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

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

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.

1: Review of the global evidence on safer drug consumption facilities

Background

For many years, Scotland has experienced very high levels of drug-related harm. There were 1,051 recorded drug deaths in 2022, which is a welcome fall on the previous year. However, rates remain significantly higher than a decade ago and recent data suggests harms may be increasing.[1] Drug-related deaths currently represent the third highest burden of disease in Scotland, following ischaemic heart disease and Alzheimer's / dementia.[2] The Scottish Government has made tackling drug-related deaths a priority, establishing the Scottish Drug Deaths Taskforce in 2019 and the National Mission to reduce drug deaths in 2021.[3]

In July 2023, the Scottish Government published its goals for drug policy in Scotland. Prominent among these is a call for the introduction of Supervised Drug Consumption Facilities (SDCFs).[4] This is the latest statement of Scottish Government support for the establishment of SDCFs in Scotland. A 2016 needs assessment by NHS Greater Glasgow and Clyde called for an SDCF to be opened in the city, and the final report of Scottish Drug Deaths Taskforce called for the Scottish Government to 'explore all options within the existing legal framework' that would enable SDCF provision to be piloted.[5] A 2023 report by the House of Commons Home Affairs Committee called for SDCFs to be piloted in areas where need was identified.[6] Support for SDCFs to be explored in the UK has also been expressed by, among others, the Advisory Council on the Misuse of Drugs, the Faculty of Public Health, the House of Commons Health and Social Care Committee, and the Scottish Affairs Committee.[7]

On 11th September 2023, the Lord Advocate of Scotland published a statement of prosecution policy that 'it would not be in the public interest to prosecute drug users for simple possession offences committed within a pilot safer drug consumption facility'.[8] Further discussion of this statement and its implications is contained in the 'Legal Issues and Challenges' section below. Shortly after the statement was published, Glasgow City Council approved plans for a pilot facility to open in Hunter Street, Glasgow. The facility is expected to open in 2024 and will be subject to detailed evaluation as required in the Lord Advocate's statement. As will be discussed below, the proposed Glasgow facility has specific design and service delivery features which represent one of a number of different service models in operation globally. The type of service model to be adopted in any area seeking to open an SDCF, and the practical implications that flow from this, are key to any deliberations. They therefore form a substantial part of the discussion below.

SDCFs are variously referred to as supervised injection sites, supervised injection facilities, safer consumption spaces, drug consumption rooms, and overdose prevention centres. They are low-threshold services where people are able to consume pre-obtained drugs in a supervised area with trained staff who can respond in the event of an overdose.[9] A more complete discussion of different SDCF models is set out below; however, in their most basic form they are usually an enclosed location (either a building, temporary structure or mobile vehicle) which provides hygienic spaces (often booths with a table, mirror and bin) where drugs can be ingested under some form of supervision in case of overdose or adverse reaction. Safe injecting materials are usually supplied, and there is often a space for post-consumption monitoring.

Interior of the Insite SDCF in Vancouver, Canada

Interior of the HS17 SDCF in Copenhagen

Interior of the mobile SDCF that operated in Glasgow in 2020-1

First implemented in the 1980's, more than 200 SDCFs currently operate globally in at least 12 countries.[10] There are currently no SDCFs in operation in the UK; however, an unsanctioned, mobile SDCF operated in Glasgow for nine months in 2020-1.[11]

While commonly linked to the prevention of overdose deaths, SDCFs have the potential to serve a number of additional purposes. Importantly, they can help reduce the transmission of blood-borne viruses (BBV) such as HIV and Hepatitis B and C, through creating hygienic injecting environments, preventing needle-sharing, and providing effective on-the-spot care for wounds and injuries.[12] They can also support people who are significantly marginalised, including from health services, to access wider support through both the provision of on-site harm reduction information and signposting to other services.[13] By providing a compassionate, non-stigmatising environment, SDCFs can also act as a critical point of contact for people who may otherwise not engage with health or wider services.[14] SDCFs also have the potential to reduce public injecting and associated street litter by providing a single, sheltered location where paraphernalia can be securely disposed.[15]

While all SDCFs have core essential features, they vary in relation to a number of factors including: the rules and regulations governing their operation; the extent to which they are legally sanctioned; location and model of service delivery; and the extent to which staffing is provided by 'peers' (i.e., those with lived or living experience) or professionals with formal clinical training.[16] Staffing can be paid and / or voluntary. Staffing models are discussed in more detail below.[17]

SDCFs are not a singular solution to the complex problems associated with drug use. However, there is well-established international evidence that they are effective in reducing a number of specific harms. Evidence reviews commissioned by the Scottish Government, Public Health England, and The European Monitoring Centre on Drug and Drug Addiction (EMCDDA) have all concluded that SDCFs can contribute to reductions in risky injecting behaviours, drug-related litter, and ambulance callouts.[18] Evaluations of well-established SDCFs in Canada and Australia have found that very large numbers of overdose events, many of which will have been potentially fatal, are dealt with each year. For example, a recent review of the Medically Supervised Injection Centre in Melbourne found that in a five-year period it had managed almost 6,000 overdose events and prevented up to 63 deaths.[19]

There is also evidence that, in addition to preventing overdose on the premises, SDCFs can reduce drug-related mortality rates in a wider vicinity. One study found that in the two years after the Insite SDCF opened in Vancouver, the rate of overdose deaths within 500 metres of the facility fell by 35%, compared to just 9% in the rest of the city.[20] Another study found that people regularly accessing SDCFs in Vancouver were almost half as likely to die of any cause as those who did not.[21] Research also suggests that people who inject drugs are likely to use SDCFs, and have a positive view of their role, which means that they have a good chance of reaching and attracting their intended beneficiaries.[22]

There are limitations to the evidence base on SDCFs.[23] Evidence tends to be drawn from a relatively small number of sites, and it is challenging to carry out randomised controlled trials (RCTs) due to both ethical constraints and difficulties in measuring behaviours within the target population. As a result, it is not possible to make definitive claims concerning the impact of SDCFs on overall overdose rates within a population, as consumption will take place both within and outside of the facilities, and overdoses can only be prevented within facilities themselves.[24] Like many complex public health interventions, the case for SDCF adoption can only be made on the balance of available evidence. Decision makers, therefore, need to assess potential benefits as part of a wider harm reduction and treatment ecosystem.[25]

Beyond overdose response and the provision of safe injecting spaces, a key feature of SDCF impact is the establishment of non-judgemental, non-stigmatising spaces for otherwise marginalised, and sometimes also highly stigmatised, individuals who may have experienced a range of intersecting

vulnerabilities and challenges. Evidence suggests that this aspect of SDCF provision is viewed as a vital component both by people who use drugs and their families.[26] SDCFs are, therefore, widely viewed as not only addressing acute health risks, but as contributing to a wider, non-stigmatising approach to drug problems.[27]

Models of SDCF provision

There is no single model of SDCF provision. While service models vary considerably across the hundreds of SDCFs that operate globally, a number of broad types can be identified.

'Integrated' models are embedded within existing facilities or services for people who use drugs, such as specialist drug treatment services.[28] This is the most common model of SDCF provision, with one study finding that over half of SDCFs in Europe, Canada, and Australia were co-located in this way.[29] This model may reduce costs by drawing on shared resources[30] and allow the creation of 'one stop shops' that provide a range of care services.[31] Delivery will often be led by professional staff including clinical specialists; however, they may also include a degree of staffing by peers with lived / living experience working either paid or on a voluntary basis.

'Specialised' or 'standalone' models are distinct facilities, located in a dedicated, permanent site. Additional services or signposting are often provided in standalone SDCFs, but much of the additional support is expected to be through referral to other providers.[32] Such models are estimated to account for around one third of SDCFs globally.[33] Similar to integrated models, they are often located near large open drug scenes and/or other harm reduction services and involve a combination of professional and peer staffing. The proposed Glasgow facility falls broadly under this category.

'Embedded sites' are less common, and are located within settings that are not directly associated with drug treatment, such as housing facilities.[34] Embedded safe consumption areas may reduce risks associated with drug use in bathrooms or other non-sterile spaces and also reduce the risk of people having to leave such services due to rules prohibiting drug use.[35] However, they may also create workforce challenges as staff may lack the specialist training needed to ensure the law is adhered to in ways that do not put them, or their service users, at additional risk.

'Mobile sites' are often employed where a number of smaller drug scenes are dispersed throughout a city.[36] Mobile SDCFs operate in Montreal, Barcelona, and Berlin.[37] Mobile sites can be responsive to local needs and emerging trends, and can reach people who may not be willing or able to access fixed site facilities.[38] However, space is often limited meaning fewer people can access the service per day, and there are increased costs per supervised consumption episode.[39] While around a fifth of SDCF providers globally report operating a mobile site, this is usually in conjunction with a fixed site.[40]

Informal or unsanctioned sites operate in a number of places, especially in Canada where they are sometimes referred to as 'Overdose Prevention Services' (OPS).[41] They are often integrated into health, housing, and/or community organisations and can have lighter rules and regulations than legally sanctioned SDCFs.[42] They are commonly staffed primarily by peers and harm reduction workers, often working voluntarily, rather than medical staff, and sometimes allow peer assisted injecting, which is forbidden in most sanctioned SDCFs due to issues around legality and risk governance.[43] Informal services generally operate at a lower cost than sanctioned SDCFs, but typically also provide a lower level of additional services.[44]

It should be noted that the distinctions between these models are not hard and fast. Informal sites may operate on a mobile basis, for example, as was the case for the van that operated in Glasgow in 2019-20. Furthermore, the strongly peer-led approach adopted by many informal SDCFs does not

mean all other models are strictly medicalised. Many SDCFs use a combination of clinical staff, peers, and a key consideration in service design is how to strike the best balance between the two. Table 1 below outlines advantages and disadvantages for each service model.

Table 1: Service model advantages and disadvantages

Service model	Key advantages	Possible disadvantages
Integrated	• Existing interventions and wrap-around support often available on site. • Potential to draw on existing staff to reduce cost of intervention (but need to consider resources and staff workload).	• May require physical separation if service shared with clients working towards, or in, abstinence-based recovery.[45]
Standalone	• Can be located in optimal areas (areas of high drug related harm). • Can be custom designed for the purposes of supervised drug consumption.	• May provide less wrap around/ancillary support, depending on scale and funding of the service.
Embedded	• Reduces risk associated with drug use in bathrooms or non-sterile spaces. • May reduce the risk of drug use alone at such sites. • Reduces risk of eviction due to rules prohibiting drug use.	• May require significant additional staff training and changes to workplace culture
Mobile	• Can travel to multiple hotspots • Responsive to local needs and emerging trends • May reach people not willing / able to access fixed facilities	• Restricted physical space meaning fewer people can access the service at once. • Potentially higher cost per supervised consumption episode.
Informal	• Peer leadership can encourage wider engagement • Lower threshold and fewer rules can be more attractive • Lower costs	• Risk of closure and / or legal action • Less wrap-around support and interventions • May be housed in temporary structures • Less access to clinical expertise

Staffing

Staffing models vary widely across SDCFs. Medically supervised services are staffed primarily by clinically trained professionals, whereas hybrid or peer-led services make more extensive use of harm reduction professionals and peer workers.[46] Staff may also include social workers (97% of European SDCFs in one survey employ social workers) and addictions counsellors.[47]

A survey of European SDCFs found that 22% employed peer staff; 38% reported formulating service goals collaboratively with service users; 31% involved service users in the establishment of services on offer; 36% organised service user meetings; and 12% involved service users in decisions regarding the organisation and internal affairs. However, this varies widely, with more than 75% of services in Denmark, the Netherlands, and Switzerland reporting structured mechanisms for service user involvement and feedback.[48]

Many sites are required by law to employ medically trained staff to supervise injections, and the majority employ at least one clinically trained professional.[49] In a 2018 survey, 80% of SDCFs in Europe, Canada, and Australia reported employing nursing staff, 46% medical doctors, and one fifth peer staff.[50]

There is strong evidence that higher levels of peer staffing can both facilitate initial engagement and support ongoing relationship-building, with service users often expressing a preference for peer staff involvement.[51] Peer staff are viewed as having essential experiential knowledge and being better able to de-escalate any conflict that may arise.[52] Qualitative research in the UK suggests a preference for

services that are low-threshold, familiar, comfortable, and accessible, over more clinical environments or highly medicalised provision, especially among more marginalised or vulnerable populations.[53] However, there is also evidence that access to on-site health professionals is seen as positive by SDCF clients, and may increase engagement with health, social and drug treatment related support.[54]

There is an important distinction between peer staff involvement in delivery and establishing a fully 'peer-led' model. Peer-led services (such as OPS in Canada, described above) are where peers are centrally involved in all aspects of provision, including overseeing consumption.[55] Such models also tend to have more relaxed rules and regulations which are jointly shaped by peer staff and service users.[56] The distinction is not binary, however, and degrees of peer provision and leadership are described in the literature. For instance, a service may include peers extensively in the staff team but have limited mechanisms for joint decision-making amongst service users; or peers may be extensively involved in some aspects of provision (e.g. social support) and not others (e.g. clinical support).

'Peer-led' staffing models can support the development of non-stigmatising environments where service users feel respected, safe, and cared for.[57] However, sources have also noted the risk of burnout, emotional exhaustion, and grief for peer staff.[58] Further, research has highlighted that peer labour can be valued less compared to professional staff, creating environments where peers experience insufficient pay, poor training, a lack of counselling and employee protection (sick pay, holidays), and limited opportunities for career progression.[59]

While a number of prominent SDCFs are strongly clinical in their design and delivery, the advantages of this model need to be balanced against the risk that highly medicalised environments may be less attractive to potential clients. Similarly, the attractiveness of highly peer-led models needs to be balanced against the level of clinical oversight and risk-management that is felt to be necessary in relation to a given service, and the extent to which this can be carried out by peers.

In practice, SDCF delivery often involves a combination of clinically trained and peer-led delivery, and the available research points to a need for flexibility in the scope for service model design: enabling providers to draw a balance in staffing that reflects the needs of potential clients, without being tied to models that may exclude those at greatest risk. Higher levels of peer staffing are liable to be less expensive,[60] although, as noted above, cost-reduction should not be the primary reason for including peer staffing and should not enable exploitative or unfair working conditions. Creating a staffing balance that allows for safety to be guaranteed, while ensuring a welcoming and non-judgemental environment, is a key goal.

Barriers and facilitators to engagement in SDCFs

Several studies have found high willingness to use SDCFs amongst people who use drugs, including the majority of participants in a recent Scottish survey.[61] Established SDCFs generally report high levels of engagement, particularly amongst high-risk groups such as those who inject frequently, those experiencing homelessness, and those with a history of overdose. Service users report viewing SDCFs as providing safe and sterile spaces for consumption, reducing the need for public drug use and associated risks and harms and providing life-saving overdose response.[62]

Despite this, only a small percentage of all community injections are likely to take place within SDCF. For example, Insite hosts an estimated 6% of total injections in the wider community.[63] Nevertheless, in 2016, the same site reported approximately 1700 unique individuals accessing the service each month, performing around 220,000 injections each year.[64] A global survey of SDCF providers found an average of 78 reported visits per day, ranging from 20 to 400.[65] The mobile SDCF in Glasgow reported 894 injection events in nine months of operation.[66]

Location

SDCFs are often located near an established drug scene and/or near easily accessible transport routes.[67] However, fixed locations may not be suitable for people wishing to avoid the area in which an SDCF is located.[68] Mobile models may have an advantage in this sense, but can only engage a small proportion of people at any one time due to limited space.[69] Providing multiple SDCF locations within a city may make the service more accessible, especially for those injecting multiple times a day.[70] A number of cost-benefit analyses have suggested that multiple sites may be cost-effective, although this depends on a number of factors including the population of people who inject drugs, the rates of HIV and HCV, and rates of needle sharing.[71] However, cost-benefit analyses of hypothetical SDCF provision in Toronto and Victoria, Canada found that multiple dedicated sites could not likely be justified from a purely economic standpoint.[72]

Opening hours

Lack of extended opening hours (after 5pm and on weekends) and long waiting times can be barriers to use, particularly among those in withdrawal or who inject multiple times per day.[73] A 2014 survey found that 61% of SDCFs in Europe reported being open on Saturdays and 64% on Sundays, with facilities opening for an average of 8 hours per day, ranging from 3.5 to 20.[74] A recent study in Barcelona found that extending opening from 15 to 24 hours was associated with greater engagement among those who inject cocaine, women, and those experiencing homelessness.[75] It also reported a significant increase in risk of heroin overdose within the service during night time opening hours. However, extended or 24-hour opening hours can substantially increase operating costs and lead to work overload and staff exhaustion if not adequately resourced.[76]

Wider service integration

Additional service integration can help facilitate engagement in wider health and social support.[77] However, sites with more extensive service integration may also feel less relaxed, and feeling pressured into engaging with wider services may be a barrier for some potential service users.[78] Additionally, the presence of social workers on site may present a barrier to some, particularly for mothers where there may be concerns around care of children.[79]

The capacity of wider services also needs to be considered. One Canadian SDCF found that while service users expressed a preference for immediate access to rehabilitation and treatment services, the waiting time was around nine months. Effective signposting also relies on clients accessing services offered, which prior research shows does not always happen.[80]

Police activity

Determining the level and nature of policing around an SDCF requires clear operational decisions and agreements. Police, staff, clients, local residents and businesses need to understand how the law is to be applied in order to provide the assurances necessary for a service to function. In developing these agreements, it is important to note that excessive police activity in the vicinity of a SDCF can act as a barrier to engagement.[81] At the same time, however, people may have concerns over violence and harassment, either within the service or from people congregating nearby, which may also act as a barrier to engagement as well as reducing levels of public acceptance.[82] Indeed, it is not simply the scale of police activity which matters, but also the quality of police interactions with service users and the wider public. For example, 'enforcement-based' practices, such as heavy patrol, surveillance, questioning and/or charging people accessing the service, can discourage engagement.[83] By contrast, police activity may also facilitate engagement, for example, by police signposting individuals to the service.[84]

Rules and regulations

A key consideration in SDCF design is whether the service allows injecting only (and in what form – e.g. neck and groin), or also permits inhalation, snorting, or swallowing.[85] Injection-only services inevitably exclude those who consume drugs in other ways.[86] Many sites allow inhalation, particularly in Europe, and a 2014 survey found that only 21% did not do so.[23] However, allowing inhalation onsite requires consideration of issues such as smoking legislation, staff safety, and ventilation.[87]

Table 2: List of service rules and regulations reported in the literature

Rules and regulations
Eligibility • First time users are not allowed to access some SDCFs in Europe[88] • Minimum age (often 18 years)[89] • Intoxicated service users may be excluded from entry[90] • Those on opioid substitution therapy (OST) may be excluded (in e.g. Germany and Luxemburg)[91] • Pregnant women prohibited[92] • Some SDCFs in Switzerland, Germany and the Netherlands specify that a service user must live in the vicinity of the site[93] • Alcohol and tobacco use prohibited[94]
Drug administration methods • Regulations prohibiting or allowing assisted injection[95] • Regulations prohibiting or allowing autonomy in administration methods (including smoking, swallowing, site of injection)[96] • No sharing of injecting equipment[97] • Number of injections allowed per visit[98]
Rules, regulations, and processes for staff • Rules, regulations, and processes for responding to overdose[99] • Registration processes – how much information (if any) is required on first use[100] • Required staff training and or qualifications[101] • Strategies for dealing with verbal abuse, including de-escalation[102] • Syringe discarding[103] • Equipment and processes (latex gloves, sterilising surfaces)[104] • Number of staff required on site during operation[105]
Rules and regulations related to managing demand and the flow of service users • Time limits for consumption room and/or chill out space[106] • Prohibiting loitering[107] • Going back into the waiting room after use if the service user wishes to access the service again[108] • Required monitoring after consumption[109]
Further rules and regulations • No drug dealing or sharing drugs[110] • No walking around with open syringes[111]

Current legislation places key constraints on viable consumption practices. As will be discussed below, while there are legal means to allow supervised consumption with the UK legal framework, any activities that can be construed as supply need to be avoided. Therefore, assisted injecting would not be feasible under UK law as it stands. This may exclude potential clients who are unable to inject themselves, such as people with physical disabilities, who may face additional vulnerabilities and are more exposed to the risk of BBV transmission.[112] Services which cannot allow assisted injection may instead provide injecting education and guidance and/or 'vein mapping'.[113] Some existing sites prohibit neck or groin injecting.[114] However, 68% of injections in the unsanctioned Glasgow SDCF were in the groin, and the groin is the most common body location for injection across Scotland.[115]

Where this is allowed, service users have noted the importance of private spaces for more intimate injecting practices.[116]

The number of injections permitted per visit may impact levels of use. Many sites allow only one injection per visit, though do not typically restrict the number of visits per day. People who inject cocaine may do so multiple times per day, so limiting injection numbers may present a barrier to engagement.[117] Evidence points to a significant increase in the numbers of people injecting cocaine in Scotland in recent years. In the unsanctioned Glasgow SDCF, 61% of injecting episodes involved cocaine, so such patterns of use will need to be a key consideration.[118] While some studies have found service users would prefer to be able to share drugs, this would not be possible under UK legislation so is not a viable option.[119]

Many SDCFs have allocated time slots in order to manage demand and reduce waiting times. A 2014 survey of European provision found that most services operated a maximum duration policy (range: 15-90 minutes).[120] However, since a key benefit of SDCFs is preventing people from needing to rush, as is the case with public injecting, fixed time slots may reduce the attractiveness of a service.[121]

Core and ancillary provision

A key consideration in the establishment of an SDCF is to determine the balance between core and ancillary provision. There is evidence that SDCFs can facilitate engagement in wider harm reduction and health supports such as: injecting equipment provision (IEP); naloxone; drug education and training; BBV testing and treatment; and drug treatment.[122] Therefore, having wrap-around care and support on site, or effective pathways to relevant services, is important in maximising health and harm reduction benefits. However, this needs to be set against cost and capacity implications.

