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Executive Summary

The health needs assessment collected data from service users, service providers and epidemiological sources. The findings were well aligned and this has made it possible to identify the unmet harm reduction needs of people who inject drugs in Edinburgh.

1.0 Conclusions

A stronger systems approach to care: There is a degree of service integration from the service perspective, but there are not common standards for harm reduction that are understood and consistently implemented across the whole patient journey. Therefore the system as a whole does not provide the full range of holistic, patient centred care or the quality and continuity that people need.

More intelligence led services: The services are often not intelligence led because of limitations in data quality, lack of data linkage between services, no agreed performance indicators across the system and no shared approach for monitoring and evaluation.

Making the best of all available assets and resources: There have been severe cuts to addiction services in the last year and this has a major impact on capacity. However, it is important to invest in and make best use of the many well trained and experienced staff, the infrastructure and effective outreach systems that already exist and the people with lived experience, who can provide crucial psychosocial support.

2.0 Key messages

2.1 Improve access and retention for opioid substitution therapy

In 2016, the opioid substitution therapy programme in Edinburgh reached approximately 3440 (52%) of an estimated 6600 potential beneficiaries. This is higher than the national average. However, there are long waits and low retention, up to 80% of treatment is low intensity as provided by GPs, most services do not routinely provide other harm reduction measures and there is a lack of routinely available data for monitoring and evaluation. Services need to agree common standards, conduct a pathway audit against the standards, conduct small tests of change where needed and establish data systems to monitor progress and quality.

2.2 Provide harm reduction as part of all service contacts

In 2015-16, injecting equipment was provided to approximately 1,319 regular users in Edinburgh. However, the full range of harm reduction interventions are not opportunistically available as part of all 'drop in' or by appointment consultations. For example, up to 46% of users may not be receiving enough injecting equipment and naloxone is not adequately provided through key settings such as A&E, general practice and pharmacies; despite up to 80% of addictions treatment being provided by GPs, 83% of regular users accessing pharmacies for basic injecting equipment services, and a monthly average of 102 hospital admissions via A&E for psychoactive substance use. So there are many missed opportunities. We must

extend the reach of harm reduction interventions to include generic hospital, primary care and social services, and also promote harm reduction as part of the core intervention for addictions services.

2.3 Reduce missed opportunities for hepatitis C testing, care and treatment

Data from the Needle Exchange Surveillance Initiative 2015-16 survey reports the hepatitis C antibody prevalence of people attending injecting equipment provision services in Edinburgh as 48%. This is a 7% rise from 41% in 2013-14. Hepatitis C testing for eligible individuals on specialist drug treatment can improve: 45% of eligible individuals in specialist services, and 58% under the general practice drug misuse National Enhanced Service were untested in the year since last test in 2015/16. NHS Lothian exceeded treatment targets for 2016/17 and has high rates of treatment success. However, in 2015-16, 51% of current or ex- injectors referred for hepatitis C treatment at the Royal Infirmary of Edinburgh and its outreach clinics, did not attend their first appointment and 57% of those who did attend, did not commence treatment. The attrition is lower for people referred for treatment at the Edinburgh Access Practice. We need to improve hospital/community outreach through targeted case finding, trial additional general practice based hepatitis C treatment sites, ensure a greater role for locality teams in blood-borne virus testing and treatment support, and further develop data systems to monitor progress and quality.

2.4 Improve support for general health and wellbeing

There is an ageing population of people who inject drugs that has much higher rates of comorbidities than people of the same age in the general population; 10 times more admissions for mental health issues, six time more for chronic respiratory disease. In 2015/16, 64% of drug related deaths had a co-morbidity (60% mental health, 54% alcohol misuse). Patients and staff identified high levels of unmet need around mental health, often linked with traumatic events, and specialist clinics are seeing increasing rates of advanced skin and soft tissue complication of injections. Current specialist addictions services are not configured to provide care for comorbidities, and other services that come into contact with problem drug users are not usually configured for provision or referral to addictions care. We need to improve referral pathways and hospital in reach for harm reduction, improve the skill mix in localities, develop a system wide approach for chronic and enduring mental health care and support interventions that reduce social isolation.

