Heroin Assisted Treatment - Exploring a Business Case

Andrew Horne, Dip Drug and Alcohol Studies, PGDIP Social Work Management

Kenny Leinster, BA (Hons) Social Sciences, PGDIP Social Work, PGDIP Collaborative Leadership

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1. Brief

The writers have been commissioned to prepare a detailed and sustainable business case exploring options for Heroin Assisted Treatment (HAT) in Dundee. This will support Dundee ADP in partnership with the Scottish Government to make fully informed decisions about any potential future implementation of HAT in Dundee. It will also be an important source of information for the Scottish Government and other ADPs across Scotland to inform their future discussions and decisions relating to HAT.

2. Background

HAT is one of a number of approaches identified as attempting to resolve some of the issues of heroin use within a population. In some countries it has become an integral component of an attempt to curtail the use of intravenous heroin injecting with significant capital and revenue investment in this approach. Supervised injectable heroin (SIH) treatment was first introduced in Switzerland in the mid 1990s as a way of managing the increased street use of heroin. HAT has since become available to long term heroin users in a number of European countries and Canada. HAT is delivered under direct medical supervision in order to ensure safety and prevent the introduction of medicinal heroin to the illicit market. It is administered in specialised premises which are open seven days per week fifty two weeks of the year. Patients attend up to three times per day determined by the opening hours of the clinic and the needs of the patients.

HAT has most commonly been used as a model of treatment for a specific and highly vulnerable population of individuals, this is people who have a history of injecting "street" heroin, have previously attended community based treatment services with little progress towards stability and recovery. They may in the past have been on Opiate Replacement Therapy (ORT) programmes and are no longer in treatment.

The intention of HAT is to reduce the use of "street" heroin and its associated harms, reduce the risk of drug related deaths, improve the physical and mental health of patients and their overall

well being and social functioning. In addition, the aim is to reduce involvement in criminal behaviour and involvement with the criminal justice system.

In Britain there has been limited use of this approach, the two areas with most recent experience being Middlesborough and Glasgow. The former service is no longer operational while the service in Glasgow has been running for over three years. Dundee has a high level of drug related harm and is keen to explore routes to reducing drug related deaths and developing innovative ways of reducing the use of illicit drugs across the city.

This report examines the issues associated with the introduction of a HAT service in Dundee and considers the environmental conditions in which a HAT service can be most effective.

3. Literature review.

It is important to identify where similar services have been developed and consider the outcome of these. Heroin Assisted Treatment (HAT) has been described in a number of ways which include Injectable Opioid Treatment, (IOD), Supervised Injectable Heroin (SIH) and Diamorphine Assisted Treatment (DAT)

There is a body of literature relating to this work dating back to the 2009 *BMJ* 2009;339:b4545 RIOTT British Randomised Injectable Opiate Treatment Trial (RIOTT) where a randomised trial of supervised injectable heroin was seen as more effective than oral methadone in enabling injecting heroin users to remaining abstinent from street heroin. The EMCDDA Insights report of 2012 (EMCDDA Insights NO.11 New heroin-assisted treatment) considered the findings from a number of international trials which, overall, indicated that the supervised use of medicinal heroin could be an effective second line treatment for a small and previously unresponsive group of heroin users.

In 2016 the Advisory Council on the Misuse of Drugs (ACMD) (ACMD Reducing Opioid-related Deaths, a Report of the Advisory Council on Drugs) concluded that "the increasing vulnerability of the UK's ageing cohort of heroin or opioid users with increasingly complex health needs

(including long-term conditions and poly-substance use), social care needs, and continuing multiple risk behaviours is highly likely to have contributed to recent increases in DRDs." This prompted the recommendation that "Central government funding should be provided to support heroin-assisted treatment for patients for whom other forms of OST have not been effective" (recommendation 5,section 5.4.18) and contributed to the Public Health England Guidance Injectable Opioid Treatment: Commissioning and Providing Services 2021.