As described above, integrated models often provide the most extensive support, while standalone models typically provide fewer on-site services, relying instead on signposting and referral.[123] However, provision of additional interventions and support requires sufficient funding, as a significant portion of operational costs may be related to ancillary provision.[124] Integrated models may reduce operational costs by drawing on existing services on site, but these need to be adequately resourced to ensure that demand can be met.[125]

Core service provision

All SDCF identified in the literature provide sterile injecting equipment and allow individuals to safely discard used syringes and needles.[126] They have oxygen and naloxone available to administer in case of an overdose, with many also providing take-home naloxone along with training.[127] Additionally, most services provide some form of harm reduction education, for example in relation to safer injecting practices.[128] Education provision can be viewed as an essential feature, as estimated cost-effectiveness is partly based on the assumption that clients adopt safer practices when using elsewhere.[129]

Common ancillary service provision

A large number of SDCFs also provide testing for BBVs and provision of associated harm reduction advice. 65% of SDCFs surveyed in 2018 provided HCV testing on site, with 54% providing HIV testing.[130] BBV testing is not only intrinsically valuable for clients, but prior cost benefit analyses have identified prevention of BBV transmission as a major cost-saving element of SDCF delivery.[131] However, any impact on BBV transmission is dependent on a range of factors, including: rates of needle sharing in the wider community; coverage and uptake of BBV testing within other existing services; needle sharing outside of the facility; and existing rates of BBV amongst the population of people who inject drugs.[132]

Many SDCFs offer 'chill-out' spaces, sometimes in the form of low-cost cafés.[133] These allow for monitoring after use and responding in the event of an overdose, as well as providing a safe space for people to escape the stress, stigma, and risks of their daily lives, and build relationships with peers and staff.[134]

SDCFs very often provide at least a degree of psychosocial and emotional support, either formally or informally. As noted above, staff may also support individuals to navigate wider social systems such as housing and social security/welfare benefits.[135]

Many SDCFs also provide additional materials for safe consumption (e.g., alcohol swabs, cookers, filters).[136] Some services also provide basic material resources such as clothing, food, and toiletries (including feminine hygiene products), and practical and logistical resources such as showers, bike storage, lockers for secure storage of possessions, and charging sockets.[137]

Wider harm reduction and health services

Beyond these basic levels of service provision, SDCFs may provide a range of further ancillary services and supports, including:

- access to drug checking technologies
- wound care
- vaccinations
- access to healthcare professionals for general health matters
- OST provision by a healthcare professional
- footcare
- on-site social work
- addictions councillors and mental health support
- a range of 'in-reach' services, including in relation to housing, legal affairs and social security.[138]

Table 3 below provides a list of core and ancillary elements that might be considered in the Scottish context. Table 4 provides a list of common services offered in European SDCFs. Table 5 provides a list of services provided in Europe, Canada, and Australia. Table 6 provides detail of BBV testing, monitoring, and treatment provision.

Table 3: Core and ancillary service provision elements for SDCF in Scottish context

Core features
- Safe, sterile space for drug injection
- Sterile injecting equipment and sharps boxes for disposal
- Oxygen available
- Provision of on-site and take-home naloxone
- Space for monitoring after use
- Staff trained to deal with medical emergencies and naloxone administration (see above for discussion on balance between peer and medical staffing)
- Protocols and guidelines to ensure robust risk management, clinical governance, and legal responsibilities
- Agreed protocols with local police to ensure consistency of law enforcement in vicinity
- Signposting to wider health and harm reduction services

Recommended ancillary provision
- Drug education relating to safer drug consumption practices and harm reduction
- HCV and HIV testing
- Safe, sterile spaces for oral consumption, snorting and smoking
- Additional materials for inhalation (e.g. foil, sterile pipes)
- Café/chill-out space to enable relationship building, socialising and respite
- Mechanisms for shared decision making around rules to involve service users

Further potentially beneficial features

- Formal or informal opportunities for psychosocial support
- In-reach support on social security, housing, and healthcare service navigation
- Drug checking services
- In-reach medical staff to provide e.g., wound care, OST prescribing, pain management, general medical advice
- On site addictions counsellors
- Provision of food
- Provision of clothing

Table 4: Services commonly offered at European SDCFs[139]

Services/supports offered	% of surveyed SDCF offering service
Needle and syringe provision	100%
Health and drug education	100%
Drug paraphernalia	97%
Referrals to other care and treatment services	88%
Provision of bread, tea, and coffee	88%
Nurse on site	84%
Personal and hygiene care	78%
Warm meals	63%
Physician on site	59%

Table 5: Provision of services amongst surveyed SDCFs in Europe, Canada, and Australia[140]

Service offered	% of surveyed SDCF offering service
Referral to wider health services	94%
Provision of drug paraphernalia	94%
Needle and syringe provision	94%
Use of a phone/charging facilities	91%
Coffee/tea	89%
Condom provision	89%
On-site overdose management	89%
Personal care (shower)	78%
Support with finance/admin	74%
HIV related counselling	67%
Case management	63%
Meals	61%
Recreational activities	57%
Outpatient counselling	46%
Mental health care	44%
HBV vaccination	41%
Work/reintegration projects	41%
Postal address for service users	39%
Legal counselling	39%
Take-home naloxone	37%
Lockers	26%
OAT	24%
Abstinence treatment	20%

Table 6: Provision of BBV testing, monitoring and treatment services among surveyed SDCFs in Europe, Canada, and Australia[141]

Service offered	% of surveyed SDCF offering service
Referral to HCV treatment at other service	96%
HCV related education	94%
HCV testing on site	65%
HIV testing/screening	54%
Services not offering HCV testing who were planning to do so	50%
Liver health/cirrhosis monitoring	24%
HCV treatment onsite	8% (6% additional services planning to provide this treatment on site in near future)
HIV treatment	4%

Scale, space and design

The scale and size of SDCF provision varies considerably. A recent survey found a median of ten spaces offered for consumption within facilities, with the largest service offering 63 spaces.[142]

There is limited research evidence on preferred physical design. Some studies describe the importance of having a service which feels 'cosy and homely', with a non-medicalised and relaxed atmosphere that encourages sociability.[143] Several note the importance of safety, comfort, and community as mechanisms of engagement, using artwork, music, warm colours, and motivating messaging to help create a welcoming environment.[144] Encouraging service users to 'take ownership of the space' also supports this.[145] There is limited research on whether service users prefer open injection rooms or private booths, though booths are commonplace and provide greater privacy.[146]

Cost of SDCF provision

The total cost of introducing an SDCF in Edinburgh will depend on the cost of staffing, buildings (or vehicles if provision is mobile), and scale of provision. This will be affected by the agreed service model and the factors discussed above, including the staffing model, hours of operation, and the extent of ancillary services provided on-site.[147] The facility proposed for Glasgow will receive around £2.3 million in funding per year. Vancouver's Insite facility, which may be viewed as at the upper end of both scale and service provision, operates at an annual cost of approximately $2-$3m (Canadian dollars). The annual staffing and equipment cost for the SDCF itself is estimated at around $1.5m, with the rest of the cost accrued by services offered on site, including addictions counselling, public health screening and housing services.[148] In 2018, Clarke and Torrance estimated that a standalone SDCF could cost £800,000-£1m annually, providing 12 injecting booths, five smoking booths for 12 hours per day, 365 days per year, while an integrated model could cost between £650,000 and £800,000, with the reduced cost partially accounted for by the intervention drawing on existing service staff.[149] It is not possible to provide a detailed estimate of how much a service in Edinburgh may cost, as that would depend significantly on service design and would require costings from potential providers. However, a broad estimate of between £1-2 million per year, depending on design, may be considered realistic.

In purely economic terms, the capital and operating costs of SDCF provision need to be set against potential savings in relation to prevented overdose deaths and wider healthcare savings. Several cost-benefit and cost-effectiveness analyses have found that the annual healthcare savings accrued through the harm reduction impact of SDCF outweigh the costs of service delivery.[150]

Because of the range of models used to estimate cost-effectiveness in the existing literature, it is difficult to draw firm conclusions or apply estimates directly to Edinburgh. For example, the most common measure for estimating benefits is reduced BBV transmission rates through a reduction in needle sharing, and concomitant reductions in treatment costs for HIV and HCV. Most of the studies that find higher levels of cost-effectiveness base their estimates on the assumption that SDCF provision reduces the rate of needle sharing in the wider community.[151] Studies which do not make this assumption tend to estimate more modest cost-savings in relation to BBV prevention.[152]Importantly, Edinburgh currently has relatively low rates of HIV, and declining rates of HCV, among people who inject drugs. Cost savings ascribed to BBV prevention are liable, therefore, to be somewhat lower in Edinburgh than in areas where BBV prevalence is higher.

Studies also differ in estimated benefits from prevented overdose deaths due to variations in the economic value afforded to lives saved.[153] Where such an outcome is included it is commonly estimated according to lost value of average wages across a lifetime.[154] Other measures include reduced medical costs for treatment of soft-skin tissue infections; cost-savings related to reduced non-fatal overdose; cost-savings from reduced ambulance call-outs; and cost-savings from increased uptake of Medication Assisted Treatment (MAT).[155]

The existing cost-benefit literature needs, therefore, to be approached cautiously: the differing model parameters and outcome measures utilised makes comparison of results challenging, and it is difficult to make direct comparisons to the Scottish context. Nevertheless, the balance of available evidence points to cost savings and positive cost-benefit ratios, especially in relation to reduced BBV transmission.

Public, community and political challenges

The Scottish context

In recent years, public and political support for the introduction of SDCF provision has grown across Scotland, and they are strongly supported by the current Scottish Government. More broadly, recent UK-wide polling found that 55% of participants supported the implementation of SDCFs, with only 25% opposed.[156]

The UK Government continues to formally oppose the establishment of SDCFs on the grounds that they may encourage drug use and that evidence for their effectiveness is mixed.[157] The international literature finds no evidence for the former claim.[158] The view that the evidence for effectiveness is mixed is based on the lack of RCT studies, the challenges of which are discussed above. A 2022 report into the views of senior strategic decision makers in Scotland found that most were keen to move ahead, and believed that the available research was sufficiently compelling.[159] A recent *Lancet* commentary echoed this position, noting that lack of RCT-level evidence is not usually a barrier to the adoption of public health measures when their mechanism of action is clearly understood.[160] Among strategic decision makers in Scotland, the primary barrier to adoption was seen as a lack of clear political leadership. There was a general view that legal barriers could be addressed, but that the tendency for SDCF provision to be treated as a 'political football' undermined progress.[161]

An associated study of Scottish families affected by drug harms also found evidence of support for SDCF adoption. Among families, the primary reason for support was the potential for SDCFs to create a non-stigmatising, compassionate space where loved ones could be safe and supported. This was seen as both intrinsically valuable, and a potentially powerful element of journeys towards recovery.[43]

Public concerns around SDCF

International research has identified a number of key areas where SDCFs are assumed to achieve public benefits, including:

- harm reduction: through reductions in both fatal overdoses and the transmission of infectious diseases[162]
- cost-effectiveness: long-term savings to wider health and social services in the long run[163]
- allocation of resources: allowing police to focus on crimes which threaten public safety[164]
- amenity: potential reduction in public disorder, public drug use and drug-related litter[165]
- stigma reduction: the creation of spaces that reduce stigma and provide compassionate support for those suffering with drug problems.[166]

Nevertheless, SDCF provision can provoke a degree of public and political controversy.[167] Common objections include the argument that public funds would be better spent on other modes of treatment or support; that the state should not enable activities that, de facto, tolerate illegal activity; or that SDCF provision will lead to more illegal activity and public disorder where they are located – the so-called 'honeypot effect'.[168] The potential 'honeypot effect' has been assessed in a range of research studies, which find that SDCF provision does not increase crime or disorder around

the service location.[169] Evidence reviews by both Public Health England and the Scottish Government have also concluded that crime rates do not increase in the vicinity of an SDCF.[170]

The establishment of an SDCF can reasonably be expected to contribute to a reduction of amenity issues such as street litter; however, in areas with deeply entrenched problems such problems will not be resolved by this intervention alone. A recent evaluation of an SDCF in Richmond, Australia found some local residents reported no perceived change to factors such as public drug use and discarded needles. However, the SDCF was also associated with 25% reduction in ambulance callouts in the vicinity. The formal review noted that the continuing amenity problems were primarily a consequence of 'the ongoing public burden of a drug market that existed long before the trial began.'[171]

Community consultation and dialogue

Several studies note the importance of early community consultation and dialogue when implementing an SDCF.[172] An evaluation of a pilot SDCF in Australia emphasised the need to 'develop a strategy to build and maintain relationships with people who live and work in the local community', noting that strong relationships allow challenges to be openly and proactively discussed and addressed.[173] Support for SDCF implementation is often determined by what communities understand the key purposes of SDCF to be.[174] Emphasising the role of SDCF as a health intervention, stressing the potential improvement to amenity, highlighting available evidence, and involving the perspectives of those with lived experience, tend to build support.[175]A recent study of public views in Scotland found that, in addition to providing information about the evidence base for such interventions, explicitly addressing common objections, along with foregrounding human narratives, was associated with an increase in support.[176]

Legal issues and challenges

The United Nations International Narcotics Control Board (INCB), which is responsible for overseeing the implementation global drug control treatises, has stated that SDCF provision is consistent with international law if the 'ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking'.[177]

The primary barrier to the adoption of SDCF in Scotland is their legal status. The consumption activities that would take place in an SDCF are controlled under the Misuse of Drugs Act (MDA) 1971. Because this is not reserved legislation, it can only be amended by the Westminster government. However, the legal risks under the existing law can be addressed through a multi-agency approach whereby 'police, prosecutorial, and administrative discretion is sensibly and pragmatically exercised in the interests of personal and public health and welfare'.[178] In the absence of a formal statutory framework, it is changes to the discretionary application of the MDA 1971, and the establishment of clear policing protocols, that has thus far been explored for Scotland.

The MDA 1971 sets out a range of offences which could apply in the operation of an SDCF, including:

- possession of controlled drugs by clients
- supply of controlled drugs by staff
- staff 'permitting' or 'abetting' either the consumption or production of drugs
- provision of drug paraphernalia.

Legal analysis (especially Fortson, 2017) has concluded that these legal considerations are largely surmountable through careful rules and operational practices within the SDCF, and the establishment

of clear memoranda of understanding with local police.[179] We summarise some of the key elements of this analysis below.

- The issue of supply can be addressed by ensuring that no staff touch illegally purchased substances, and there is no assisted injecting.
- It is highly unlikely that 'cooking' heroin would be construed as 'preparation' under the MDA 1971.
- There is a strong case that permitting consumption would form a legitimate activity in the service of a greater health good, and that prosecution would not be in the public interest.
- Possession by service users would be addressed through police operational discretion, with local agreements to clarify operational details
- Provision of paraphernalia (e.g., swabs, citric acid etc.) is allowed under the 2001 Misuse of Drugs Regulation, where the person is 'engaged in the lawful provision of a drug treatment services'. This does not apply to tourniquets, however, which means these would need to be brought by the clients. Exemptions to the provision of syringes are already widely used in IEP services.

In addition to the establishment of memoranda of understanding with the police, legal concerns suggest a number of operational considerations, such as:

- the need for clear operating manuals, protocols, and practice guidelines within the SDCF to protect staff and ensure inadvertent breaches are avoided
- providing clear links to wider harm reduction and treatment to help ensure the service complies with the INCB position on integration.

Lord Advocate's statement of prosecution policy

When NHS Greater Glasgow and Clyde originally announced plans to open an SDCF in 2017, the project was paused when the then Lord Advocate declined to provide a so-called 'letter of comfort' on the basis that he did not have the power to make an SDCF lawful under the Misuse of Drugs Act and that there would be 'practical difficulties in defining with sufficient precision the circumstances which would and would not be subject to the immunity'.[180] In 2021, the new Lord Advocate said she 'would be prepared to consider any such future proposal, but it would have to be specific and underpinned by evidence, and it would require fresh consideration'.[181]

On 11th September 2023, the Lord Advocate published a statement of prosecution policy in response to a formal request from the cross-committee on tackling drug deaths and drug harm. This stated that 'it would not be in the public interest to prosecute drug users for simple possession offences committed within a pilot safer drug consumption facility'.[182] In effect, the statement gave the legal go-ahead for the existing plans for a pilot SDCF in Glasgow to be approved, which the City Council did shortly afterwards.

While the full interpretation of this statement is still being considered at the time of writing, it should be noted that the statement is explicitly in response to the specific proposal set out for the Glasgow facility. It clearly refers to both the service design and location and states that:

> *Central to my consideration of the request has been the fact that the proposed facility would be co-located with other services which, taken together, may be able to offer a range of support and assistance to those consuming drugs. Further, although I am aware it is not the main aim of the proposed facility, my understanding is that the facility could, over time and in some cases, provide the necessary resources to assist those using the facility into recovery*.[183]

The statement accepts the legal advice provided to NHS Glasgow and Clyde that 'the proposed facility could operate within the current legal framework, except in so far as users would be in

possession of controlled substances, contrary to Section 5(2) of the Misuse of drugs Act 1971.'[184] Therefore, it is only simple possession that is seen as potentially contravening the law, given the operating procedures and safeguards put in place. It is to be expected that a facility adopting a different service design would require additional consideration by the Lord Advocate, and reassurances on these wider points, before being able to open. However, this has yet to be tested.

The Lord Advocate's statement has significantly shifted the legal landscape in regard to SDCF provision in Scotland. However, it is not a blanket policy and it is to be expected that additional services would require further consideration. Service design for further pilots facilities will need to consider how activities remain as far as possible within the overarching legislation, while making a clear case to justify extension of the public interest principle regarding simple possession to different models of provision.

Policing issues

In developing an operational strategy with the local police, a number of issues need to be taken into consideration:

- the vicinity within which relevant discretion is applied
- what activities will remain subject to police action (e.g., supply, loitering, congregation etc.)
- the level of police presence that will best balance the need for law enforcement against the need to not deter potential service users.

Balancing these concerns will be a matter of negotiation, but this is not unique to the UK situation: the number of functioning SDCFs operating globally demonstrates that they can be addressed through local agreements and MOUs. Essentially, if the police are enabled, and agree, not to view use of the facility as grounds to prosecute for drug possession then, with the right internal protocols in place to protect staff from inadvertent breaches of the law, there is extensive evidence that a facility can operate effectively and over a sustained period of time.

Conclusion

There is strong international evidence that SDCFs can be effective in tackling a number of drug-related harms. There are also a range of service models now in operation across the world, though it is possible to specify core and ancillary levels of provision. The extent to which varying harms are mitigated is likely to depend on scale of provision, location, service design and other factors. Different service models, locations and operating practices can affect the extent to which services are attractive to those in most need, the types of consumption that take place, levels of community support, costs and so forth. The design of an SDCF should, therefore, be responsive to the specific challenges facing the community, local drug consumption trends, and needs of potential clients.

Clear clinical governance, operating procedures and risk management systems are important both for the safety of staff and clients and to help reassure police and legal authorities that potential contraventions of law are avoided. However, the involvement (including leadership) of peer staff, and the creation of welcoming and supportive environments, are also important in attracting people to the service. The inclusion of expertise drawn from lived experience is also important in ensuring service provision matches need.

The cost of providing an SDCF is highly dependent on the service model adopted. Models that make more extensive use of peer-led provision are liable to be less expensive, but it is important to avoid exploitation of low-paid or voluntary labour where such a model is adopted. Estimates have been made which provide some broad parameters for possible costs, but further work with potential providers would be needed to firm these up.

Overall, the available evidence suggests that SDCFs have the potential to tackle many of the drug-related harms being faced in Edinburgh. There is also a wealth of evaluation and review literature available on which to make informed decisions as to preferred service design in the Edinburgh setting. Legal challenges remain, but the recent decision regarding the Glasgow facility demonstrates these are not insurmountable. Therefore, there is a strong case in principle for safer consumption facilities to be introduced. The details of what this might involve are discussed in the following sections.

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2: Assessment of need and spatial patterns of harm in Edinburgh

Introduction

Drug-related deaths (DRDs) in Edinburgh have doubled in the last decade. In 2021, there were 118 DRDs, the highest number on record.[1] Recent calls for provision of SDCFs in Scotland , as discussed in the previous section, reflect the view that such facilities could play an important role in reducing harm as part of the wider treatment and harm reduction response. However, needs and feasibility differ between localities, and it is critical that any decision to introduce SDCF provision in Edinburgh reflects, and represents a constructive response to, specific conditions within the city. This section sets out the available quantitative data which can inform such a decision.

Data sources

This needs assessment used an epidemiological approach to collate data on the population of interest (people who use drugs in Edinburgh), current service provision, and existing drug-related harms. Secondary data were collected at health board (Lothian) and city level (Edinburgh) where possible, although how data were categorised geographically differed depending on the data source. Data sources synthesised for this report are listed below (see Appendix A for additional details).

The sources used for this report collate and aggregate their data at different levels. Some use postcodes, others use datazones, while others use geographical units unique to their sector (e.g. beat maps as used by Police Scotland). It is not possible to precisely synthesise these data sets; however, we seek below to arrive at broad conclusions regarding city areas where concentrations of harms are highest.

Patterns of injecting drug use

Geographical unit: Edinburgh

Data from the Needle Exchange Surveillance Initiative (NESI) were utilised to provide insights into patterns of use, and associated harms, among people who inject drugs in Edinburgh City.[2] NESI surveys are conducted in sites providing injecting equipment and completed by people using those services consenting to participate in the study.

Drug-related deaths

Geographical units: Datazones, postcode district and HSCP locality

Overall data on DRDs were taken from the NHS Lothian Drug-related Death Annual Report.[3] The Lothian Public Health Intelligence Team has DRD records at granular levels, but access was limited by data confidentiality protections. The research team was provided with DRDs within each Edinburgh postcode district from 2019-21, as well as aggregated into Health and Social Care Partnership (HSCP) sub-group localities of North East, North West, South East, and South West (see Appendix B for a map of the localities). A map of DRDs at datazone level for the years 2019-21 was also provided.

Scottish Ambulance Service (SAS) non-fatal overdose callouts

Geographical unit: Intermediate datazones, datazones, and HSCP locality

SAS non-fatal overdose callout data from 2018-21 was gathered as part of a previous study carried out by the University of Stirling, funded by the Scottish Drug Deaths Taskforce.[4] Intermediate and datazone areas in Edinburgh that had experienced five or more overdose callouts in at least one

calendar month out of each studied year were identified. The results were also aggregated to HSCP localities.

Drug checking

Geographical unit: Postcode district (see Appendix C for a map of postcode districts)
Edinburgh-specific drug checking data were analysed from the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) service. WEDINOS receives and tests postal samples of substances in order to provide information about contents and, where appropriate, issue alerts. WEDINOS data from Jan 2014-Oct 2022 was analysed to track trends in samples submitted from both Edinburgh and Scotland more generally.[5] Data from January-October 2022 was drawn on to provide analysis of specific recent drug market trends (e.g. types of substances submitted for testing; expected vs actual content). Edinburgh-specific drug warnings contained in Public Health Scotland Rapid Action Drug Alerts and Response (RADAR) reports were also analysed.[6]

Injecting equipment provision (IEP)

Geographical unit: IEP provider address
Data were reported from a pre-existing dataset based on Needle Exchange Online (NEO 360) data, which was made publicly available as part of the Injecting Equipment Provision in Scotland report.[7] For insight into injecting drug use across Edinburgh specifically, the Lothian Harm Reduction Team provided additional NEO 360 data from pharmacies in Edinburgh which had administered more than 5,000 syringes/barrels per year in 2020-22.

Treatment referrals

Geographical unit: Postcode district
NHS Specialist Addiction services referral data from 2019-22 were gathered by LAS and amalgamated by postcode district to show the GP locations where patients were most frequently referred to specialist drug services. From this, we analysed data on:

- OAT patients who had been referred to specialist drug services
- patients admitted to hospital with clinical notes reporting injecting drug use
- patients registered at the Edinburgh Access Practice (which we used as a proxy for homelessness); and
- patients admitted to hospital with clinical notes reporting injecting drug use, and who were registered at the Edinburgh Access Practice.

Blood-borne virus (BBV) testing

Geographical unit: Testing location and HSCP locality
LAS provided data showing the number of Hepatitis C (HCV) tests carried out in Edinburgh-based services that explicitly support people who use drugs between 2019-22.