2.5 Strengthen services for vulnerable groups

There are high numbers of people who inject drugs that are particularly vulnerable; 15% have been released from prison in the previous six months, 26% of drug-related deaths have been released from police custody in the previous six months, 30% of regular service users are homeless and people aged over 35 years are at greater risk of severe comorbidities, social isolation and drug related death. All services need to be configured and staffed to provide appropriate support. The needs of people who are not engaged with services need further investigation. These include women, street injectors, people recently discharged from the criminal justice system,

homeless people, people with low literacy/numeracy and the children, families and carers of people who inject drugs.

2.6 Ensure quality improvement across all services

Across the whole system that provides care, there are no agreed common standards for harm reduction and current approaches to quality improvement are not coordinated. Data collection is variable across the city and across different databases. There are no clear links between databases in settings such as police custody, social care, third sector or NHS addictions and this means that there are many missed opportunities for shared care. There is insufficient data on key services such as opioid substitution therapy to guide development, monitoring and evaluation of services, and feedback of intelligence to front line workers is limited. We need to establish common service standards, an integrated approach to quality improvement, systems for data sharing and dissemination, and a strategy for workforce development.

Recommendations

Recommendation 1: Improve access and retention for opioid substitution therapy

Services need to agree common standards, conduct a pathway audit against the standards, conduct small tests of change where needed and establish data systems to monitor progress and quality.

Actions

- 1.1 An addictions consultant should lead a multidisciplinary group to conduct a pathway audit of opioid substitution therapy (OST) services against agreed standards and make recommendations for service improvement such as: non medical prescribing, greater choice of treatment (e.g. buprenorphine), discharge policies, better managing critical transition points and extended provision of high intensity/low threshold OST treatment for very high risk patients across Lothian.
- 1.2 Recovery hub teams, with support from the ADP Support Team, NHS Lothian Public Health and the local addictions consultant should identify areas where small tests of change are needed to achieve agreed standards for OST services; e.g. drug testing by third sector colleagues to reduce the number of visits before starting OST.
- 1.3 The Primary Care Facilitation Team should co-ordinate with the Edinburgh Alcohol and Drugs Partnership to explore options for non-medical prescribing in primary care, learning lessons from current practice in Edinburgh Access Practice and pilots in Boroughloch and Mill Lane Surgeries.

Recommendation 2: Provide harm reduction as part of all service contacts

There is a need to extend the reach of harm reduction interventions to include generic hospital, primary care and social services, and also promote harm reduction as part of the core intervention for addictions services.

Actions

- 2.1 The harm reduction team should work with community pharmacy and third sector to provide enhanced harm reduction services in pharmacies:
 - a) Use the lessons learned from the 2017 pilot of 'in-reach' provision of enhanced services in community pharmacies.
 - b) Explore options to enhance existing pharmacist *contacts* and where necessary *contracts*. Many pharmacists already provide services for drug users including dispensing of hepatitis C (HCV) drugs and OST, plus the minor ailments and smoking cessation services. Options range from provision of harm reduction information packs and online training modules to increase awareness, to contract changes that include distribution of IEP 'one hit kits',

provision of take home naloxone (THN), hepatitis B vaccination and blood-borne virus (BBV) testing.

2.2 The Primary Care Facilitation Team should work with the harm reduction team, recovery hub teams, drug misuse National Enhanced Service (NES) GPs and GP cluster quality improvement leads to make sure that people cared for under the drug misuse NES can benefit from additional harm reduction services in the general practice:

- a) Conduct a trial of opportunistic IEP 'one hit kits'.
- b) Promote provision of take home naloxone.
- c) Promote annual BBV testing for people who inject drugs.

2.3 Recovery hub teams should develop a strategy to provide injecting equipment, THN, BBV testing and hepatitis B vaccination through existing contacts with clients. Many clients are known to continue injecting while on OST and IEP/THN distribution by specialist addictions staff already takes place in NHS Lothian.

2.4 Recovery hub teams and the harm reduction team should work with secondary care to establish referral pathways for harm reduction interventions for people seen in secondary care. This would include input from a designated drugs liaison person to work between A&E/in patient wards and the harm reduction team/recovery hubs.