The Global Drug Policy Observatory Working Paper Series (Working Paper No.7 (July2021) "Heroin-Assisted Treatment and the United Nations international drug control apparatus" records the history of HAT on a worldwide basis and offers insights into the key policy debates surrounding HAT. It indicates that the introduction of HAT in Switzerland was in response to a public health emergency where thousands of people were sourcing and injecting heroin openly in public. It should be noted that one of the key drivers for the introduction of the HAT service in Glasgow was the public health crisis which emerged in 2015 (Taking Away The Chaos, 2016) with a dramatic increase in the incidence of HIV and Hepatitis specifically among the injecting drug population in the city.

The study of the Middlesborough service, FINAL Heroin Assisted Treatment Evaluation January 2021 by Hannah Poulter, Rob Crow and Dr. Helen Moore is the most recent study of a service within the English framework. The Glasgow Enhanced Treatment Service presentation provides the most up to date evaluation of a service in Scotland.

While these studies analysed services which operated in slightly different ways there has been some consistency in the overall objectives for each of them. These were described in the Insights report following trials in Switzerland in which heroin prescribing delivered within new supervised injecting clinics was seen as a potential way to "solve the heroin problem" and improve the health and social well-being of entrenched heroin users for whom conventional treatments have repeatedly failed. This aim has developed into a broader set of ambitions for HAT services which are identified within the Home Office Guidance and includes the following:

- reducing the harm associated with injecting drug use for people who are in treatment but continue to inject illicit opioids
- reducing blood-borne virus transmission and injection-site damage and infections
- tackling opioid related deaths in areas where they are especially high

- engaging populations with major health needs that are not currently in standard oral OST and are unwilling to enter or return to such treatment

This guidance goes on to state that “HAT should be viewed as an additional option in an optimised treatment system, **not as a fix for systems that are inadequate or ineffective**. Some patients will need long term treatment, so planning and funding commitments should be based on this expectation.”

From the literature review it is possible to discern a number of learning outcomes which have been demonstrated. These were identified within the Home Office Guidance and can be characterised as follows:

- increased engagement with psychosocial interventions,
- reductions in consumption of street heroin,
- reduction of risky injecting practices,
- improvements in physical and psychological health,
- improvements in secure housing,
- reductions in the volume and cost of criminal behaviour.

It has also been identified that there is a population who do not engage with HAT. Therefore while there can be evidenced benefits for those who do engage, there remains a population for whom HAT is not seen as an option.

Analysis of the literature indicates that there should be close monitoring of the delivery and operation of HAT with identifiable criteria for the assessment of beneficial or detrimental effects. This is important in determining the efficacy of a programme. There should also be clear pathways into other treatment and services, particularly where a patient is transferred out of HAT to another treatment model. This is a point of emphasis within the Glasgow service and

recognises the high level of vulnerability of the individuals attending the service. A further important area is the identification of individuals who could benefit from HAT and the pathway which is required to ensure there is a clear and identifiable route into HAT.

This is why HAT should not be considered as a stand alone option, but should be a component part of a wider treatment plan which incorporates a range of service provision. This was identified within the Middlesbrough study also. HAT was identified as having the potential of being part of a wider programme with some movement towards recovery and not simply a long term harm reduction model. A HAT service, to be most beneficial, should be aligned with other services such as BBV treatment, housing support, money matters, advocacy, sexual health, family planning, smoking cessation and the broader aspects of mental and physical health.

It is helpful then to reflect on the learning gained from analysis of the literature.

- In setting up a HAT programme it is important to specify clearly what the aims and objectives are.
- Prior to the introduction of a HAT scheme there are some clear criteria which are required in order to achieve maximum benefit. These include the provision of a fully comprehensive treatment service which is operating at an optimum level. This service requires to be integrated with wider public services such as Benefits, Housing, Income Maximisation, BBV and Advocacy.
- A HAT scheme is not a temporary service and is not a solution to sub optimal service delivery.
- A HAT scheme should not operate as a stand alone service but should be fully integrated with high performing treatment services and the corresponding health and public services.
- The focus should be on long term recovery for participants. This long term recovery model should also incorporate a harm reduction approach as a component part of the wider recovery plan.
- There should be clear pathways into a HAT scheme and subsequent pathways out of HAT and into mainstream services for individuals who stop participating or who stabilise sufficiently to be managed with ‘standard’ treatment and recovery services. This is equally relevant where an individual is admitted to custody or hospital.

