements, while receiving an average high score, prompted a wide range of responses. For example under the theme of pharmacies the statement (G1) on the need for pharmacy staff to assess capacity to consent in line with the Fraser Guidelines (Box 4) received the full range of scores (1-9). Similarly the role of pharmacies in referring young people into specialist services, but providing needle/syringes in the first instance to reduce harm (G3) received a wide range of scores (2-9).

*Table 1: Consensus statements and summary of the Delphi exercise*

| **A** | **Engagement of young person** | **Mean** | **Median** | **Range** |
|---|---|---|---|---|
| A1 | All services working with young people who inject drugs must provide good harm reduction advice at the earliest opportunity, or connect young injectors with people who can. | **9** | **9** | **8-9** |
| A2 | Adult NSP services require clear pathways into Young Peoples' Services that enable assessment and access to the range of support that may be required. These need to engage the young person while minimising general exposure to older injectors. | **9** | **9** | **8-9** |
| A3 | Outreach (e.g. mobile services) is an essential component of effective engagement of young injectors within NSP. | **7** | **8** | **3-9** |
| A4 | There is a need for peer-based approaches that facilitate under 18 injectors' contact with services. | **7** | **7** | **4-9** |
| A5 | The local availability of Young People's Needle Syringe Programmes (YP-NSP) as a component of Young People's drug and alcohol services should be advertised through targeted settings. | **8** | **9** | **1-9** |
| A6 | Better opportunities should be created to enable young injectors to learn from *trained* people who have been drug users/injectors themselves, including from people who have stopped injecting. | **6** | **7** | **6-9** |
| A7 | Under 18s are much more likely to be in contact with the range of other young persons' services beyond drug services therefore clear pathways are needed that can identify young injectors and channel them towards specialist support that can help address the risks associated with their injecting. | **9** | **9** | **6-9** |
| A8 | The role of YP-NSP as part of YP drug and alcohol services and safeguarding needs to be clearly communicated to personnel in agencies working with young people where injecting may first be identified. | **9** | **9** | **6-9** |

| B | Assessment | Mean | Median | Range |
|---|---|---|---|---|
| B1 | Injecting among young people should be viewed as an indicator of vulnerability and this should be incorporated into other agencies' tools for assessing vulnerability. | **8** | **9** | **6-9** |
| B2 | Adult NSP services require a clear policy on how to assess and respond to someone who may be under 18, which balances the anonymity of the service with their duty of care to that individual. | **9** | **9** | **6-9** |
| B3 | Once a person regularly attends the service, on-going assessment of the young person needs to occur with frequent face to face contact where possible. | **9** | **9** | **5-9** |
| B4 | Assessment of injecting risk among young people needs to be conducted by someone competent[2] around injecting practices. The different concerns that may arise regarding the range of drugs (including traditional injected drugs, club drugs or performance and image enhancing drugs) that may be injected must be considered. | **9** | **9** | **8-9** |
| B5 | When considering capacity to consent a detailed assessment of the young person should be undertaken that considers not only their age and drug use but also individual circumstances, their capacity to mediate risk, their social circles, family situation, the extent to which they may be coerced by others and any indicators of vulnerability such as homelessness or sex work. | **9** | **9** | **7-9** |
| B6 | Assessment should address the four parameters identified in DrugScope's (2005) guidance: 1) age and maturity of the child; 2) the degree of seriousness of drug misuse; 3) whether harm or risk is continuing or increasing; and 4) the general context in which drug use is set. | **8** | **9** | **7-9** |
| B7 | Different considerations need to be taken into account for younger age groups. Guidance may differ for those aged between 11-13 compared to 14-15, 16-17 and 18+ years. These age bands should be a guiding point rather than definitive and the individual's level of development including cognitive and emotional development as well as their personal circumstances should be taken into account when considering what approach to take with them. | **9** | **9** | **7-9** |

[2] These competencies are specified in the policy review section on 'Training' and refer to the applicable Drug and Alcohol National Occupational Standards for guidance on training on safer injecting (DANOS)

| C | **Balancing safeguarding and engagement** | **Mean** | **Median** | **Range** |
|---|---|---|---|---|
| C1 | If someone under 18 comes into a needle exchange they should not be sent away just because they are under age. | **9** | **9** | **7-9** |
| C2 | A balance needs to be made between the duty to safeguard and the need to maintain engagement and provide services to young injectors | **9** | **9** | **8-9** |
| **D** | **Competencies of Staff** | **Mean** | **Median** | **Range** |
| D1 | All staff of Young People's services should have a minimum level of competency around injecting to enable them to identify those at risk and give basic safer injecting advice. | **9** | **9** | **6-9** |
| D2 | All adult NSP and other drug treatment staff should be able to identify when issues around safeguarding, confidentiality and consent as it applies to under 18s arise. | **9** | **9** | **6-9** |
| D3 | Assessment of risk, including injecting risk, among young people needs to be conducted by competent individuals and staff need to ensure that they provide services with the same non-judgemental values as those provided to adults. | **9** | **9** | **7-9** |

| E | **Organisation of services** | **Mean** | **Median** | **Range** |
|---|---|---|---|---|
| E1 | Young people should participate in all decisions about their care pathways. | **8** | **9** | **6-9** |
| E2 | YP drug services should include staff with an identified lead role on injecting and harm reduction for under 18s. | **8** | **8.5** | **1-9** |
| E3 | NSP needs to be provided as part of a range of services, including treatment services, mental health services, education, social services, youth offending services etc. | **9** | **9** | **7-9** |
| E4 | When youth custody sentences come to an end, young injectors who are going to go and use/inject again anyway should have access to harm reduction services including overdose prevention services that will help keep them safe. | **9** | **9** | **9-9** |
| E5 | As within adult services, NSP for under 18s receiving opiate substitution therapy (OST) needs to be able to address the complex reality that people's injecting does not necessarily stop immediately when they receive OST. Pharmacies dispensing methadone/suboxone may sometimes need to provide NSP within the context of a service that is still generally discouraging injecting. Not enabling and addressing this simply invites dishonesty about whether the person is still sometimes injecting and can hinder an ongoing and accurate understanding of the risks to which the young person is exposed. | **9** | **9** | **7-9** |
| E6 | Ideally, NSP for under 18s should be provided as part of YP drug services. These need to provide the same high quality harm reduction expertise as adult services. Where injecting is more rarely encountered in YP services, the expertise may need to be provided through a clear pathway to services and expertise based in adult NSP services that enable co-working. | **9** | **9** | **7-9** |
| E7 | YP-NSP should provide take home naloxone services for young people and their parents/carers. | **8** | **9** | **4-9** |
| F | **Parent's involvement** | **Mean** | **Median** | **Range** |
| F1 | For under 18s parental or carer involvement should generally be sought but may not always be possible or appropriate. | **8** | **8** | **3-9** |

| | | | | |
|---|---|---|---|---|
| F2 | The way parents or anyone involved in a caring relationship with the young person are involved should reflect their role and engagement in the young person's life and the extent to which it is a healthy caring relationship. Their potential importance in helping the young person is important to identify. | **8** | **9** | **5-9** |
| F3 | Parents and carers of young people who inject drugs should be provided with specific information to support the young person to reduce the harms related to their drug use, including harm reduction, safe injecting practices and overdose as well as they themselves being provided with counselling and other support. | **9** | **9** | **7-9** |
| F4 | Services need to be able to communicate the justification for NSP to parents/carers clearly, as this is something that can be a challenge to understand. | **9** | **9** | **8-9** |
| F5 | Occasionally, parents or carers will buy drugs for the young person to try to protect them from harms related to the drug market and withdrawals (and presumably injecting equipment). Information to parents should address their legal concerns about this, drug use and injecting in the home should be provided. | **8** | **9** | **5-9** |
| G | **Pharmacies** | | | |
| G1 | Pharmacy NSP provision to young people may be appropriate where staff are able to assess competency to consent in line with the Fraser Guidelines. | **8** | **8** | **1-9** |
| G2 | Pharmacy NSP may similarly be the first point of contact with someone under18 whose young age is not immediately obvious and policies and procedures should acknowledge this. | **8** | **9** | **7-9** |
| G3 | Pharmacies NSP should refer young people into specialist services, although needles/syringes should be provided to reduce immediate harms where indicated as needed. | **8** | **9** | **2-9** |
| H | **Governance** | | | |
| H1 | The responsibilities of Drug Action Teams and safeguarding boards should be made clear and local YP-NSP policies should be approved and ratified by the safeguarding board. | **9** | **9** | **2-9** |

