15.0 Conclusions and Recommendations

The data collected from service users, service providers and epidemiological sources is well aligned. This has made it possible to identify the unmet harm reduction needs of injecting drug users in Edinburgh, and to make recommendations to address these needs.

15.1 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.

15.2 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.

Evidence Summary

Epidemiology and services

- In 2016, the opioid substitution therapy (OST) programme in Edinburgh reached approximately 3440 (52%) of an estimated 6600 potential beneficiaries.
- OST services do not routinely provide other harm reduction measures as part of the core service.
- Up to 80% of drug treatment is low intensity and provided by general practitioners through the drug misuse National Enhanced Service.
- In all settings there is an increasing number of people aged over 40 years receiving treatment; 24% of the total with 19% being current injectors. This

population's health needs can be predicted to deteriorate in the medium term and for them to place severe pressure on secondary and bed-based care.
- A 2016 audit of specialist OST services, conducted at a time of transition, found long waits and low retention; of those presenting, approximately 20% of individuals received OST and 50% disengaged from all services within less than 3 months. This poses a significant clinical risk

Stakeholder consultation

- Service users identified as a major issue the difficulties posed by a lengthy assessment period for OST, a number of respondents suggested that 8-12 weeks is not unusual.
- Several service users talked in negative terms about what they perceived as a lack of control over how and when they could access services preferring for example 'drop ins' to an appointment system or specified time slots.
- Continuity of care is valued and critical transition points where care was disrupted, were highlighted by service users, e.g. release from prison or hospital, the OST assessment period, return to previous social networks.
- Staff in specialist services are generally perceived as supportive and helpful; this extends to some but not all providers in other services, such as some pharmacies and GP practices
- The quality of provision of OST was rated good or excellent by the majority of staff, but rapid access to OST (especially for high risk clients) was rated poorly.
- When asked about heroin assisted treatment, there were mixed views as to whether or not it was a good idea to introduce it.

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 polices, 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.

Evidence Summary

Epidemiology and Services

- Between August 1st 2015 and July 31st 2016, the Edinburgh Alcohol & Drugs Partnership provided injecting equipment to 1319 'regular' users; however 46% of users may still not be receiving enough injecting equipment (NEO 2015-16).
- 83% of regular injecting equipment provision (IEP) clients access community pharmacies and of these 89% exclusively so (NEO 2015-16). Pharmacies usually offer very limited harm reduction interventions, education or advice.
- IEP is mainly provided through designated 'IEP' services; harm reduction interventions are not opportunistically available as part of other consultations across the other tiers of addictions care.
- 75% of naloxone kits are distributed through NHS and third sector addictions services; there are opportunities for more distribution through hospital, social care, general practice and pharmacy services.

Client characteristics

- 19% of people reported injecting in the last month with injecting equipment other than needle/syringe that had previously been used by someone else, and 20% of people had reused the same needle/syringe more than 5 times it in the last six months (NESI 2015-16).
- 58% of people accessing IEP services are also on methadone (NESI 2015-16).
- There are an average of 102 admissions for psychoactive substance use admissions per month across Lothian A&E departments; 78% occurred in Edinburgh, and 55% of admissions stayed in hospital for >24 hrs (TRAK 2015-16). However, there are no formal arrangements in place for referral of in patients to harm reduction services.
- Needle discards in the city centre and interviews with homeless people indicate ongoing outdoor injecting.

Stakeholder views

- No service users interviewed said they had ever encountered difficulties in getting hold of clean works.
- When asked about safe injecting rooms, there was broad support but many reported that given the choice between a private place or a safe injecting facility, they would rather inject in a personal place due to privacy and comfort.

Actions

2.1 The harm reduction team should work with community pharmacy and third sector colleagues 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.

Evidence Summary

Epidemiology and services

- NESI 2015-16 reports the hepatitis C antibody prevalence of people attending IEP services in Edinburgh as 48%. This is a rise of 7% from 41% in 2013-14.
- 59% of people attending IEP sites had been tested for HCV in the last year (NESI 2015-6). However, local data for 2015-16 indicates that 45% of current injectors in specialist services, and 58% under the general practice drug misuse National Enhanced Service were untested for HCV in the year since last test.
- NHS Lothian exceeded its HCV treatment targets for 2016/17 and has high rates of treatment success. However, in 2015-16, 51% of current or ex- injectors referred for HCV 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.