To be considered for HAT, patients will have a significant treatment history of repeatedly being unable to complete standard oral OST. This should include attempts to administer optimal, evidence-based doses of OST under supervision.

A detailed list of suggested eligibility criteria is in the operational and clinical guidance but should cover issues such as:

- Opioid injecting history: only patients with a significant history of injecting opioids and evidence of regular injecting opioid use in preceding months will usually be eligible.
- Treatment history: only patients currently in unsuccessful optimised oral treatment, long acting buprenorphine and who have a history of unsuccessful attempts at such treatment will usually be eligible.
- Other conditions: active, significant medical or psychiatric conditions can make HAT unsafe or interfere with the patient's ability to engage in treatment, such as severe lung or liver disease, or severe psychiatric illness.
- Alcohol dependence and misuse of other GABA-ergic drugs including benzodiazepines, pregabalin or gabapentin, and zopiclone or zolpidem may make HAT unsafe for the patient, interfere with their ability to engage in treatment or disrupt it for others.
- Pregnancy, breastfeeding, or plans to become pregnant may exclude patients, or at least require special attention, because of the effect the opioid would have on the foetus.
- Willingness to participate: the patient must be able and willing to participate in the treatment schedule as required. This can include attending the clinic 2 to 3 times a day at the start of treatment and once a day, 7 days a week, for the rest of the time in treatment.
- Age: it would be unusual to start HAT with a patient younger than mid-20s

Further analysis of the literature identifies the outcomes which can be anticipated. These can be characterised as individual outcomes for participants within the HAT scheme and strategic outcomes which demonstrate wider societal benefits. Some outcomes, of course, can be considered within both of these categories.

Individual outcomes:

- An identifiable improvement in physical health
- A reduction in illicit drug injecting
- Reduction of being at risk of an overdose
- Reductions in the use of other illicit drugs
- Improved mental well being
- Beneficial improvement in Housing options.
- Improved social involvement

Strategic outcomes:

- Reduction in offending behaviour and subsequent outcomes.
- Reduction in contact with community justice system
- Reduction in use of custody
- Opportunity for involvement with Recovery Communities and societal involvement.

Capacity

When creating the budget we took account of the number of people who are using the Glasgow HAT and those who used the Middlesbrough service. In addition we were cognisant of the ability of staff to oversee a number of people injecting at any given time. We therefore settled on 20 patients enrolled at any given time.

In terms of criteria and referral routes we note the UK guidelines as outlined previously. Our judgement is that the likey target patient population would be people who use Heroin and have had frequent treatment episodes with DDARS but have not been able to sustain stability.

4. Methodology

In the writing of this feasibility study it was important that we gain the knowledge, understanding and experience of those who have developed and managed HAT services in Britain. We also

wanted to identify the specific circumstances relevant to Dundee and ascertain the views of a range of stakeholders in Dundee, including those with a lived history.

During the course of our work we met with a number of key stakeholders in one to one and focus group settings. We met with people with lived history and living experience, peers, managers across both the statutory and voluntary sector, family members, senior management, pharmacy and frontline staff. We also met with staff and management from the Glasgow Enhanced Drug Treatment Service, the Middlesbrough service and senior officials within the Scottish Government. In total we met with 41 people.

We used open-ended semi-structured interviews for all of our meetings. We agreed with all participants that their responses would be anonymous.

We learned much from Glasgow and Middlesbrough which reflected the findings identified within the Literature Review.

5. Glasgow

The Glasgow HAT service was, as previously indicated, a response to a sharp increase in HIV and hepatitis within the drug injecting population clustered around the city centre, many of whom were homeless. This was accompanied by a corresponding increase in public injecting. The response in Glasgow was not to go directly to the setting up of a HAT service but to conduct a needs assessment which included a number of recommendations. The first set of recommendations related to the development of existing services. This included a strategic multidisciplinary response to the group defined as having "severe and multiple disadvantage" with specific reference to housing. A further recommendation was the development of a peer network for harm reduction aimed at current injecting drug users. The third recommendation was a review of the models of delivery for specialist services to meet the needs of the injecting population with an emphasis on access, engagement and harm reduction. The final recommendation for existing services was to maximise the opportunity for harm reduction through assertive outreach and harm reduction.