## Summary

Key findings from the consensus development exercise suggest that local/national assessment of need is weak and may systematically under-estimate the size of the population. **There is a need to collect data to estimate the number of young people who inject drugs and clearly assess their needs. There are good examples of monitoring systems that can provide data to inform service provision such as in Wales.**

A key tension point of tension highlighted is the conflict between duty of care and requirement to fulfill safeguarding duties versus engaging a young person and delivering the service. An over-zealous approach to excluding uncertainty before providing NSP using highly detailed assessment procedures, which often involve signposting or referral to specialised services risks creating obstacles to engagement. There is no comfortable path for policy making in this context but, on balance, **the findings point towards a need to increase the emphasis on engagement and create an improved, clearer environment in which competent practitioners can better apply their professional judgment within difficult situations.**

The principle of providing young person-centred services in a non-judgmental way is reflected in guidance for services and much of the rhetoric surrounding their delivery. However, our interviews with young people (although limited) suggest that there can be a sharp discrepancy between such aspirations and the actual experience of young PWID. **There is a need to fundamentally reappraise the way these principles of being youth centred are translated into practice**. Communication style is critical to encouraging young people to engage in the service.

The near absence of the voices of young PWID within policy development (identified in the policy review) may be an important factor that has contributed to this problem. All interviewees stressed the importance of outreach as a way of engaging young people in services. However there was less consensus on this point in the Delphi exercise. **Clear guidelines are needed on how outreach among young people can be used.**

Peers (i.e. other, sometimes older injectors) will often be the only people present when young people begin to inject. **Although the possible risk that peers pose to vulnerable young people should not be neglected, the findings from the interviews, if carefully managed, opportunities may exist for positive roles for peers that might substantially improve the protection and well-being of young PWID who are most vulnerable and beyond the immediate reach of services.**

The pharmacy context increases the problem of trying to provide a duty of care while engaging the young person in the service. Lack of privacy and time may mean there is little opportunity to conduct an assessment. However, in practice, pharmacies will often be the first point of contact for young PWID and, in some localities, they provide the only available NSP. **Pharmacists working with young people need to be trained in basic skills required for working with young people (such as communication skills, knowledge of safeguarding) as well having clear links with young peoples' services. Schemes such as the C-Card scheme used for distribution of condoms to young people should be considered.**

**Effective interagency working is critical within systems that support young PWID.** Besides separate AOD services for young people, specialist adult NSP or pharmacy NSP, a far wider network of services intermittently has contact with young PWID including Youth Offending Teams, Child and Adolescent Mental Health Services and need to connect young people with the services they need.

**The information needs for parents and carers with a young person receiving YP-NSP appear to be neglected.**

**The near complete absence of consideration of 'very young injectors' (aged up to 14) may be a limitation to the applicability of the findings within this report.**

# Policy Review

## Methods

This component of the project sought to identify *policies* and *guidelines* for the provision of NSP to young people (YP-NSP). Although publications sometimes conflate the distinction, *policies* are concrete statements about a course of action that should be followed, whereas *guidelines* consider the way that policies should be implemented and typically require a measure of judgement regarding their implementation. For brevity, where this report uses the term *policies* it should be understood to include both *policies* and *guidelines* unless the distinction is explicitly considered.

### Research Questions

The primary research questions were:

1. What are the different policies to facilitate access to services among people under 18 who use drugs?
2. How do policies designed to safeguard young people impact on access to services?

### Search strategy

This review sought to include documents from the widest possible range of sources including:

- Papers identified as part of the linked systematic qualitative and quantitative reviews
- A call for evidence undertaken through NICE
- Re-examination of documents gathered between January and June 2012 a previous review (Harm Reduction International 2013 (forthcoming))
- Consultation with members of the expert panel
- UK drug agencies including: the National Treatment Agency for England and its equivalent agencies in Northern Ireland, Scotland and Wales; organisations with a prominent role regarding drug policy or harm reduction including DrugScope; Exchange Supplies; CRI; Turning Point; Addaction; and Lifeline
- UNICEF, UNESCO, UNAIDS, WHO and Save the Children
- Targeted searching within English speaking countries with an established history of injecting: Australia, Canada, New Zealand and the US
- European documents from non-English speaking countries identified through the EMCDDA and the European Quality Standards (EQUS) review (Uchtenhagen and Schaub 2011)

For the earlier Harm Reduction International review, the primary literature search was undertaken using "Web of Knowledge". WoK is an academic meta-index that incorporates the main academic databases in the health and social science fields including:

- **Science Citation Index Expanded** with Cited References (1970– ), Author Abstracts available from 1991
- **Social Sciences Citation Index Expanded** with Cited References (1970– ), Author Abstracts available from 1992
- **Arts and Humanities Citation Index** with Cited References (1975– ), Author Abstracts available from 2000
- **Conference Proceedings Citation Index - Science edition** (1990– ) indexes the published literature of the most significant conferences, symposia, seminars, colloquia workshops and conventions in a wide range of disciplines in science and technology.

- **Conference Proceedings Citation Index - Social Science + Humanities edition** (1990– ) indexes the published literature of the most significant conferences, symposia, seminars, colloquia workshops and conventions in a wide range of disciplines in social science and humanities.
- **MEDLINE** (1950– ) MEDLINE is the U.S. NLM (National Library of Medicine) premier database of biomedicine and health sciences, covering the fields of medicine, life sciences, behavioral sciences, chemical sciences and bioengineering, as well as nursing, dentistry, veterinary medicine, the health care system, and the preclinical sciences. MEDLINE also covers life sciences vital to biomedical practitioners, researchers and educators, including aspects of biology, environmental science, marine biology, plant and animal science, biophysics and chemistry.

To limit the number of papers to those most likely to be relevant, WoK was searched for papers during the past 22 years between January 1990 to February 2012.

Twenty one relevant international and national websites were hand-searched for relevant publications and two guideline portals were searched. Guideline portals provide searchable databases of clinical and public health guidelines:

- NHS Evidence https://www.evidence.nhs.uk/

- The National Guideline Clearinghouse of the US Department of Health and Human Sciences http://www.guideline.gov/

### Inclusion and exclusion criteria

The initial inclusion criteria were deliberately broad including policies with a scope that was international, regional and national, but also covering sub-national units (local authority areas, primary care trusts, states and provinces). Furthermore, policies developed by drug treatment providers relating to a service or organisation were included, because it was known that some examples included quite detailed descriptions of relevant aspects of policy. Documents were included irrespective of whether they were solely concerned with YP-NSP or just contained sections addressing YP-NSP. Young person was defined as aged under 18 years.

Exclusion criteria included: policy documents that only discussed the necessity of YP-NSP without providing details of how this should be undertaken; lack of clarity about the age group to which the policy refers; policies that explicitly stated they were not applicable to young people under 18; and policies aimed at adult drug services that merely gave onward referral information for young people.

### Quality assessment

Included policy documents were assessed drawing on the Agree instrument for appraising guidelines. (The AGREE Collaboration 2001) The AGREE instrument has 23 standards across six domains. Because of the diverse nature of the identified 12 policies a decision was made to simplify the rating process and just use the six domains. Five additional standards were added to include four elements that had emerged as key during the in-depth interview process of the consensus development exercise. All criteria were scored according to whether the standards were met (Yes, No, Not sure).

**Box 3: AGREE Criteria**

Quality was assessed drawing on the AGREE criteria relating to the development of policies:
Scope and purpose; Stakeholder involvement; Rigour of development; Clarity and presentation; Applicability; Editorial independence; and relevance to the English policy context.

In addition quality was assessed according to content and the extent to which policies covered key topics identified as important in the consensus development exercise including:

1. Assessment of individuals in relation to competency to consent and level of risk
2. Safeguarding young people

3. Multi-agency working
4. Training of staff

### Analysis

The analysis of the policy content focused on: i) providing an accessible overview of the few policies that seem in any way able to inform current practice; ii) highlighting policies where particular issues are covered in more useful depth; iii) identifying areas of convergence or conflict between policies; and iv) identifying areas that have received little or no attention.

