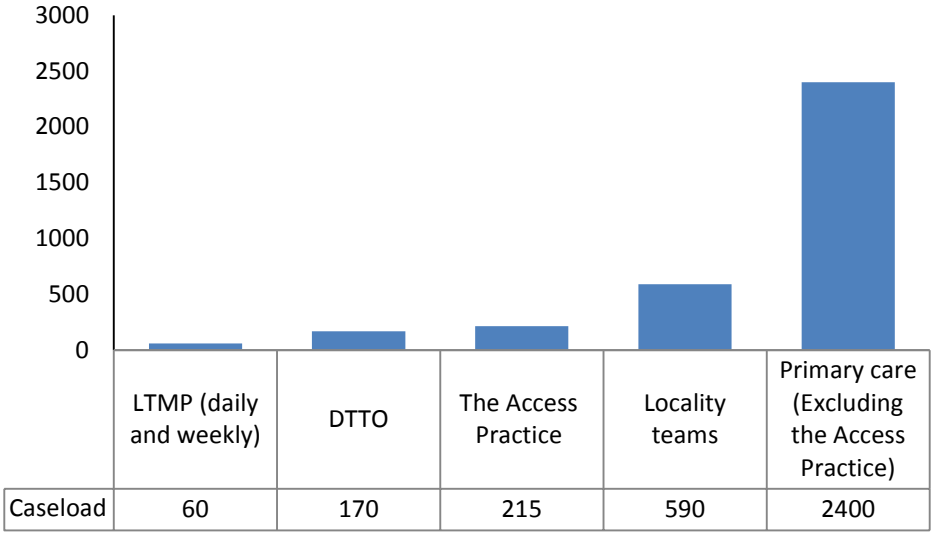
5.0 Opioid Substitution Therapy

There are an estimated 6,600 problematic drug users in Edinburgh, of whom 4,500 are male and 2,100 are female [34]. Based on 'snap shots' of the caseload, there are approximately 3,440[1] patients receiving clinical treatment for drug use in Edinburgh at any one time; i.e. about half of those in the city of Edinburgh who may benefit from prescribing are receiving it (Figure 5.1). This is lower than treatment reach in England (in 2011-12, 62% of opiate users in England were in treatment) but significantly better than the Scottish average of 35% [35]. In Edinburgh and the Lothians, the general aim is that specialist services initiate care and manage the most complex patients while primary care provide maintenance treatment and manage more stable patients.

Figure 5.1: *Approximate OST caseloads of different services in Edinburgh*



5.1 Treatment in specialist services

Of the 1,200 people entering specialist treatment in 2015-16[2], 240 (20%) reported injecting within the last month and a further 356 (30%) reported ever injecting but not within the last month (Table 5.1).

Table 5.1: *Number of people in specialist drug treatment, Edinburgh 2015-16*

Non-injectors	604 (50%)
Former injectors	356 (30%)
Current/ recent injectors	240 (20%)

Source: ISD SMR25a records for SMD drugs treatment patients, 2015-16

[1] Sources: LTMP and DTTO (teams' internal data), locality teams [36], the Edinburgh Access Practice and primary care (PCFT). Note that there is a risk of double counting.

[2] Sources: locality clinical teams, LTMP, DTTO and LEAP. Note that there is a risk of double counting.

Younger patients entering drugs treatment are less likely to use heroin and less likely to be injectors [37]. However, the age and the complexity of the population in treatment has increased in recent years; this is true for those presenting for the first time and those in established treatment.

In Edinburgh during 2015/16, 24% of people in specialist treatment were aged over 40 years; 19% of current injectors and 32% of people who had ever injected. Nationally, the percentage of individuals assessed for specialist drug treatment who were aged 35 and over increased from 30% in 2006/07 to 50% in 2015/16 [37]. A recent review of older people shows much higher rates of co morbidities and hospital admissions compared to the general population and makes recommendations to address these issues through specialist and primary care services [38].