Drug-related litter

Geographical unit: Ward
City of Edinburgh Council (CEC) provide a Street Cleaning needle removal service, which allows members of the public to request removal of drug-related litter. Removal request data from 2019-22 were provided by the CEC Environmental Team, and ward and locality areas with the highest numbers of service requests were identified.

Drug-related crime

Geographical units: Beat area, ward and HSCP locality
Police Scotland provided recorded drug-related incidents in Edinburgh 2021-22 from the national incident recording system, STORM. Data were categorised according to beat areas (see Appendix D).

Corresponding HSCP localities were added to the data to provide a level of continuity in reporting across data sources. Police Scotland also provided datasets recording disposed possession and supply incidents from 2019-22.

Willingness to use a SDCF

Geographical unit: Edinburgh

A previous study quantified willingness to use a SDCF among people who inject drugs in Scotland using data from the NESI survey in 2017-18.[8] The data on the willingness to use a SDCF from participants recruited in Edinburgh City recruitment sites are drawn on for this report. Data for this indicator relate to 2017-18 only. A qualitative analysis of willingness to use an SDCF among potential clients in Edinburgh is provided in the following section of this report.

Findings

Drug-related deaths

In 2021, 197 DRDs were recorded in Lothian: an increase of 25 deaths from 2020, and a 98% increase since 2014. Of these, 118 (60%) were recorded in Edinburgh City, followed by 35 in West Lothian (18%), 24 in Midlothian (12%) and 16 in East Lothian (8%) (Figure 1).

Of the 197 deaths in Lothian, 135 (69%) were men, and 61 (31%) were women. This is consistent with national data, which shows men accounting for approximately 70% of all DRDs. The proportion of women has increased from 23% in 2020. In 2000, men were four times as likely as women to suffer a DRD, whereas currently they are 2.4 times as likely.

46 different drugs were implicated in DRDs in 2021. This is similar to previous years (42 in 2020; 55 in 2019). Opioids were implicated in 173 (88%) of DRDs, while benzodiazepines were implicated in 139 deaths (71%), and stimulants in 91 deaths (46%). Polydrug use remains commonplace, and the median number of drugs implicated per death was four.[1] This remained the same from 2019 and 2020.

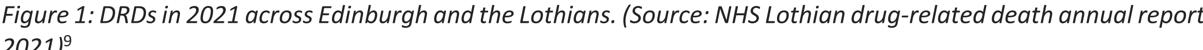
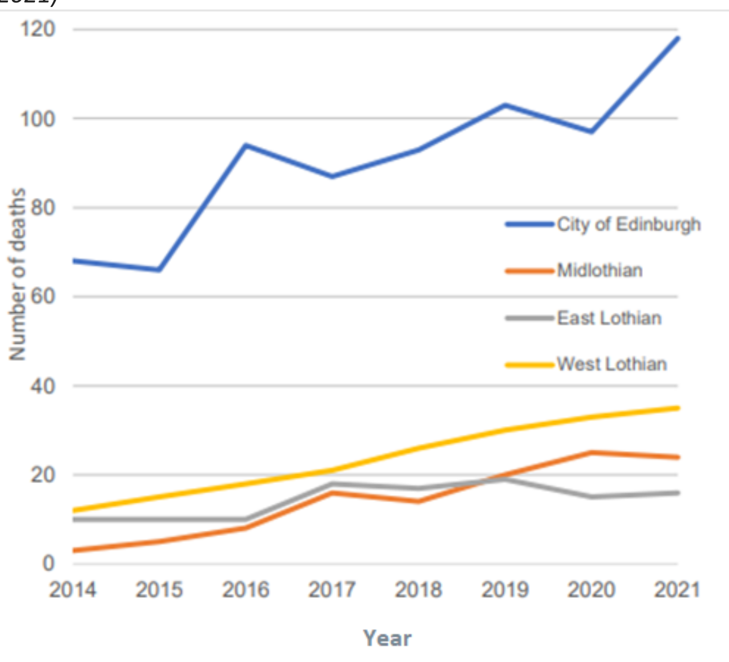


Figure 1: DRDs in 2021 across Edinburgh and the Lothians. (Source: NHS Lothian drug-related death annual report 2021)[9]

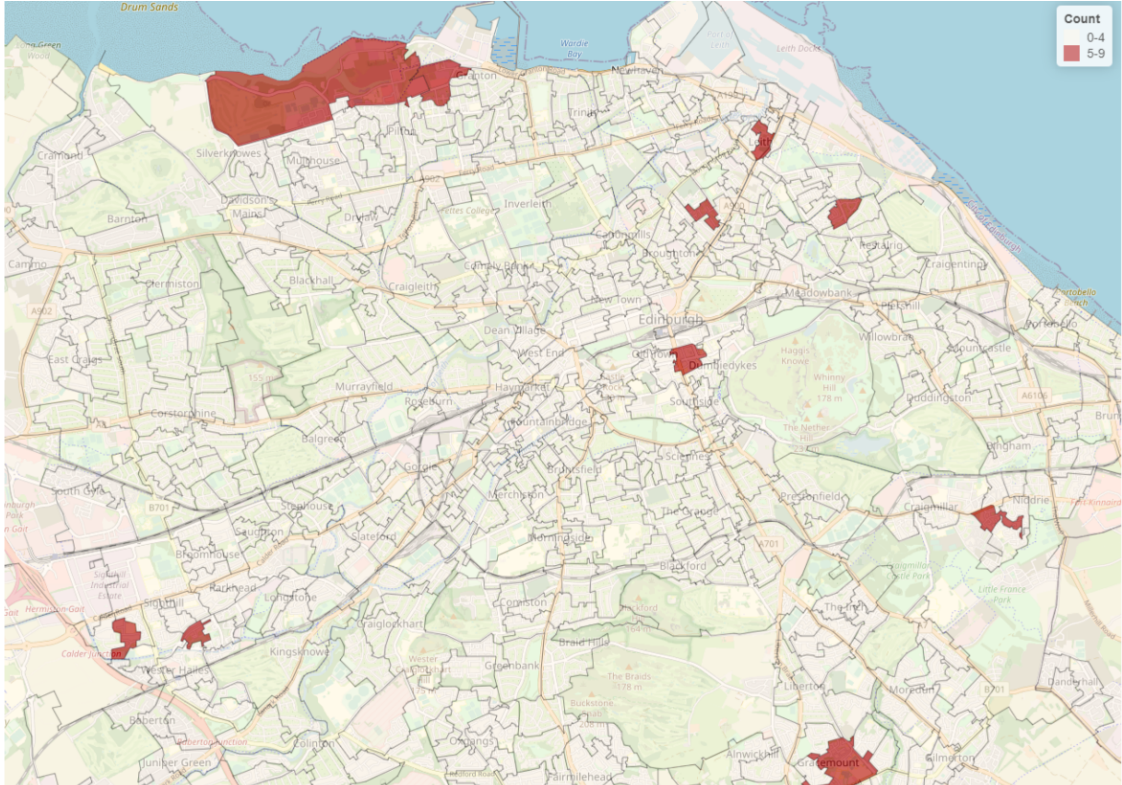


The majority of Lothian deaths in 2021 occurred in the 35-54 age group range (n=124, 63%). This is slightly lower than in 2020 (69%). National Records of Scotland data shows that the average age of a person dying from a DRD in Scotland has increased from 32 to 43 years old in the last 20 years.

Critically, DRDs are not spread equally across geographical areas in Edinburgh. Data protection constraints meant the research team was not able to access DRD locations at the most granular level. However, the Public Health Intelligence Team was able to provide a map highlighting datazones that had experienced 5 or more DRDs in the period 2019-21. NB: no single datazone had more than 9 deaths in that period.

Datazones are the key geography for small area statistics in Scotland. They have roughly standard populations of 500 to 1,000 household residents and are shaped to reflect physical boundaries where possible, and to contain households with similar social characteristics.

Figure 2: Total drug-related deaths by datazone 2019-21 (Source: Public Health Intelligence Team)



We were also provided with DRD at postcode district level for the period 2019-21 (see postcode district map in Appendix C). This also shows a wide variation by area, with the highest aggregate numbers in the EH11, EH7 and EH6 postcode districts (Table 1). It is important to note, however, that these figures need to be treated with caution as single-year spikes within a given postcode district could create the false impression of sustained trends in some cases. Postcode districts also cover relatively large, and sometimes diverse, geographical areas with varying populations. Therefore, DRDs may be high across a postcode district without smaller (e.g. datazone level) clusters appearing.

Table 1. Postcode districts and numbers of DRDs in the period of 2019-2021.

Postcode district	Number of DRDs	Postcode district	Number of DRDs
EH11	52	EH5	12
EH7	33	EH15	10
EH6	31	EH12	8
EH14	29	EH3	7
EH16	26	EH1	6
EH4	23	EH9	5
EH8	20	EH10	5
EH17	15		

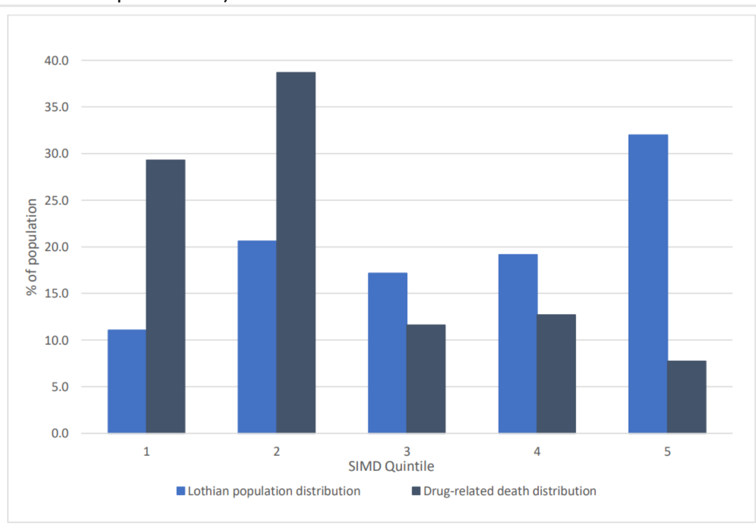
Edinburgh ADP has access to more complete, small area data which cannot be shared due to data protection. The analysis of patterns below was completed in consultation with them, and accords with their knowledge of the more granular data.

The DRD data for 2019-21 shows that there is a wide geographical spread of harms with no small single area containing such a concentration of DRD that a local solution there would have a decisive impact on the aggregate level of city citywide harm. However, there are significant localised areas of harm where a local intervention has the potential to achieve a significant effect.

The densest, largest groupings are around Leith and the Old Town. However, there are also smaller but significant clusters in parts of Pilton/Muirhouse/Granton, Gracemount, Niddrie, and Wester Hailes. There is also some clustering on the axis along the length of the A70/ Gorgie Road (Gorgie/ Dalry and Fountainbridge), which, although not evident on the map emerges from the more granular data. Many of these areas are identified by interview participants as locations of increased use, as discussed in Section 3.

Postcodes with the highest DRDs include some of the most deprived quintiles of the city (Scottish Index of Multiple Deprivation).[10] This is important because 68% of all Edinburgh-based DRDs were people who lived in the two-most deprived quintiles of the city, despite only 32% of the Lothian population living in these areas (Figure 3). Indeed, after adjusting for age, people living in the most deprived areas (SIMD quintile 1) are shown to be 15.3 times more likely to die of a DRD than those in the least deprived quintile (quintile 5). This gap between the risk of DRD in the most and least deprived areas has doubled since 2000.

Figure 3: Lothian population by SIMD quintile and DRD distribution (Source: NHS Lothian drug-related death annual report 2021)[11]



When aggregated to HSCP locality (Table 2), we see that deaths are rising in the South East of the city, with an almost 67% increase from 2019 to 2021.

Table 2. The number of DRDs across Edinburgh localities in 2019, 2020, and 2021.

HSCP locality	2019	2020	2021
Edinburgh North East	34	23	30
Edinburgh North West	13	20	20
Edinburgh South East	18	24	30
Edinburgh South West	31	25	29

Ambulance callouts for non-fatal overdose

The Scottish Ambulance service record location data for events where they are called out to non-fatal overdoses. The number of non-fatal overdoses is a key indicator of harm in itself; however, it is also important to note that previous overdose is a risk factor for future overdose.[12] Table 3 shows the intermediate datazones that have been the location for 25 or more non-fatal overdose callouts between 2017 and 2021.[13]

NB in Tables 3 and 4 cells marked with an asterisk represent areas where the total number of callouts was fewer than 5 in that year. This means that the actual number in that year will be between 0 and 4. The figure in the total column may, consequently, be up to 4 fewer than the actual total for each year marked with an asterisk. In Table 3, for example, the total for Muirhouse will between 27 (as shown) and 31. In Table 4, the total for Great Junction Street 01 will be between 31 (as shown) and 35.

Table 3: Intermediate datazone areas experiencing 25+ non-fatal overdose callouts between 2017-21

Datazone	2017-8	2018-9	2019-20	2020-1	Total[a]
Old town, Princes Street and Leith Street	93	70	114	70	347
Great Junction Street	15	21	48	18	102
Canongate, Southside and Dumbiedykes	27	30	24	15	96
Tollcross	27	20	24	7	78
South Leith	14	13	16	7	50
Meadows and Southside	12	11	20	6	49
Deans Village	12	6	8	14	40
Gracemount, Southhouse and Burdiehouse	11	13	7	7	38
Murrayburn and Westerhailes North	7	11	11	9	38
Restalrig and Lochend	11	7	9	8	35
The Calders	5	10	11	8	34
North Leith and Newhaven	8	5	8	10	31
Gorgie West	10	9	6	6	31
Muirhouse	7	*	11	9	27
Dalry and Fountainbridge	6	12	0	7	25

[a] This figure is the *minimum* total. The actual figure may be up to 4 more callouts than shown for each year marked with an asterisk.

Table 4 breaks the intermediate datazones that were the location of 50 or more non-fatal overdose callouts between 2017-21 into their constituent datazones. Importantly, numbers were only reported for datazones where five or more callouts occurred in a given single year. Therefore, the totals for some intermediate areas may be slightly more than the constituent datazones reported below because they include datazones within the intermediate area that received fewer than five callouts in the overall total.

Table 4: Non-fatal overdose callouts in datazones that constitute intermediate areas with 50+ callouts 2017-21

Datazone	2017-8	2018-9	2019-20	2020-1	Total[a]
Old town, Princes Street and Leith Street 04	36	29	41	22	128
Old town, Princes Street and Leith Street 06	35	21	37	28	121
Old town, Princes Street and Leith Street 03	6	*	14	13	33
Great Junction Street 01	*	10	13	8	31
Tollcross 02	12	8	9	*	29
Great Junction Street 02	6	*	22	*	28
Old town, Princes Street and Leith Street 05	6	10	8	*	24
Great Junction Street 06	5	5	10	*	20
Canongate, Southside and Dumbiedykes 06	8	*	6	6	20
Old town, Princes Street and Leith Street 01	5	*	10	*	15
Tollcross 05	8	6	*	*	14
Canongate, Southside and Dumbiedykes 02	*	8	6	*	14
Canongate, Southside and Dumbiedykes 03	*	7	5	*	12
South Leith 02	6	*	6	*	12
Canongate, Southside and Dumbiedykes 01	6	*	*	*	6
Old town, Princes Street and Leith Street 02	5	*	*	*	5
Canongate, Southside and Dumbiedykes 04	*	5	*	*	5
Tollcross 01	*	*	5	*	5
South Leith 01	5	*	*	*	5

[a] This figure is the *minimum* total. The actual figure may be up to 4 more callouts than shown for each year marked with an asterisk.

These data show that locations within the Old Town, Princes Street and Leith Street district, and locations around Great Junction Street, have experienced particularly high rates of non-fatal overdose callouts in recent years. Figure 4 (generated using the SIMD online mapping tool) locates the datazones in these two areas with 25+ non-fatal ambulance callouts 2017-21.

Figure 4: Edinburgh datazones with minimum of 25+ NFOD callouts 2017-21 (Source: Scottish Ambulance Service)

When data are aggregated to HSCP locality from 2018-21, Table 5 shows that a high number of ambulance callouts in Edinburgh South East may be of particular concern given that the DRD data

also showed deaths to be rising in the South East. Note that figures for 2020/1 are likely to have been impacted by Covid.

Table 5. The number of non-fatal overdose ambulance callouts across Edinburgh localities in 2018/19, 2019/20, and 2020/21.

HSCP locality	2018/19	2019/20	2020/21	Total
Edinburgh South East	107	155	69	331
Edinburgh North East	20	61	18	99
Edinburgh North West	5	16	20	41
Edinburgh South West	10	18	5	33

Patterns of injecting drug use in Edinburgh

As part of the NESI study, people who inject drugs in Edinburgh were asked about their patterns of use. The study recruited 140 people in 2017-8 and 101 in 2019-20 (see Appendix E). Nearly half of respondents had experienced homelessness in the last six months. Between 10-20% had been arrested for drug offences in the last six months, and the same proportion had been incarcerated in the last year.

The vast majority of respondents in both years (95%) reported injecting heroin in the past six months, and nearly a quarter reported cocaine or crack cocaine injection. Additionally, around a fifth reported injecting in a public place in the last six months. These numbers remained relatively stable across the two surveys. Participants who had injected in the last six months reported a high injecting frequency (more than four times per day) and reuse of injecting equipment. In 2019-20, 60% reported benzodiazepine consumption, and nearly half reported smoking or snorting cocaine.

A quarter of respondents in 2017-18 had experienced a non-fatal overdose in that year. This fell to 17% in 2019-20. In 2017-18, 31% were experiencing a current HCV infection, falling to 14% in 2019-20, likely as a result of scaled up direct-acting antivirals used to treat HCV.[14] The rate of participants reporting skin and soft tissue infection also fell (from 38% to 19%) in the same period.

Drug checking

Number of substances submitted for testing

Substances submitted to WEDINOS from Scotland increased tenfold between 2014-22. 1,512 substances were submitted over the period, of which 1,049 were submitted between January 2020 and October 2022. 213 submissions in this latter period were from Edinburgh. Importantly, 44% of submitted substances to WEDINOS in this time period were expected by the purchaser to be benzodiazepines prior to testing.

Substances were sent for analysis from 19 Edinburgh postcode districts, showing a geographically distributed demand for drug information (see Table 6). The most recent data shows the highest number of WEDINOS sample submissions came from locations in EH14, EH6 and EH12. However, these do not provide a direct indicator of drug-use prevalence, as they may equally reflect areas where awareness of WEDINOS is highest, or there are higher numbers of people prepared to submit drugs for sampling.

Table 6. Number of substances/samples submitted to WEDINOS from Edinburgh by postcode district (January-October 2022)

Postcode district	Number of submissions
EH14	13
EH6	13
EH12	12
EH1	10
EH16	8
EH11	6
EH8	7
EH3, EH4, EH7, EH10, EH17	<5

Risk of adulterants

One factor exacerbating DRDs is the complex, unregulated drug market, placing people at heightened risk of experiencing drug-related harm.[15] Drugs vary widely in content and strength, are often mis-sold (meaning drug contents do not correspond with what they were bought as) and may contain dangerous adulterants. WEDINOS submissions from Edinburgh between January and October 2022 show significant mis-selling and adulteration, with 33% of substances analysed during this time period found to be either only 'partially as expected' or 'other than expected'.

A key concern in Edinburgh is the increased availability and use of novel/synthetic benzodiazepines (often referred to as 'street benzos'). Street benzos can be much more potent than traditionally prescribed benzodiazepines but are often designed to replicate the appearance of prescribed medicines such as diazepam. The most common 'street benzo' implicated in DRDs is etizolam, implicated in 100 deaths in Lothian in 2021, compared to 43 in 2018.

Bromazolam is another potent synthetic benzodiazepine and is currently the most commonly detected benzodiazepine in Scotland, and is implicated in an increasing number of drug-related harms. The strength of Bromazolam reportedly varies widely between pills and batches. This unpredictability can place people at increased risk of experiencing drug-related harms such as black-outs, injury, or overdose. There is evidence of increased availability of Bromazolam on the drug market in Edinburgh, and a number of benzodiazepine tablets submitted to WEDINOS in the past year reportedly contained Bromazolam.[16]

Analysis of expected benzodiazepine substances submitted to WEDINOS from Edinburgh in 2022 demonstrates the complexity of the street benzo market. Whilst individuals accessing the service often described the submitted substance using generic terms such as Diazepam or Xanax, analysis of the actual contents reveals the presence of 13 different substances (Table 7).

Table 7. Contents of benzodiazepine samples (n=12) submitted from Edinburgh found to be other than expected (January-October 2022)

Expected substance (described by service user)	Packaging information/label	Actual substance composition after testing
Diazepam	Not stated	Bromazolam, etizolam, melatonin
Diazepam	Diazepam	Bromazolam
Unspecified benzodiazepine	Roche-10	Etizolam
Valium	Not stated	Etizolam, phenacetin
Diazepam	Not stated	Flubromazolam, phenacetin
Diazepam	Not stated	Etizolam, paracetamol
Diazepam	Activis	Phenacetin
Diazepam	Diazepam Terapia	Flubromazolam
Alprazolam	Not stated	No active component identified
Alprazolam	Not stated	Flualprazolam
Xanax	Not stated	Adinazolam, caffeine
Xanax	Xanax	Mephedrone, caffeine

As well as the risk of street benzos, increased detection of '2-Benzyl benzimidazole' ('nitazene') opioids in Scotland has raised concerns around the potential for further increases in DRDs and harms, given their potency.[17] There have been detections of nitazene opioids in Lothian and Etonitazene, sold as oxycodone, was detected in four Edinburgh-based WEDINOS samples.[18] There is increasing concern over the risk posed by nitazenes in the UK, especially following a possible reduction in the supply of heroin resulting from a clampdown on opium production in Afghanistan.[19] Public Health Scotland produced an updated RADAR alert on nitazenes in March 2023, and a National Patient Safety Alert on potent synthetic opioids was published by the Office for Health Improvement and Disparities in July 2023.[20] The extent to which recent increases in nitazene detection in Scotland marks the start of a sustained trend remains unclear at the time of publication, but would present a significant increase in the risk of overdose among people who currently use opioids if it does continue.

Additionally, quarterly RADAR reports describe a range of suspected adverse drug events or new drug use trends in Edinburgh.[21] These include:

- suspected fake/novel pregabalin resulting in seizures amongst experienced users
- low priced crack cocaine associated with serious adverse side effects
- reports of young people drinking cough mixture with crushed up codeine
- strong heroin (referred to as 'scab') posing an overdose risk for inexperienced users
- circulation of synthetic cannabinoids adulterated with opioids; and
- reports of heroin and cocaine suspected to be adulterated with mephedrone causing adverse effects.

In regard to SDCFs specifically, the emergence and prevalence of novel benzodiazepines and synthetic opioids creates a need for facilities that can deal with accidental overdoses or other adverse reactions *in situ*, and/or can provide services that check for the content of drugs being taken. An SDCF can help with the first of these, whereas a drug checking service (DCS) co-located within an SDCF could also support the latter.