The second set of recommendations focused on new services and included the introduction of a HAT service for people who continue to use street heroin despite optimal OST.

These recommendations reflect a dual approach which incorporates the learning from previous experience i.e the need to ensure the availability of comprehensive community services working at an optimal level and the requirement to embed a HAT service as a key component part of this well functioning system. These points were well made by the staff and management within the HAT service in Glasgow. **The need for supportive pathways into the HAT service and importantly out of the HAT service on transition to another community based service was emphasised.** An assertive outreach model has been adopted to engage with potential participants, to keep them engaged in HAT and to support them into further services if they moved away from HAT. The desire to have integrated service provision within Glasgow was evident through the management structure in which the HAT team was a component part of the HSCP Alcohol and Drugs system of care with a clear single management structure. In addition there was a strong leadership approach with senior staff demonstrating clear direction and commitment. At the time of interview there were 21 people attending the HAT service in Glasgow, the capacity was considered to be 40.

At the outset, the referral route for Glasgow was through the Homeless Addiction Team who were working from the same site as the HAT. The team was disbanded following a separate review and many patients were transferred to primary care services within their own locality, and as a result, referrals reduced.

The operational requirements in relation to the storage, dispensing and administration of Diaphin within the Glasgow HAT service are **extremely onerous.** These roles are performed in a room which is heavily reinforced, has the most up to date storage and dispensing facilities and incurred significant capital outlay.

The Glasgow HAT is embedded within the HSCP. This is important as it has afforded the service with the significant resources (both financial and in people) to ensure it is compliant, safe and underwritten. Glasgow HAT, being the first in Scotland, strived to get it right from the set off. In doing so they sought advice and guidance from a range of stakeholders including the Home Office and their own senior pharmacy officers.

In summary:

- The introduction of the HAT model in Glasgow was in response to a specific problem: an increase in the incidence of HIV and Hepatitis among street drug users in Glasgow.
- Glasgow undertook a needs assessment which identified between 400 and 500 people who were potentially suitable for HAT.
- Glasgow strongly recommends that evaluation is built into any new HAT service.

The cost of the Glasgow service is £1.3 million per annum.

6. Middlesbrough

Middlesbrough is a city in the North East of England. It has a population of 148,000. It is ranked as the 5th most deprived city in England. Rates of opiate users in Middlesbrough are 57% higher than the north east region and 66% higher than the rest of England. The north east has the highest level of drug related deaths in England and Wales.

Foundations is a specialist GP practice working with people who are homeless, people with problems with substance and people who have had their access to NHS Primary Care limited. They work with people on all aspects of patients' health and wellbeing. Foundations is a social inclusion practice supporting people who find themselves excluded.

Like Glasgow, the service in Middlebrough, was scoping out two new interventions, an Overdose Prevention Centre and a HAT. For legal reasons the former could not come to fruition. The management did extensive background research visiting and working in HAT services in other countries.

They opted to set the service in the Foundation’s GP building so that there would be both integration and wrap-around services. The service opened daily for 2 visits a day by each patient.

The service was originally funded through a mixture of funds from the Police and Crime Commissioner, Probation and prison services. Public Health assisted with start up and staff redeployment.

Foundation initially had a list of 70 potential patients. These were based on the 5 to 10% of the treatment population who were not progressing with OST. Based on a triangulation of data: health, crime, drug treatment and social impact, patients were selected for the programme, there were consistently 10 patients on the programme, though this may not have been the same ten individuals at any given time.

The service was staffed by a nurse and a clinical support worker. A mental health nurse, housing officer and probation staff were in the service one day a week. The HAT was well integrated into other services available in the practice. Consequently HAT patients had access to a full range of care co-ordinators and Psycho Social Interventions. These were delivered by one of the partner agencies.

From the outset they elected to follow European standards with regard to managing multi dose vials. They were supported and advised by pharmacists attached to the public health team and the controlled drugs accountable officer, lead consultant. In effect the nurse on duty carried out the dispensing, witnessed by the clinical support staff.