5.2 Treatment in primary care

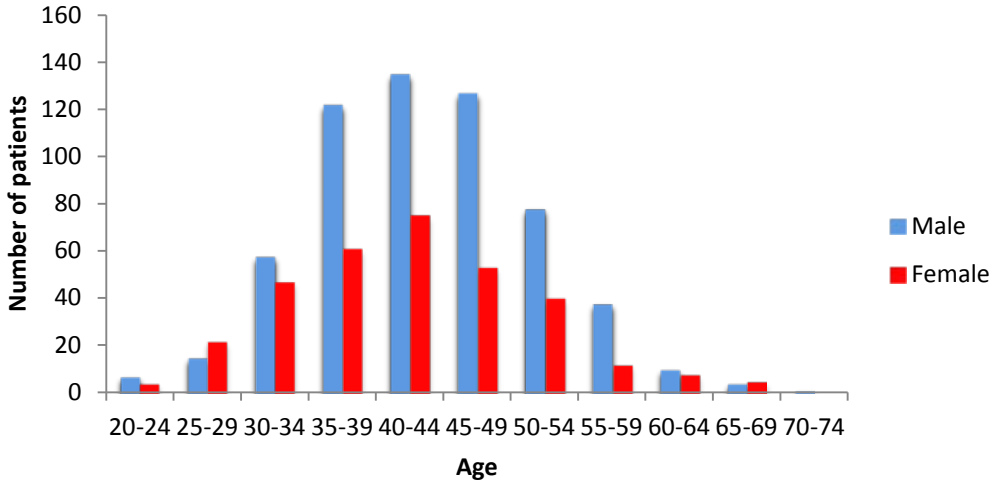
Over 2016, 2,817 people in Edinburgh received treatment for problem drug use in general practice (excluding the Edinburgh Access Practice) under the drug misuse National Enhanced Service (NES). This represents about 80% of the total in treatment for addictions. Most were prescribed opioid substitution therapy (OST): approximately 1,900 (67%) were prescribed methadone, and 150 (5%) buprenorphine.

The majority were coded as either previous injectors (52%) or had never injected (33%), and 378 (13%) were current injectors (defined as those reporting injecting in the last 12 months). Of current injectors, 247 (65%) were aged 30 to 49 years and 24% were female. There was no significant difference between localities and the age and sex distribution in Figure 5.2 is representative of the population in general practice treatment.

Table 5.2: *Number of people in Edinburgh receiving treatment for problem drug use by locality*

Latest recorded injecting status	North West	South West	South East	North East	Total
Currently Injecting	71	60	160	87	**378**
Never Injected	216	211	156	337	**920**
Previous Injector	312	312	367	488	**1479**
Not recorded	9	1	20	10	**40**
Total	**608**	**584**	**703**	**922**	**2817**

Figure 5.2 *Age group and gender of drug misuse National Enhanced Service (NES) patients in Edinburgh North East 2016*



