# Needs assessment and feasibility study for a safer drug consumption facility in Edinburgh

## Executive summary and recommendations

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# Executive summary

## Background

In January 2023 the Edinburgh Alcohol and Drug Partnership commissioned an independent needs assessment and feasibility study for a safer drug consumption facility (SDCF) in Edinburgh. The research was carried out by a team based at the University of Stirling, Glasgow Caledonian University, University of Glasgow and Figure 8 Consultancy. It involved four key work packages:

- a review of the global literature on SDCFs, with a focus on service design and evaluation
- an assessment of available data for drug consumption trends, harms and service provision in Edinburgh
- interviews with people with lived and living experience of substance use in the city, and family members affected by substance use
- interviews with key professional stakeholders and decision-makers likely to be involved in either the commissioning or delivery of a service in the city

This report presents the findings from these four work packages, with recommendation for next steps.

## What we know about safer drug consumption facilities

At the time of writing, over 200 SDCFs operate globally in at least 12 countries. There is extensive global evidence on the effectiveness of safer drug consumption facilities, including evaluations of a range of outcomes in a number of settings. While the evidence base is discussed in detail in Section 1, it is broadly accepted that SDCFs can play a key role in:

- reducing the risk of overdose for those consuming in the facility
- supporting safer injecting practices among people attending the facility
- providing harm reduction advice for people attending facilities
- signposting and / or referring attendees to wider social support and treatment services
- reducing drug litter in the vicinity and improving public amenity

Research has also pointed to the key role SDCFs can play in tackling experienced stigma, and supporting compassionate care, by providing non-judgemental spaces for people who use drugs.

In September 2023, it was announced that NHS Glasgow and Clyde would open an SDCF in 2024. This was made possible following a statement of prosecution policy by the Lord Advocate which accepted that such a facility could play a role in tackling the specific harms faced in Glasgow. The Glasgow facility will be subject to detailed evaluation, as required by the Lord Advocate in her statement.

The facility proposed for Glasgow will be co-located with an existing Heroin Assisted Treatment facility and delivered primarily by NHS staff. As such, it represents one of a wide range of possible service models for SDCF provision. Section 1 of this report discusses the global evidence on the range

of existing service models and facility designs in detail. Fundamentally, facilities vary on whether they are fixed or mobile; integrated with existing services or standalone; and on the balance of staffing between people with lived or living experience and clinically trained professionals. Services also vary considerably in regard to internal design features, with different facilities aiming to create more or less informal atmospheres, as well as wide variation in range of ancillary services on offer.

Section 1 describes the advantages and costs associated with different service designs, according to the available global evidence. It demonstrates that, while there are a number of core elements of provision that any SDCF can be expected to provide, commissioners may consider a wide range of possible design approaches, staffing models, and levels of ancillary provision. Ideally, these should reflect the needs identified in the specific setting and be designed to maximise use while maintaining appropriate levels of oversight and risk mitigation.

While there is strong evidence that SDCFs can contribute to the reduction of a number of harms, they only represent one element in the wider harm reduction and treatment landscape for people who use drugs. This is borne out by the available evidence on outcomes, and is a view strongly expressed by the interview participants in our study. Furthermore, while overdose prevention is a key purpose of SDCF provision, their potential for providing wider support, signposting and referral to other services is vital. Globally, most SDCFs provide some degree of wider support, and there was very strong agreement across our interview participants that these broader benefits were a critical aspect of SDCF provision.

None of our participants viewed SDCF provision as a 'silver bullet', and the global evidence base does not suggest that is how they should be viewed. Rather, their adoption should be based on a thorough assessment of whether they can make a positive, and unique, contribution to the range of harm reduction and treatment services currently available in any given setting. The evidence presented in the following report suggests that SDCF provision could make such a contribution in Edinburgh.

## Current patterns of use and harm in Edinburgh

Calls for the adoption of SDCF provision in Scotland have been driven by continued increases in drug related harms, including drug-related deaths, transmission of blood-borne viruses, non-fatal overdoses and hospital admissions over the preceding decade. While the scale of the public health crisis across Scotland is widely recognised, there remain debates as to the best balance of measures and consequent funding allocation to tackle these problems.

Rates of drug-related harm in Edinburgh and the NHS Lothian region have consistently been above the national average. Section 2 collates the available data for drug consumption trends, harms, and access to harm reduction and treatment service from across the city. It aims to provide a comprehensive picture of need within Edinburgh, including an indication of trends over time, and to identify where areas of harm are concentrated. It reveals a situation in which both consumption and harm are relatively dispersed across the city, albeit with specific areas of elevated harms including the city centre, especially around the Old Town, parts of Leith and areas within the EH11 postcode.