2.5 The Harm Reduction Team should:

- a) Work with localities to implement small tests of change and provide oversight for wider roll out; including promotion of injecting equipment provision, take-home naloxone, BBV testing and wound care in all care settings.
- b) Strengthen links and services with police custody and prison through care.
- c) Lead development of a 'dashboard' for Needle Exchange Online (NEO) data.
- d) Work with secondary care A&E and in patient wards, to ensure provision of THN and hepatitis B vaccination to people who inject drugs.

Recommendation 3: Reduce missed opportunities for hepatitis C testing and treatment

There is a need to improve hospital/community outreach through targeted case finding, trial additional general practice based hepatitis C treatment sites, ensure a greater role for locality teams in blood-borne virus testing and treatment support, and further develop data systems to monitor progress and quality.

Actions

3.1 The Lothian Viral Hepatitis Managed Care Network should:

- a) Establish a 'HCV dashboard' to monitor service delivery, including data from NHS Lothian Virology, SMR25a, the drug misuse National Enhanced Service and clinical data bases.

- b) Recruit an individual to work with hospital and community services to provide additional outreach that can identify and follow up HCV positive individuals.
- c) Work with Muirhouse Medical Practice to establish an additional primary care site for HCV treatment.
- d) Work with recovery hubs to establish an accelerated plan with targets for the transfer of community testing from the BBV team to recovery hub teams.

Recommendation 4: Improve support for general health and wellbeing

There is a need to improve referral pathways and hospital in reach for harm reduction, improve the skill mix in localities, develop a system wide approach for chronic and enduring mental health care and support interventions that reduce social isolation.

Actions

- 4.1** The recovery hub teams, supported by NHS Lothian Public Health should work with secondary care and other providers to establish clear two way referral pathways; e.g. for respiratory disease, smoking cessation, oral health, and sexual health (e.g. 'priority access cards' for sexual and reproductive services).
- 4.2** Community pharmacists and recovery hubs should promote pharmacy services including the minor ailments service, chronic medication service and pharmacy smoking cessation service.
- 4.3** The harm reduction team should work with recovery hubs to pilot locality based wound care with clear referral pathways to the specialist wound clinic at the Spittal Street Centre.
- 4.4** The Edinburgh Alcohol and Drug Partnership should develop and strengthen approaches that reduce social isolation and promote social inclusion. This should include support from people with lived experience working within the multidisciplinary team.
- 4.5** An addictions consultant and a mental health consultant should lead a multidisciplinary group to explore ways to address the unmet need for chronic and enduring mental health care. This may require a system wide approach to free up capacity within the addictions team and will require liaison between A&E, in patient wards, liaison psychiatry and addictions psychiatry.

Recommendation 5: Strengthen services for vulnerable groups

The needs of people who are not engaged with services require further investigation so that services can be configured appropriately. Vulnerable groups include: women, street injectors, people recently discharged from the criminal justice system, homeless people, young people, individuals with significant risk factors for drug-related deaths (e.g. non-fatal overdose), the children, families and carers of people

who inject drugs, transgender people, men who have sex with men, people with low literacy/numeracy, people who work and people from diverse ethnic and linguistic backgrounds.

Actions

5.1 The Lothian Drug-related Deaths (DRD) lead should work with the Lothian steering group to:

- a)** Identify systematic ways to identify and intervene with people at risk of DRD.
- b)** Develop interventions according to need e.g. 'Keep Well' type interventions for older people who inject drugs with comorbidities and poly pharmacy, outreach to engage younger people who experienced non-fatal overdose and interventions to address social isolation.

5.2 The harm reduction team should conduct a pilot of a dedicated Image and Performance Enhancing Drugs clinic at Spittal Street Centre.

5.3 Edinburgh Alcohol and Drugs Partnerships should work with colleagues in the City of Edinburgh Council to:

- a)** Modify the homeless database to enable recording of drug use status.
- b)** Establish a protocol with community and hospital partners to allow continuity of care across health and social care services.

5.4 The harm reduction team and NHS Lothian Public Health should lead an investigation into the needs of vulnerable groups and explore options for targeting services, such as extended use of the 'NEON' outreach bus.