5.3 Description of the main pathways to opioid substitution therapy

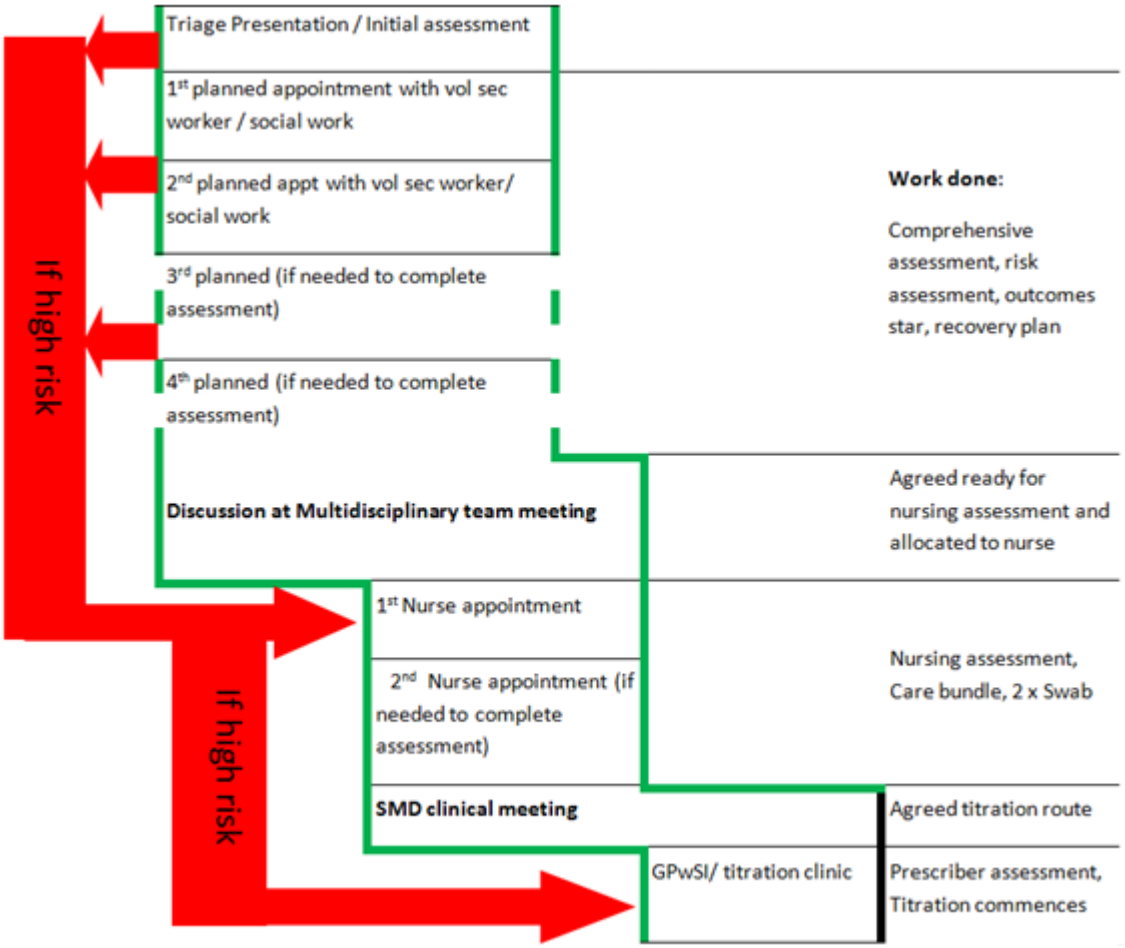
There are six pathways into OST. Each provide assessment and titration, and aim to support recovery or open-ended maintenance through either primary care or locality teams.

Pathway 1: Access though locality teams (hubs)

This is the most widely used pathway into OST. Rapid treatment access is a long term challenge in Edinburgh and prescribing services have never consistently achieved the HEAT target of 90% of those referred being engaged in treatment within 3 weeks of referral [39]**.** This challenge has been exacerbated by declining resources.

Arrangements for access to prescribing via the hubs were revised in April 2016 and the standard pathway is set out in Figure 5.3. There are weekly, or more regular, drop in sessions at eight locations in the city where people can access initial assessment with a third sector worker. The pathway thereafter involves assessment from key workers, nurses and prescribers (GP's with a special interest [GPwSI] in addiction, or consultants). Initial assessment identifies people at highest risk (e.g. recent release from custody, those with low tolerance or high risk injecting practices) and their assessment can be expedited. The pathway is flexible; clients are risk assessed at each stage and it is possible to accelerate progress towards titration or refer to the Low Threshold Methadone Programme (LTMP) at Spittal Street Centre.