## Results

A highly divergent collection of publications was identified in the policy search. A total of 81 documents were identified and screened. On the basis of our exclusion criteria, a total of 69 policies were excluded and 12 selected for appraisal within the review, summarized in Table 3. These ranged in length from policies containing a single paragraph discussing aspects of YP-NSP to a 76 page policy for one English local authority area. .

*Scope of policies*

The geographical spread of the policies included: Australia (3); England (7); and one each from Republic of Ireland and Wales. No policy document could be identified for Northern Ireland. Scotland published NSP guidance in 2010, however, this was excluded as its scope excludes under-16 year olds and it does not address issues of relevance to 16-17 year olds. (The Scottish Government 2010)

Five of the policies were specifically focused on Young Persons (under-18) NSP (YP-NSP), five were general policies for NSP with a subsection on young people (NSP-YP) and two policies focused on young person's alcohol and other drug treat Young Persons' Alcohol and Other Drug (AOD) Treatment with a sub-section on NSP (YP-AOD-NSP).

The emphasis within different types of policy is one reason why the depth in which practice is discussed varies so extensively. An NSP policy for a young persons' service should provide comprehensive coverage of the issues, whereas an NSP policy mainly addressing adult services may cover the issue more briefly, if it is to be used in conjunction with a separate YP-NSP policy and likewise for YP-AOD policies. In practice, the depth of coverage within YP-NSP sub-sections in general NSP policies varied a great deal from a single paragraph (Ireland) to eight pages (Wales). Page numbers in brackets after the page count in table 3 give a guide to this (where applicable).

*Ownership*

Policies were addressed to audiences at different levels: National (Government) (4); National (Non-statutory) (1); State (federal) (3); Local Authority area (4); National Treatment Provider (non-statutory) (10); and two NHS and non-statutory treatment providers. The owners included: policy makers; local commissioners; and treatment providers. The policy developers included treatment providers from both NHS and non-statutory services. These differences limit comparability as the work the policies are expected to do varies according to ownership. For example, a national body would not expect to determine the detail of local operational policies, which need to be tailored to local needs and circumstances; whereas it would be the more likely body to determine the minimum competencies that members of the workforce should possess and any ways these should be accredited.

**Table 2: Summary of ownership of policies**

| | |
|---|---|
| National (Government) | 4 |
| National (Non-Statutory) | 1 |
| State (Federal) | 3 |

| | |
|---|---|
| Local Authority/Drug Action Team | 1 |
| National Treatment Provider - Non-Statutory | 1 |
| Local Treatment Provider – NHS | 2 |
| Local Treatment Provider - Non-Statutory | 2 |

Categories are not mutually exclusive.

**Table 3: Detail of included policies**

| Year | Title | Pages (YP sub-section) | Type of service | Country | Ownership (Including area and/or organization) |
|---|---|---|---|---|---|
| 2001 | Victorian Needle and Syringe Program: Operating Policy and Guidelines | 45 (1) | NSP-YP | Australia | State |
| **2004** | 'BreakOut' Under 18s Needle Exchange Policy, Derbyshire Mental Services NHS Trust | 11 | YP-NSP | England | Local Treatment Provider – NHS |
| **2005** | Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people: DrugScope | 8 | YP-NSP | England | National (NS) |
| **2005** | Southampton Harm Reduction Unit provision of needle exchange facility for under 18 year olds, Hampshire Partnership NHS Trust | 11 | YP-NSP | England | Local Treatment Provider – NHS |
| **2005** | Young people's substance misuse treatment services: essential elements, NTA | 27 (1) | YP-AOD-NSP | England | National (Government) |
| **2006** | Needle and Syringe Program Policy and Guidelines for NSW, Department of Health | 40 (2) | NSP-YP | Australia | State |
| **2007** | Assessing young people for substance misuse, NTA | 28 (1) | YP-AOD-NSP | England | National (Government) |
| **2008** | Needle Exchange Provision in Ireland: Inter-Departmental Group on Drugs | 52 (1) | NSP-YP | Republic of Ireland | National (Government) |
| **2009** | Needle & Syringe Program Policy, Queensland Health | 4 (1) | NSP-YP | Australia | State |
| **2011** | Substance Misuse Treatment Framework (SMTF) Service Framework for Needle and Syringe Programmes in Wales, Welsh Gov't | 29 (8) | NSP-YP | Wales | National (Government) |
| **2012** | a)Young Addaction Needle exchange policy for working with clients under 18 | 7 | YP-NSP | England | National Treatment Provider - Non-Statutory |
| **-** | b) Young Addaction Needle Exchange Guidance For Under 18's (Appraised jointly) | 3 | | | Local Treatment Provider – NHS |

## Quality assessment of policies

The assigned scores for the AGREE domains and additional five fields are summarized in Appendices 6 and 7. For four domains including stakeholder involvement, rigour of development, applicability and editorial independence a large number of items are rated 'not sure', because there was insufficient detail to make an assessment.

Each of the four non-UK policies includes only brief consideration of young people within documents that focus on NSP in general [Victorian; Queensland; Ireland; NSW). These largely concern questions of consent and child protection, however, the different legal environments of Australia and Ireland mean that for all practical purposes these are not especially useful to consider. The following analysis is therefore largely restricted to the eight UK documents.

The policies included address different audiences from national to local levels that encompass a wide range of information on young people from 1 paragraph to 28 pages. The diversity of the scope of the policies made it impossible to impose an overall quality score on policy documents. Individual scores for each criterion are therefore presented only.

### Scope and purpose

The scope and purpose of the policies was generally stated, although the purpose was described in greatly varying detail and with quite contrasting emphasis. For example Derbyshire has a succinctly stated aim that focuses on the young person's well-being and reducing harm (Derbyshire Mental Services NHS Trust 2004), whereas DrugScope is more explicit about some of the considerations that need to be balanced and specifically the need to encourage individuals into methods of non-injecting and engagement into treatment and balancing the need for harm reduction with consideration of the individuals legal status. (DrugScope 2005)

Hampshire's policy has a primary focus on providing improved clarity for personnel working within a controversial area of practice. (Cookson and Gordon 2005) The policy from the Torbay NSP is most detailed and in this respect provides the clearest and most comprehensive statement of the purposes of YP-NSP to reduce immediate harms of blood borne viruses and drug related deaths as well as a need to reduce harm to the wider community. It is explicit about an essential objective of engagement without which none of the other objectives can be achieved. (Torbay DAT 2007)

### Stakeholder involvement

The extent of stakeholder involvement is unclear for six of the policies, with the exception of The NTA guidelines and Torbay. A broad range of stakeholders were consulted for the Torbay policy including authorities responsible for local safeguarding, local AOD services, the lead agency for AOD policy nationally and a leading national body regarding the general wellbeing of young people.

The involvement of young people who inject is not reported on the whole, with the exception of the Welsh guidance which was preceded by survey research that included a sub-sample of young injectors and a series of qualitative interviews with young injectors that informed its development. (Welsh Government Llywodraeth Cymru 2011) The views of parents of young PWID as a distinct stakeholder group do not appear to have been formally incorporated within any of the documents, despite a general expectation that services should aim to work with parents and that this may be a necessity for young people aged 16 or less who are not competent to give informed consent.

### Rigour of development

Clear links between policies and evidence were hard to identify, reinforcing the view that emerged from the quantitative and qualitative reviews that research is limited. Rigour of development should be seen as distinct from any questions of the care with which the policies were developed. The DrugScope and NTA documents are directly informed by a well documented programme of work on the delivery of young people. (DrugScope 1999) The Torbay policy draws on this programme of work and most clearly demonstrates links between

its content and supporting research. The Welsh guidance also draws on the review of NSP evidence undertaken for NICE's 2009 guidelines. (National Institute for Health and Clinical Excellence 2008) The other English policies are also clearly informed by the programme of work at DrugScope. (Derbyshire Mental Services NHS Trust 2004; National Treatment Agency for Substance Misuse 2005; Cox 2008; Addaction 2012)

### Applicability

There was little consideration of the different local contexts that arise and minimal considerations for services and their resourcing when implementing the guidelines. This was more implicit in local policies, which are written for a particular setting and/or service. Welsh guidance provides exceptional discussion of different models of NSP (Specialist NSP, Pharmacy NSP, Outreach/mobile, Home visits, Custody suite, Prison, Secondary exchange, Peer-led, Dispensing machines and Hospital-based) and in this respect has the clearest discussion of the advantages and disadvantages of the varied approaches that may be required to engage young people in different settings.

