

Assessing the need for, and views on, drug checking services in Edinburgh

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Executive summary

Introduction

The unregulated and complex nature of the illicit drug market poses risk of harm, including fatal and non-fatal overdose, to people who use drugs. In Scotland, use and availability of non-prescribed 'novel' benzodiazepines (often termed 'street' benzos) has significantly contributed to high levels of drug-related deaths. Street benzos, often used in conjunction with alcohol, opioids, and other substances, are often designed to mimic traditionally prescribed benzodiazepines but can vary significantly in potency and composition. Additionally, there has been an increase in detection of highly potent synthetic opioids, 'nitazenes', in the Scottish market, raising further concern about the risks posed by the variable, unregulated drug market. Given such challenges, there has been increased policy support and interest in developing harm reduction interventions to address such issues.

One such intervention, currently being planned in Aberdeen, Dundee, and Glasgow, is drug checking services (DCS). DCS enable people to submit a small amount of a substance for testing and subsequently provide information about the tested substance as part of a broader harm reduction consultation. The number of DCS has grown globally in recent years, including in the UK. The Loop have provided festival-based drug checking since 2016 and are in the process of setting up a fixed-site service; and the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) provide a postal-based service. DCS can provide individuals with accurate information about the composition of drugs and enable the adoption of harm reduction behaviours and safer drug use practices. Additionally, there is evidence that DCS can increase systemic capacity for drug market monitoring and inform subsequent public health communication and strategies. Internationally DCS vary widely in relation to: how and where they operate; the time taken to provide results; the target population they attract; the detail and comprehensiveness of results provided; and the extent of funding and government support they receive. Such differences are outlined further in the main body of the study.

Previous research has been conducted on the feasibility, acceptability, and barriers and facilitators to implementation of DCS in Aberdeen, Dundee, and Glasgow, highlighting a range of important considerations. The current study, commissioned by the Edinburgh ADP, aims to assess the need for, and views on the potential of, DCS in Edinburgh, as part of a wider study on safer drug consumption facilities (SDCF). Eleven participants were interviewed comprising of eight professionals working in relevant roles, and three people with experience of drug use. We have also included data from the SDCF study in which 18 participants with experience of drug use/family members were asked their views about drug checking as part of their interview about SDCF. This executive summary and the report discussion pulls together the overall messages from these two studies.

Key findings

Findings relate to three primary themes: the perceived need and demand for DCS in Edinburgh; service delivery considerations; and the planning and implementation process.

Perceived need and demand for drug checking services

Participants in both studies (DCS and SDCF) expressed general support for the implementation of DCS, viewing it as an important harm reduction intervention in light of current levels of drug-related harms and death. DCS were seen as having a number of potential harm reduction impacts, including:

- providing opportunity for the adoption of safer drug use practices through increasing the availability of information about drug contents;
- increasing uptake of other harm reduction interventions through building trust and engagement;
- providing staff with opportunity to have detailed and specific harm reduction conversations with service users;
- increasing systemic capacity for drug market monitoring; and
- the potential to change drug markets.

Despite discussion of the potential benefits of implementation, some participants expressed reservations in relation to the strength of evidence for DCS and described challenges in achieving the above impacts. For example, it was noted that more marginalised individuals, with a range of intersecting vulnerabilities, may face limitations in their capacity to consistently adopt safer drug use practices in light of the information provided by DCS.

Participants generally felt that many people who use drugs may want to access a DCS as a means of reducing risk and taking care of their health. All three participants with experience of drug use noted that they would use a DCS, contingent on it being accessible and delivered in a suitable manner, as did those interviewed for the SDCF study. Participants noted that a wide and heterogeneous group of individuals may access DCS, across a continuum from 'recreational' use to those using more dependently. Given the diversity of potential service users, it was highlighted that services models may need to operate differently to be suitable for different groups. Such considerations were reflected in discussion around who DCS should primarily be targeted at. Some felt that DCS should be broadly inclusive and acceptable to wide groups of individuals. However, others noted that, given current rates of drug-related deaths and a constrained fiscal environment, there may be a need to focus on engaging those at highest risk.