Figure 5.3: *Standard pathway from presentation to titration onto OST via hubs teams*



The minimum number of assessment appointments needed prior to initiation of prescribing for a new patient can be as low as two for high risk clients, but typically it would be six or more with two to four practitioners involved. Once a patient is accepted for nursing assessment the wait is short and service data indicates that over 90% of people engage with treatment. However, overall the number of new patients engaging with treatment is much lower.

Almost all the patients on OST in the locality teams are on the caseload of a nurse and for many years the main restriction on access to OST has been the finite nursing capacity available. Although the drug misuse NES GPs do manage some complex patients and non prescribing practices tend to be in areas with low problem drug use, the numbers entering the specialist service cannot always be balanced by the numbers leaving. As resources have reduced this has resulted in increased pressure on the nurse caseloads, and staff shortages in nursing or voluntary sector teams can lead to delays in treatment access.

National guidance recommends that treatment for drug misuse should include psychosocial aspects and the pathway provides opportunities for nursing and third

sector staff to provide this support [40]. It is not clear, however, that this is always effective; a recent small audit in Edinburgh North West, indicated that most patients disengaged from third sector services once started on OST, and delivery of psychosocial interventions by the pressurised nursing teams is challenging.

Table 5.3: *Strengths and challenges: access to OST though locality teams (hubs)*

Strengths
Locality based, easy access for initial presentation and ongoing treatment
Comprehensive, multi-disciplinary range of interventions, some co-located services
Ability to fast track to OST and LTMP based on risk
Thorough assessment and screening of patients for 'capacity to benefit'
Follow up and outreach provided by the third sector, social workers and nurses
Integration with primary care in localities
Challenges
High demand and throughput challenges
Complex assessment process for non-urgent patients
Long waits
High drop-out rates pre-titration
Where no physical 'hub' continuity of care difficult across dispersed service locations

Pathway 2: Low threshold Methadone Programme

The Low Threshold Methadone Programme (LTMP) is delivered by the Harm Reduction Team at the Spittal Street Centre. It treats high risk injectors who self-present or who are referred by the Hubs. Most have psychiatric or other co-morbidities, present behavioural risks or are homeless. At any given time, there are approximately 30 people being seen with daily appointments and 30 with weekly appointments.

LTMP offers the most intensive supervision and support for people initiating OST. There is daily contact with the therapeutic team (weekday medication is collected and consumed on the premises) and twice weekly contact with a non-medical prescriber (NMP). Clients can opportunistically engage with the other psychosocial, and clinical interventions available at Spittal Street Centre. These include routine contact with people with lived experience and a recent qualitative study found that peer support enables service user engagement with treatment [41].

Evaluation and monitoring of the model indicates that open drop in sessions where patients can access support from a team of workers, versus, reliance on pre-booked 1:1 appointments for all contacts, can increase retention in treatment [42]. Following titration and stabilisation, people are seen weekly in the LTMP (with daily collection from pharmacy) and when ready they return to general practice or locality teams.

Table 5.4: *Strengths and challenges: Low Threshold Methadone Programme*

Strengths
Good access to initial and ongoing care with good retention and continuity of care
High intensity intervention including weekday contact with therapeutic staff
Opportunistic engagement in other psychosocial and clinical interventions
Safe rapid titration with twice weekly increases, close observation of mental and physical state, easy to resume OST following missed doses
Challenges
Geographically limited and regular attendance at a single location is required
Slightly longer wait and more complex access than the Edinburgh Access Practice; patients can only self-refer once per week
Integration with other teams and the stepped care model is unclear