### Relevance to England

As described above applicability of criteria included varied according to different policies. For example policies around safeguarding of children are country-specific but policies around making a service youth-friendly used in other countries may apply to the English context too. By focussing the analysis on UK policies we ensured that policies are more relevant to the English context.

## Analysis of policy content on service delivery

### Assessment

Policies defined the role of an assessment to be gaining an understanding of the young person's needs relating to injecting-related risks and the need for injecting equipment, as well as the broader social and environmental context that may increase vulnerability and consideration of age and competence to consent.

*Injecting related risk behaviour*

The assessment of immediate injecting-related risks is discussed in different levels of depth and reflect the same areas that would be considered in adult NSPs generally including issues relating to borne viruses, overdose, local infections and vein care etc.

The NTA's guidance on assessing young people provides one of the fullest descriptions of the different dimensions to consider. (National Treatment Agency for Substance Misuse 2007) The Torbay policy includes an assessment tool called the 'Comprehensive Safer Injecting Assessment' specifically tailored for young people and includes the full range of topics that a service should cover throughout an assessment process. This includes several questions relating to the necessity of injecting that supports assessment of whether injecting equipment is required or whether its provision might enable injecting when the young person might otherwise use a different, generally safer route of administration such as 'chasing' (inhalation). It also promotes a dialogue about transitions away from injecting that can guide subsequent interventions, for example if injecting-related problems escalate.

Assessment of risk routinely involves inspection of injecting sites and several policies give specific guidance about inspecting intimate sites. (Young Addaction ; Derbyshire Mental Services NHS Trust 2004; Cookson and Gordon 2005; DrugScope 2005; National Treatment Agency for Substance Misuse 2007; Torbay DAT 2007). For intimate[3] injecting sites, Young Addaction's policy requires a nurse or doctor to perform the assessment and the NTA assessment guidance identifies the desirability of chaperoning by a parent/carer or a second practitioner of the same sex as the young person present.

*Social and environmental context*

Situational aspects of risk that could increase a young person's vulnerability are also identified in detail. For example, the NTA state the need to establish who is injecting the young person as a function of assessment in order to assess child protection consequences. In addition they list other vulnerabilities that should be identified as part of the assessment including: criminal behaviours; sexual exploitation; parental involvement and views; substance use of other family member; levels and type of substance use; social and personal circumstances. The Torbay assessment tool incorporates many of these questions and additional questions on ability to inject oneself and location of injection (whether it is outdoors, a public toilet, dealer's house etc.) It also seeks to establish sexual risk behaviours and family planning needs.

*Timing of assessment and provision of injecting equipment*

Some tension arises regarding the extent to which there should be a full assessment before a young person can be provided with injecting equipment. DrugScope and the NTA guidelines identify a principle that YP-NSP is something that should only occur after assessment and in the context of care-planned treatment and this is reflected in all English and Welsh guidelines. The NTA 2007 Policy also states that assessment should be conducted and an initial care plan in

[3] Intimate most comonly applies to femoral injecting, but may refer to injecting in the vicinity of the breasts or any other area of the body that the person regards as intimate for either personal or cultural reasons

place before injecting equipment are provided. While they do not clearly clarify the minimum standards required for the initial assessment, they recommend that substance related risks are prioritised in the first assessment. The detailed set of questions recommended for this assessment would be difficult to complete during a first contact, but they also identify assessment as a process that should be undertaken with active participation of the assessor, client and parents, where possible, and used to engage the young person and develop trust rather than as a single one-off task. The guidelines go on to state that 'injecting equipment and advice should only be supplied to a young person where there is evidence that withholding it would pose a greater risk than continued or increased drug misuse' and therefore necessitating a judgement call to be made on the part of the provider.

Two policies offer guidance on what the minimum required information to make this judgement might comprise. (Young Addaction ; Torbay DAT 2007) The Young Addaction policy draws on a universal framework used by drug treatment services referring to the needle exchange assessment as a minimum standard. The Torbay policy emphasizes certain information fields extracted from their assessment form as a minimum requirement including in relation to injecting practices and some child protection issues.

*Age and competency to consent*

Assessing age and competence to consent are two inter-related tasks that policies address in starkly contrasting detail. There is a high level of consistency and generally some detail in the way that the principles for assessing competence to consent are described. These typically quote the Fraser Guidelines (see Box 4) and describe their different application to people aged under-16 (required) or aged 16/17 (desirable).

Only the Torbay policy addresses how these guidelines should be translated into practice with a assessment tool providing detailed questions deemed necessary to fulfil the Fraser Guidelines, with justifications offered for each question. (Torbay DAT 2007)They provide the clearest example of guidance identified within this review.

The NTA assessment policy provides a detailed framework for considering competence to consent that besides drawing on the Fraser Guidelines, incorporates principles of informed consent. (National Treatment Agency for Substance Misuse 2007) It distinguishes interventions that do not require consent such as advice on '*risks and harms of substance misuse that allow young people to reflect on their substance misuse'* from those that do such as *'advice and information about safe injecting techniques and access to injecting equipment.'* It also clarifies that informed consent is required for information sharing between organisations (discussed in more detail below). Derbyshire and Young Addaction offer the additional guidance that young people aged under-13, are unlikely to be deemed competent to consent, which principles agreed at the Conference on Drug Abuse and Children's Legal Centre (SCODA/CLC). (DrugScope 1999) (see Appendix 8).

**Box 4: Fraser Guidelines**

The Fraser Guidelines apply specifically to contraceptive advice but have been applied to other healthcare provision including NSP. (1999) Usually, young people over 16 should be able to consent to treatment and confidentiality. The Fraser guidelines (1999) identify that young people under the age of 16 can consent to confidential medical advice and treatment, provided that:

- They understand the advice and have the maturity to understand what is involved
- The health professional cannot persuade them to inform the person who holds parental responsibility or allow the health professional to inform that person
- Their physical or mental health will suffer if they do not have treatment
- It is in the best interests to give such treatment without parental consent

In the case of contraception or substance misuse, young people will continue to put themselves at risk or harm if they do not have advice or treatment

Assessing competence to consent is predicated on knowing the age of the young person, because of the differing expectations for people under-16, between 16 and 17, and 18 or older. Although the young person's age can often be established easily, for example if there has been a referral from youth offending services, there are situations where this may not be straightforward.

Specialist NSP or pharmacy NSP primarily targeting adults operate on principles of anonymity in order to maximise the population that uses them and their corresponding public health benefits. When a young person presents to these services, the practitioner has a greater duty of care regarding informed consent and safeguarding, however, these services usually operate on the basis of a simple set on non-attributable unique identifiers where precise details of name, age, date of birth are not required. If someone aged under-18 uses these services and misrepresents their age, how should the practitioner fulfill his or her duty of care? NSPs have to balance a requirement not to be too intrusive and risk deterring young adults who are sensitive about their anonymity, with the need to avoid being negligent in cases where young people seek to use the service on.

The Torbay policy is the only document to address this issue and does so in relation to the pharmacy NSP programme, with the following guidelines:

- The obligation for staff to be vigilant about the possibility that someone is under-16 is explicit
- There is a clear procedure for documenting the claimed age
- The means for establishing the age of someone suspected to be under-16 is explicit and uses a clear standard (authentic photo card ID)
- The response is clear if the authenticity of the ID is doubted
- There are clear expectations about onward referral to the relevant service
- The expectations promote onward referral but are more accommodating for young people aged 16/17

*Involvement of young people*

The NTA policy addresses the need to elicit views of young people during an assessment explicitly, stressing the importance of the involvement of parents and young people during the development of care plans. This aspect of assessment is implied in the ten key policy principles developed by SCODA/CLC and adopted by the NTA, in both the 2005 and 2007 policies. (1999; National Treatment Agency for Substance Misuse 2005; National Treatment Agency for Substance Misuse 2007) Several policies reproduce these 10 principles, but descriptions of the areas to be explored within assessment do not include a prompt asking about the young person's perceived needs and goals. (Derbyshire Mental Services NHS Trust 2004; Torbay DAT 2007)

### Safeguarding

Safeguarding is an umbrella term that refers to the promotion of young people's welfare, the prevention of harms and 'child protection' i.e. activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. (Department for Education and Skills 2004) In the context of YP-NSP all aspects of service contribute to safeguarding including: engagement; assessment; seeking to involve parents; giving (or withholding) injecting equipment and the particular means by which this is done; referral to other agencies; and the involvement of social services when child protection concerns arise.