The Middlesbrough HAT has been extensively researched. Among the group of patients evaluated there were the following outcomes:

- 80% drop in street heroin use
- A decrease in crime
- Some drop off in other illicit drug use
- Significant improvements in housing - in effect everyone “levelled up” in that their housing situation improved
- Significant improvements in individuals wellbeing, health and quality of life

The HAT opened in October 2019 and closed in December 2022 due to lack of funding. The service cost £300K a year.

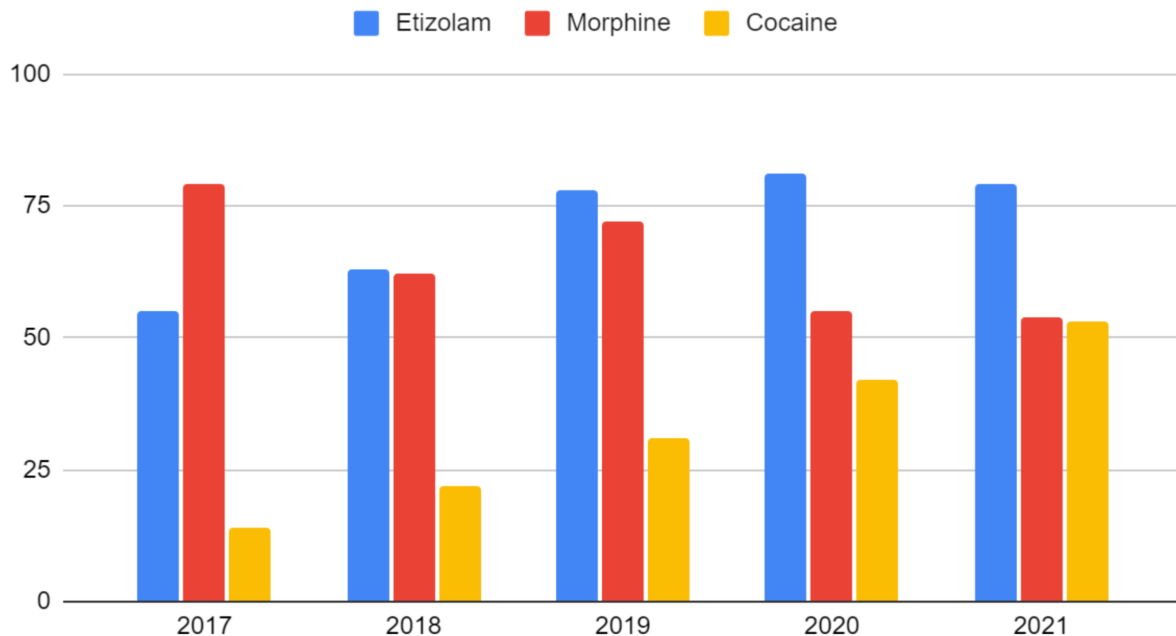
It should be noted that the evaluations of Glasgow and Middlesbrough were completed by a small number of patients, 18 and 14 respectively.

7. Dundee

The knowledge gained from literature and interviews with the team in Glasgow and Middlesbrough informed our approach to Dundee.

Dundee is a city with a similar population to Middlesbrough. It has had a historically high rate of drug related deaths. An expert commission has looked into the circumstances and there have been two reports from this. The rate of drug related deaths remains high. **An analysis of the Drug Deaths In Tayside 2021 Annual Report** and subsequent stakeholder interviews notes the following:

- Whilst the small reduction in drug deaths between 2020 and 2021 is to be welcomed, drug deaths remain a public health emergency for Tayside.
- **Drug deaths amongst women are increasing and a cause for concern.**
- Etazolam was present in people who died more than any other drug - 85% for people who died in Dundee. There was a much higher incidence of cocaine - 53% in Tayside compared to the rest of Scotland - 30%.
- The presence of Morphine in toxicology reports has dropped by over a quarter (79%) in 2017 to 54% in 2021
- There is a significant decrease in heroin use in Dundee. This was reported repeatedly by professionals and people with lived history.
- Services report that they see an increase in people now presenting with alcohol, benzodiazepine and cocaine problems.