Injecting Equipment Provision (IEP)

Lothian provides the second highest number of needles and syringes across NHS Scotland Health Boards. However, both the number of outlets and levels of uptake have declined in recent years despite increasing DRDs, a pattern that is seen nationally. The number of IEP outlets peaked at 44 in 2011-12, before falling to 31 in 2020-21. The reported number of people using outlets has also declined from 56,339 in 2014-15, to 16,031 in 2021-22. The number of needles and syringes distributed in Lothian peaked at 892,920 in 2014-15, before falling significantly to 376,595 distributions in 2021-22. Similarly, the number of other injecting equipment items and foil distributed in Lothian fell from 488,921 in 2015-16 to 233,526 in 2020-21 (Figure 5). It is important to note that falling numbers will have been exacerbated by the COVID-19 pandemic given the impact this had on service provision.

Figure 5: Number of needles and syringes distributed across NHS Boards in Scotland (Source: Public Health Scotland (2022). Injecting equipment provision in Scotland)[22]

GGC= Greater Glasgow and Clyde, Lo= Lothian, Fi=Fife, Gr=Grampian, La=Lanarkshire, AA= Ayrshire and Arran, T=Tayside, FV=Forth Valley, DG=Dumfries and Galloway, B=Borders, H=Highlands, O=Orkney, Sh=Shetland, WI=Western Isles.

Table 8 shows the locations in Edinburgh with more than 5,000 syringes/barrels administered in 2020-22, the number of clients attending each location in those years, and the number of opiate and stimulant transactions. Additional IEP data from these locations can be found in Appendix F.

Levels of IEP activity can provide some indication of where the highest levels of need are located, although higher footfall in the city centre will likely skew numbers of clients attending / transactions in this area but not necessarily indicate higher rates of harm. However, Table 8 also shows that, while not as high in city centre locations, the number of clients attending services in areas with the highest number of DRDs (EH11) is still notably higher than other suburb postcode districts of Edinburgh. The pattern of this finding is similar to previous analysis of drug-related death data in European countries where drug-related death rates are correlated with rates of problem drug use.[23]

Table 8 also highlights how the ratio of opiate to stimulant transactions varies across locations. Despite variability, across all years, the high number of opiates implicated in reported injecting practice is concerning since opiates are linked to increased risk of overdose.[24] However, there is now also an increase in stimulants implicated in reported injecting practice in all locations aside from EH4 and the Walter Scott Avenue location in EH16, with a significant increase in locations such as Newington Pharmacy. Recent increases in stimulant injecting have significant implications for SDCF provision. People injecting cocaine, for example, tend to do so much more frequently and may do so in a number of different locations. As noted in the previous section of the report, the majority of injections overseen in the Glasgow safer consumption facility involved cocaine.

Table 8. The locations in Edinburgh with more than 5,000 syringes/barrels administered yearly 2020-22.

Pharmacy name	Postcode district	Clients attending			Number of syringes administered			Opiate transactions			Stimulant transactions		
		2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Lindsay and Gilmour Leith Walk	EH6	587	492	410	44599	30340	28037	2932	1835	1441	250	264	305
Boots Shandwick Place	EH2	660	668	572	28164	27058	25737	2129	1831	1603	238	315	522
Newington Pharmacy	EH8	478	461	449	28020	36008	38585	1932	2374	2160	294	814	1161
The Exchange Lady Lawson Street	EH3	328	290	312	25227	30337	39554	840	714	719	205	207	357
Turning Point - Leith	EH6	244	326	372	22950	22487	24661	554	648	637	39	71	156
Lindsay and Gilmour Crewe Rd	EH4	229	190	200	22898	21497	23222	1297	1015	957	77	115	94
Omnicare Pharmacy Springwell	EH11	163	164	222	9714	7289	17271	639	638	1207	46	98	267
Omnicare Pharmacy (Walter Scott Avenue)	EH16	61	54	52	8666	16207	5033	302	312	236	72	114	53
Craigmillar Pharmacy	EH16	166	208	161	8483	14709	10564	781	1118	685	36	61	93
Lloyds Pharmacy Wester Hailes Centre	EH14	149	150	158	7949	6441	7827	499	352	468	19	34	192
MacKinnon Pharmacy - M&D Green	EH11	229	247	244	7914	10095	10894	1039	1009	997	134	189	289

Treatment referrals

The number of Edinburgh-based OAT patients who have also been referred to specialist drug services is reported in Table 9, categorised by GP referral postcode district. Within this group, the patients deemed to be most at risk of drug harms are those who have been 1) admitted to hospital that year with their clinical notes reporting injecting drug use and, 2) were registered at the Edinburgh Access Practice (a proxy for homelessness). The number of people meeting these criteria is reported in Table 10. The total number of referrals in each postcode from 2019-22 have been amalgamated to show concentrated areas of referrals overall, although these are approximate numbers as areas with less than five referrals have been excluded in the amalgamation.

Table 9. Overall number of OAT patients who had been referred to specialist drug services, data grouped by GP referral postcode district

Postcode district	2019	2020	2021	2022	Total
EH6	109	82	52	61	304
EH11	65	95	68	75	303
EH7	66	69	54	47	236
EH16	23	50	39	46	158
EH14	41	36	41	35	153

EH4	41	27	32	24	124
EH8	23	43	22	24	112
EH17	20	35	27	21	103
EH12	22	36	19	23	100
EH5	18	31	16	13	78
EH15	16	20	18	19	73
EH1	14	8	13	9	44
EH3	11	11	6	11	39
EH13	7	13	6	<5	26
EH10	6	<5	5	6	17

Table 10. OAT and specialist drug service patients who had been admitted to hospital that year with their clinical notes reporting injecting drug use and were registered at the Edinburgh Access Practice, data grouped by GP referral postcode district

Postcode district	2019	2020	2021	2022	Total
EH11	14	19	20	18	71
EH6	22	14	12	14	62
EH7	12	20	8	13	53
EH14	12	8	11	9	40
EH16	<5	18	10	11	39
EH8	8	19	5	<5	32
EH12	<5	11	6	<5	17
EH1	<5	<5	7	<5	7
EH17	<5	7	<5	<5	7
EH3	<5	<5	<5	7	7
EH15	6	<5	<5	<5	6
EH5	<5	6	<5	<5	6

The data in these tables suggest higher levels of harm in EH11, EH6, EH7, EH16, and EH14. However, it is important to note that these data show absolute numbers rather than rates per capita. Therefore, larger numbers are liable to be seen in highly populated areas and this does not necessarily indicate higher rates of harm relative to the size of the population.

Blood-borne virus (BBV) testing

Table 11 shows the number of HCV tests in different Edinburgh-based services that explicitly support people who use drugs. While these data do not provide insight into the number of positive tests across Edinburgh, they illustrate hotspots of BBV testing. The total number of tests in each service from 2019-22 have been amalgamated to show concentrated areas of testing overall. Note that these are minimum numbers since areas with less than five tests have been excluded and are marked with an asterisk. As with IEP data, locations in central Edinburgh show a substantially higher number of tests than other postcode districts mainly due to increased footfall and increased testing initiatives, but this may not be where risk is highest. As noted previously in, NESI data show that 31% (n=34) of people recruited in 2017-18 had a current HCV infection. This declined to 14% (n=12) in 2019-20, likely related to the scale up of direct-acting antivirals.[25]

Table 11. The number of Hepatitis C tests in different services from 2019-2022

Testing location	2019	2020	2021	2022	Total	HSCP locality	Total across locality
CGL Edinburgh South-East	14	<5	<5	<5	14	South East	918
SMS Edinburgh South-East	<5	<5	<5	6	6		
Harm Reduction Team, Spittal Street	228	131	200	309	868		
Crew 2000 Scotland	19	6	5	<5	30		
Substance Misuse Services (SMS) Edinburgh North-East	20	<5	24	6	50	North East	253
Turning Point Edinburgh North-East	61	19	48	75	203		
SMS Edinburgh North-West	13	5	21	38	77	North West	202
CGL Edinburgh North-West	79	16	22	8	125		
SMS Edinburgh South-West	15	<5	19	9	43	South West	75
CGL Edinburgh South-West	32	<5	<5	<5	32		
Waverley Care*	27	<5	<5	<5	27	Various	27

**Waverley Care operates across different localities*

Drug-related litter

The number of requests submitted to CEC for the removal of discarded needles from 2019 to 2022 is reported in Table 12.

Table 12. The number requests to CEC for the removal of discarded needles in each ward from 2019 to 2022

Ward name	Locality	2019	2020	2021	2022	Total
City Centre	South East	53	22	19	41	135
Leith Walk	North East	15	26	19	23	83
Leith	North East	8	16	16	14	54
Southside/Newington	South East	12	14	8	6	39
Sighthill/Gorgie	South West	9	8	8	12	37
Craigentinny/Duddingston	North East	7	5	9	6	27
Forth	North West	3	7	8	8	26
Pentland Hills	South West	6	4	7	9	26
Portobello/Craigmillar	North East	5	5	7	5	22
Fountainbridge/Craiglockhart	South West	2	7	2	2	13
Inverleith	North West	2	1	1	4	8
Liberton/Gilmerton	South East	3	3	1	1	8
Meadows/Morningside	South East	0	3	4	0	7
Almond	North West	1	2	1	1	5
Drum Brae/Gyle	North West	1	1	2	0	4
Colinton/Fairmilehead	South West	0	1	0	2	3

When synthesised into localities, there were 189 litter callout requests in the South East, 186 in the North-East, 79 in the South West, and 43 in the North West. Importantly, the number of requests for drug litter callouts is not a direct indicator of activity, as it may also reflect the likelihood of residents to request callouts in a given neighbourhood. However, the North West has both the fewest discarded needle callouts and the smallest number of drug deaths, while the North East and South East have the highest numbers for both. The city centre, Leith Walk and Leith wards also contain the datazones that experience the highest number of non-fatal overdose callouts. This suggests that the

apparent hotspots for discarded drug litter are also likely to be, or at least correlate with, areas of higher risk of drug-related harm.

Drug-related crime

Drug-related incidents captured in Police Scotland's STORM data include a wide range of events, including, for example, 'strong smell of cannabis', 'man injecting in stairwell', 'drug dealing', 'bag of drugs found' etc. They therefore reflect a wide variety of incidents recorded by police, many of which do not lead to follow-up action. Table 13 lists the top ten beat areas with the highest number of total incidents in 2021 and 2022, alongside the ward and locality that corresponds to the beat area. While Leith Walk and the City Centre have the highest number of incidents overall, the data highlight that incident numbers differ across beat areas within the same wards. For example, while NW24 has 347 incidents, NW29, which is close by, has 148.

It is important to note that the drug involved these incidents is not recorded, and it is likely that a significant proportion will involve cannabis or other substances not directly implicated in the harms addressed by an SDCF. Furthermore, while recorded incidents of drug-related crime provide an indication of areas where there may be higher levels of drug-related activities, they are also not a direct indicator of where harm or risk is concentrated because recorded incident figures also reflect police actions, capacity, and priorities.[26] Therefore, the drug crime data presented below should be viewed as contributing to the broader picture of drug trends in the city, rather than indicating where specific risks under consideration in this report are located. It should also be noted, as discussed in the first section of the report, that the available evidence suggests SDCFs are not associated with increases in crime or antisocial behaviour in the vicinity.

Table 13. The number of drug-related incidents across Beat areas recorded by Police Scotland in 2021 and 2022

			Number of incidents		
Beat area	**Ward**	**Locality**	**2021**	**2022**	**Total**
NW24	Leith Walk	North East	118	229	347
CE21	City Centre	South East	146	134	280
SN37	Southside/Newington	South East	141	67	208
CE20	City Centre	South East	122	66	188
PC48	Fountainbridge/Craiglockhart	South West	85	101	186
PW51	Sighthill/Gorgie	South West	88	94	182
NF07	Forth	North West	125	51	176
NL27	Leith	North East	92	77	169
CE22	City Centre	South East	68	90	158
NW29	Leith Walk	North East	82	66	148

Table 14 contains data on incidents of possession or supply that were recorded with a completed disposal. These are incidents that resulted in police action – though the severity or nature of that action (whether caution, arrest etc.) is not recorded. Beat areas with the ten highest number of supply and possession incidents in 2019-22, alongside the ward and locality that corresponds to the beat area, are provided below. Beat area SN37 covers the northern half of the Southside / Newington ward; WA03 is a large area covering Kirkliston and Newbridge (See Appendix D).

Table 14. The number of possession- and supply-related incidents across beat areas recorded by Police Scotland from 2019-2022

			Total number from 2019-2022	
Beat area	**Ward**	**Locality**	**Supply**	**Possession**
SN37	Southside/Newington	South East	80	1054
WA03	Almond	North West	60	914
CE21	City Centre	South East	87	554
CE20	City Centre	South East	37	377
CE22	City Centre	South East	29	343
NL27	Leith	North East	52	300
SE41	Liberton/Gilmerton	South East	23	262
PW51	Sighthill/Gorgie	South West	75	257
NF07	Forth	North West	67	241
PW53	Sighthill/Gorgie	South West	45	234

Willingness to use an SDCF and/or drug checking service

Table 15 shows that 84% (n=114) of Edinburgh-based NESI participants in 2017-8 said they would be willing to use an SDCF. Willingness was highest among those who reported homelessness (96%, n=52), public injecting (92%, n=26), sharing of injecting equipment (92%, n=11), and high injecting frequency (four or more times per day) (89%, n=58). Willingness was highest among females (96%, n=26) in comparison to males (81%, n=88).

Table 15. Willingness to use SDCFs among current people who inject drugs (injected in the last six months) recruited in Edinburgh as part of the NESI in 2017-18

	N	Willing to use a safer drug consumption facility if available in their area, n (% of N)
Total sample (4 not recorded (NR) relating to DCR use)	136	114 (84%)
Gender		
Male	109	88 (81%)
Female	27	26 (96%)
Age		
<35	40	35 (88%)
35-44	71	59 (82%)
45+	23	19 (83%)
Homeless in last six months		
Yes	54	52 (96%)
No	82	62 (75%)
Arrested for drug offenses in the last six months (7 NR)		
Yes	28	25 (89%)
No	105	87 (83%)
Been incarcerated in the last year (2 NR)		
Yes	19	17 (89%)
No	116	96 (83%)
Injected heroin in last six months (1 NR)		
Yes	129	112 (87%)
No	6	1 (17%)

Injected cocaine (powder) in last six months[a] (1NR)		
Yes	25	17 (68%)
No	110	96 (87%)
Injected crack cocaine in last six months (1 NR)		
Yes	14	10 (71%)
No	121	103 (85%)
Injected in a public place in last six months (1 NR)		
Yes	28	26 (92%)
No	107	87 (81%)
Shared needles/syringes in last six months		
Yes	12	11 (92%)
No	124	103 (83%)
Re-used needle/syringes in last six months (1 NR)		
Yes	81	72 (89%)
No	54	41 (76%)
High injecting frequency (1 NR)		
Low frequency (<4 times per day)	70	55 (79%)
High frequency (4+ times per day)	65	58 (89%)
Current HCV infection (29 NR/indeterminant samples)		
Yes	33	29 (88%)
No	76	63 (83%)
Overdosed in the last year (4 NR)		
Yes	34	28 (82%)
No	99	84 (85%)
Skin and soft tissue infection in the last year (1 NR)		
Yes	52	44 (85%)
No	84	70 (83%)

[a] Includes heroin injection

There is also emerging evidence that people who use drugs in Scotland would be willing to access drug checking services if available. Provisional results from the NESI survey in Glasgow suggest 71.2% of respondents would be willing to use a DCS (Needle Exchange Surveillance Initiative unpublished data 2022-2023. A more detailed consideration of current views on willigness to use an SDCF among people using drugs in Edinburgh is contained in the next section of the report.

Discussion

Alongside the rest of Scotland, Edinburgh has seen a continuing increase in drug-related harms in recent years, including a rising number of DRDs. There remain very high levels of opiate injecting, and polydrug use, especially involving benzodiazepines, is widespread. Opiates are linked to increased risk of overdose in comparison to other drugs, and recent increases in reported use of synthetic opioids, such as nitazenes, is a cause for serious concern. The rising prevalence of stimulant injecting is also of significant concern. Increased cocaine injecting in Glasgow was a leading factor in an outbreak of HIV infections due to the increased number of injections per day in comparison to other drugs, and the potential for increased needle sharing.[27] While higher rates of stimulant injecting raise questions for optimal service design, SDCFs represent one potentially vital response to the increased risk of BBV transmission that comes with more frequent injecting practices.[28]

The data presented show high levels of drug-related harm in many parts of the city, but with notable concentrations in particular areas (often associated with higher levels of deprivation). In 2021, DRDs in were highest in EH11, EH7, EH6, EH14, and EH16. These postcode districts also represented the highest numbers of treatment referrals for people at the highest risk. Non-fatal overdose callouts were highest in the city centre and around Great Junction Street in Leith. The highest levels of drug litter requests were also in the city centre, Leith Walk and Leith. When looking at wider geographies, non-fatal overdose callouts are highest in Edinburgh South East, which also saw an almost 67% increase in deaths from 2019 to 2021. This HSCP locality includes the old town and a number of the postcodes where most IEP is provided.

The data presented point to a dispersed pattern of consumption, service access and drug-related harms across the city. While there is not a single, narrowly defined area where drug problems are highest, nor a specific location associated with an open drug scene, areas around the old town and Great Junction Street appear to have particularly elevated concentrations of harm. The high numbers of people accessing IEP in the city centre suggests this may be an area where people are willing to travel for safer injecting services. Although levels of footfall may not indicate where drug-related harms are highest, the city centre ranks highly on indicators suggesting it is also where drugs are often consumed. However, high levels of harm in both parts of Leith and the EH11 postcode district suggest there is a need for further provision, and a probable concentration of higher-risk drug use, in these locations as well.

The clustering of indicators highlights the importance of triangulating sources as synthesising the postcode, datazones, and/or localities most implicated in each indicator can help guide decisions about hotspots (Table 16).

Table 16. The postcode or datazones and HSCP localities most implicated in each indicator

Indicator(s)	Postcode/datazones most implicated in indicator data	HSCP locality most implicated in indicator data
Drug-related deaths	Old Town, Leith, EH11, EH7, EH6, EH14, and EH16	Edinburgh South East
Non-fatal overdose callouts	Old Town, Leith and Tollcross	Edinburgh South East
Drug checking	EH14 and EH6	N/A
Injecting equipment provision	City centre and Leith	N/A
Treatment referrals	EH11, EH7, EH6, EH14, and EH16	N/A
Blood-borne virus testing	N/A	Edinburgh South East
Drug-related litter	City centre and Leith	Edinburgh South East
Drug-related crime	City centre, Leith, and Southside/Newington	Edinburgh South East (when combining drug-related incidents, supply, and possession data)

Conclusion

The findings of this needs assessment have shown that drug-related harms are relatively dispersed across Edinburgh. However, when triangulating indicators, areas of elevated and concentrated harms emerge. At HSCP locality level, the South East of the city appears to be the area most affected. This includes the ward areas of: City Centre, Southside/Newington, Morningside, and Liberton/Gilmerton. The postcode districts of EH11, EH7, EH6, EH14, and EH16 show the highest rates of many key drug-related harms. The smallest area (datazone) data is only available for ambulance overdose callouts, but this suggests the city centre and parts of Leith and Tollcross contain hotspots of acute harm.

SDCFs are commonly located in, or near, areas where consumption and harm is concentrated and the data presented here provides key evidence on where those locations are in Edinburgh. However, other factors – including an understanding of the kind of locations that would be accessible and amenable to people likely to make use of an SDCF – are critical in deciding where a facility may be located. These are explored in the following chapters.

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3: The views and experiences of people with lived and living experience

Introduction

In determining the need for, and feasibility of, an SDCF in Edinburgh it is essential that the views and experiences of people with lived and living experiences of substance use are considered. SDCFs will only add value if they address an identified need among people who use drugs in the city, and if it is likely that the people who would benefit most from provision are likely to use the facilities. Available data from the NESI reports indicates a general willingness to use SDCFs among people who use drugs in Scotland. However, in order to explore this in more detail and depth we interviewed 22 people with lived/living experience of substance use (15 men and seven women) and five family members affected by a loved one's drug use (four women and one man). Participants were recruited from specialised services in Edinburgh and a family support group in Midlothian. All participants had a direct connection to Edinburgh. In carrying out this research, we wanted to know whether participants:

- had views on current patterns of drug use in Edinburgh
- saw specific benefits from SDCF provision
- would be likely to use an SDCF, and how service design and location might affect this
- saw specific barriers to potentially using an SDCF

As part of an ongoing Scotland-wide research project, a member of the research team also carried out a 'Discrete Choice Experiment' study with 21 participants (three of whom were also interviewed). This study is described in Appendix G. The findings from this pilot study are exploratory and limited, but where results were deemed statistically significant they are included in the analysis below.

On some issues there was a high degree of consensus, whereas on others views were more varied. We seek to fairly represent the diversity and range of perspectives in what follows, while capturing areas where there were high levels of agreement.

Perceived patterns of drug use in Edinburgh

While SDCFs are most commonly associated with opioid injecting, as the previous sections have noted facilities can also provide spaces for safer use of other drugs, and for different methods of consumption. Patterns of drug consumption can differ regionally, and harm reduction strategies need to reflect this. While it is not possible to ascertain precise information on consumption trends at city level through interviews, we sought to gain insights into perceived patterns of use from among our participants.

A key theme that emerged from our interviews was the diversity of the drug consumption in the city. In particular, many respondents felt that cocaine (or 'prop') injecting had become widespread and that this had changed the dynamics of the local drug scene.

> *Cocaine is basically quite a big thing now. Everybody is going for cocaine. One minute there was no cocaine in Edinburgh, now it's flooded. A lot of folk have started to inject it, or just wash it back and smoke it now. So, yeah [...] cocaine has gone through the roof in Edinburgh.*
> [Interviewee 11, Living Experience, Male]

I tell you, that's probably been the biggest like outbreak I've seen in the last couple for years with people injecting prop. It's scary how quick it's built up […] It's an epidemic, aye, it's definitely that. It's actually shook the town to be honest. [Interviewee 15, Living Experience, Male]

Participants reported that, while heroin use was still widespread, 'prop' use involved much more frequent injection and was associated with different behaviours and risks, including higher levels of aggression and paranoia. Some implications of this for service design are discussed in the 'Risks and Challenges' section below.

Participants also commented on the prevalence of benzodiazepines and pregabalin use among their peers. Many felt that 'street benzos' represented a particularly acute risk.

It seems like a lot of the folks that I know passing away is from the benzos and the fake Valium. Street Valium. I don't know anyone who has been dying from crack or heroin. It seems to be pills. [Interviewee 04, Living Experience, Male]

I've got mixed feelings on it because fair enough, great, it could help people, but heroin is that shit in Scotland, in Edinburgh. It's mixed with that and so many addicts know that, that they don't even bother taking it now. So, people would rather take Pregabalin, Diazepam. [Interviewee 12, Living Experience, Male]

Patterns of consumption among potential SDCF clients have implications for operational practices, which are discussed below. In general, however, the drug scene described in Edinburgh was different to that commonly imagined when thinking about the development and design of SDCFs, which are often – though not always – assumed to primarily be a response to risks presented by injected opioid use. Nevertheless, there was a widely held view that the city would benefit overall.