There are several key policy guidelines on child protection and safeguarding that have informed YP-NSP guidelines reviewed here, but some have subsequently been superseded. NSP policies published before 2006 do not reflect important DfES[4] policy published that year that sets out details of the role and function of the Local Safeguarding Children Board (Department for Education and Skills 2006b). The implications of at least two further documents should be considered within any new guidance on YP-NSP including: 1) NTA guidelines on the development of protocols and partnerships between drug and alcohol and children and family services (National Treatment Agency for Substance Misuse 2011); and 2) a newly published government policy on multi-agency working to promote the welfare of children. (HM Government 2013) Detailed analysis of new implications for YP-NSP arising from these is beyond the scope of this report.

Within the reviewed policies all UK policies address child protection in a broadly similar way. The limitations to confidentiality are identified, if it is to be breached the young person should be informed and involved in this decision as fully as possible, and the criteria for deciding whether to do this include fours parameters: 1) age and maturity of the child; 2) the degree of seriousness of drug misuse; 3) whether harm or risk is continuing or increasing; and 4) the general context in which drug use is set. There are some administrative differences in Wales. Policies published before 2006 do not reflect the most recent guidelines outlined above. (Young Addaction ; DrugScope 1999; Derbyshire Mental Services NHS Trust 2004; Cookson and Gordon 2005; National Treatment Agency for Substance Misuse 2005)

The 2007 NTA assessment policy reflects the most current policies with specific guidance on confidentiality and how that should be explained to young people and the boundaries within which it can be maintained. (National Treatment Agency for Substance Misuse 2007) These boundaries are defined as situations where abuse, neglect, self harm, high risk injecting behaviours, injection by a third person are suspected and when service providers have a duty to act and may breach confidentiality. The Torbay policy reiterate these boundaries and explicitly outline situations where physical harm, sexual abuse and emotional abuse/neglect is occurring when confidentiality may have to be breached. These boundaries are clearly displayed to service users on posters and fliers at services.

[4] Department for Skills and Education set up under Labour government and replaced by Department for Education in 2010

The NTA guidelines also draw on the SCODA/CLC parameters to determine whether confidential information should be disclosed. (DrugScope 1999) No decision can be the sole responsibility of one individual but must be made in consultation with an individual's line manager. The guidelines state that in addition to collaboration with LSCBs multi-agency working, relationships must be established with children's social care services, including duty teams where informal discussions can occur on individual cases and training on child protection issues can be given to specialist substance misuse staff. (National Treatment Agency for Substance Misuse 2007)

### Multi-agency working

*Existing guidance*
A requirement for multi-agency working was established in Every Child Matters, which has informed English YP-NSP policies published since 2004. (Department for Education and Skills 2004) The NTA 2007 policy provides the fullest guidance on this emphasizing the need for multi-agency working. The guidelines state that sharing information should not be compromised by concerns of breaching confidentiality but information should be shared on a need to know basis after obtaining informed consent from the individual or a parent. Agencies should be informed of how to make referrals and which agencies should be involved. (National Treatment Agency for Substance Misuse 2007) Multi-agency working is also implicitly described by the NTA in relation to two specific assessment systems: the Common Assessment Framework (CAF) and the Youth Justice Board 'Asset'. The CAF aims to promote early and more effective identification of needs, particularly in universal services such as schools. It is a very general tool and does not directly mention AOD use, but an implication would be that if injecting is identified as part of the CAF process, there should be clear pathways to local young persons' AOD services including YP-NSP, if required. The Asset does contain a section on AOD use and, likewise, where a youth offending team (YOT) identifies injecting, there should be similar pathways.

The SCODA/CLC's '10 Principles' (see Appendix 8) referred to in the Torbay, Derbyshire and NTA 2005 policies provides an early overview of the range of organisations relevant to a holistic, multi-agency approach and the ways that improved joint working was envisaged: 'In addition to holistic strategic planning, multi-disciplinary training, protocols and practice forums will include staff from among youth offending teams, Connexions[5], Child and Adolescent Mental Health Services (CAMHS), education, youth services, social services, voluntary sector children services and drug services.' This can be read as a list of agencies that should be suitably well-informed of the existence, purpose and local contact details for YP-NSP and other AOD services. Links to social services and youth offending teams (YOT) have already been discussed. In practice, requirements will vary for different agencies and expectations are not detailed. For example, relatively close links with agreed care pathways and some joint working might be expected for CAMHS as they may occasionally work directly with young people who inject and have a co-existing mental health problem. Connexions services should probably have good awareness of the existence of local AOD services and how young people should access them.

*Links with pharmacy NSP*
The final dimension of multi-agency working to mention concerns links between young persons' AOD services and NSP services for adults e.g. specialist and pharmacy NSP. These services may be commissioned independently from different agencies provided by the same organization, or from different agencies within one over-arching contract. Either way, the pathways and expectations should be clear.

[5] Connexions is an independent information, advice, guidance and support service for all young people aged 13 to 19 years

The guidance diverged to some extent in its recommended practices highlighting an area where best practice seems more uncertain. The DrugScope policy questions the capacity of pharmacy based NSP to work for young people specifically in relation to conducting assessments and developing care plans. They recommend that specialist NSPs should support pharmacies to respond to needs of under 18 year olds. (DrugScope 2005) These views are reiterated in the Hampshire policy. (Cookson and Gordon 2005) The Welsh policy places a greater emphasis on engagement advising that an emergency pack of injecting equipment should be issued in the interests of safeguarding the health of the child (under 16) while at the same time referring the individual to a specialist service. (Welsh Government Llywodraeth Cymru 2011) This approach is echoed in the Torbay policy. The Young Addaction policy requires an initial assessment within their young persons' service prior to NSP use but identifies pharmacy NSP as a possible option when other services are closed and where this is the young person's preference, taking a more young person-centred approach. (Young Addaction)

*Links with specialist adult NSP*

DrugScope's is the only policy appraised that gives guidance on the way that specialist adult NSP should respond to people under-18. This identifies the desirability of separate YP-NSP, yet addresses the reality that sometimes this will not be an option. (DrugScope 2005) The NTA 2007 policy discourages the use of adult NSP by young people on the grounds that these are low-threshold environments in which full assessment and care-planned YP-NSP cannot occur. However, they do not give guidance on how to provide a service if YP-NSP is not otherwise accessible to the young person. (National Treatment Agency for Substance Misuse 2007) It is questionable whether this accurately reflects the diversity of English services, some of which are provided as part of integrated treatment programmes offering a range of services from different providers within one building. In these cases, it is not clear that assessment and care-planned YP-NSP could not be provided if no separate service is available and this is the best available option.

## Training

A need for training is acknowledged in all the appraised UK policies, however, the guidance varies substantially regarding what competencies should be considered and their specificity, to whom it should be provided and the context in which it should be delivered. Broadly speaking, the two main domains of competence addressed in the policies are identified by DrugScope and based on SCODA/CLC guidelines covering: 1) the ability to work with young people under 18; and 2) needle exchange competencies. Despite this identified need for training across different skill sets and agencies, only the NTA 2007 has a policy on reciprocal training. This policy states the need to explore reciprocal training between specialist substance misuse staff and staff within children's services on child protection and young people's substance misuse.

*Working with young people under 18*

The Drugscope policy describes the skills required to work with under 18s to include both specialist knowledge in working with children as well as understanding of issues related to substance misuse. Specific skills listed include: communication and engagement skills; awareness of specialist services; knowledge of legislation around confidentiality; child and adolescent development; ability to conduct assessment; and working within Child Protection guidelines.