The graph above shows that the prevalence of Heroin in drug related deaths has been falling. During our consultations it was generally agreed that this trend was continuing to a position where many remarked that there was little or no Heroin in the city.

It is worthwhile also noting the following points from the 2021 Drug Death report.

"Overwhelmingly, those who die of drug death are living in poor social and economic circumstances, and have histories of significant child and adult trauma. Services are committed to ensuring all staff can deliver trauma informed care, but in many cases people who had suffered substantial and multiple trauma had not received therapeutic interventions to help manage the psychological impacts of this.

• The continuing rise in drug deaths for women contrasts sharply with the reduction seen in men in 2021. There are also marked differences in the level of engagement with specialist services between men and women who suffer drug death, and this merits further exploration to identify the reasons behind this.

• Poly-drug use remains a significant risk factor for unintentional overdose, and the trend of increased detection of alcohol is continuing which adds further to risk, especially where cocaine use is rising rapidly. Referrals to alcohol services have been rising across Tayside in recent years and there can be significant waits for access which may increase risks for those who use drugs and alcohol concurrently.

• Overall, a somewhat changing pattern of drug use is emerging, with more need for supports and services for non-opioid substances, including cocaine and benzodiazepines.

• The role of opiates, alongside other substances, implicated in the causes of death reinforces the imperative for access to and use of naloxone. Further improvement is needed in recording who is supplied with naloxone. The number of incidents where naloxone is administered by a witness will continue to be limited as there has been an increase in the number of people who suffer drug related death whilst alone. This data further demonstrates the potential value of overdose prevention facilities.

• There are well developed near-fatal overdose (NFOD) assertive outreach pathways across Tayside. These could, however, be further developed to gather reports from additional sources including A&E departments, and to respond to other situations that may present increased risk of drug death.

• There are many opportunities to improve the physical health of people who use drugs and potentially reduce susceptibility to overdose, and to increase access to comprehensive harm reduction when people come into contact with secondary care services. People who use drugs require better support to remain in hospital when they need to, and they need enhanced services that effectively connect hospital and community in order to manage chronic illness.

• Co-occurring mental health issues continue to be identified at a high prevalence in the cohort and improved joint working between substance use and mental health services remains a priority, including timely joint learning reviews of significant events, including drug death and suicide. In 2021 there was a rise in the proportion of people who had a diagnosis of schizophrenia, although numbers remain relatively small in absolute terms so it is hard to draw conclusions from this. The drug deaths review group will maintain

awareness and monitoring.

• The data reinforces the potential for inter-generational harm due to the impacts on children of loss of significant family members through drug death, and the need to develop more robust responses to these circumstances.

• There is potential to enhance the strength and reach of the learning from drug deaths reviews through better connections with other similar processes across Tayside, including suicide reviews, service reviews, including in mental health, and Adult Support and Protection reviews."

Our initial observations from **The Drug Related Deaths in Scotland Report 2022** (Aug 2023) indicates that drug deaths are falling in the city. Fatalities are down from a high of 55 in 2019 to 38 for 2022. That is a drop of some 30%.

Drug trends are also changing. Heroin was present in 44% of the deaths in 2022 from a high of 79% in 2017. This fall is repeated across Scotland with heroin present in less that 50% of people who died.

Pregabalin was present in just over 60% of the deaths, up 10% on last year. Methadone was found in nearly 74% of the deaths, up almost 20% on last year.

8. Consulting with Stakeholders

Service provision in Dundee for people affected by drugs and alcohol is provided by a combination of core services delivered by the NHS from a central location (Constitution House and direct access clinics) and a number of third sector services which are commissioned from the Dundee Health & Social Care Partnership or provided by external funding including funding administered by the Corra Foundation. These third sector services are delivered from a number of locations, Hillcrest Futures in South Ward Street where a number of organisations are based with an Injecting Equipment Provision (IEP) service, We are With You who have a base in Whitfield and also run the residential rehabilitation pathway for the city. The Steeple Church is the venue for the Parish nurses who run a weekly drop in cafe with a number of services available to support people at the cafe and throughout the week. Positive Steps operates as an

assertive outreach service and is based in a small business estate near the airport. Other third sector organisations include, TCA operating from the Wishart Centre, and there is an independent advocacy service delivered by the Dundee Independent Advocacy Service (DIAS). Dundee Volunteer & Voluntary Action (DVVA) are responsibly for the lived experience and peer support project.