Stakeholder consultation

- Most service users interviewed had been tested for HCV and HIV and knew their status. There was no clear evidence of widespread reluctance to take up treatment for hepatitis C.
- Most staff respondents felt that availability of blood-borne virus testing and referral for assessment for was good or excellent, although 46% reported that active support for completion was fair or poor.

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.

Evidence Summary

Epidemiology and services

- The population of people who inject drugs is ageing and older drug users have significantly higher rates of hospital admission for comorbidities such as chronic obstructive pulmonary disease, depression, deep vein thrombosis/pulmonary embolism and skin and soft tissue infections than comparable groups of the same age.
- In Lothian in 2016, in 64% of drug related deaths a co-morbidity was present: 20% chronic respiratory, 10% hepatitis, 60% mental health; 54% alcohol misuse.
- 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.
- Patients registered with general practitioners have access to medical care, but some people have difficulty registering with a GP especially on release from prison; the Edinburgh Access Practice support homeless individuals but others may continue to be unregistered.

Stakeholder feedback

- Poor mental health, often linked with traumatic events prior to, or arising from their drug use, was identified as an unmet need by almost all service users and was also identified as a major gap by staff.
- Most service users interviewed were smokers with a significant number suffering from chronic obstructive pulmonary disease.
- Staff and service users also felt that wound care, ulcers, abscesses and deep vein thrombosis risk were an increasing unmet health need.

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.

Evidence Summary

Epidemiology and services

- Drug-related deaths (DRD) in NHS Lothian have increased by 30% from 2015 to 2016. Seventy percent of DRD in Lothian occur in Edinburgh. Non-fatal overdoses are a major risk factor for DRD. In 2016, 37% were under the age of 35.
- Homeless people account for 30% of regular IEP users and city centre needle discards indicate ongoing street injecting.
- Older people who inject drugs have significantly higher rates of hospital admission for respiratory (six times greater), cardio vascular, bacterial infections and enduring mental health illness (10 times greater) than comparable groups of the same age.
- Men who have sex with men are at risk from ‘chemsex’.
- Younger people who inject drugs (aged under 25 years) comprise 4% of regular injectors, but 21% of people using image and performance enhancing drugs (IPED) are aged under 25 years (NEO 2015-16). NESI 2015-16 reports that 33% of people in Lothian start injecting between 19-25 years and that people leaving prison in the last six months are younger and more likely to be homeless than the general drug injecting population.
- Contact with the criminal justice system is associated with DRD. NESI 2015-16 reports 15% of injectors have been in prison in the last 6 months and 80% have

ever been in prison. In Lothian in 2016, 26% of DRD had been released from police custody in the previous 6 months.
- Women account for 25% of DRD in 2016 and the average age is 37 years; 7 years younger than men. The social care homeless data base indicates that 6/7 women registered were victims of violence.

Stakeholder consultation

- Most of the service users interviewed as part of the needs assessment had been in prison or were homeless, so the feedback in previous sections can be applied to these vulnerable groups. However it is notable that the proportion of women interviewed in all settings is low and so their views may be less prominent.

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.

Evidence Summary

- 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..

- Quality and completeness of 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.

- Service providers expressed the need for protected learning time to develop their skill mix in areas such as: sexual health, wound management, substance use in transgender and MSM populations, management of people using IPEDs, motivational skills, quality improvement, chronic disease management, trauma informed practice and service user involvement.

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 Drugs 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.

15.3 Implementation

The challenges to implementation remain, as ever, availability of funds, clinical governance, logistics, availability and sharing of data and intelligence, organisational culture, staff capacity and training.

However, there does need to be service change in the areas identified by this assessment. In most cases it is proposed that the recommendations be tried out through small tests of change, which once evaluated will inform roll out across the city; and where necessary justify additional resource to support the work.

A multiagency group will oversee the implementation of the recommendations and there will be feedback and consultation with service users and providers on progress.