*Needle exchange competencies*

The Drugscope, Hampshire, NTA 2005 and 2007 policies refer to the Drug and Alcohol National Occupational Standards for guidance on training on safer injecting (DANOS). Other Needle exchange competencies listed by DrugScope draw on standard skills required for delivering services based on competencies drawn up by SCODA and Alcohol Concern, 1999. (DrugScope

1999) These include: establishing whether injecting is occurring; providing advice on safer injecting techniques; sexual risk reduction practices; primary health service; dispensing needles and condoms; liaising with other services; and monitoring and evaluation of NSP provision. The Welsh Policy states the need for staff training on alternatives to injection and prevention of initiation into injection.

*Assessments*
Three policies refer to the need for training in conducting assessments on capacity to consent. (DrugScope 1999; National Treatment Agency for Substance Misuse 2005; National Treatment Agency for Substance Misuse 2007) Young Addaction highlight the need for staff training on obtaining consent specifically in relation to examining injection sites and states that examining of injecting sites of intimate parts of the body should only be carried out by a nurse or a G.P. Other training priorities include developing a comprehensive recovery plans to encourage engagement in treatment.

## Summary

Our search of policy documents highlighted how international policy documents rarely go beyond statements that confirm the general desirability of YP-NSP. Where policy documents from outside the UK provide any detail, this is almost entirely in relation to child protection systems that operate within a different legal context to that of the UK.

The UK has a range of relevant policies that are largely founded on principles, which flow from a single, national programme of work dating back to 1999 Standing Conference on Drug Abuse and Children's Legal Centre (SCODA/CLC). (DrugScope 1999) Both explicitly and implicitly, these principles and the associated framework for practice seem generally to have been accepted within England (See Appendix 8)..

The identified guidance gives helpful directions about aspects of policy that needs to be owned at various levels (national or local) by different stakeholders (commissioners/providers). These need to be applied at different levels and adapt according to the diverse range of local contexts. **Despite a broad, national consensus on governing principles and the framework for services, policies lack clarity about detailed aspects of practice that are, however, critical for safe and effective practice that reflects the contemporary realities of injecting by young people in the UK.**

**There is general clarity about core staff competencies required for practitioners in young persons' AOD services, adult NSP and other treatment services in relation to working with young people, determining competence to consent and reducing injecting-related harms.**

The legal principles for determining competence to consent (The Fraser Guidelines) and the four main parameters for deciding when confidentiality should be breached for the purpose of safeguarding are consistently identified and appear to be largely accepted. **While it is generally clear what information an assessment should aim to gather; guidance is less clear on questions on how to gauge a young person's age in services that promise anonymity. Guidelines on how to manage the tension between conducting a comprehensive assessment while providing a service and allowing a therapeutic relationship to develop is also needed and how these judgements may be influenced according to age, vulnerability and competence to consent.**

The principle of multi-agency working is endorsed in broad terms but, in practice, many details that fundamentally affect the operation of services in the English context are lacking.

**The role of community pharmacies in YP-NSP is an area where guiding principles and local policies appear more divergent.** Although pharmacies are not generally regarded as the ideal setting for YP-NSP, some policies reflect a local reality that these are the only or main providers of NSP. Some local policies also adopt a more nuanced approach to the role of pharmacy NSP according to the age of the young person i.e. whether they are under-16 or, aged 16/17.

Ambiguities relating to the role of pharmacies reflect a wider problem for guidance that has rarely been acknowledged: an idealised 'best practice' model of a highly specialised YP-NSP service is identified as an aspiration, yet is rarely commissioned in reality. Rather, the vagaries of the lives of young PWID, coupled with relatively low demand (and correspondingly high costs) for specialised YP-NSP mean that, in practice, local services are provided pragmatically and occasionally within settings that are far from a notional ideal that is almost certainly unattainable. Consequently, numerous practical and ethical challenges currently have to be navigated by practitioners who operate within an uncertain, highly sensitive, legal and moral environment, in which existing guidance often fails to guide.

**Finally, perhaps the most important limitation to existing policy is that, to date, the development of YP-NSP policy shows very little demonstrable evidence whatsoever that young PWID or their parents/carers have been meaningfully consulted at any stage**.

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Torbay DAT (2007). Torbay Young People's Needle Exchange Policy. Drug and Alcohol Action Team and CheckPoint Under 18s Drug and Alcohol Service.

Uchtenhagen, A. and M. Schaub (2011). Minimum Quality Standards in Drug Demand Reduction EQUS, Research Institute for Public Health and Addiction.

UNICEF (2010). Blame and banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia. Geneva, United Nations Children's Fund (UNICEF) Regional Office for CEE/CIS.

Welsh Government Llywodraeth Cymru (2011). "Substance Misuse Treatment Framework (SMTF) Service Framework for Needle and Syringe Programmes in Wales."

Young Addaction "Needle Exchange Guidance for Under 18's."

# APPENDICES

## Appendix 1 : List of experts interviewed

| Name | Organisation | Domain |
|---|---|---|
| Mary Glover | Freelance trainer/consultant. Formerly service manager for a young persons' specialist service (social services) | Safeguarding children<br>young persons' alcohol and other drug use; |
| Harry Sumnall | Liverpool John Moores University | young persons' alcohol and other drug use; |
| Margaret Melrose | Professor of Social Policy and Applied Social Research; Director Centre for Young People, Poverty and Social Disadvantage; Institute of Applied Social ResearchDepartment of Applied Social StudiesUniversity of Bedfordshire | child development, particularly relating to psychological and social development |
| Viv Evans | Adfam | Parents and carers of people with AOD problems |
| Danny Morris | Freelance trainer/consultant.<br>UK Harm Reduction Association | Young persons' alcohol and other drug use |
| Charlie Lloyd | University of York | Young persons' alcohol and other drug use; |
| Sarah Mills | KCA, Drug Alcohol and Mental Health Services | Young persons' alcohol and other drug services. |
| Martin Chandler | National Needle Exchange Forum | Young persons' alcohol and other drug use |
| Jill Britton | Strategic Commissioning London Borough of Newham | Young persons' alcohol and other drug services. |
| Jenny Carpenter | Manager, CASA Family Service | Safeguarding children |
| Katherine Wadbrook | Team Manager, CRI West Sussex Young Person's Substance Misuse Service | Young persons' alcohol and other drug use |
| Josie Smith | Health Protection Wales | Young persons' alcohol and other drug use |
| Lisa Mellen | In an independent capacity | Young persons' alcohol and other drug use |
| David Humphreys | Addaction | Young persons' alcohol and other drug use |
| Roxanne | Young person who injects drugs | Own experience of drug use and services |
| Ryan | Young person who injects drugs | Own experience of drug use and services |

Particpants were recruited based on their expertise in one of more of the following four domains: i) child development, particularly relating to psychological and social development; ii) safeguarding children; iii) young persons' alcohol and other drug use; and iv) young persons' alcohol and other drug services.

## Appendix 2: Interview Topic Guide

There are a number of aspects of U-18 NSP that we will be discussing, but before we start I'd be interested to know what **you** particularly consider to be the most important area(s) to address regarding NSP for under-18s?

*Prompt*
Any aspects that are specific to the English context?
Examples from practice and experience
Anything else?

*Open question*
Can you describe your views on the ideal model(s) of NSP provision for under-18s that should be provided? (Assuming you take the view that under-18s should have access to NSP)

*Prompt*
Are there any differences that apply to NSP for psychoactive drugs such as heroin or cocaine or, performance and image-enhancing drugs (PIEDs)?
Examples from practice and experience
Anything else?

*Narrative*
Current NSP guidance says "Providing young people under 18 (particularly those under 16) with an NSP is legally and ethically difficult and involves a different service model." Consequently, four major themes that we will cover are:

- The changing implications of age and development
- Legal considerations as they affect children and young people
- Ethical practice
- Any ways that service models for U-18 NSP need to differ

**The changing implications of age and development**

*Open question*
Can you talk specifically about any ways in which a child or young person's development is relevant to NSP practice?

*Prompts*
What distinguishes or defines any age/developmental boundaries that the interviewee identifies?
Examples from practice and experience
Anything else?

*Open question*
Within guidelines, one important question concerns the extent to which specific age or developmental boundaries might influence best practice. Are there particular developmental stages where best practice would generally be different depending on whether a person has passed through it?

*Prompts*
What distinguishes or defines any age/developmental boundaries that the interviewee identifies?
Examples from practice and experience

Anything else?