Edinburgh's got a huge drug culture, and I think it's about time that we addressed it and made it safe, and try and take away the stigma. People are taking it on the streets. Do you want kids to be finding needles? Do you want all this paraphernalia lying about? No. [Interviewee 24, Family Member, Female]

It's a major one if you want to save people's lives. I think people would use it. I really do. [Interviewee 06, Living Experience, Male]

A key perception among participants was that drug consumption in the city was widespread and involves a range of substances, which are not always taken in isolation. The intensity and patterns of use were seen as creating significant risks, which require active harm reduction responses. There was widespread support from participants for SDCF provision to be introduced as part of this response.

Perceived benefits of SDCF provision

A significant majority of interview participants supported the principle of SDCF provision in the city – a result reflected in the pilot DCE study, which found 68% of participants would prefer the addition of SDCF provision to the current status quo. In discussing their reasons, interview participants identified a range of key expected benefits that they felt SDCF provision could achieve, including:

- enhanced safety and supervision
- improvement of public amenity
- community development and peer support
- reduced anxiety for family members
- tackling stigma

- greater access to services, support and opportunities for recovery.

Safety and supervision

A key theme in many interviews was safety. Participants were aware of available harm reduction services and reported high levels of uptake. There were also high levels of knowledge around safe injecting practices and use of naloxone. Nevertheless, many participants had experienced or witnessed overdoses, and a number had lost friends or family. Among these there was widespread support for facilities that could directly reduce the risk of accidental overdose through supervision and intervention where needed.

> *I'm thinking a drug consumption room is good because it's a safe place. You're being supervised. It's a safe place. I think that would reduce deaths. And also, people don't want to see people on the street taking drugs. If you get what I'm saying? But for the individual that is taking drugs, it's a safe place for them to take drugs*. [Interviewee 04, Living Experience, Male]

> *I've lost so many mates and like everybody in my life died with overdoses. It's crazy. But a drug consumption room: I just see it as somewhere clean and safe for people to go and inject, take drugs. It's more about the safe part because so many overdose. And I've noticed nobody has a fuckin' clue what to do when it happens, though*. [Interviewee 15, Living Experience, Male]

Many respondents described public injecting as both a risk to themselves and as problematic for the wider public, and felt that the establishment of an SDCF could address both issues.

> *I think that would be absolutely brilliant from all angles, even for people that don't take drugs. They'd see that as brilliant, to not have all these people jagging in stairs, jagging up alleyways. And it's not nice for people to see when they're walking past with their bairns and stuff.* [Interviewee 15, Living Experience, Male]

> *People would use it. They would use it [...] I think it would get the jagging off people's stairs and out on the street and seeing needles all lying about.* [Interviewee 06, Living Experience, Male]

> *I support them all the way […] it would be a lot better place for me to take my drugs instead of taking drugs on the stairs or sitting in the street taking drugs.* [Interviewee 02, Living Experience, Male]

SDCF provision was, in this sense, viewed as mutually beneficial: something that could enable people to take drugs in less risky spaces, while improving amenity for the wider public.

SDCFs were also viewed as playing a vital role in improving the safety around injecting practices, especially for those with less experience of injecting. One of the risks associated with public injecting is the need to do so quickly, which participants felt could be mitigated by SDCF provision.

> *Anywhere else I've gone, I'm having to rush things, I'm not cooking up properly. I'm missing where I shouldn't be missing because I'm rushing. So that's where the abscesses come from*. [Interviewee 07, Living Experience, Male]

> *Yeah, there'll probably not be as much abscesses because they're all doing it fast.* [Interviewee 06, Living Experience, Male]

Overall, participants viewed the potential for SDCF provision to address short-term risks very positively.

Community and peer support

Participants described experiencing a range of acute risks in their lives: both in terms of the physical and environmental risks associated with homelessness, and the psychological risks that came with living lives that were often characterised by trauma, stigma, marginalisation and extreme economic

insecurity. These experiences were described as exacerbating risks of self-harm, risky drug behaviours and suicidal ideation. From this perspective, any service that provided a compassionate, safe space was seen as providing respite from such pressures of everyday life, and an opportunity to reconnect with a supportive community.

Therefore, many participants felt that a key role for SDCFs, in addition to reducing acute risks, was the creation of non-judgemental spaces where a sense of community could be fostered. Such spaces were anticipated to reduce the stigma associated with drug use and provide a constructive, compassionate environment where individuals whose daily lives were otherwise characterised by marginalisation and anxiety could benefit from shared experiences and access support.

> *It's somewhere that you don't have to sit in the street cold, or watching over your back because you're scared of getting seen by certain people, or hiding in car parks or parks. It's just a place you can go and you won't be judged [...] Yeah it is a safe place. A safe haven for people that are drug users. Because I don't think they've ever had that, really.* [Interviewee 19, Living Experience, Female]

> *It's just about connecting people as well as keeping them safe. Connecting people, yeah, and that's what it is. And making people feel part of society, not that they're on the sidelines of it.* [Interviewee 23, Family Member, Female]

The positive impact of establishing a constructive, community space was raised by a large number of participants. This was often linked to a belief that SDCFs could also play a role in developing the connections necessary to access treatment or begin journeys towards recovery.

> *If there had been something like that in our area when I was younger, it might have helped me quicker. It might have caught me quicker and encouraged me to get help quicker. I'm glad that they're trying to do something like that now.* [Interviewee 13, Living Experience, Male]

> *And it's not just all about taking drugs: it's about somebody being there that you can talk to. And they can help you and refer you to other places. Things like that*. [Interviewee 18, Living Experience, Male]
> *I think it might actually help a lot of people, even start their journey on recovery*. [Interviewee 01, Living Experience, Male]

Participants, therefore, not only viewed SDCF provision as addressing acute harms but also as contributing to longer term change.

Impact on families

Many family participants described the prospect of SDCF provision as providing peace of mind, knowing that their loved ones would be using drugs in a safer and supervised setting.

> *Well for the family part of it, I would say well you're taking the onus off the fact… that worry off the family. Where they are for one. Where they're using and what they're using.* [Interviewee 26, Family Member, Female]

> *I think for family members as well, it's, well, it would be a lifeline wouldn't it? Because if my son was using one of them, I would just feel a hundred times calmer, safer, able to work, able to concentrate, because I'd know he's safe.* [Interviewee 23, Family Member, Female]

Previous research with family members in Scotland has found similar hopes and expectations, and a strong sense that SDCFs can provide hope in lives otherwise marked by persistent anxiety.[1] We should note that our participants represent only a small number of family members, so it cannot be directly inferred from the available data that this is a general view. However, among those we spoke to there was considerable agreement on the positive impact an SDCF could have.

Tackling stigma

Participants described daily lives that were marked by multiple levels and sources of stigma: the sense that '*Being an addict, even walking down the street and you think everybody's looking at you*' [Interviewee 03, Living Experience, Male]. The fear and shame associated with this was not viewed as in any way constructive or conducive to positive change. As one participant put it: '*Aye, judgement's a big thing. That just makes you feel worse and want to take more drugs as well*' [Interviewee 01, Living Experience, Male]. By contrast, participants felt that the provision of non-stigmatising, compassionate environments could support processes of healing that were an essential step towards improving lives.

> *It sends a message to the wider community saying: look, these are humans; these are people, so we're going to make space for them. And maybe it might open their eyes in a different way, make them view drugs users in a different light. […] That's what it's all about: giving them a place so they can do these things and it's not affecting the community, not affecting them. But also, they're being accepted too, and being given a chance and a place, and not just being told to go under a bridge and stay there.* [Interviewee 19, Living Experience, Female]

> *That's another thing. You go anywhere, you try and get away from people so you don't get looked down on, or with kids and that. And obviously safety. Aye it would be something I'd use.* [Interviewee 08, Living Experience, Female]

This suggests that not only is a facility's acceptability tied to the degree to which it is seen as non-stigmatising, but that, in line with the existing research evidence, therapeutic potential of an SDCF is rooted in the creation of a space that allows clients to experience compassionate care and social environments based on mutual respect.

> *Again, just a safe haven. Maybe meeting people that understand, that you can talk away to, about their addiction, and just feeling accepted as part of the community. This is a place for us. We're not being judged. There are people out there who do understand, and they do care.* [Interviewee 19, Living Experience, Female]

SDCFs, in this respect, were viewed as places where people who use drugs could be met 'where they were': not only in order to promote safety in relation to injecting practices, but also to allow a space in which the pressures of persistent stigmatisation were reduced, and positive social environments could be developed.

Provision of and referral into wider services

Many participants felt that a key role of an SDCF was either the provision of wider services on site, or effective referral and signposting.

> *The other thing is trying to get people involved with the services to obviously reduce, and then eventually go into some kind of treatment format. I think these consumption rooms have to be linked with other services as well so that people aren't seeing it as like a public house where you just go along and you order, or whatever.* [Interviewee 24, Family Member, Female]

A number of participants, both PWUD and family members, described an ideal location that could serve as a one-stop-shop: integrating both safer injection provision and wider support services, including for mental health:

> *I personally think it should be wider than just an injection room. You know what I mean? That's my feeling about it. I think it's getting back to that one-stop shop. Not just from the social services side but for the different types of drugs.* [Interviewee 25, Family Member, Male]

There was a recognition that the breadth of provision was constrained by funding and capacity. Participants understood that an SDCF could not provide every service. However, there was a strong view that wider referral and links to other services formed a critical aspect of SDCF provision.

Likelihood of using an SDCF, including impact of service design and location

Prior research has found high levels of support for SDCF provision among people who inject drugs in Scotland.[2] Participants in those studies reported that they would be likely to use a service if one were to be made available. However, as discussed in Section 1, the attractiveness of facilities depends to a large degree on service design. We therefore sought insights from PWUD in Edinburgh on what service design features and delivery ethos they would wish to see in an SDCF.

Perceived acceptability

Almost all participants said they believed an SDCF would be used by a proportion of people using drugs in Edinburgh. There were different views on who they might attract, including '*new users as well like people new to the street*' [Interviewee 07, Living Experience, Male]; '*people that are living on the street and that*' [Interviewee 14, Living Experience, Male]; '*a lot of older people*' [Interviewee 17, Living Experience, Female]; and '*people that you would never reach in a million years*' [Interviewee 24, Family Member, Female]. While a few participants felt that a facility would appeal to all potential clients, there was a widespread view that a SDCF would be particularly attractive to populations at the highest risk.

Diversity of substances used and impacts on provision

Many participants commented on the challenge of providing a facility that could address the diverse needs, and behaviours, of people taking a range of different substances. There was a strong sense that what works for opioid injecting may not be the same as for cocaine injection or the use of benzos.

> *You've got folks who take the Valium right. They might go into a room and they're just couched out. They just want to sleep there. Are you going to have room… is there going to be rooms? Is it going to be one room? I don't… have they got a time limit? I don't know, because with the crack, to be honest with you, with crack, it's quite easy. You can smoke and it's not a downer. So, for me, if I was going to use the room, I would be in and out.* [Interviewee 04, Living Experience, Male]

> *It's not like heroin you just take it and boom that's you and it's one thing. People take so many tablets, and they're taking cocktails of tablets, and hitting them with Naloxone. It's not helping them because it's not opiates that they're going over on.* [Interviewee 12, Living Experience, Male]

The potential impact of different substance use is a significant consideration for service design. Among participants, the potential acceptability of a SDCF was linked to its ability to meet these diverse needs. This highlights the need to consider the inclusion of, for example, inhalation spaces or 'gouching rooms' for heavily intoxicated clients – though the DCE study participants showed a preference for services without an inhalation space, compared to injection only. Nevertheless, the reality of multiple drug use described by interview participants emphasises the need to plan for stimulant consumption, which involves far more frequent injecting than usually associated with heroin.

Staffing

Participants were strongly supportive of peer involvement in the delivery of any SDCF. They described the importance of knowing that the people they interacted with had a lived understanding of their own experiences, and an ability to provide support based on a deep awareness of the challenges being faced.

Because they're the only people that understand, truly understand. I don't care how many books you've read and how many seminars you've sat through and how fuckin' many times God's spoke to you and told you to go on this path. I don't care about all that. It makes absolutely no blind bit of difference. [Interviewee 07, Living Experience, Male]

Somebody who's already gone through that situation. Like drugs and drink, that kind of situation. Because it's somebody who can acknowledge what you're going through. So, instead of somebody who's never taken drugs, didn't know about that or anything like that. Ken, you dinnae even ken what I'm talking about! [Interviewee 18, Living Experience, Male]

It was notable that a number of participants felt that lived experience was not only invaluable for understanding, but that working with peers in recovery could also provide a positive model for clients seeking to improve their lives.

I would imagine it would be users that are reformed, people that have been there, and done that, and understand, but they don't have any moral high ground or judgement. Or maybe even just drug users. Or both. That's the way I would see it. [Interviewee 19, Living Experience, Female]

I think maybe like somebody who is maybe a recovered addict who can… because that's always helped me hearing people… like successful it is, basically. I've always liked hearing success stories. That's always given me a bit of hope that it can be done. [Interviewee 01, Living Experience, Male]

For these, and other reasons, it was clear that the involvement of people with lived experience of substance use was viewed as critical to the success of a facility.

However, there was also support for the involvement of clinically trained professionals. Among many participants, it was felt that while peer delivery was vital for creating a supportive, constructive environment, trained professionals were critical to ensuring safety.

So, controlled environment is controlled environment. That means […] certain educated people, especially chosen for that. They're going to supervise them; they're going to look after them. [Interviewee 03, Living Experience, Male]

I think it maybe would be NHS working alongside with Streetwork or something like that. I would think so [...] Because, like, NHS would come in obviously for the health obviously. But I was going to say people like Streetwork and that for your support workers and all that. But nurses and that obviously from the NHS. I think they should bring a couple of nurses in, just in case people are going over. [Interviewee 15, Living Experience, Male]

There's medical professionals. You would never want your loved one taking anything, but if they've got to you would rather have them surrounded by people that are sympathetic and also have medical knowledge if they need it. [Interviewee 24, Family Member, Female]

Basically because you see people that are new to taking drugs, or not new, but just quite wet around the ears, wet around the gills, basically. By having medical professionals there, which I would imagine would be a very, very strong point of the service. Drug people that know what they're doing. [Interviewee 17, Living Experience, Female]

Critically, participants described a need to trust the staff involved in service delivery. Because the service was not viewed simply as an alternative space to take drugs, but rather as a place of support, safety and community building, it was vital that the providers and staff were viewed as familiar with the local scene, conscious of risks and sensitivities and prepared to maintain confidentiality where appropriate:

> *You want somebody that you can trust to be able to use it, just so you know it's not going off the record and the police to use it or whatever. Getting in the wrong hands.* [Interviewee 25, Family Member, Male]

There was, overall, support for a hybrid model of delivery: one that recognised the central importance of lived experience in creating non-stigmatising, trauma-informed environments, and the need for staff who intimately understood the experience of drug use; but which also benefitted from the more formal knowledge and skills brought by staff with professional training. The two were seen not as in conflict, but as mutually beneficial.

Location

The analysis of routine data presented in Section 2 of this report demonstrates that drug-related harms are dispersed across Edinburgh, albeit with hotspots in areas such as the Old Town, parts of Leith and in the EH11 postcode area. Participants described a dispersed drug scene, with a number feeling that multiple locations would be necessary in order to meet current needs:

> *I think in a city like Edinburgh, I think you need one of these places in every district area. How you've got to Nidds, ken Niddrie, because you've got all these different areas. I think there should be one in every single one of them.* [Interviewee 16, Living Experience, Male]

> *I think should there not be a few of them located through Edinburgh because there can't just be the one. Maybe are people going to be getting on the bus and just going up to… Aye, that's what I mean: Fuck it, I'm not going on the bus. I'm going away for a hit. If they're using prop it's: "I'm not fuckin' going way up there," type of thing, "fuck that." [...] So, people from the town I could see coming here, but not people from the schemes.* [Interviewee 15, Living Experience, Male]

By contrast, others felt that the dispersed nature of consumption patterns meant that a centralised location would be the most practical. However, in describing possible central locations a number of participants expressed a desire for discretion and / or location in places that were already viewed as safe and supportive.

> *It would have to be centralised. You put it in Wester Hailes and the only people using it live in Wester Hailes. If you put it in Niddrie, the only people using it are the people in Niddrie – do you know what I mean?* [Interviewee 07, Living Experience, Male]

> *Aye, in the centre because that's where the majority of homeless people are.* [Interviewee 01, Living Experience, Male]

> *Somewhere in the city centre but somewhere hidden […] maybe in places like Streetwork and all that, that it is safe.* [Interviewee 03, Living Experience, Male]

> *A lot of people would be embarrassed to go to something like that. It would have to be away out of the way down King's Stables Road or something. Or even like the Cowgate or something.* [Interviewee 06, Living Experience, Male]

No clear consensus emerged on how to resolve the issue of location, and it was recognised that there was no ideal solution. The centre was viewed as the most practical option by many participants, but there remained a sense that if more dispersed options were available they should be considered.

Opening hours

Participants largely supported opening hours that would align with the daily routines of people who use drugs. There was a strong view that early morning and late evening were particularly critical times.

Maybe eight, nine o'clock [in the morning] I'd say just because it's the first thought when you wake up when you're an addict... probably around the evening. [Interviewee 01, Living Experience, Male]
Getting clean works. After seven o'clock, you can't get needles anywhere. [Interviewee 02, Living Experience, Male]

I'd say first thing in the morning and maybe the last thing at night. In the morning I'd say six to ten or six to 11. [Interviewee 06, Living Experience, Male]

Three interviewees noted that current access to injecting equipment was undermined by limited opening hours, emphasising the need for access out-of-hours.

24-hour opening was discussed, with some participants arguing that this would cater particularly to the needs of individuals experiencing homelessness. However, many also expressed reservations, mainly around the facility's ability to maintain control and safety.

Again like ideally it would be 24 hours because homeless people use 24 hours. Early hours of the morning and it's been… that's what's needed. [Interviewee 08, Living Experience, Female]

You wouldn't get people to leave. I don't think 24 hours, because 24 hours you're going to get people going away, coming back, trying to take the piss out of yous, when you are trying to do a good thing. [Interviewee 10, Living Experience, Male]

Noticeably, participants in the DCE study were more likely to choose daytime opening over 24-hour provision. Overall, interview participants acknowledged the practical challenges of providing a 24-hour services and emphasised the importance of striking a balance between accessibility and operational feasibility. Within those constraints, however, it appeared that early mornings and evenings were especially important.

Risks and challenges

Participants discussed a range of potential risks and challenges around the establishment of an SDCF. In particular, participants were concerned that the use of crack, 'prop' and benzodiazepines could create specific problems for an SDCF, with some expressing concern over what they saw as 'uncontrollable' behaviour among some people using these drugs.

They're quite irresponsible when they're on these benzos, so I don't know if it will work in that kind of controlled environment because how are you going to control them? [Interviewee 03, Living Experience, Male]

For a number of participants, the question of how effectively an SDCF could manage the range of needs and risks arising from multiple drug types being consumed on the premises was key.

Well, a lot of people get paranoid when they take that coke as well. They'd just leave straightaway. [Interviewee 14, Living Experience, Male]

I think it would be a good idea as long as the people are honest and that when they come in […] Some of them, if they take Valium, you don't know how much they've taken and then they've taken heroin on top of that and you didn't know: they didn't tell you. It's, what do you do? [Interviewee 14, Living Experience, Male]

Participants also identified several risks to clients not directly linked to consumption itself.

Because it's going to be a drug consumption room, someone is going to come here to use their drugs. So, you might have people that don't have drugs watching for: 'Oh, he must have drugs – I'm going to rob him'. He might… you know what I mean? That type of thinking. [Interviewee 04, Living Experience, Male]

Yeah, I think the one concern that I would have if I was doing it myself is that people might try and use this opportunity to sell drugs. [Interviewee 19, Living Experience, Female]

Another strong emerging theme was the need for measures to be in put place for the protection of both staff and clients. Many participants highlighted the need for clear rules and protocols to prevent the facility from being misused, including temporary bans and other disciplinary actions to facilitate the maintenance of a respectful and orderly environment.

Yeah, I'd probably see it as somewhere that you would maybe have to have maybe security, or a few big guys, because when people take drugs, people tend to kick off. Maybe they'll bump into somebody that owes them money. You need to think about these sort of things too. Maybe only four or five people allowed in at a time. Something like that. [Interviewee 15, Living Experience, Male]

But aye, you have to show respect to the surrounding out of the building. You go in that building, the staff are not just staff; they're there to… part of the public. So they should be getting the respect as well. If they don't get respect, the person has to leave right away, the way I see it. They would have to leave right away because they're not giving the respect you're giving to people in the building. [Interviewee 18, Living Experience, Male]

Keep it authority as well, like you kind of have got to say: this is the rules, and no bendy ones. [Interviewee 09, Living Experience, Female]

Potential risks identified by participants included: drug dealing in the vicinity of the premises; clients being threatened (especially where money was owed); other clients becoming disorderly after taking substances; people bringing used needles into the facility; and staff being abused. Therefore, while informality was identified by participants as critical to creating an inviting atmosphere, there was also a clear desire to see rules and regulations established that would prevent the facility from being misused or becoming a less safe space than intended.

Community concerns

Participants were conscious of the risk that communities in the vicinity of an SDCF may object. This was often expressed as a tangible fear, and sense that the levels of stigma associated with injecting drug use could lead to potentially violent responses.

I think people are going to hate it. Hate it. Because they hate drug addicts. [Interviewee 09, Living Experience, Female]

And I'm worried that if there is a consumption room, that it could be targeted by vandals and thugs, anti-drug people [...] Yes, not even just the young team. It's anybody that's anti-drugs. [Interviewee 17, Living Experience, Female]

However, many also felt that community concerns could be addressed both through better communication and education, and as a result of benefits being perceived by the wider public.

I think you get mixed emotions once they realised that. Yeah, it would be probably half and half; or probably be 60% of people would be against it and 40 would be for it. [Interviewee 12, Living Experience, Male]

The public would need to know about it. There would need to be a thing on the News saying 'Listen, this is what it is: it's going to help that, that, that, that.' [Interviewee 12, Living Experience, Male]

But I would say somewhere like this in the town would be absolutely brilliant [...] With the amount of overdoses and that, it's scary and it's getting worse. It's getting worse. And the public, they're starting to… like it's spilling out that much with people injecting. And, obviously, the way the

public's looking at it, it's not going to be... ken, and that's why I think the public would absolutely love to hear about certainly a consumption room getting built to be honest. [Interviewee 15, Living Experience, Male]

It is notable that across the interviews the experience of fear and stigma was accompanied by a sense of empathy towards sceptical and concerned members of the wider community, and a belief that a well-run SDCF could also address their needs and aspirations.

The role of policing

The issue of police involvement was as a key consideration for participants, with many arguing that limiting police involvement would be essential for fostering trust and ensuring potential clients willingness to use the service. There were concerns that the facility could become an 'easy target' for police surveillance or arrests, with some fearing that they could be subject to undue surveillance.