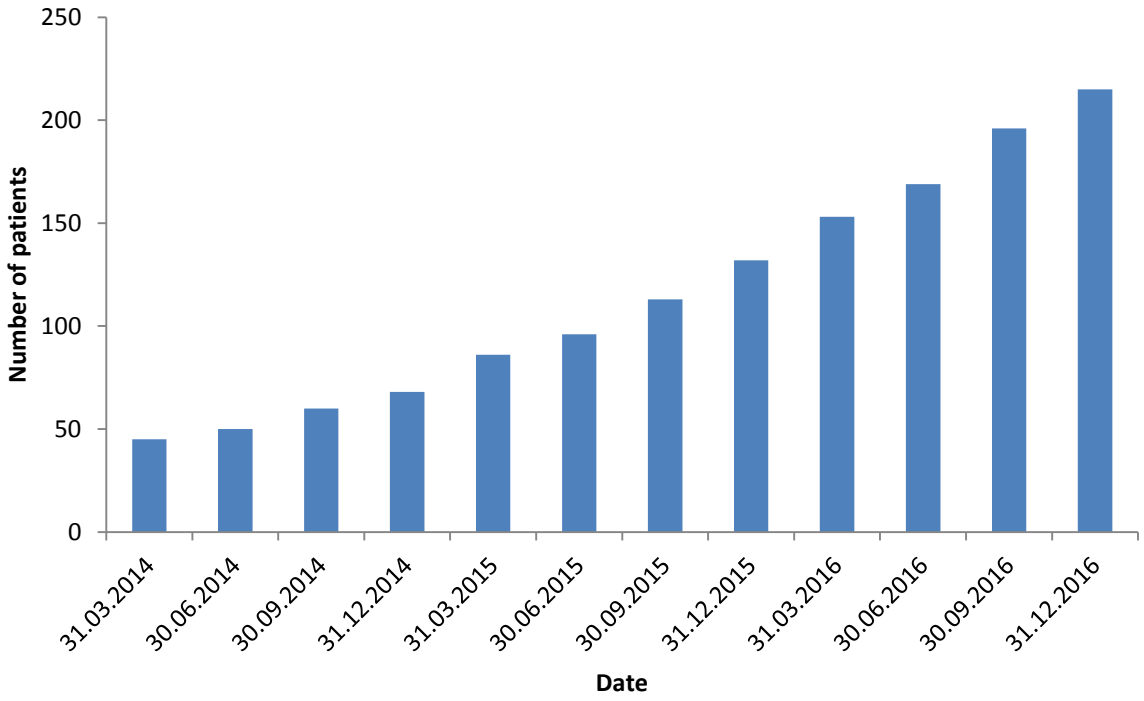
Pathway 3: The Edinburgh Access Practice.

The Edinburgh Access practice provides OST at the Spittal Street clinic.
Unlike other general practices, Edinburgh Access Practice routinely initiates prescribing with nursing non-medical prescribers (NMPs). The pathway is the shortest and simplest route to OST requiring a minimum of two appointments with the nurse and with weekday dispensing supervised in pharmacies. It is available only for those who are homeless or not registered with another GP. The demand for the service has risen sharply in recent years and there is limited opportunity for throughput by returning patients to mainstream primary care when they achieve stable housing.

Table 5.5: *Strengths and challenges: Edinburgh Access Practice*

Strengths
Good access with a single assessment process and practitioner relationship in a single location
Safe, rapid titration with 1-2 increases per week
Pharmacy medication pick up is flexible on location and time
Very close linkage to general medical interventions in primary care
Challenges
Geographically limited and regular attendance at a single location is required
Less intense observation than LTMP and fewer opportunities for other interventions
Access to this very low threshold pathway is not vulnerability/ risk, it is homelessness
Not directly linked to any wider recovery options

Figure 5.4: *Number of drug misuse National Enhanced Service (NES) patients at the Edinburgh Access Practice with one appointment in the previous 6 months*



Pathway 4: Drug treatment and Testing Order

The Drugs Treatment and Testing Order (DTTO) team offer OST as part of a legal order and can only be accessed through a court sentence. It is a major provider of OST and approximately 170 of the 200 people sentenced to a DTTO at any given time will be on OST. There is high engagement, with 70-80% of those assessed going on to treatment which is initiated within one month of an order. The team as a whole provides a diverse range of practical and therapeutic support, engagement with which is coerced by the court order.