The third sector is becoming increasingly well organised and is developing a model of recovery in Dundee through the Recovery Network and has convened a recent conference to build an inclusive approach to recovery in the city.

We interviewed 41 key stakeholders from across Dundee and beyond. These were staff, managers, senior officers and people with a lived history and living experience.

Most of the stakeholders interviewed had some understanding of HAT and on initial engagement supported the concept of HAT, viewing it as an additional tool to enable a meaningful intervention for a particularly vulnerable group. However, on reflection the vast majority of the interviewees when realising the potential costs for a small number of people felt that there were other more pressing priorities to be addressed.

It became apparent during the course of the completion of this report that there was little evidence of a coordinated approach to service provision between the third sector and DDARS. This was a recurring theme within the interviews conducted within Dundee.

In addition there was a degree of frustration about the limited provision for individuals affected by benzodiazepines and crack cocaine. Stakeholders stated that the use of these substances was on the increase along with alcohol use and some said there was very little heroin use in the city at the time of writing.

Having previously noted that HAT was introduced as a response to a public health crisis and public displays of injecting among drug users, the writers were keen to identify if this was evident in Dundee. While there was evidence of drug dealing within the city centre, there was little evidence of drug paraphernalia indicating extensive intravenous drug use and little evidence of injecting in public. In the absence of a specific needs assessment it was difficult to ascertain the use of intravenous heroin in Dundee. Indeed during our visit to one of the IEP centres, staff reported that there was a significant drop in the number of people using heroin.

When consulting with Dundee stakeholders all were agreed that progress had been made but there was so much still to do particularly around joint working.

The wrap around services required for a HAT service were prominent from the literature review and within the experience of staff in Glasgow. While acknowledging the importance of this in Dundee, stakeholders were not confident that this was the case across the city.

During our interviews with stakeholders, one of our key questions was to ascertain what the key priorities were for people with drug problems in Dundee. Not one respondent considered HAT to be a key priority. All agreed that it would be useful but not a priority. The most frequent response was the urgent need to address the benzodiazepine problem across the city.

9. Premises

The learning to date indicates that the location of a HAT service should be within a current operational service base. Glasgow's is based in the health and homeless service, the Middlesbrough service was based within a specialist homeless/substance use GP practice. The location needs to be accessible as individuals travel twice per day to get to the service. In Glasgow, there was a requirement for significant building works to ensure the security of the location where drugs are stored and dispensed.

From our knowledge of Dundee and our discussions with stakeholders, some people thought that co-location with the IEP centre at Hillcrest would be possible given it is a central city location and patients can have access to other services. This was not discussed with Hillcrest.

Options for delivery

When undertaking this feasibility report and in our discussions with key stakeholders we considered a number of options regarding service delivery. There are a number of possibilities but the 2 likely options for the delivery of HAT is that it could be delivered by NHS Tayside (on its own or in partnership) or by one of the larger voluntary sector organisations with the clinical capacity and associated governance (on its own or in partnership). Our assumption is that given that HAT in Glasgow is delivered by Greater Glasgow and Clyde with strict operating guidelines, there could be an expectation that Tayside would have to follow suit.

10. Conclusions

a. There is a sufficient evidence base to indicate that HAT is an effective method of working with a small number of people who inject street heroin and who experience significant harms as a result.

b. The benefits of HAT for individuals are, improved physical and mental health, improved social wellbeing and a reduction in offending and contact with the Community Justice process.

c. HAT programmes require to be well planned, have an initial capital investment and have ongoing long term revenue funding.

d. Two models of HAT have been operational in Britain in recent years. The current model in Glasgow has the highest possible pharmaceutical and clinical governance standards in the

storage, dispensing and administration of the drug. As a consequence there are extremely high capital and revenue costs.

e. The operational model in Middlesbrough was accommodated within a specialist GP practice providing services to drug users across the city. The service standards were based on those within other European countries which resulted in significantly less start up costs and less ongoing revenue costs. Despite this the revenue costs still remained relatively demanding due to the need for the nursing and support staff within the provision of a seven day service.