Could they use it as an easy target? Would people be frightened because they'd feel that the police would be able to spot them? [Interviewee 24, Family Member, Female]

Well nobody will get involved if the police are going to get involved, so that's one corner. I am not going to go there if I'm going to get stopped by the police. [Interviewee 02, Living Experience, Male]

By extension, confidentiality within the facility was viewed as critical. On one hand, there was an expressed need for stringent security measures and surveillance to deter external threats and maintain a secure environment. On the other was an equally compelling need to ensure confidentiality and privacy.

Wherever they come, whatever's said in here and whatnot, nothing goes back to the police. Confidential. You need to have confidentiality. [Interviewee 18, Living Experience, Male]

If there was that sort of surveillance I think they'd want to stay away, and the drugs would get dealt in other places. [Interviewee 15, Living Experience, Male]

These views emphasise the need for operational plans to carefully consider the balance between law enforcement and the need to maintain the trust of potential clients.

Prioritisation

Participants were aware that SDCF provision came at a financial cost. They discussed the problem of how to prioritise responses to drug harms, and the potential opportunity costs associated with establishing a service. However, a sense of urgency was palpable. Given the current drug death crisis, many believed that SDCF provision could contribute to a reduction in drug-related deaths.

The drug deaths are terrible just now and I think something has to be done pretty much ASAP. [Interviewee 01, Living Experience, Male]

I think there'd be a lot of benefits, I really do. I think it would be helping the people that are taking drugs. There's a lot of people are dying out there. If something like that was there, they wouldn't be dying. [Interviewee 06, Living Experience, Male]

Participants consistently identified SDCF provision as a priority. The general consensus was that an SDCF would serve as a critical entry point for those seeking help, from which they could be signposted to other services.

Number one because everything else comes after that. [Other treatment and support] wouldn't be needed as much if this was an option to start with. [Interviewee 08, Living Experience, Female]

Since the interviews focused specifically on the benefits and risks of SDCFs and did not include a detailed consideration of other interventions, their costs or their relative benefits, these comments need to be treated with caution. Furthermore, without a detailed knowledge of current system capacity and budgets, it is only possible to arrive at an impression of what may be the most effective allocation strategy. We discuss prioritisation and opportunity costs further in the following section.

Discussion

> *Look, what I said, these are people and we do need a place. They don't have one. They never have. It's something that should have been done way, way before now. I think it's an amazing idea.* [Interviewee 19, Living Experience, Female]

There was strong, though not universal, support among our interview participants for the establishment of SDCFs in Edinburgh. While saving lives through overdose response was a clear value, participants also focused on other key benefits. These included the opportunity to develop non-judgemental communities, to promote safer injecting practices, and to enable better access to wider support, services and treatment. There was strong support for peer staffing and a degree of informality in service design; however, there was also support for clinically trained staff and the enforcement of clear ground rules and procedures to protect employees, volunteers and clients. Participants described a dispersed drug scene within the city, which could benefit from the establishment of more than one SDCF. However, pragmatically, it was broadly accepted that the city centre may provide the best location for an initial pilot. The diverse nature of drug use in the city was widely commented on, making it clear that any service design needed to account for the fact that heroin or other opioid use forms only one part of the drug scene. In particular, 'prop' injection represents a novel challenge, and one that would need to shape service design – both in regard to frequency of injection and behavioural responses after consumption.

Fundamentally, participants described daily lives that were vulnerable and characterised by high degrees of marginalisation, shame, fear and stigma. They felt strongly that an SDCF could contribute to reducing these harms, alongside protecting against accidental overdose, such that they could promote longer term benefits and help support journeys towards sustained improvement and recovery.

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4: The views and experiences of key professional stakeholders

Introduction

In order to assess the feasibility of SDCF provision as part of the wider drug response system within Edinburgh we conducted 18 interviews, which involved 21 participants from statutory and third sector health, social care, housing, and criminal justice services. Participant roles covered operational, strategic, policy, and commissioning perspectives. A number of participants had more than one role of interest.

We were interested in a range of considerations, including:

- current patterns of drug consumption in Edinburgh
- what SDCF should seek to achieve
- service design considerations
- location(s)
- SDCF provision within the wider service landscape

While we interviewed participants from a number of professions and sectors, the views expressed do not obviously account for the full range that will be held by stakeholders across the city. They should therefore be read as indicative and illustrative, rather than representing a fixed consensus.

Current patterns of drug use in Edinburgh

Echoing the perceptions among participants with lived experience, many of the stakeholders we spoke to described a dynamic drug scene in the city. While heroin was still recognised as a serious concern, and as a leading cause of drug-related harms, the increasing use of street benzos and cocaine injecting was consistently commented on as representing a major shift in drug use patterns. These changes were regarded as significant and pressing.

> *It's changed, but there is still that polysubstance misuse where it's like heroin, a lot of street Valium... Valium: it's such a problem in the city. And then you've got a lot of cocaine users and you've got a lot of people using intravenously with cocaine now as well and mixing a whole cocktail of drugs. People are just using a multitude of stuff*. [Interviewee 09 - Operational, Third Sector, Criminal Justice]

> *I've seen a lot of people come through the door with heroin-related infections, and now I'm seeing the same people with cocaine-related infections. So, that's quite interesting.* [Interviewee 12 - Operational, Public Sector, Health]

> *I think there is a change there in terms of there's more variety. Like cocaine, people in here, like some of the guys are injecting cocaine, prop they call it, and then there's injecting… you can inject anything of course and it's a bigger high, or it's supposed to be a bigger high. So, I think everything has become more sort of balanced and there's not one dominant thing.* [Interviewee 07 - Operational, Third Sector, Homelessness]

There was a recognition that the varied nature of drug consumption in the city had concrete implications for service design and the range of harm reduction interventions on offer. SDCFs were considered within that context and also, as discussed below, in the context of consumption being dispersed across the city.

There was a widely held view that SDCF provision could be effective in reaching those people whose drug consumption was especially risky, but who were not currently accessing services.

> *So, we've got a real cohort of people there not on anybody's radar, not engaged in any form of support or treatment, which we know is a protective factor against drug-related death, and they're not receiving that.* [Interviewee 01 - Operational, Public Sector, Health]

> *You've got the ones that are high risk down at like Salvation Army, and the ones that are accessing Streetwork and everything all the time. But you've got a whole host of other people that aren't accessing any of these services, and it's trying to get in touch with these kinds of people.* [Interviewee 09 - Operational, Third Sector, Criminal Justice]

The combination of increasingly risky patterns of consumption, and there being a cohort of people who were often beyond the reach of existing services, were viewed as two key arguments for adopting SDCF in the city.

What SDCF provision should seek to achieve

Current knowledge and understanding

While there was very strong support for SDCF provision in principle, there was a range of knowledge and understanding around both the evidence base and design options. Some participants felt confident in addressing key arguments, while others felt they were '*on the outskirts of the conversation*' (P07APSP). There was also debate around the precise outcomes that a service should aim to achieve, and a sense that '*people discussing it don't have an absolute descriptor of it. So, we've all got a very slightly different understanding of what our expectations of these services would be*' (P18APKB). Clarity was thus seen as important to the debate on next steps, and there was strong support for a wider, evidence-informed discussion of what SDCF provision would, and could, involve going forward.

Participants understood that at the core of SDCF provision was the prevention of, and response to, acute harms including risky injecting practices and accidental overdose. There was a strong view that both were a feature of drug risks in Edinburgh, especially among the most marginalised communities.

> *For me the other reason why I'm so keen about* [having a SDCF] *is that when we did get the IEP into the service, and doing some AIR tool assessments for some of the people that I was working with, and being absolutely horrified about some of the stories where they were telling me. That they had been using in a car park – and, actually, instead of having clean water and citric, it was an old can of Fanta that somebody else… and just feeling absolutely horrified that that's what people were experiencing.* [Interviewee 14 - Operational, Third Sector, Homelessness]

Interviewees also echoed the views expressed by participants with lived experience and family members that the safety provided by an SDCF would also be a consequence of providing a compassionate, non-stigmatising space.

> *Because my understanding of safer spaces, overdose prevention sites or drug consumption rooms, is that they're ultimately a place where people who don't feel very safe in other places, because services can be very stigmatising and discriminatory, and have huge expectations in terms of people's behaviour.* [They are] *a place where people feel genuinely safe and cared for and understood and supported.* [Interviewee 06 - Strategic, Third Sector, Homelessness]

> *To me, it's about giving people a better hope in life and society, and a better opportunity for those individuals that seem to just get lost.* [Interviewee 10 - Strategic, Public Sector, Health]

However, while the provision of a safe, compassionate space was viewed as fundamental to SDCF provision, many participants emphasised the importance of goals that extended beyond acute support. A number made the point that SDCF provision should not simply be a matter of coming '*in one door and out another*' [Interviewee 21 - Operational, Public Sector, Social Work], but should include, or be integrated with, wider harm reduction support and signposting to services.

> *It's not a one size fits all. This is all we're doing to help people use substances, it's part of a wider suite of harm reduction measures, with the understanding it's there to gauge, help and support, and prevent death. Essentially, it is really the kind of end goal, to prevent all the other harms that come within that time frame that it's […] another string to the bow in harm reduction within the Edinburgh area*. [Interviewee 01 - Operational, Public Sector, Health]

> *It has to be more than just a place where people can come to access clean equipment and to be able to use safely. It has to be that gentle step into other services. But, before that, it has to be like relationships.*[Interviewee 14 - Operational, Third Sector, Homelessness]

There was strong support for an SDCF to provide, or be part of, a hub providing both short-term advice and helping to develop pathways to longer-term interventions. In this respect, SDCF provision was viewed as part of a wider harm reduction and treatment landscape with its value being both the prevention of acute harms and a contribution to longer-term outcomes.

Language and terminology

Participants also commented on how the varied language often applied to SDCF provision might impact on understanding. There were concerns that services were still called by stigmatising names such as 'shooting galleries' and 'fix rooms' in some media reports. Others felt that more widely accepted terms such as 'overdose prevention centre' focused too narrowly on the acute response element of provision, and 'drug consumption room' didn't reflect the fact that services could, and should, provide a wider range of support.

> *I don't mind drug consumption rooms, I don't mind overdose prevention sites. I think though that they don't go far enough in terms of what they actually do and deliver, and the opportunities that exist within them. And I think it limits the public's understanding in terms of what they actually do. For me, for our services, we talk about safer services. I'm glad that we've moved away from injecting facilities and things like that because I think they're so much more than that, and I think that really limits the conversation. Because what we're talking about here is, ultimately, a holistic service that's realistic and understanding of people's needs.*[Interviewee 06 - Strategic, Third Sector, Homelessness]

> *I think we should allow service users to make the decision of what they want the service called. However, I think in order for people to understand it, the wider population and not those using the services, I think it has to be as general and unstigmatising as possible. What that actually is, I don't know.* [Interviewee 10 - Strategic, Public Sector, Health]

There were, however, no significant concerns that the Glasgow facility was being called a safer drug consumption facility, or that this term had been adopted in much of the contemporary policy literature. This was, in part, because 'safety' was viewed as such a fundamental element of provision, and as an underpinning principle that should guide both design and delivery.

Local amenity

Some participants also discussed the potential of an SDCF to tackle local amenity issues such as drug-related litter. However, this was not a significant feature of discussions and, when raised, it tended to be in relation to concerns about possible community opposition.

> *Because with all of that comes the paraphernalia. And certainly in this area. If you go down to, say, St Cuthbert's Churchyard, or the car park around the corner, that's where you're getting the collateral damage in a sense. And the big worry, of course, is a child picking up a needle and pricked by a dirty*

> *needle in a playground. We see that as the big news headlines. But the reality is that doesn't really happen very often. But, nonetheless, I suppose the drug consumption option may be an argument for safer streets in a way. And also the facility provides the option for people to consume the drugs safely.* [Interviewee 15 - Operational, Public Sector, Substance Use]

> *Well, we still have people that are in the papers saying about all the "junkies" that are coming here, and all of that kind of stuff. It is quite important. You want to make it the best place it possibly can for the people you're supporting. You don't want them to face hostility, you know? You do have to: I think it is really important to work with the community on anything.* [Interviewee 17 - Operational, Public Sector, Homelessness]

Overall, interviewees viewed SDCF provision primarily as an opportunity to address acute harms among a particularly high-risk population, while providing opportunities to access wider support and treatment. While other positive outcomes, such as improved amenity, were noted these were secondary to those core goals.

Service design considerations

Importance of peer staffing

Interviewees echoed the views expressed by those with lived experience around the importance of providing spaces that were welcoming, non-judgemental and trauma-informed. They viewed peer staffing as an essential component in achieving this goal.

> *It needs to be a really easy accessible place. And, for us to get that right, it's really important all these things are co-produced with people with living experience*. [Interviewee 01 - Operational, Public Sector, Health]

However, there was also an awareness that 'peer delivery' was a complex process which involved proper recognition of the work involved and a triangulation of skills across lived and learnt knowledge.

> *So, the worrying concern I have about drug consumption room, and we're going back to that name again, and that terminology, is it's run by the professionals. It's managed by the professionals. And, really, I think we're on a path in some senses [...] where we want to involve peers in the treatment programme and understand what the needs and the requirements really are. And that takes a bit of careful managing as well, because just because you're a peer, doesn't necessarily mean that you've got all the right qualities and skills to do that job. But there's no doubt that some of them do and it's about garnering that.* [Interviewee 15 - Operational, Public Sector, Substance Use]

> *Can we approach some of our service users, if they'd like to be participating and helping in a paid way? I'm not saying let's expect volunteers. We could have volunteers as well, but people who bring that experience. Gone are the days where we can expect them to do that for nothing. This isn't charity. This is really important work, so we have to invest in them.* [Interviewee 10 - Strategic, Public Sector, Health]

Broadly, it was felt that the best staffing model would involve peers working within a trained and specialist context. There were some concerns around recruitment, including whether working in a service outside of NHS governance would be viewed as too risky for some. However, there was general optimism that a constructive combination of skills, knowledge, and experience could be achieved with careful planning.

Responding to complex patterns of consumption

The reality of mixed, and often high-risk, patterns of consumption among target populations was seen as having implications for service design. Few participants felt that a service could, or should, cater only to opiate injecting when consumption in the city was characterised by use of multiple

substances. In part this was simply about providing a service that was appropriate to the needs of the intended clientele.

> *I think there's some examples of drug consumption rooms where they have smoking spaces. From a harm reduction perspective, I think having a space that you can smoke your substances is a no-brainer for me, particularly if you are able - and this might be a bit of a far reach - but if you're able to provide things like safe inhalation devices.* [Interviewee 06 - Strategic, Third Sector, Homelessness]

> *It's more about keeping somebody safe […] Yeah, because that can incorporate a lot of things within that because if it's a safe space. Then it's not just, kind of, focused on heroin and near-fatal overdose. It's about providing that clean equipment to the cocaine injector that injects, kind of, five to ten times a day. Or a safe space for their mental health if they get drug-induced psychosis. And we can provide other things within that safe space as well. Sort of a more holistic approach.*
> [Interviewee 12 - Operational, Public Sector, Health]

Participants, however, also raised concerns about possible risks and the need for services to plan for the different types of behaviours and potential harms that could arise when drugs other than, or in addition to, opiates are being taken.

> *Hadn't really thought about everybody that's potentially using cocaine turning up on a Friday night at half past three in the morning fleein'. And I suppose that would kind of open it up quite significantly. I don't know how I feel about that because, I don't know: would that increase the risk of having so many people that could potentially just drop in? And could we accommodate that kind of level given how many people seem to be using cocaine just now? It's freely, freely available.* [Interviewee 11 - Operational, Public Sector, Health]

> *Will drug consumption rooms take benzos into consideration? It's a huge risk factor in Edinburgh, if you are opening a drug consumption room but you are not taking into consideration that that individual has very probably taken something else before, during, or after, then you're putting them and yourselves at huge risk.* [Interviewee 21 - Operational, Public Sector, Social Work]

The risks associated with multiple drugs being used in a service were viewed by some participants as making the case for on-site drug-checking within any SDCF.

> *So, yeah: I could see it for all substance use. But the testing* [drug checking] *facility for me is really important. Yeah, particularly around the… because obviously we've got a high number of people using benzos as well. So, at least if they could get their benzos checked, that would be amazing.*
> [Interviewee 12 - Operational, Public Sector, Health]

> *If I was having a drug consumption facility,* [drug checking] *would be part of it. That would definitely be part of it.* [Interviewee 14 - Operational, Third Sector, Homelessness]

Overall, there was a very strong, shared view that SDCF provision needed to be flexible and responsive to the full range of high-risk consuming behaviours that currently characterise drug consumption in Edinburgh. This was seen as having implication for staff knowledge and training, service design (e.g. provision of inhalation rooms), risk assessment and mitigation, and the potential provision of drug checking services (see the linked drug checking report where co-location with SDCF is also noted).

Formal and informal design

There was extensive discussion of the relative merits of more or less formal models of delivery, and an awareness that SDCF provision in Edinburgh would need to respond to local needs and conditions. Almost all participants felt that it was essential for any service to be approachable and relatively informal.

There'd obviously have to be some clinical space, but then something more informal as well. I don't know, whether like a café style. Not a café, but somewhere that's got… there's maybe a couple of round tables. It would have to be round. I'd like maybe a sofa. It needs to be welcoming, definite. [Interviewee 12 - Operational, Public Sector, Health]

A really low barrier, high tolerance service. Like, not clinical. Not NHS-type service. [Interviewee 14 - Operational, Third Sector, Homelessness]

Not everyone wants to go to a professional service to sit, and you're in quite a vulnerable state, you know? [Interviewee 02 - Operational, Third Sector, Substance Use]

Many participants were aware of the planned SDCF for Glasgow and explicitly considered design options in relation to that model. In all cases where that occurred, participants felt that, for a range of reasons (including costs), a less 'formal' model would be preferable for Edinburgh, which participants generally framed as being 'softer' than a clinical/institutional model.

I would still be supportive of it, but it would depend on what that looked like and what model we might adopt in Edinburgh. And, if I'm honest, I don't see the Glasgow model as being relevant here in the same way as it might be in the West Coast. [Interviewee 15 - Operational, Public Sector, Substance Use]

I would love Glasgow to get that opportunity [to set up a SDCF] *and obviously it would be highly evaluated, and the outcomes would be reviewed and all the rest of it. But why would we* [Edinburgh] *want to replicate that at this moment in time? And why would we tie ourselves into a medicalised model when there is a whole host of different experiences and abilities and professionalism of other organisations.* [Interviewee 10 - Strategic, Public Sector, Health]

Having the small amount of money we've got divided up and put into a super specialist service, a very high demand service like the Glasgow project, is going to suck resources out of the rest of it, and that's a big worry. [Interviewee 03 - Medical, Public Sector, Health]

Some participants also highlighted the value of more formal aspects of provision. In particular, these focused on the need for confidence in clinical responses, and the degree to which knowing specialist medical skills were also available would increase the level of trust placed in the service – a point also made by a number of participants with lived experience in the previous section.

The reason being a clinical environment is that in some way if it's associated with, say, NHS care, there's a familiarity with that and a trust in that already established. So, it couldn't be too informal. I think there would have to be some sort of formality about it. [Interviewee 07 - Operational, Third Sector, Homelessness]

Overall – and partly by way of establishing a contrast with what was viewed as a relatively clinical model in Glasgow – participants generally emphasised the importance of informality; viewing the creation of a welcoming environment as fundamental to achieving success.

So, I think location and accessibility, and environment… we talk about psychologically-informed environments and you look at what The Simon Community have done with the Hub in Glasgow. It's absolutely amazing. That is just the pinnacle of what everything should look like. [Interviewee 01 - Operational, Public Sector, Health]

The overall view was that while clinical expertise, governance and oversight were vital, the creation of spaces that were unwelcoming or intimidating would defeat the main purpose. However, there was also a strong view that any final design needed to be developed in close consultation with people with lived experience, and that levels of current expertise were not sufficient to determine precisely what final provision should look like.

Gender

Other design considerations raised by participants included a need to be sensitive to gender, and especially the additional risks faced by women in using services such as SDCFs.

> *Without a doubt we need to have female specific spaces or female specific times. That has to come into it. There's already so much stigma for women. I often worry about women in general hiding their level of substance use. Because of that, and the fear that comes there, that if we don't do that, then we're not going to… women won't come near the service. Absolutely not.* [Interviewee 14 - Operational, Third Sector, Homelessness]

Although not raised explicitly by participants, this observation speaks to a broader issue around who the assumed clientele of an SDCF might be, and how service design may be impaired if it doesn't account for the full range of people who may benefit.

Location(s)

Similarly to participants with lived experience, professional stakeholders struggled with the problem of how to identify a single ideal location given the often dispersed nature of drug consumption and harm in the city.

> *Like, location for me would be a big consideration. Because is the population of people who are likely to use it, or likely to need it, is it spread out across the entire city? And if we put it in one particular place, we're only serving the needs of that local population or people.* [Interviewee 01 - Operational, Public Sector, Health]

> *In my view it's very much part of the solution in relation to decentralising some of these models into community spaces and, ultimately, where people live.* [Interviewee 06 - Strategic, Third Sector, Homelessness]

Some felt that a mobile service could address this issue; however, others argued that previous mobile services had struggled and so preferred alternative approaches.

> *I'm sceptical about a mobile setting personally, and that's simply driven by the fact that every time we've had peripatetic things like that, they've never operated as well as having one place that's open and people know where it is. They don't remember the times that they're going to use it; they don't remember the time when it's going to come. It doesn't actually fit their lifestyle to go there.* [Interviewee 16 - Strategic, Public Sector, Commissioning]

A number of participants suggested multiple sites across the city, though it was recognised that this would be limited by both financial constraints and the problem of travel for people outside those areas. Therefore, some viewed a single location as justified on pragmatic grounds.

> *I don't see why Edinburgh… we've got north, south, east and west. Each of those centres should have an injecting room. Why not have an injecting room in each of those centres?* [Interviewee 03 - Medical, Public Sector, Health]

> *However, that place I think is not necessarily a building because you can see the hotspots over time. So, those hotspots move, depending on many things. What drugs are available? What's been taken? What's being used? So, to have a static place in one particular part of the city because, oh we've identified a need at this moment in time: it doesn't identify a need that might crop up at the other side of the city in a moment in time*. [Interviewee 10 - Strategic, Public Sector, Health]

> *So, I suppose in my head, from a practical perspective, if this was going to go ahead, it feels most feasible that it would be one place because that's more efficient. You have more people coming, you need a smaller number of trained professionals.* [Interviewee 13 - Strategic, Public Sector, Health]

Some participants noted that no location would fully address the problem of travel times, especially for some heavier users.