*Detailed probes*
Children develop physically, psychological and socially. Physically, we know that certain medicines or procedures for adults sometimes need to be very different for children as they make the transition through puberty to adulthood. It may be that there are specific features of this physical development that are important to consider within NSP, for example, regarding their developing cardio-vascular system and any differences in the way injecting affects children's venous health.

Psychologically, brain development often continues into a person's early 20s. Hormonal changes during puberty affect people emotionally. Navigating the process of individuation and transition towards independence also has psychological effects all of which overlap with social development. These may have a bearing on aspects of NSP for under-18s e.g. how risks are communicated.

*Open question*
Are there specific stages of a young person's physical, psychological or social development that you view as particularly relevant to NSP?

*Prompt*
Evidence or experience that justifies views on developmental boundaries
Anything else?

*Open question*
Can you talk about the extent to which any age-specific boundaries are meaningful and should be clearly demarcated within the guidelines e.g. "for children below the age of 13..."? Or, alternatively, whether children and young people's different rates of development mean this needs to be assessed and subject to a professional judgement (for example, as happens with 'capacity to consent' for under-16s)?

*Prompt*
Evidence or experience that justifies views on age-specific boundaries
Examples from practice and experience
Anything else?

**Legal considerations as they affect children and young people**

*Open question*
So far we have mainly talked about age and development, can you describe any specific legal boundaries that are relevant to NSP?

*Prompt*
Evidence or experience that justifies views on legal boundaries
Anything else?

*Open question*
The current guidance highlights concerns around "young people under 18 (particularly those under 16)" i.e. the ages when someone respectively achieves legal majority, or below which the 'Fraser Guidelines' apply[6].

[6] *"As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."*

From your perspective, how do these legal boundaries relate to U-18 NSP and any specific differences that arise and need to be addressed in guidance?
*Note - Explain Fraser Guidelines if necessary*
Examples from practice and experience
Anything else?

*Open question*
Besides the Fraser Guidelines, are there any other ages that have relevant legal/policy significance?
*Prompts:*

- *For example, the age of criminal responsibility (10 in England)*
- *Alcohol legislation (>5 drink at home, >14 go to pub, 16 drink with meal)*
- *Different levels of legislation i.e*. England, UK, EU, international (e.g. Convention on Rights of the Child)
- Examples from practice and experience
- Anything else?

**Ethical practice**

*Open question*
In terms of ethical practice, in what ways, if any, does the provision of services to young people need to differ to that for adults?

*Prompts*
How does this relate to:

- Establishing a young person's competence and autonomy to consent?
- Anonymity, confidentiality and establishing someone's age where relevant e.g. regarding capacity to consent
- The duty of care that applies
  - Are there relevant ways that the duty of care is affected by context (e.g. NGOs, health services, social care services, youth offending, youth services, education) or profession (e.g. nursing, social work, medicine, youth work, probation)
- Safeguarding/child protection
  - General obligations
  - Role of different agencies
  - Specific procedural requirements.

Examples from practice and experience
Anything else?

**Any ways that service MODELS FOR U-18 NSP need to differ**

We talked about service models earlier. Are there any additional ways in which service models need to differ from those for adults that you want to discuss?

*Prompts:*
Practitioner competencies

Communicating information – oral, written, other?

Accessibility

- Time

- Location
- Other aspects?

Modes of provision
- Pharmacy
- Specialist
- Outreach
- Secondary exchange etc

Specific needs that differ e.g. links to other services/agencies e.g. links to:
- Treatment
- Youth services

Specific risks that need to be addressed
- Mixing with older adult PWID
- Consolidating PWID identity

Anything else?

**Cross cutting issues**
*Note - Cross-cutting issues will be referred to, as required, throughout the interviews and returned to towards the end of the interview*

Is there anything else you want to add regarding:

*The English context*
- Young people's drug use in England – historic drugs (e.g. heroin/coke/amphet), novel psychoactive substances, PIEDs
- English injecting cultures
- Organisation and provision of YP drug services
- Organisation and provision of NSP

*Effectiveness*
Evidence that this a) varies for different ages b) may apply differently

*Vulnerable groups*
Looked-after children, young offenders, homeless, sex-workers, others

**Identification of further guidance/grey literature**
Guidance – Agency-specific, England, UK, EU, international, other

Evidence relating to U-18 NSP
- grey literature (including local policies for providing NSP to u-18s),
- in press,
- old and overlooked/under-valued,
- buried in non-obvious sources e.g. academic disciplines not immediately considered in public health/harm reduction

Is there anything else that we haven't covered? Thanks and explain what happens next

## Appendix 3: Information sheet and consent form

**Analysis of national and local policy and protocols on the delivery of Needle Syringe Programme services to young people under 18**

**INFORMATION SHEET AND CONSENT FORM**

We are conducting some research for the National Institute for Health and Clinical Excellence (NICE) to develop specific recommendations on how needle/syringe programmes (NSP) should be provided for young people aged 18 or younger. These recommendations will inform an update of the NICE best practice guidelines for the delivery of NSP services.
This project consists of two linked components. Firstly, we will interview experts in working with young people in the field of drug treatment and harm reduction. During the interview we will discuss key issues relating to the provision of needle/syringe programmes to young people and discuss what specific services should be provided, how they should be provided, where and by whom. We are inviting you to take part in your capacity as an expert in the field [*specify expertise*].

The interviews will last between 60 and 90 minutes. They will be recorded and transcribed verbatim. Following this we will write up a summary of the interviews and returned to you for approval. Findings from the interview will also be analysed and used to inform recommendations summarised in a final report submitted to NICE. We may well quote you in the report, but this will be done anonymously.

For the second stage of the project you are invited to a day-long meeting to take part in a facilitated discussion with an expert panel consisting of others working in the field. Summaries of the interviews will be presented at the meeting and discussed in turn in order to generate consensus on the main issues around NSP and make recommendations on the best models of care.

You can take part in the interview and not the meeting, but everyone who attends the meeting needs to have been interviewed.

**At this stage, do you have any questions?**
Do you agree to take part in the interview? _____Yes/No
*[In the case of a telephone interview, verbal consent will be obtained.]*

Is it OK with you to record the interview ? _____Yes/No

Do you agree to be quoted anonymously in the final report?_____Yes/No

Do you agree to take part in the group meeting?_____Yes/No

Signature of respondent _____

Signature of researcher_____

Date_____

**London School of Hygiene & Tropical Medicine**
Keppel Street, London WC1E 7HT
United Kingdom
Switchboard: +44 (0)20 7636 8636

**www.lshtm.ac.uk**

**Observational / Interventions Research Ethics Committee**

Lucy Platt
Lecturer in Public Health Epidemiology
SEHR / PHP
LSHTM

25 January 2013

Dear Dr. Platt,

**Study Title:** **Analysis of national and local policy and protocols on the delivery of Needle Syringe Programme services to young people under 18**
**LSHTM ethics ref:** **6346**

Thank you for your letter of 23 January 2013 responding to the Observational Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Conditions of the favourable opinion**

Approval is dependent on local ethical approval having been received, where relevant.

**Approved documents**

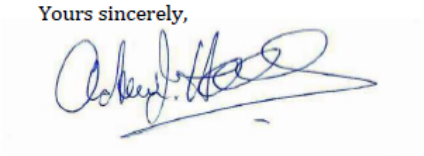
The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|---|---|---|
| LSHTM ethics application | n/a | 13/12/2012 |
| NICE Information Sheet & Consent Form | 2 | 23/01/2013 |
| NICE U-18 NSP Interview Guide | 1.1 | |

**After ethical review**

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form. All studies are also required to notify the ethics committee of any serious adverse events which occur during the project via form E4. At the end of the study, please notify the committee via form E5.