Whilst it is not possible to estimate levels of demand from a small sample of largely professional participants, other evidence triangulates need and demand for DCS in a Scottish context, including the data from participants interviewed for the SDCF study. For example, use of WEDINOS in Scotland has increased significantly in recent years, with approximately half of all submitted substances expected to be benzodiazepines. Similar trends have been observed for substances submitted to WEDINOS from Edinburgh in recent years. Additionally, provisional data from the Needle Exchange Surveillance Initiative (NESI) in Glasgow has highlighted high willingness to use a DCS amongst respondents. A related study of DCS in Aberdeen, Dundee, and Glasgow has also reported a strong perceived need for, and willingness to engage with, DCS amongst people who use drugs and affected family members.

Service delivery considerations

Several different service locations were discussed as potentially suitable for DCS delivery, with a varied benefits and challenges associated with each. For those at highest risk of experiencing drug-related harm, recovery hubs, homelessness services and SDCF (if implemented) were thought to be most suitable for the integration of DCS. Recovery hubs (multi-agency drop-ins across the city providing drug and alcohol treatment and support services) were often noted as the most intuitive and straightforward setting for DCS delivery, given high levels of existing footfall amongst those at higher risk, the range of harm reduction and treatment options offered on site, and the presence of highly skilled and specialist staff. However, given the potential stigma associated with such services, and their perceived association with the drug treatment landscape, there were doubts whether such settings

would be attractive to people who do not view their drug use as problematic. Crew, an existing third sector harm reduction service, was described as an appropriate and inclusive location for wider groups of individuals due to its relaxed and informal environment, and perception of being less associated/integrated with the drug treatment landscape.

DCS in both a pharmacy and a mobile van setting drew mixed responses with varied views on: whether they would afford discretion and confidentiality; whether they were logistically feasible; and which groups/individuals would be most likely to access DCS in such settings. The varied perceptions of these two potential service delivery settings suggests a need for further research and exploration. However, it should be noted that a Home Office Licence would not currently be granted for DCS in a mobile van. In addition to the specific challenges and advantages associated with each model, a number of cross-cutting considerations were discussed relating to the need to: ensure that staff had adequate capacity to deliver drug checking; ensure that potential service users felt confident about the confidentiality and discretion afforded by the service; and to consider space and layout of settings for DCS delivery.

Findings highlight a general perception that any one model would be limited in its capacity to be appropriate and accessible for all who may wish to use a DCS. As discussed, people who may wish to use DCS are likely to vary widely in experiences, preferences, and needs, and may differ in terms of preferred settings and model of delivery. Further, participants noted that Edinburgh has a number of dispersed locations of high drug-related harms, further adding to the challenge for one site to be accessible to all. Participants interviewed as part of the SDCF study also noted the importance of the DCS being flexible, accessible, and user-friendly, and located in a place that would ensure that those who needed the service most would be able to access it. Participants suggested some alternative, lower cost means of expanding access to DCS, including implementing multiple sites for substance collection, where substances can be transported to a central site for testing within a longer timeframe, and postal provision.

In addition to discussion about specific locations for DCS delivery, participants noted a range of more general considerations around service delivery. A central issue was result turnaround time (i.e., length of time required for a service user to receive their results). It was noted across both studies (DCS and SDCF) that many individuals, particularly those using dependently and who are experiencing withdrawal, may require quick results (between 30 minutes and 2 hours), and that longer waiting times (1-7 days) may present a barrier to engagement. However, findings highlight that not all individuals would require quick results. For example, all three participants with experience of drug use in the DCS study described being willing to wait up to a week for results, although those interviewed as part of the SDCF study reported being less willing to do so. It should be noted that there may be a trade-off between speed of testing and comprehensiveness of results. For example, quicker testing (conducted on site at a DCS) may not be able to consistently provide information on substance strength and may, in some cases, be unable to detect or identify novel or emerging substances. Conversely, where substances are transported to a lab for more detailed and comprehensive testing this may entail a longer timeframe for results.