> *There's my own personal opinion on it from when I used substances. Would I have sought out a safe consumption room? Would I have scored my drugs in the city and then went maybe down to Leith or something, wherever it is, and travel to a safe consumption room to use safely? I don't think so. […] Logistically where do you put it? Are you going to have one in every area of the city? Would I travel to use something safely? When I'm at the stage of intravenous heroin using I'm certainly not thinking about my safety. It's not the top of my list*. [Interviewee 09 - Operational, Third Sector, Criminal Justice]

No-one viewed the question of location as something that could be easily resolved, or for which there was a perfect solution. However, few saw these problems as undermining the general case for provision. The question was less about whether location issues meant SDCF provision was impractical, and more around how to balance the pros and cons of multiple locations, mobile provision or a single service in regard to accessibility, capacity and costs.

Location in existing services

One possible solution raised by a number of participants was the possibility of locating SDCFs in existing services that were near to areas of elevated need, such as Leith or the city centre.

> *I'm thinking there's a project in Leith, a Links project that provides a great facility for folk with addictions. So, potentially they are, I don't know… but the NHS provide a unit in terms of the outreach work with the street prostitution down in Leith as well. So, a similar model for folk wishing to inject safely potentially? Absolutely. I think there's no… what's the word? There's not one size fits all.* [Interviewee 08 - Strategic, Public Sector, Community Safety]

> *So, actually thinking of the places where it could be a safe place to take drugs, if you know what I mean, a safe place to have drug consumption, then where would those* [existing services] *be and what additionality would they need? Rather than saying we're going to have this thing in the middle of the city that is just... You know?* [Interviewee 20 - Strategic, Public Sector, Commissioning]

A number of participants identified sheltered accommodation as a potentially key location for supporting safer consumption.

> *And then you could basically look at the hostels and stuff and then you could look at like the hostels that have a cohort of intravenous users and then offering that to them. That would absolutely make sense, absolutely.* [Interviewee 09 - Operational, Third Sector, Criminal Justice]

The possibility of location in hostels also led to discussions about the role, and benefits, of 'tolerated use' in sheltered accommodation. This issue raises separate legal and practical questions beyond the scope of the current study. However, a number of participants felt that existing hostels were sites where safer consumption could be encouraged and supported in ways that could be particularly effective. This also led to a number of comments highlighting the need for greater support for tolerated use, and – in some cases – a view that this should take priority over proposals for a more formalised SDCF.

> *I think there's also a conversation about how we normalise that into housing provision as well, so that people aren't being excluded and having to go elsewhere* [to use]. [Interviewee 13 - Strategic, Public Sector, Health]

> [In] *my experience of working in homelessness environments, third sector of staff are doing overdose prevention every single day. They're doing these interventions every single day within these environments. And actually, I think there's something about acknowledging the greater tolerance that a lot of homelessness services have now. For example, the service that I'm in now has a vending machine for injecting equipment. We have naloxone that we're giving out. There's discussions about how to keep safe. We do wellbeing checks.* [Interviewee 14 - Operational, Third Sector, Homelessness]

It is really, really challenging sitting in this environment knowing the harm that people are facing and we're still at this kind of pause, this very, very long pause between safe consumption when we could be acting on high tolerant housing now. [Interviewee 06 - Strategic, Third Sector, Homelessness]

The discussion of tolerated use in sheltered accommodation raised important questions about prioritisation, as well as about the possible models of safer consumption under discussion. They point to the possibility of framing the issue around a principle of enabling safe consumption spaces across numerous sites where people facing elevated risk are already located, in contrast to focusing on the establishment of single locations where that degree of tolerance, and support for safe practices, is provided but in a separate, and possibly distant, facility. This issue was not resolved in these interviews, and – as with other discussions around location – the possibility of improved tolerated use was not viewed as a reason not to proceed with separate SDCF provision. However, some participants did make the case that it could present a viable alternative.

SDCF provision within the wider service landscape

Interview participants were mindful of the opportunity costs associated with SDCF provision. They recognised that it required the allocation of finite resources, even if – in principle – there was a case to be made that no investment in saving lives was too high. The reality of budget limits, and the need to make cost-benefit assessments, often with imperfect information, was an unavoidable consideration. A number of participants, while supportive of SDCF provision in general, felt that other interventions remained a higher priority.

I wouldn't put the DCR above a very well-funded treatment system. And if you told me I had to choose between the two, I would have a very well-funded treatment system. [Interviewee 16 - Strategic, Public Sector, Commissioning]

But 60 to 70 per cent [of non-fatal overdoses being] *on the streets or out in the community is a significant amount. But does that mean that a drug consumption room is the answer? Or, is it that we put the funding into the services that are already out there to do the prevention work?* [Interviewee 19 - Operational, Public Sector, Homelessness]

I'm not convinced it's the most urgent. I'm not convinced there aren't other issues or other options that we could be looking at. And one of them would be alcohol as well as the benzo use and how do we work that up. [Interviewee 21 - Operational, Public Sector, Social Work]

My other point really is about that workforce issue, and I think that's where the challenge is, and that's a separate... We need to improve our health and social care workforce recruitment across the board. It's not just about substance use. Mental health is another huge issue, but until we have an abundance of workforce, I do think we need to be careful: not just about where we direct our financial resources, but about where we direct our skilled professionals. [Interviewee 13 - Strategic, Public Sector, Health]

Others argued that achieving the MAT standards, and providing comprehensive opioid replacement therapy, remained '*the first line of treatment*' [Interviewee 16 - Strategic, Public Sector, Commissioning].

There was also discussion of the need for advocacy around SDCF provision, however justified in terms of the specific problems it could address, to not distract attention from other parts of the treatment system, and other social drivers of drug-related harm.

It's not just about safe injecting facilities or safe consumption facilities or overdose prevention sites. You need to have good welfare, good quality housing provision. You need to have opportunities for people to link in with training. [Interviewee 06 - Strategic, Third Sector, Homelessness]

And I think there is that slight careful balance between: yes, absolutely, we want to support people who are in this difficult position right now; but we can't take our eye off the ball of the poverty and the place

and the children, health and wellbeing and education issues that we need to be supporting people to have aspirations, and be part of society in a way that doesn't mean […] substance dependence as a coping mechanism. [Interviewee 13 - Strategic, Public Sector, Health]

Nevertheless, these concerns were largely expressed in the context of support for the principle of introducing SDCF provision and presented as caveats and issues for further consideration rather than clear arguments against adoption. Overall, there was a strong view that provision needed to be trialled in order to fully assess its relative value.

The only way we're going to know if it's needed is if we offer it, and then start actually getting those stakeholders telling us what we're doing wrong and what we need to fix. [Interviewee 02 - Operational, Third Sector, Substance Use]

In Edinburgh we've had a long history of doing really good harm reduction work […] We've always had that approach to harm reduction, which to me drug consumption rooms are part of […] If you think that our principles are around harm reduction, this this is just the next step within that, isn't it? [Interviewee 20 - Strategic, Public Sector, Commissioning]

Participants felt that while SDCF provision presented an important opportunity to tackle a range of acute harms, and to support some of the most marginalised people into wider support, they should not be viewed as an entirely special case or as, by necessity, a higher priority than other interventions. Rather, they were seen as a potentially important element within the range of interventions offered to address drug related harms in Edinburgh.

Discussion

There was very strong support for the principle of SDCF provision among the professional stakeholders that we interviewed. SDCFs were viewed as both addressing key acute risks, and as providing pathways to wider support and services. They were seen as being especially effective in supporting the most marginalised people using drugs, and as helping tackle the stigma and exclusion that exacerbated drug dependency and risky use.

Participants recognised that there were complexities in delivering this type of service in Edinburgh. In particular, the multiple range of drugs – including street benzos and injected cocaine – currently in use in the city required careful consideration of both service deign and risk mitigation. Also, the dispersed nature of drug consumption and harms across the city led to a general preference for multiple sites across the city – albeit recognising that financial and capacity constraints may necessitate a smaller number of services located in areas of especially high need.

There was strong support for informal service design, and an explicit desire to see Edinburgh adopt an alternative model to that proposed for Glasgow – both for reasons of cost and a perception that needs in the city were different. There was also strong support for peer delivery, albeit retaining the specialist skills needed to address clinical needs.

SDCF provision was not, however, viewed as a 'silver bullet'. Rather, it was seen as an important part of a wider harm reduction response to a public health crisis. For some, other interventions took priority, and no participants saw the issue of resource allocation as easily resolved. However, while participants recognised that all financial decisions involved opportunity costs, it was recognised that multiple interventions were needed and key gaps in provision remained. With these considerations in mind, there remained strong support for adding SDCF provision to the services currently available, and ensuring it was integrated with those other services, while protecting the overall harm reduction and treatment system as an adequately funded priority.

5. Summary of findings and recommendations

This report reveals a complex picture in regard to prevalence, patterns of drugs use, and geographies of harms across the city. It also identifies a wide range perceptions, attitudes and aspirations among people who use drugs, families and professional stakeholders. Nevertheless, a number of broad findings emerge which should shape next steps.

These are:

- That there are significant levels of drug-related harm across the city, a number of which could be mitigated by SDCF provision
- That patterns of drug consumption and harm are dispersed across the city, but with identifiable hotspots in some areas
- That patterns of use in the city are varied and dynamic, with particularly high levels of cocaine injecting and benzodiazepine use
- That there is a recognised risk of increased harms due to higher levels of synthetic opioids entering the drug supply
- That there is strong support for SDCF provision among the people with lived / living experience, family members and professional stakeholders interviewed for the study
- That 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
- That 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
- That there is strong support for extensive service delivery by peers / people with lived experience and a degree of informality in service design
- That there is also support for trained clinical expertise and clear operating procedures to protect safety and security on-site
- That strong links between SDCF provision and wider services are seen as critical

While a range of other insights and observations can be drawn from the data presented in this report, we feel that these represented the overarching findings that are of particular relevance to discussions and planning around SDCF provision.

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.

Appendix A: Data source details

Document section	**Data source**	**Data source description**	**Indicator(s)**	**Time period**	**Geographical information**	**Limitations of data source**
Epidemiology of injecting drug use	The Needle Exchange Surveillance Initiative (NESI)	NESI is a national cross-sectional bio-behavioural survey of PWID in Scotland which is conducted across mainland Scotland every two years. The main aim of NESI is to measure and monitor the prevalence of injecting-related harms and risk behaviours among PWID. PWID are recruited from harm reductions services across mainland Scotland and provide a dried blood spot test to measure BBV infection and complete a questionnaire to measure demographics, injecting risk behaviours, and other injecting and social risk factors	The epidemiology of injecting drug use and drug-related harms in Edinburgh	PWID who had been recruited in Edinburgh recruitment sites in 2017-18, and 2019-20	Data gathered at recruitment sites: - Boots Shandwick Place - Lady Lawson St/Spittal Centre - McKinnon's Calder Road - Turning Point Leith - Prestonpans pharmacy - Lloyds Pharmacy, Livingston - Rowlands Pharmacy, Penicuik - Howden bus - Lloyds Westerhailes - Lindsay and Gilmour, Leith Walk - Lindsay and Gilmour, Crewe Road - Lindsay and Gilmour, Craigmillar - Omnicare Springwell, Edinburgh - Lloyds, Ferniehill Road - Newington pharmacy	All data collected through NESI (apart from BBV status) is self-reported, which may be subject to response and recall bias. However, the likelihood of response bias is minimised by the use of independent researchers to collect data. The data relate to those who attend services that provide injecting equipment, and thus may not fully represent the PWID population in Scotland; however, other data from elsewhere in Scotland highlights that the majority of PWID are regular attendees of these services. No data on HIV diagnoses due to low numbers and protection of anonymity. A final limitation is that data collection for 2019-20 was suspended early due to the COVID-19 pandemic and thus impacted sample size

Drug-related deaths	NHS Lothian Drug-related Death Annual Report (2021); and National Records of Scotland data (NRS) (collated by Public Health Intelligence Services for this report)	The NHS Lothian Drug-related Death Annual Report provides figures across Edinburgh and the Lothians in terms of drug-related deaths, related demographics, and drugs implicated. It is important to note that there is a difference in the definition for drug-related deaths between NHS Lothian and NRS. NRS counts deaths only where drugs were listed as the first primary cause of death, whereas NHS Lothian includes all primary drug-related deaths. However, the NHS Lothian report was used as well as NRS data, because it provides additional information on demographics and drugs implicated. Lothian Analytical Services provided drug-related deaths broken down into Edinburgh city postcode districts	Drug-related deaths in Lothian (and Edinburgh specifically); details of demographics; and drugs implicated in the cause of death	Numbers of drug-related deaths between 2019 and 2021 were collated	Numbers of drug-related deaths within each Edinburgh postcode district between 2019 and 2021 were collated. Drug-related deaths were then also synthesised into the four Health and Social Care Partnership (HSCP) sub-group localities (Edinburgh North East; Edinburgh North West; Edinburgh South East; and Edinburgh South West)	Due to the small number of deaths when broken down into postcode level, some data were suppressed to protect anonymity and the postcode was not reported
Scottish Ambulance Service (SAS) non-fatal overdose callouts	SAS non-fatal overdose callout data collected originally for the ACODOS study	In Scotland, SAS attends approximately 5,000 overdose callouts per year where naloxone is administered to reverse an opioid overdose (Scottish Government, 2021). These incidents are recorded by ambulance staff (paramedics and ambulance technicians)	Non-fatal overdose callout numbers	The SAS records from 2018-2021 in Edinburgh city were examined	Areas in Edinburgh that had experienced five or more overdose callouts in at least one calendar month out of the year were mapped. Scottish Government geographical boundary and centroid data was used at a datazone level, allowing the mapping of non-fatal overdose callouts across six local authority areas to show hotspot areas relating to non-fatal overdoses. Datazones are the key geography for the dissemination of small area statistics in Scotland and are widely used and understood across the public and private sector. Like drug-related death data, non-fatal overdose callout data were synthesised across HSPC localities	When datazones had less than five callouts, the exact number was not recorded and therefore could not be accurately included in the amalgamation across HSPC localities. This means that the amalgamated data across localities is only an approximation of the true number

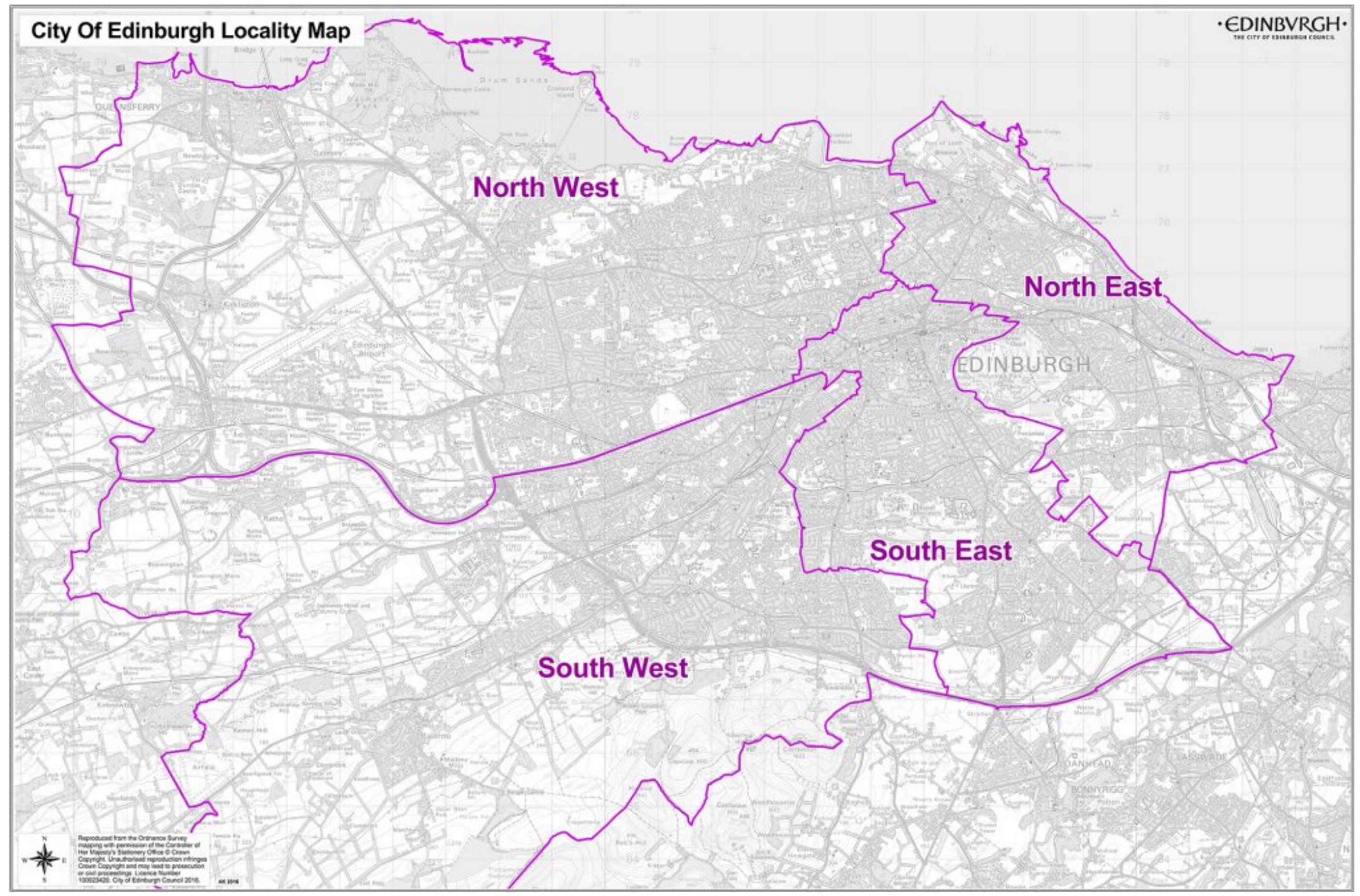
Drug checking	Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS); Public Health Scotland Rapid Action Drug Alerts and Response (RADAR) quarterly reports	WEDINOS receives postal samples of substances to test and provides information about the contents of the substances. Although primarily set up as a service for Wales, WEDINOS accepts and tests samples from across the UK. Public Health Scotland RADAR reports provide Edinburgh-specific drug warnings	Contents of substances submitted for drug testing from Edinburgh city; as well as reported harms from substances	WEDINOS data from Jan 2014-Oct 2022 was analysed to track trends in samples submitted from Edinburgh, and Scotland more generally. Data from January-October 2022 was drawn on to provide analysis of specific drug market trends. RADAR reports from 2023 were analysed	Where possible, data were categorised by postcode district	Due to small numbers, many of the findings cannot be categorised by postcode district in order to protect anonymity. Given the sample is small, findings may not be accurately representative of the drug market in Edinburgh
Injecting equipment provision (IEP)	NEO 360 data available from Public Health Scotland's IEP report as well as Edinburgh-specific data collated by Lothian Harm Reduction Team	The Injecting Equipment Provision in Scotland report provides NEO 360 data showing IEP services and uptake across Scotland. NEO 360 is a commercially available database used by NHS Boards to record and monitor IEP activity. For greater insight into injecting drug use across Edinburgh specifically, the Lothian Harm Reduction Team provided additional NEO 360 data from the locations which provide IEP in the city	IEP data (number of clients, number of transactions, substance per transaction, client demographics) from the ten busiest places that provide IEP in Edinburgh city	2020-2022	The IEP data from the IEP in Scotland report were provided at a health board level. Edinburgh-specific data were categorised by pharmacy/service name and postcode	No IEP dataset provides full insight into prevalence of injecting drug use, and there are often missing values, uncertainties, or inaccuracies reported when analysing NEO 360 data. Additionally, footfall is higher in the city centre. This means that client numbers and transactions are typically skewed towards city centre locations, but this does not necessarily mean drug harms are highest in these areas

Treatment referrals	Specialist drug treatment referral data from NHS specialist addiction services. Referral data will then be cross referenced against people on OAT by Lothian Analytical Services	Trak data (NHS database) provides specialist drug service referral information, and ILLY data (NHS database) provides data on people on OAT prescriptions	Overall numbers of OAT patients who had been referred to specialist drug services, and referral data from three specific cohorts of patients within this group: - patients who had been admitted to hospital that year with their clinical notes reporting injecting drug use - patients who were registered at the Edinburgh Access Practice (which was used as a proxy for homelessness) - patients who had been admitted to hospital that year with their clinical notes reporting injecting drug use and were registered at the Edinburgh Access Practice	2019-2022	Data were amalgamated by postcode district to show the GP locations where patients were most frequently referred to specialist drug services. GP location was deemed an accurate substitution for patient address as it is likely that patients will be accessing GP services near where they live or stay	Data rely on self-report and therefore is susceptible to inaccuracies. Patients with injecting drug use in their clinical notes may not be currently injecting drugs. Patients registered with the Access Practice may not currently be experiencing homelessness. When using raw numbers rather than rate data, postcodes in highly populated areas will inevitably have more numbers. While this shows services with the highest footfall, it does not necessarily mean risk is higher in these areas

Blood-borne virus (BBV) testing	Number of Hepatitis C tests (collated by Lothian Analytical Services)	Lothian Analytical Services provided data showing the number of Hepatitis C tests in different Edinburgh-based services that explicitly support people who use drugs	The number of Hepatitis C tests	2019-2022	Data were categorised by service name and postcode district	Positive Hepatitis C tests were not able to be reported due to small numbers and to protect anonymity. If there were less than five tests for every year (2019-2022), the service location was not reported. As with other indicators, while data show the services with the highest footfall (particularly in the city centre), it does not mean that BBV rates and drug harms will be higher in those areas
Drug-related litter	City of Edinburgh (CEC) street cleaning needle removal service (collated by CEC Environmental Team)	Requests for the removal of discarded drug litter is received by the street cleaning needle removal service	The number of requests to CEC for the removal of discarded needles		Data are recorded by Scottish Government ward area and locality	Service requests do not identify if the callout is for one needle or many needles. Therefore, it is not possible to tell the true scale of discarded litter per callout. Secondly, higher numbers of service requests in a ward are not necessarily representative of higher levels of drug use in that area. Higher numbers of service requests may be because of higher levels of resident concerns, rather than a direct result of increased public injecting

Drug-related crime	Drug-related crime data collated by Police Scotland	Data from Police Scotland's national incident recording system, Storm, were first analysed to provide a list of drug-related incidents recorded. A Storm incident is listed as: any matters reported to the Police, which require despatch of a Police Officer to the scene; any matter that the Police will be committed to and will take time to resolve; or any matter reported to the Police which, whilst not requiring a Police Officer to attend the scene, still warrants information being recorded. Most of these incidents related to reports of drug-related smells (such as smells of cannabis), public drug use, possession, or supply incidents. Secondly, to provide more detailed insight into possession and supply specifically, a Police Scotland possession-specific dataset and supply-specific dataset were analysed	All drug-related incidents; possession- and supply-related incidents	Storm data: 2021-2022; possession/supply data: 2019-2022	Data were analysed and categorised according to Beat area. Beat areas are the geographic areas used by Police Scotland to map Edinburgh. Given that data were not categorised by postcode district like other data sources, corresponding HSCP localities were added to the data to provide a level of continuity in reporting across data sources	The data provided by Police Scotland are only the number of incidents actually reported, and therefore not a true representation of drug-related incidents in particular areas. Higher numbers of possession and/or supply incidents may not be representative of higher numbers of drugs in an area, but could be a result of increased police presence and differing practices such as stop and searches in certain areas (Deuchar et al., 2019). Additionally, much of the crime-related data are specific to cannabis. Cannabis data provides limited information relating to recommendations for SDCFs where cannabis is not typically used
Willingness to use a SDCF	The Needle Exchange Surveillance Initiative (NESI)	NESI is detailed in the first row of this table	Willingness to use a SDCF from PWID who were recruited in Edinburgh city NESI sites	2017-2018	Data gathered at recruitment sites city-wide (see first row for detail)	These data only represent a small number of PWID in Edinburgh and may not reflect the views of others. Additionally, the data are from 2017/18 making it slightly more dated than other indicators in this report, and the pandemic could have had an impact that is not captured by this date range. 'Willingness to use a SDCF' is only hypothetical about potential behaviour and may not be representative of actual behaviour. This limitation also applies to the data reported for willingness to use DCS