5.5 The harm reduction team, NHS Lothian Public Health and health promotion should liaise with the prisons and third sector to:

- a)** Provide injecting equipment provision on prison release, e.g. using the IEP 'one hit kits' as part of discharge packs.
- b)** Explore the experiences of recently liberated prisoners and their needs in relation to harm reduction, especially women, young people and homeless people.
- c)** Identify individuals with risk factors for drug-related death and provide additional support for them to engage with treatment and harm reduction services.
- d)** Investigate how admissions to the prison mental health and addictions team can be captured on the Lothian drug and alcohol dashboard.

5.6 The harm reduction team should liaise with police custody and the third sector to identify ways to provide the full range of harm reduction services for those attending the police custody suite including: IEP 'one hit kits', BBV testing and community link workers (especially for younger detainees).

5.7 Change Grow Live should work with police custody to identify individuals with risk factors for drug-related death and provide additional support for them to engage with treatment and harm reduction services.

5.8 The Edinburgh Alcohol and Drugs Partnership should:

- a) Work with Community Justice to progress the provision of the arrest referral service within the custody suite.
- b) Regularly review routine data related to detainees with problematic drug use to identify and respond to changing patterns or emerging needs.

Recommendation 6: Ensure quality improvement across all services

There is a need to establish common service standards, an integrated approach to quality improvement, systems for data sharing and dissemination, and a strategy for workforce development.

Actions

6.1 Edinburgh Alcohol and Drugs Partnership, recovery hub teams, Lothian Drug-Related Deaths Steering Group and NHS Lothian Public Health should convene a system wide multiagency group to:

- a) Agree local service standards and key performance indicators.
- b) Agree a quality improvement approach to recovery and harm reduction.
- c) Oversee the establishment of data systems (e.g. dashboards for OST, IEP, HCV) to monitor and evaluate service performance and quality.
- d) Ensure that best practice and relevant data is shared across the system.
- e) Ensure that as this work progresses it should become inclusive of all Lothian as appropriate.

6.2 The Edinburgh Alcohol and Drug Partnership should work with health promotion, recovery hubs, the harm reduction team and other to develop and implement a strategy to increase the skill mix in hubs. This should include:

- a) A skill based workforce audit to look at existing assets and gaps.
- b) Consideration of options to provide protected learning time.
- c) Work with the Scottish Prison Service and NHS Prison healthcare team to identify and support workforce development needs.
- d) The elements identified above such as: 'keep well' type approaches to chronic disease management, provision of THN, BBV testing and injecting equipment, low threshold methadone prescribing, wound care, sexual health, respiratory assessment, smoking cessation and trauma informed practice.

Abbreviations:

Accident & Emergency	(A&E)
Adolescent Substance Use Service	(ASUS)
Alcohol and Drugs Partnerships	(ADPs)
Blood-Borne Virus	(BBV)
Business Improvement District	(BID)
Change, Grow, Live	(CGL)
City of Edinburgh Council	(CEC)
Community Health Index	(CHI)
Drug related deaths	(DRD)
Drug Testing and Treatment Orders	(DTTO)
Dry blood spot testing	(DBST)
Edinburgh Access Practice	(EAP)
Edinburgh Alcohol & Drug Partnership	(EADP)
Edinburgh Common Housing Outcomes	(ECHO)
Edinburgh and Midlothian Offender Recovery Service	(EMORS)
General Practice	(GP)
General Practitioner with Special Interest	(GPwSI)
Hepatitis C virus	(HCV)
Hepatitis C antibody	(HCV Ab)
Hepatitis C antigen	(HCV Ag)
Her Majesty's Prison Edinburgh	(HMP Edinburgh)
Injecting Equipment Provision	(IEP)
Image & performance enhancing drugs	(IPED)
Integration Joint Board	(IJB)
Information Services Division	(ISD)
Local Enhanced Service	(LES)
Low Threshold Methadone Programme	(LTMP)
Multi-agency through care service	(MATS)
National Enhanced Service	(NES)
Needle Exchange Surveillance Initiative	(NESI)
Needle Exchange Online (database)	(NEO)
Non medical prescribing	(NMP)
Novel Psychoactive Substances	(NPS)
Opioid substitution therapy	(OST)
People Who Inject Drugs	(PWID)
Point of care testing	(POCT)
Polymerase chain reaction	(PCR)
Primary Care Facilitation Team	(PCFT)
Royal Infirmary of Edinburgh	(RIE)
Scottish Ambulance Service	(SAS)
Scottish Prison Service	(SPS)
Soft skin & tissue infections	(SSTI)
Scottish Morbidity Record	(SMR25a)
Substance Misuse Directorate	(SMD)
Take Home Naloxone	(THN)
Western General Hospital	(WGH)
World Health Organisation	(WHO)
National Records Scotland	(NRS)