Table 5.6: *Strengths and challenges: Drug Treatment and Testing Order*

Strengths
High intensity of psychosocial support and a legal incentive to engage and progress
Safe, rapid titration with 1-2 increases per week
Access to a multidisciplinary team to provide motivational and wrap around support
Challenges
Necessarily restricted eligibility
Not closely integrated with mainstream treatment services
Intensity of support during order cannot readily be sustained after its completion

Pathway 5: Prison

This is described in the chapter on Criminal Justice Services

Pathway 6: Drug Misuse National Enhanced Service

After stabilisation, most individuals in all pathways move to ongoing OST with their GP. This ability to retain patients in treatment without further pressure on the specialist teams is the main reason that Edinburgh has a relatively high proportion of opiate users engaged with OST. In this setting, patients probably have improved access to care for co-morbidities, but may have reduced access to psychosocial interventions and other harm reduction measures, although there are examples of third sector outreach in practices to provide additional support.

Table 5.7: *Strengths and challenges: Drug Misuse National Enhanced Service*

Strengths
Large numbers of people are cared for, in accessible locations at relatively low cost
Provision of general medical services
GPs have long established relationships with the individual and their community
Challenges
Inconsistent provision across practices and the risk that GPs capacity may reduce
It is hard for GPs to get patients “up” the stepped care model to restart OST
Variable intensity of review and psychosocial interventions limit patient progress

5.4 Evaluation of the opioid substitution therapy pathway in Hubs

A review of OST provision in Edinburgh hubs was commissioned by the Edinburgh ADP in 2016 [36]. Evaluation of the pathway identified high levels of drop out between initial presentation and prescribing; of those presenting, approximately 20% of individuals received OST and 50% disengaged from all services within less than 3 months. This data requires careful interpretation as it was gathered at a time of transition to a new model of care and does not offer a comparison with the previous models of care. However, it does suggest a significant clinical risk.

The review proposed a stepped care model of OST in localities to lower the barriers to prescribing. This would include an extended role for third sector workers, non-medical prescribers and closer integration with GP prescribing. However, these recommendations create significant challenges in terms of governance, use of the skill mix within the teams and the relationships between primary and secondary care. Furthermore, there is a view that the move to third sector as the first point of referral following triage for most new assessment has contributed to delays in accessing OST and that one way to reduce delays and increase retention may be to increase investment in Substance Misuse Directorate (SMD) nursing. At this point in time the recommendations have not been adopted.

5.5 Opportunities to build on current best practice

To expand or replicate, in other areas of Lothian, the approaches of the Edinburgh Access Practice or LTMP in their current form would be extremely resource intensive. However, elements of the approaches could be adopted elsewhere according to the needs of the local population and capacity of locality teams. Key

elements may include: task shifting of third sector staff to take on roles such as testing for drugs and blood-borne viruses; non medical prescribers in locality teams; increased skill mix of locality teams e.g. to include wound care and psychosocial interventions; and an increased contribution made by people with lived experience.

5.6 Key findings: Opioid substitution therapy

- The six pathways to OST in Edinburgh provide a good range of options for drug users in the city and are linked with psychosocial and other health and harm reduction interventions.

- In Edinburgh, 52% of those who may benefit from prescribing are receiving it; this is lower than the England figure of 62% but higher than the reported Scottish average of 35%. (ISD 2014)

- Low intensity opioid substitution therapy in primary care is an essential part of the service and includes up to 80% of the case load in Edinburgh.

- An increasing number of patients on OST are over 40 years and have much higher rates of comorbidities than in the general population. (drug misuse NES data)

- 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.

- At present, there is a lack of reliable routinely available data which can be used to monitor access to and retention in OST in Edinburgh.

- There are opportunities to learn from, and adapt for other localities, current good practice in Edinburgh such as the Low Threshold Methadone Programme and Edinburgh Access Practice low threshold services.