Edinburgh does not have a single, geographically specific 'open drug scene', and there is not one outstanding location which obviously presents itself as the natural site for a standalone SDCF. Instead, there are pockets of increased harm within more widespread areas of elevated consumption. Both the data analysis and participant interviews point to particularly dense clusters of harm in the Old Town and parts of Leith. There are also clusters in more outlying areas including Granton, Gracemount, Niddrie and Wester Hailes, and along the A70 in parts of Gorgie, Dalry and Fountainbridge.

This has implications for both the possible location and design of a proposed SDCF. Among interview participants, the balance of opinion fell towards the provision of more than one SDCF in the city, in order to meet need where it was most acute and address issues around the time needed to travel to the service. However, there was also a common view that the city centre would provide the best location for a single service on pragmatic grounds, and because it was also an area of very high harm.

Sections 2 and 3 also draw attention to significant changes in patterns of drug consumption in Edinburgh, especially within the city's more marginalised populations. In particular, many participants highlighted a rapid increase in the levels of cocaine (sometimes referred to as 'prop') injecting in the city, as well as increasing harms from the use of benzodiazepines. While injected heroin use remains a very significant concern, and source of considerable harm, it is one form of consumption among a wide range of high-risk behaviours. Furthermore, multiple drugs are often taken at the same time.

These developing patterns of use also have critical implications for SDCF provision. Participants noted that injected cocaine use often involves much higher frequency of injection and leads to different behavioural responses to injected heroin. Because they are generally consumed as pills, benzodiazepines also imply different harm reduction responses that may complicate the assessment of risks and harms within an SDCF. The reality of complex and variable patterns of drug consumption suggests that SDCF provision needs to be designed to accommodate drugs other than injected heroin, and ensure staff are trained to deal with a range of possible adverse effects.

At the same time, Edinburgh – alongside the rest of the UK – faces the prospect of increased levels of synthetic opioids in the drug supply chain. 2023 saw spikes in drug deaths in a number of regions across the UK that were associated with nitazenes and other synthetic opioids. In the context of a significant – and possibly sustained – reduction in the global supply of raw opium, the risk of increased synthetic opioid use is pronounced. SDCF provision would clearly provide a key opportunity for harm reduction in this context, as it creates spaces in which inadvertent overdose can be monitored and responded to quickly and effectively.

## Feasibility and acceptability

Section 1 discusses the available research evidence on the acceptability of SDCFs among people who use drugs, as well as addressing what aspects of service design are likely to increase the attractiveness of facilities. The global evidence demonstrates high levels of acceptance among key target populations, and high levels of use for established facilities.

In Sections 3 and 4, many of the interview participants for this study note that there is no 'one size fits all' for SDCF design. However, there are key features that are shared among established and successful services. In terms of safety and governance, clear operating procedures, risk management, and clinical oversight are essential for a formally commissioned service. However, there are also many examples, as discussed in Section 1, of informal and 'pop-up' services, where the demands of conventional clinical governance are balanced against the advantages of providing highly accessible, 'low threshold' services in areas of acute need.

There was a very strong preference among all interview participants for a service that was relatively informal and welcoming. It was felt that this required, in part, considerate design that avoided an excessively 'clinical' feel. The inclusion of people with lived experience in the design and development of any SDCF was viewed by many as vital to achieving this. There was also very strong support for the inclusion of people with lived experience in the staffing and delivery of any SDCF. This

was not, however, to the exclusion of trained clinical staff. The broad preference was for services that combined the skills and knowledge acquired through both lived experience and specialist professional training.

There was also a strongly expressed concern that physical safety be protected in any SDCF. Many participants with lived experience commented that, while informality was important, there was also a need to maintain clear rules and regulations in order to protect both staff and service users from either disorder or attempts to supply drugs in or around the premises.

The available evidence suggests that, where services are viewed as safe and welcoming, there is significant demand among people who use drugs, often among the most vulnerable and marginalised in those communities. Participants with lived experience showed high levels of support for a service and viewed SDCF provision as an opportunity to not only address acute issues around safety but also to create spaces where the pressures and anxieties of day-to-day life could be reduced, and the persistent experience of stigma eased. This was seen as creating significant additional benefits in terms of developing relationships and finding support towards treatment and recovery.

The potential of a safe, welcoming space to support longer-term goals, including moving towards recovery and reducing drug use, was emphasised by many participants. This highlights the importance of creating facilities that support clients to connect into wider services and enable pathways into treatment for those who are seeking it. There was little backing for a service that simply provided a space for consumption of drugs alone. Therefore, the commissioning of any future facility needs to place an emphasis on the capacity of the service providers to facilitate this wider support, and to integrate the service effectively with existing treatment and harm reduction provision within the city.