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1.0 Introduction

Between 1982 and 1984, Edinburgh experienced an epidemic of HIV among young people injecting heroin in the city. This prompted an innovative shift in policy in Scotland towards harm reduction services that provided opioid replacement and needle exchange, plus, population HIV testing once technology became available in 1986. Subsequently, there was a gradual decrease in new cases of HIV among people who inject drugs in Edinburgh and the 2015-16 Needle Exchange Surveillance Initiative (NESI) indicated that of 471 individuals tested for HIV in Lothian, three were positive (0.6% prevalence) [1].

However, over 2013-15 the City of Edinburgh experienced a large rise in people injecting novel psychoactive substances (NPS) and from April 2013 to December 2015, 418 individuals were admitted to Lothian hospitals with a diagnosis relating to NPS use [2]. Those involved frequently demonstrated chaotic and unsafe injecting practice and were vulnerable to overdose, transmission of blood borne viruses (BBVs) and severe soft tissue infections. The multiagency response across the city included increased provision of information to drug users and health and social care staff, injecting equipment provision (IEP), blood-borne virus (BBV) testing & treatment, as well as a local ban which was followed by national legislative changes that eventually restricted the availability of NPS [3].

Since 2015, addictions services report that many individuals have returned to the injecting of opiates and stimulants, such as crack cocaine, and concerns remain over continued risk behaviour among people who inject drugs in the city. This is particularly worrying in the context of the increasing prevalence of hepatitis C virus (HCV) among people who inject drugs in Edinburgh (a rise from 41% to 48% of drug users with positive HCV antibody between 2013-14 and 2015-16), the re-emergence of HIV infection among people who inject drugs in Glasgow (47 new cases in 2015) and the continuing rise in drug-related deaths across Scotland (a rise from 485 deaths in 2010 to 706 deaths in 2015) [1].

At the end of 2015, the Scottish Government announced a 23% reduction in funds for Alcohol and Drugs Partnerships (ADPs). This together with the above noted risks prompted the Edinburgh Alcohol and Drugs Partnership to commission a review of the harm reduction needs of people who inject drugs in Edinburgh. The needs assessment was governed by a multiagency steering group convened on 12th September 2016, and the day to day work was conducted by a core group, in partnership with NHS Lothian virology lab, Lothian Analytical Services, the Primary Care Facilitation Team and Health Protection Scotland.