Yours sincerely,



**Professor Andrew J Hall**
**Chair**
ethics@lshtm.ac.uk
http://intra.lshtm.ac.uk/management/committees/ethics/

## Appendix 4: List of participants consulted in Delphi exercise

| Name | Organisation |
|---|---|
| Amador Calafat | IREFREA - European Institute of Studies on Prevention |
| Dagmar Hedrich | EMCDDA |
| Jenny Carpenter | Blenheim CDP |
| John Jolley | Blenheim CDP |
| Martin Chandler | National Needle Exchange Forum |
| Paul Griffiths | EMCDDA |
| James Pierce | Young Addaction |
| Nina Ferencic | UNICEF CEE |
| Gill Hession | Community Alcohol and Drugs Services Shetland (CADSS) |
| Harry Sumnall | Liverpool John Moores University |
| Craig Moss | Addaction |
| Ambros Uchtenhagen | Zurich University |
| David Humphreys | Addaction |
| Jo Choi | Blenheim CDP |
| Dave Hubball | Addaction |
| Neil Harvey | Addaction |
| Katherine Wadbrook | CRI |
| Eliot Albers | INPUD |
| Francis Cook | National Users Network |
| Steve Freer | National Users Network |
| John Howard | Reading User Forum |
| Simon Parry | M.O.R.P.H |
| Kevin Jaffray | SUSSED |
| Anita Krug | Youth Rise |
| Nigel Brunsdon | HIT |
| Andrew Preston | Exchange Supplies |
| Michael Linnell | Lifeline |
| Kevin Flemen | KFx |
| Ken Stringer | The Alliance |
| Mary Glover | Freelance consultant |
| Harry Shapiro | DrugScope |

## Appendix 5: Quality assessment of methodological development using AGREE criteria

| Policy | Scope and Purpose | Stakeholder involvement | Rigour of development | Clarity | Applic-ability | Editorial independence | Relevance local context |
|---|---|---|---|---|---|---|---|
| 1. Victorian Needle and Syringe Program: Operating Policy and Guidelines (2001) | 2 | 1 | 0 | 2 | 1 | 1 | 1 |
| 2. 'BreakOut' Under 18s Needle Exchange Policy, Derbyshire Mental Services NHS Trust (2004) | 2 | 1 | 1 | 2 | 1 | 1 | 2 |
| 3. Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people: DrugScope (2005) | 2 | 1 | 2 | 2 | 1 | 1 | 2 |
| 4. Southampton Harm Reduction Unit provision of needle exchange facility for under 18 year olds, Hampshire Partnership NHS Trust (2005) | 2 | 1 | 1 | 2 | 1 | 1 | 2 |
| 5. Young people's substance misuse treatment services: essential elements, NTA (2005) | 2 | 1 | 1 | 2 | 2 | 1 | 2 |
| 6. Needle and Syringe Program Policy and Guidelines for NSW, Department of Health (2006) | 2 | 1 | 1 | 2 | 2? | 1 | 1 |
| 7. Assessing young people for substance misuse, NTA (2007) | 2 | 2 | 2 | 2 | 2? | 1 | 2 |
| 8. Torbay Young People's Needle Exchange Policy, Torbay DAT/CheckPoint (2007) | 2 | 1 | 2 | 2 | 2? | 1 | 2 |
| 9. Needle Exchange Provision in Ireland: Inter-Departmental Group on Drugs (2008) | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| 10. Needle & Syringe Program Policy, Queensland Health (2009) | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| 11. Substance Misuse Treatment Framework (SMTF) Service Framework for Needle and Syringe Programmes in Wales, Welsh Gov't (2011) | 2 | 2 | 2 | 2 | 2 | 1 | 2 |
| 12. a) Young Addaction Needle exchange policy for working with clients under 18 b) Young Addaction Needle Exchange Guidance For Under 18's | 2 | 1 | 1 | 2 | 1 | 1 | 2 |

## Appendix 6: Quality assessment of policy content

| Policy | Assessment | Safeguarding | Multi - agency working | Training |
|---|---|---|---|---|
| 1. Victorian Needle and Syringe Program: Operating Policy and Guidelines (2001) | 0 | 2 | 1 | 0 |
| 2. 'BreakOut' Under 18s Needle Exchange Policy, Derbyshire Mental Services NHS Trust (2004) | 2 | 2 | 1 | 1 |
| 3. Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people: DrugScope (2005) | 2 | 2 | 1 | 2 |
| 4. Southampton Harm Reduction Unit provision of needle exchange facility for under 18 year olds, Hampshire Partnership NHS Trust (2005) | 2 | 2 | 1 | 1 |
| 5. Young people's substance misuse treatment services: essential elements, NTA (2005) | 2 | 2 | 2 | 2 |
| 6. Needle and Syringe Program Policy and Guidelines for NSW, Department of Health (2006) | 2 | 2 | 1 | 2 |
| 7. Assessing young people for substance misuse, NTA (2007) | 2 | 2 | 2 | 2 |
| 8. Torbay Young People's Needle Exchange Policy, Torbay DAT/CheckPoint (2007) | 2 | 2 | 1 | 2 |
| 9. Needle Exchange Provision in Ireland: Inter-Departmental Group on Drugs (2008) | 1 | 0 | 0 | 1 |
| 10. Needle & Syringe Program Policy, Queensland Health (2009) | 0 | 1 | 0 | 1 |
| 11. Substance Misuse Treatment Framework (SMTF) Service Framework for Needle and Syringe Programmes in Wales, Welsh Gov't (2011) | 2 | 2 | 1 | 1 |
| 12. a) Young Addaction Needle exchange policy for working with clients under 18 b) Young Addaction Needle Exchange Guidance For Under 18's | 2 | 2 | 1 | 1 |

## Appendix 7: 10 Key principles from the SCODA/CLC

SCODA/CLC Standing Conference on Drug Abuse and Children's Legal Centre (1999) *Young people and drugs: Policy guidance for drug interventions* London: DrugScope

**1. "A child or young person is not an adult. Approaches to young people need to reflect that there are intrinsic differences between adults and children and between children of different ages."**
Drug services should have guidelines and competent staff on the assessment of the following:
- differences in legal competence
- age appropriateness
- parental responsibility
- confidentiality
- "risk" and "significant harm".

**2. "The overall welfare of the child is paramount."**
This should be reflected in assessment guidelines and referral procedures between young people's services and child protection agencies in accordance with the Children Act 1989 and the UN Convention on the Rights of the Child.

**3. "The views of the young person are of central importance and should always be sought and considered."**
Drug services will be able to demonstrate how care planning reflects a dialogue between the young person, assessor and carer, where appropriate, in line with the *National assessment framework for young people in need and their families* (Department of Health, 1999) and the forthcoming *Common assessment framework*. In addition, drug services will provide young people with an opportunity to contribute to operational and strategic planning.

**4. "Services need to respect parental responsibility when working with a young person"**
The education, involvement and support of parents or carers may be beneficial to successful work with young people. All young people should be encouraged to discuss their substance use with a parent or carer.

**5. "Services should co-operate with the local authority in carrying out its responsibilities towards children and young people."**
Protocols for liaison and joint working between the young person's drug service and child protection and children in need services should be established. The passing of the Children Act 2004 establishes a statutory duty on all services, both voluntary and statutory, to safeguard and promote children's wellbeing.

**6. "A holistic approach will occur at all levels."**
In addition to holistic strategic planning, multi-disciplinary training, protocols and practice forums will include staff from among youth offending teams, Connexions, CAMHS, education, youth services, social services, voluntary sector children services and drug services.

**7. "Services must be child-centred."**
Services should be accessible and attractive to young people. Services should be in safe areas and separate from adult services. Available literature will need to reflect the age, culture, gender and ethnicity of the client group. Consideration must be given to the accessibility of services to *Young people's substance misuse treatment services – essential elements* – June 2005 21/27 young people, particularly opening times, location and age appropriate publicity. All staff must have received Criminal Records Bureau clearance.

**8. "A comprehensive range of services should be provided."**

DATs will need to ensure that service providers will be able to offer a range of services reflecting different patterns of alcohol and drug use by young people. The range of interventions should include drug education, targeted prevention programmes, advice, counselling, prescription and detoxification, rehabilitation and needle exchange services, as well as information, advice and support for parents.

**9. "Services must be competent to respond to the needs of young people."**
Staff should be competent to work with children, adolescents and families in line with social care and DANOS occupational competencies. Managers and supervisors will also need to be competent in considering the needs of young people.

**10. "Services should aim to operate in all cases according to the principles of good practice."**
Services will operate within the current legal framework, respecting the underlying philosophy of the Children Act 1989 and the UN Convention on the Rights of the Child. They should also reflect evidence-based effectiveness.