Related to the trade-off between speed of testing and comprehensiveness of results, participants noted that information about substance strength would be valuable for informing dosage and the adoption of risk reduction strategies – a finding in line with the existing evidence base. However, all still described being willing to use a DCS which provided only information about the contents a substance with no information on substance strength. Clearly explaining the limitations of testing prior to engagement was described as essential to managing expectations and ensuring the continued engagement of service users. Given the small sample of participants with experience of drug use included in the current study, further consultation is required to gauge optimal service design in light of the described trade-offs (i.e., speed of testing vs comprehensiveness of results).

A range of further issues relating to service design were discussed including the need for: non-judgemental staff with relevant expertise, including peers; DCS to be linked with other harm reduction services; as small an amount of a substance as possible to be used in the testing process; consideration of extended opening hours beyond Monday-Friday 9am-5pm; and further exploration the suitability of a range of methods for communicating results including in-person, over the phone, by text, and online. Participants highlighted the need for ongoing consultation with varied groups of people who use drugs to ensure that service design and delivery is appropriate and inclusive.

Planning and implementation process

Owing to the complexity entailed in DCS implementation, participants described the need for multi-party dialogue across a wide range of stakeholders. Central parties were described as: third sector and NHS services and staff; people who use drugs; existing DCS; local and national public health staff; local and national police; local and national government; Alcohol and Drug Partnerships (ADPs); the Home Office; staff and services in the wider drug landscape; and local communities and the wider public. It is important to note that the DCS planning process in Aberdeen, Dundee, and Glasgow has highlighted the benefit of involving a range of stakeholders in design and implementation. For example, relating to the complex considerations around the testing and analysis process, Scotland is developing expertise and infrastructure around DCS testing. Additionally, Police Scotland have been involved in dialogue from an early stage. Such infrastructure, progress, and knowledge could be drawn on for implementation in Edinburgh. Participants in the current study described the importance of bringing together a range of expertise, assigning roles and responsibilities, and ensuring shared understanding from an early stage of the implementation process.

Recommendations

The City of Edinburgh Council and the Alcohol and Drug Partnership should take steps to introduce drug checking services (DCS) in the city. Several models and locations of DCS have the potential to reduce drug related harms in Edinburgh, and approaches serving a range of potential users should be explored.

- For those at highest risk of drug-related deaths and harms, DCS within recovery hubs, homelessness services, community pharmacy, and safer drug consumption facilities (SDCF) would have the greatest acceptability and impact. For this group, local and quick access to results (ideally with additional lab testing to follow up and provide surveillance) are key considerations
- For wider groups of people who use drugs, sites such as Crew may be more appropriate as they opportunities for a low threshold, drop-in service which may be broadly acceptable and accessible for individuals with a range of experiences and preferences. Postal services or multiple drop off locations may supplement this provision. For this group, there may be a lower premium on immediacy of response

To this end, we recommend the following next steps.

Consultation

- Carry out consultations with potential providers to explore feasibility in specific locations
- Liaise with those leading development of drug checking within Aberdeen, Dundee and Glasgow, and the national implementation group led by Scottish Government, to apply both practice and policy learning

- Consult further with a range of people who use drugs in the city to explore needs and preferences
- Urgently discuss the feasibility of Edinburgh also using the national lab-based testing services that are currently being developed as part of the national implementation work

Service development

- Explore the creation of multiple drug checking services in locations across the city, or the establishment of a distributed model where a primary site collects samples from other locations for testing
- Explore options for the creation of city-wide postal provision
- Consider the balance between speed of testing results and comprehensiveness of the analyses in developing service design
- Develop service designs that include:
 - flexibility, ease of access and user-friendly, non-judgmental approaches, including peer support
 - access to other harm reduction interventions
 - operating procedures that ensure safety of staff and people using the service
 - clear plans for design coproduction, including people with lived and living experience

Legal considerations

- Ensure planning takes account of Home Office licensing requirements, and other national plans for confirmatory testing

Finance and costs

- Initiation of discussions with local and national government decision makers to ascertain the potential financial envelope for service provision
- Liaison 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 drug checking services, and the place of potential services in the wider treatment, recovery, and harm reduction landscape in Edinburgh.