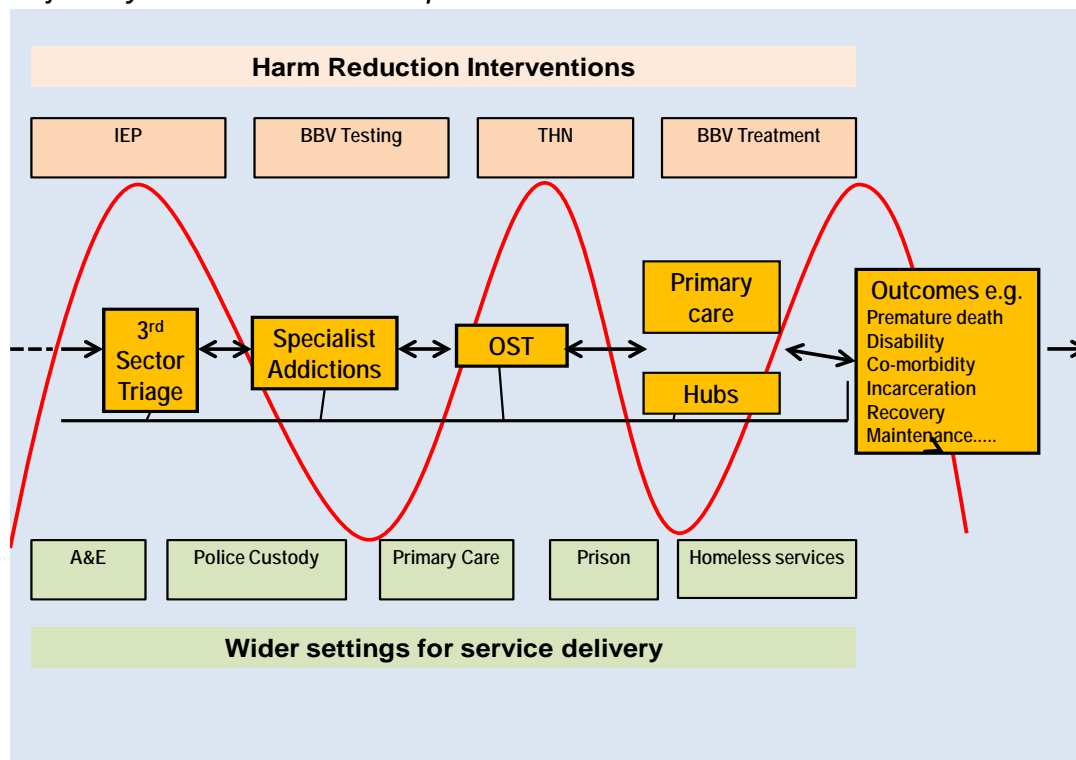
1.1 Harm Reduction

Harm reduction services for people who inject drugs aim to reduce the morbidity and mortality caused by a wide spectrum of health and social issues. There is a good understanding of what interventions are effective and these include opioid substitution therapy (OST), IEP, take home naloxone (THN), immunisation for hepatitis A and B viruses, testing care & treatment for BBVs and social support such as housing, employment and welfare. National guidance recommends that these interventions are provided as a core part of addictions services and that they are also available directly or by referral through other health and social services that care for people with problem drug use such as police custody, accident & emergency and housing services [4,5].

In 2008, the Scottish Government published 'The Road to Recovery' which emphasises recovery as the primary aim of drug and alcohol treatment services, whilst noting that harm reduction approaches are complementary [6]. However, recovery journeys are not straightforward and even those who are on OST will continue to be at risk from premature death, acquisition of blood borne viruses, severe skin and soft tissue infections, prescription poly pharmacy, incarceration, comorbidities, homelessness and social isolation. For example, NESI 2015-16 shows that in Lothian 58% of current injectors had received methadone in the last six months, 48% were HCV antibody positive and 22% had a skin or soft tissue infection in the last year. As a result, many people come into repeated contact with a variety of services including Accident & Emergency, police custody, prison, pharmacies, primary care and homeless services as well as drug treatment services. This means that throughout the road to recovery there are multiple opportunities to offer additional harm reduction interventions as a core part of care (Figure 1.1).

The recent emergence of NPS and re emergence of HIV in Glasgow both indicate that services need to be regularly refreshed so that they can continue to meet the needs of people who inject drugs. This needs assessment provides local information and recommendations that contribute to that aim.

Figure 1.1: Conceptual framework of the journey people may experience as they move through drug treatment services: the aim of harm reduction is to modify the trajectory so that there are improved outcomes



2.0 Aim, Scope and Objectives

2.1 Aim

To assess the health needs of people who inject drugs in the city of Edinburgh and make recommendations for the planning and delivery of harm reduction services.

2.2 Scope

The assessment covers the harm reduction needs of people in the City of Edinburgh who inject heroin, cocaine, other psychoactive substances and image & performance enhancing drugs.

This assessment did not have the capacity or remit to conduct a detailed review of services such as specialist opioid substitution therapy care, social care, accident & emergency, the needs of specific groups such as women or the needs of people in HMP Edinburgh. Where there is insufficient evidence to make detailed recommendations, general recommendations for further work are made on the basis of the evidence available.

Harm reduction interventions reviewed

Opioid substitution therapy; injecting equipment provision; take home naloxone; blood borne virus testing, care & treatment; and social care.

Settings reviewed

Specialist and primary care addictions services; general, enhanced and specialist injecting equipment provision services; accident and emergency; police custody; HMP Edinburgh.

2.3 Specific Objectives

In each setting and for each intervention:

1. Collate existing data on:
 - a. the characteristics and needs of the population
 - b. the current service provision – what and where services are provided, how they are provided and how they are utilised.
2. Consult service users and providers.
3. Make recommendations for knowledge and service development.