While the professional stakeholders we spoke to had varied levels of knowledge around the specific details of SDCF provision, there was significant support for their adoption in principle. All saw them as creating potential benefits in terms of both addressing acute risks and enabling longer-term outcomes. There was a clear understanding, however, that the establishment of SDCF provision would come at a cost and that there were implications for resource allocation. For some participants, there were more pressing priorities and other areas of provision that they felt could achieve more significant outcomes. There was not universal agreement that funding an SDCF was the highest priority or would necessarily represent the best use of limited resources. Across those interviewed – including people with lived and living experience, families and key professional stakeholders – there was clear and strong support for SDCF adoption as part of the wider treatment and harm reduction landscape, and a belief that it could achieve unique outcomes, especially among people at the highest levels of risk. Nevertheless, the question of resource allocation needs to be addressed openly, and agreement reached that the financial costs are justified by the potential benefits.

## Cost effectiveness

The cost-effectiveness literature is discussed in Section 1. Global evidence on cost-effectiveness suggests that SDCF provision can lead to overall savings; however, estimates are dependent on assumptions made regarding outcome effects and costs allocated to either mortality or specific conditions, and these vary by setting. For example, much of the available literature identifies a reduction in blood borne virus transmission as a key cost saving. This means assessment of potential savings is dependent both on the reduction expected from a facility, and the existing level and trends of BBV transmission within the proposed community. Furthermore, there are potential trade-offs between the cost of single or multiple services, and the level of ancillary provision that may be

available in each service if there are more than one. Therefore, detailed cost-benefit assessment requires accurate proposed costs for provision, and options for provision at different scales.

While the number and type of facilities remain undetermined, and without concrete estimates from potential providers, it is not possible to provide a robust assessment of cost effectiveness, calculated in financial terms, at this stage. In assessing this ahead of final commissioning, it is important that calculations are developed for estimating the financial costs of key harms within the city, as well as inviting detailed and costed proposals from potential providers.

## Summary of findings

- There are significant levels of drug-related harm across the city, a number of which could be mitigated by SDCF provision
- Patterns of drug consumption and harm are dispersed across the city, but with identifiable hotspots in some areas
- Patterns of use in the city are varied and dynamic, with particularly high levels of cocaine injecting and benzodiazepine use
- There is a recognised risk of increased harms due to higher levels of synthetic opioids entering the drug supply
- There is strong support for SDCF provision among the people with lived / living experience, family members and professional stakeholders interviewed for the study
- While support for SDCF provision is strong among professional stakeholders, there are mixed views on prioritisation and levels of resource allocation in relation to other relevant services
- SDCF provision is widely viewed as valuable for more than overdose response. Safer injecting support, education, signposting to wider services and support into treatment and recovery are also viewed as key functions
- There is strong support for extensive service delivery by peers / people with lived experience and a degree of informality in service design
- There is also support for trained clinical expertise and clear operating procedures to protect safety and security on-site
- Strong links between SDCF provision and wider services are seen as critical

## Recommendations

The City of Edinburgh Council and Alcohol and Drug Partnership should take steps to introduce SDCF provision in the city. Given the dispersed patterns of harm, this should ideally include more than one location. To this end, we recommend the following next steps.

### Consultation

- Explore the feasibility of provision in identified hotspot areas in depth, including:
    - continuing engagement with potential service users, and others with lived and living experience, on preferences and needs
    - launching a community consultation in hotspot areas focusing on experiences of drug-related harm and the potential impacts of an SDCF
    - consultation with homelessness and drug services in hotspot areas to explore the option of embedded provision

- establishing protocols to share relevant data at the lowest possible geographies to track patterns over time

## Service development

- Develop service designs that include:
  - extensive levels of trained peer delivery
  - provision of spaces and support appropriate to a range of drug consumption including opioids, stimulants and benzodiazepines
  - creating an inviting and informal atmosphere with psychologically informed design
  - clear plans for education provision and wider harm reduction support, including injecting equipment provision, take-home naloxone, wound care, and BBV testing and support
  - clear plans for supporting people who use the service into treatment and recovery where appropriate
  - training to support staff to address a range of drug responses effectively and sensitively
  - operating procedures that ensure safety of staff and people using the service
  - clear plans for design coproduction, including people with lived and living experience
  - clarity on clinical staffing requirements

- Engage with and learn from other sites for where SDCF are established or in development in Scotland and internationally.

- Develop an evaluation framework and begin the organised collation of baseline data at the earliest possible point to allow for robust evaluation of outcomes

## Legal considerations

- Secure bespoke legal advice to ensure proposed operating procedures remain lawful

- Embark on early engagement with local police and the Crown Office and Procurator Fiscal Service to establish shared principles and work towards the development of shared agreements

## Finance and costs

- Initiate of discussions with local and national government decision makers to ascertain the potential financial envelope for service provision

- Liaise with potential providers to explore costs and feasibility of standalone and integrated provision

## Communication

- Develop a communication plan to provide stakeholders and the public with information about SDCF provision, and the place of a potential service in the wider treatment, recovery and harm reduction landscape in Edinburgh.