f. These two HAT services were introduced in response to a drug related health crisis and an assessment of the needs of the injecting heroin population in each area. While there is a drug related health crisis in Dundee it is unclear that the most effective response to this crisis is the introduction of a HAT.

g. Dundee has a high level of drug related deaths. However it is becoming increasingly unclear whether these are heroin specific drug deaths. An analysis of the data and stakeholder reporting would indicate that heroin is less of a problem than in past years. Most stakeholders reported that the most pressing concerns for Dundee are street benzodiazepine, crack/cocaine and alcohol, often in combination.

h. In the absence of a specific needs assessment in Dundee, the heroin using population is currently unknown. This makes it difficult to quantify the need for a HAT service in Dundee.

i. From our consultations in Dundee, it was not immediately obvious that HAT is the number one priority for the city.

11. Acknowledgements

The authors would like to thank all of those who gave up their time to meet with us in person or virtually. In particular we would like to thank the staff and service users of Hillcrest for their hospitality and kindness. We would also like to make special mention to the Glasgow Enhanced Drug Treatment Service for their generosity with time and resources. We would also like to thank Cranstoun for their input regarding the Middlesbrough service.

12. About the Authors

Kenny Leinster has had a long and successful career in Social Work and Health for over thirty years and has worked in all disciplines of social work and at all levels. This has included working in residential care, group work and area team social worker. He has been a senior social worker and project leader and a Senior Manager and Head of Service in two areas. During his career his areas of responsibility have been broad and have incorporated the role of Head of Housing. Before retiring he was a Chief Social Work Officer and Head of Community Health and Care. Since retiring he has set up a consultancy business specialising in Drug and Alcohol services. Kenny is the Chair of Inverclyde ADP.

Andrew Horne retired recently from his position as Executive Director for We Are With You (formerly Addaction) after 17 years. He has expert knowledge in the fields of health and social care. In his career he has set up and managed a range of complex community, residential and digital services. He has worked all over Scotland, London and Dublin. He is the Chair of the Early Intervention Working Group on behalf of the Scottish Government. He now works for his own consultancy business specialising in drug and alcohol services.

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Evidence on the Effectiveness of Heroin-Assisted Treatment

Appendix 1 Budget

The Glasgow and Middlesbrough service differed greatly in approach and design and therefore led to very different costs. Middlesbrough piggy backed onto an existing 7 day a week specialist medical service and were therefore able to utilise existing staffing resources including medical, nursing and reception staff. In addition there were very different approaches to set up, dispensing and security. The Middlesbrough service made use of their existing arrangements for drug storage and recording. The service in Glasgow had very high capital costs associated with dispensing, storage and administration of drugs. The service in Middlesbrough was delivered by a voluntary sector organisation whereas Glasgow is staffed by the NHS. Glasgow employs a number of pharmacists and a consultant lead.

Dundee Proposed Sample Budgets				
Assumptions				
20 people on the programme				
Drug costs £5000 a year per person				
Staffing as described to us in both the Scot/Eng				
		Scot Model		Eng Model
Staff Costs - Salaries				
Salaries and Wages		743363		316000
Pension		29735		12640
National Insurance		107085		42767
Sub Total		**880183**		**371407**
Other Staff costs				
Travel/Expenses		1000		1000
Training		5400		3300
Recruitment		4000		3000
Sub Total		**10400**		**7300**
Property Costs including start Up				
Rent		20000		2000
Building Set Up/Adaptations	Capital	200000	2000	20000
heat and light		4000		4000
Sub Total		224000		**26000**
Supplies and Services				
Drug Costs		100000		100000
Office Equipment - Start Up		200000	2000	10000
Printing and stationary		2000		2000
Phones		5240		3980
Refreshments		3000		2500
Sub Total		**310240**		**118480**

Management Fee				
Costs for central services		0		52318
Sub Total				**52318**
Total Budget yr1 + start up		**£1,424,823**		**£575,405**
Total Year 2 no start up		**£1,028,823**		**£549,405**
Unit Cost Per Place		**£51,441**		**£27,470**