Appendix B: HSCP localities map



North East: Leith Walk, Leith, Craigentinny/Duddingston, Portobello/Craigmillar,
North West: Forth, Inverleith, Almond, Drum Brae/Gyle
South East: City Centre, Southside/Newington, Liberton/Gilmerton, Meadows/Morningside
South West: Sighthill/Gorgie, Pentland Hills, Fountainbridge/Craiglockhart, Colinton/Fairmilehead

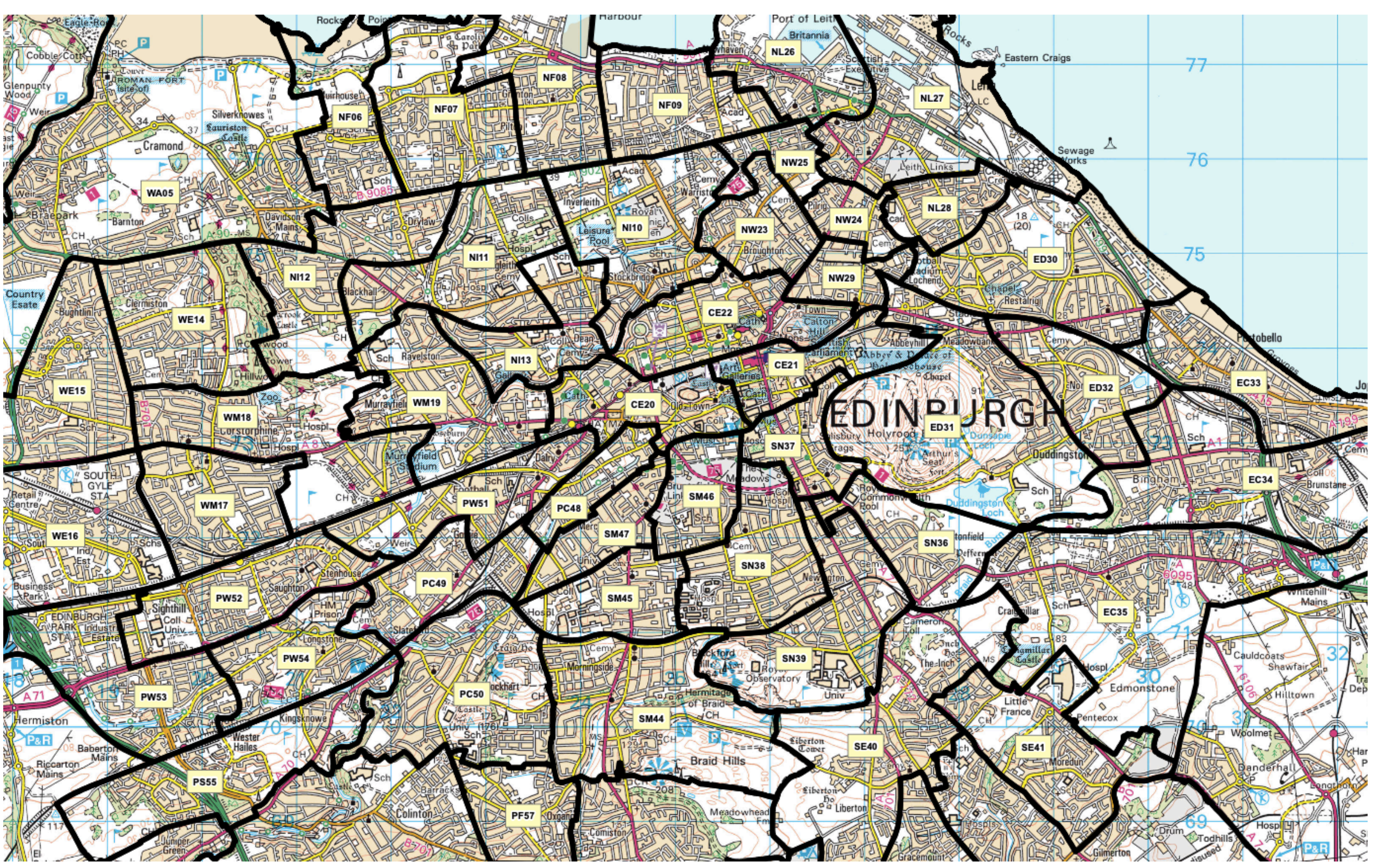
Appendix C: Edinburgh postcode districts

Postcode district	Population (2011)*	Postcode district	Population (2011)
EH1	6,423	EH11	39,292
EH2	839	EH12	38,611
EH3	24,711	EH13	14,633
EH4	53,860	EH14	39,662
EH5	19,547	EH15	20,681
EH6	39,129	EH16	29,566
EH7	34,235	EH17	18,572
EH8	24,141	EH18	2,187
EH9	23,115	EH19	13,904
EH10	33,341	EH20	6,294

Population data source: Public Health Scotland. GPD support – population: Census 2011 postcode sections population lookup files
https://www.isdscotland.org/Products%2Dand%2DServices/GPD%2DSupport/Population/Census/

*Population data at postcode district level not yet available for the 2022 Census

Appendix D: Outlines of Police Scotland beat areas



Appendix E: Characteristics of people currently injecting drugs (injected in the last six months) recruited as part of the Needle Exchange Surveillance Initiative (NESI) in Edinburgh city, 2017-20

	2017-18	**2019-20a**
Total sample	140	101
Environmental and demographics		
Gender		
Male	113 (81%)	70 (69%)
Female	27 (19%)	28 (28%)
Unknown/missing	0	3 (3%)
Age		
<35	40 (29%)	28 (28%)
35-44	76 (54%)	49 (48%)
45+	24 (17%)	24 (24%)
Unknown/missing	0	0
Homeless in last six months		
Yes	57 (41%)	49 (48%)
No	83 (59%)	51 (50%)
Unknown/missing	0	1 (1%)
Arrested for drug offences in the last six months		
Yes	28 (20%)	10 (10%)
No	105 (75%)	90 (89%)
Unknown/missing	7 (5%)	1 (1%)
Been incarcerated in the last year		
Yes	20 (14%)	10 (10%)
No	118 (84%)	90 (89%)
Unknown/missing	2 (1%)	1 (1%)
Injecting risk		
Injected heroin in last six months		
Yes	133 (95%)	96 (95%)
No	6 (4%)	5 (5%)
Unknown/missing	1 (1%)	0
Injected cocaine (powder) in last six months		
Yes	25 (18%)	20 (20%)
No	114 (81%)	81 (80%)
Unknown/missing	1 (1%)	0
Injected crack cocaine in last six months		
Yes	14 (10%)	12 (12%)
No	125 (89%)	89 (88%)
Unknown/missing	1 (1%)	0
Benzodiazepine consumption in last six months		
Yes	-	61 (60%)
No	-	39 (39%)
Unknown/missing	-	1 (1%)

Cocaine consumption (crack or powder) in last six months		
Yes	-	48 (48%)
No	-	52 (51%)
Unknown/missing	-	1 (1%)
Injected in a public place in last six months		
Yes	30 (21%)	22 (22%)
No	110 (79%)	79 (78%)
Unknown/missing	0	0
Shared needles/syringes in last six months		
Yes	12 (9%)	6 (6%)
No	128 (91%)	94 (93%)
Unknown/missing	0	1 (1%)
Re-used needle/syringes in last six months		
Yes	84 (60%)	49 (48%)
No	55 (39%)	46 (46%)
Unknown/missing	1 (1%)	6 (6%)
High injecting frequency		
Low frequency (<4 times per day)	72 (51%)	63 (62%)
High frequency (4+ times per day)	67 (48%)	38 (38%)
Unknown/missing	1 (1%)	0
Injecting-related harms		
Current HCV infection (29 indeterminant samples)		
Yes	34 (31%)	12 (14%)
No	77 (69%)	71 (86%)
Overdosed in the last year		
Yes	35 (25%)	17 (17%)
No	101 (72%)	83 (82%)
Unknown/missing	4 (3%)	1 (1%)
Skin and soft tissue infection in the last year		
Yes	53 (38%)	19 (19%)
No	86 (61%)	81 (80%)
Unknown/missing	1 (1%)	1 (1%)

a Data collection was suspended early due to COVID
b Includes heroin injection

Appendix F: IEP provision data

Location	Postcode district	Number of New Clients Registered	Unique Clients Attending	Males Attending	Females Attending	Opiate Transactions	Number of Opiate Clients	Stimulants Transactions	Number of Stimulants Clients	Total Number of Syringes / Barrels administered
Lindsay and Gilmour Leith Walk	EH6	101	587	472	115	2932	470	250	59	44599
Boots Shandwick Place	EH2	117	660	554	106	2129	553	238	68	28164
Newington Pharmacy	EH8	52	478	381	97	1932	421	294	55	28020
The Exchange Lady Lawson Street	EH3	59	328	259	69	840	234	205	42	25227
Turning Point - Leith	EH6	26	244	204	40	554	183	39	16	22950
Lindsay and Gilmour Crewe Rd	EH4	34	229	181	48	1297	182	77	15	22898
Lloyds Pharmacy Ferniehill Road	EH17	37	146	124	22	550	118	29	13	11924
Well Pharmacy	EH7	8	110	83	27	431	80	148	14	11066
Omnicare Pharmacy Springwell	EH11	23	163	134	29	639	136	46	11	9714
Omnicare Pharmacy (Walter Scott Avenue)	EH16	19	61	42	19	302	54	72	5	8666
Craigmillar Pharmacy	EH16	24	166	135	31	781	143	36	13	8483
Lloyds Pharmacy Wester Hailes Centre	EH14	30	149	120	29	499	110	19	11	7949
MacKinnon Pharmacy - M&D Green	EH11	24	229	176	53	1039	180	134	20	7914

Location	Postcode district	Number of New Clients Registered	Unique Clients Attending	Males Attending	Females Attending	Opiate Transactions	Number of Opiate Clients	Stimulants Transactions	Number of Stimulants Clients	Total Number of Syringes / Barrels administered
Newington Pharmacy	EH8	57	461	379	82	2374	387	814	91	36008
Lindsay and Gilmour Leith Walk	EH6	69	492	401	91	1835	392	264	55	30340
The Exchange Lady Lawson Street	EH3	61	290	227	59	714	194	207	41	30337

Boots Shandwick Place	EH2	133	668	561	107	1831	528	315	94	27058
Turning Point - Leith	EH6	39	326	272	54	648	232	71	29	22487
Lindsay and Gilmour Crewe Rd	EH4	21	190	160	30	1015	141	115	16	21497
Omnicare Pharmacy (Walter Scott Avenue)	EH16	16	54	38	16	312	43	114	7	16207
Craigmillar Pharmacy	EH16	40	208	156	52	1118	159	61	17	14709
MacKinnon Pharmacy - M&D Green	EH11	21	247	199	48	1009	189	189	22	10095
Omnicare Pharmacy Springwell	EH11	25	164	130	34	638	138	98	23	7289
Lloyds Pharmacy Wester Hailes Centre	EH14	23	150	128	22	352	100	34	13	6441

Location	**Postcode district**	**Number of New Clients Registered**	**Unique Clients Attending**	**Males Attending**	**Females Attending**	**Opiate Transactions**	**Number of Opiate Clients**	**Stimulants Transactions**	**Number of Stimulants Clients**	**Total Number of Syringes / Barrels administered**
The Exchange Lady Lawson Street	EH3	79	312	262	45	719	169	357	67	39554
Newington Pharmacy	EH8	64	449	355	93	2160	344	1161	129	38585
Lindsay and Gilmour Leith Walk	EH6	40	410	339	71	1441	319	305	75	28037
Boots Shandwick Place	EH2	130	572	475	96	1603	418	522	125	25737
Turning Point - Leith	EH6	70	372	299	72	637	230	156	58	24661
Lindsay and Gilmour Crewe Rd	EH4	38	200	156	44	957	140	94	19	23222
Omnicare Pharmacy Springwell	EH11	29	222	183	39	1207	184	267	46	17271
MacKinnon Pharmacy - M&D Green	EH11	22	244	196	48	997	184	289	45	10894
Craigmillar Pharmacy	EH16	13	161	126	35	685	123	93	18	10564
Lloyds Pharmacy Wester Hailes Centre	EH14	29	158	139	19	468	110	192	30	7827
Omnicare Pharmacy (Walter Scott Avenue)	EH16	11	52	36	16	236	35	53	10	5033

For each location, the number of new clients registered is reported, as well as the number of clients attending (split by sex). The numbers of trans or non-binary persons attending locations were too small to be reported without identification risks. Clients and transactions were split into opiates and stimulants to give insight into the pattern of injecting . The number of clients injecting substances aside from opiates and stimulants was relatively small across all locations. Data from people who inject substances such as performance- and image-enhancing drugs were excluded as this group have a different epidemiological profile and set of health needs (Tweed et al., 2018).

Appendix G

Discrete Choice Experiment to identify preferences for SDCF models among people who use drugs in Edinburgh

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Purpose of study

This study aimed to engage with people who use drugs (PWUD) in Edinburgh to provide insights on what features and delivery models of an SDCF would be considered most acceptable and attractive. The study used a Discrete Choice Experiment design in order to specify particular features and make a quantitative assessment of preferences among the sample.

This is the first Discrete Choice Experiment (DCE) study to explore the acceptability and feasibility for different configurations of SDCF by sampling potential service users perspectives in Scotland. This short report provides initial findings from the pilot study conducted in Edinburgh between September and October 2023.

The wider study will address the following questions:

- What are the preferences of PWUD regarding the relative important design features of a SDCF?
- How does their preference for various design features differ among subgroups?
- How do they make trade-offs between different design features of SDCF?

As this report provides results from Edinburgh only, there are slightly different aims for this initial pilot study. They are to:

- test the feasibility of participant recruitment
- examine the relative importance of service features for people who use drugs in Edinburgh
- inform the 'prior information' required for the study design that will increase the precision of estimating participants' preferences
- Provide supporting information for a needs assessment and feasibility study for an SDCF in Edinburgh

Methods

Discrete Choice Experiment (DCE) is a quantitative method that allows for engagement with stakeholders to investigate stated preferences for two or more healthcare goods or services, as well as exploring potential trade-offs that stakeholders are willing to make.[1] For example, how much longer are participants willing to travel to access a SDCF run by peer workers, as compared to a different delivery model? In this DCE study, preferences were measured by asking PWUD about their preferred choices on the service delivery model of SDCF in a range of hypothesised scenarios. Each participant was given a series of scenarios presented in multiple choice sets, which are composed of several attributes and their levels (see Table 1) in a questionnaire. Each choice set composed 2 different scenarios and an opt-out. An example of a choice set is presented in Figure 1.

A total of 36 choice sets were designed and generated. To reduce cognitive burdens, each participant was given 9 distinct choice sets, e.g., 9 choice sets where they were asked to decide their preferred scenario. The questionnaire is not personalised to each participant, but as there are 36

choice sets generated, each participant received a questionnaire containing 9 different choice sets and identical follow-up questions. Follow-up questions included information on participant characteristics (e.g., socioeconomic background, general health, drug use history, etc).
17 participants were recruited from a single third sector organisation providing support for homeless people in Edinburgh city centre. 4 participants were recruited from a single residential accommodation in the city. Two trained peer researchers collected data, with participants completing questionnaires in the presence of the researchers.

Table 1. **Attributes and levels of the discrete choice experiment (DCE)**

Attribute	**Level**	**Description**
Location	1. Stand-alone SDCF	Facility suited in close to other drug-related services and near areas known for high levels of illicit drug use.
	2. Medicalised SDCF	Facility integrated into existing healthcare centres, e.g., hospital.
	3. Embedded SDCF	Facility sets up in existing charity organisations.
	4. Mobile SDCF	Facility operates in a mobile van.
Staffing	1. Involve peer workers 2. No peer workers	People with personal experience of using drugs are employed in the facility or not.
Space allocation	1. Provide inhalation space 2. No inhalation space	Facility provides inhalation space alongside injection space or not.
Drug checking service	1. Provide drug checking service 2. No drug checking service	Facility provides drug checking service or not.
Opening time	1. 24 hours 2. Daytime (e.g., 8am-4pm) 3. Overnight (e.g., 7pm - 9am)	Facility can operate at different times.
Travel time	1. 01 minute 2. 09 minutes 3. 19 minutes 4. 29 minutes	How long you willing to travel to access the facility?

Figure 1. Example choice set

Imagine a Drug Consumption Room was available, which option would you prefer?

(1 of 9)

Characteristics	Option A	Option B	Option C
Location	Embedded drug consumption rooms	Medicalised drug consumption rooms	I wouldn't choose any of these
Staffing	No peer workers	Involve peer workers	
Space allocation	Provide inhalation space	No inhalation space	
Drug checking service	No drug checking service	Provide drug checking service	
Opening time	Overnight (7pm-9am)	Daytime (8am-4pm)	
Travel time	29 min 29 minutes	01 min 1 minute	

Please select your most preferred choice:

Option A.................. ☐ Option B.................... ☐ Option C.................. ☐

Results

21 responses were received. As shown in Table 1, all participants were white, and just over half were male (52.4%). Most participants were aged 40-49 (38.1%) and did not have a stable residence (90.5%). Over half had an average weekly income ranging from £0 to £100 (57.2%), around a third had £101 to £200 (33.3%), and the remaining had more than £200 (11.8%).

Participants were asked about their experience with drugs in the last 6 months. Benzodiazepines were the most commonly used drug, followed by cannabis. Nearly one third of participants reported always using more than one drug at a time (28.6%). The majority took drugs in public places (82.3%) and in the company of others (94.1%). The primary methods of drug consumption were smoking or snorting (N=19), followed by injection (N=12). About half used drugs 2-3 times a day (42.9%). More than half of participants received opioid substitution treatment (OST) (76.2%) and drug paraphernalia (61.9%). Just under half did not carry take home naloxone (THN) with them while using drugs (42.9%). More than half of the participants (N=12) reported experiencing mental health issues. One third (N=7) had experienced overdose events, of whom two had overdosed 2-4 times.

The summary characteristics (*Table 2*) showed that the majority of the sample supported the introduction of SDCF (90.5%). Out of 21 participants, 17 thought that PWUD would attend if the services were available, two did not think that PWUD would use SDCF, and two were indifferent. Furthermore, eight people were concerned about the legal issues with attending the service. Within an open-ended question asking about the essential elements of a SDCF, participants highlighted some further attributes, e.g., that SDCF is comfortable, hygienic, safe, provide privacy, and that they provide something beyond a place to use drugs, e.g., social opportunities or activities.

Table 1.Respondent characteristics (total=21)

	No.	%
Gender		
Male	11	52.4
Female	9	42.8
Non-binary	1	4.8
Age		
18-29	3	14.3
30-39	5	23.8
40-49	8	38.1
50-59	5	23.8
Ethnicity		
White	21	100
Residence		
Street or homeless	11	52.4
Shelter or refugee	8	38.1
Rental house or flat	2	9.5
Weekly income (last 6 months)		
£0 - £100	12	57.2%
£101 - £200	7	33.3%
> £200	2	9.5%
Drug types*		
Heroin	12	
Cocaine	15	
Crack	13	
Heroin and Cocaine/Crack	9	
Amphetamines (e.g., Speed)	1	
Benzos	19	
New Psychoactive Substances	1	

Cannabis	17	
Poly drug use at a time (last 6 months)		
Always	6	28.6
Usually	5	23.8
Sometimes	8	38.1
No	2	9.5
Drug-taking method*		
Smoke/Snorted	19	
Oral	8	
Injection	12	
Drug-taking frequency		
Less than daily	4	19.0
Once a day	5	23.8
2-3 times a day	9	42.9
4 or more times a day	3	14.3
Take drugs publicly (last 6 months)		
Yes	15	71.4
No	6	28.6
Take drugs with others (last 6 months)		
Yes	20	95.2
No	1	4.8
Chronic diseases (last 6 months)*		
Hepatitis C	3	
Skin abscesses and infections	5	
Cardiorespiratory conditions	3	
Mental health complaints/diagnoses	12	
Have not had any medical problems	3	
Overdosed event (last 6 months)		
Once	5	23.8
2-4 times	2	9.5
Not had an overdose	14	66.7
Obtain equipment(last 6 months)		
Yes	13	61.9
No	8	38.1
OST (last 6 months)		
Yes	16	76.2
No	5	23.8
Carry THN while using drugs (last 6 months)		
Yes	12	57.1
No	9	42.9
Attitudes towards opening SDCF		
Support roll-out	19	90.5
Willing to attend service	17	81.0
Concerned about legal issue	8	38.1

*Survey questions that participants can have multiple choices, therefore the percentage was not calculated.

The DCE results are reported in Table 3. It should be noted that this was the pilot study site with a small sample size (n=21), and therefore caution should be taken for interpretation of results particularly regarding statistical inference based on p-values. Given the pilot nature and small sample size, a 10% significant level was considered as a potential indicator[2] with the purpose of testing the feasibility of a larger study. However, we caution against making statements regarding statistical significance on these pilot results.

A total of 189 observations (21 participants × 9 choice sets) were obtained to analyse preferences for SDCF's design features. The results revealed that, compared to status quo (no SDCF available), two-thirds of participants preferred the option of being able to use an SDCF. Out of 189 observations, participants chose an SDCF facility 128 times (67.72%) compared to status quo (no SDCF available) 61 times (32.28%).

For service design features (Table 3), participants were more likely to choose a SDCF facility that operates during the daytime (e.g., 8am – 4pm) compared to one that opens 24 hours a day (Coeff: -0.535, *P* value: 0.019), but there was no difference between daytime and night time opening. Also, in comparison to providing inhalation space, participants showed a tendency to prefer a SDCF facility with injection spaces only (Coeff: -0.412, *P* value: 0.067). However, there was insufficient evidence to conclude preferences on other design features across the sample population, including the choice of staffing, drug checking service, and location (*P* value > 0.1).

Table 3. PWUD's preferences for SDCF's design features

Attribute	Level	Coefficient	SE	t-value	P value*
ASC**	Status Quo (Ref.)				
	SDCF	0.537	0.428	1.254	0.105
Location	Stand-alone SDCF (Ref.)	Constrained to be 0			
	Medicalised SDCF	-0.109	0.296	-0.368	0.357
	Embedded SDCF	0.060	0.290	0.209	0.417
	Mobile SDCF	0.301	0.499	0.602	0.274
Staffing	No peer workers (Ref.)	Constrained to be 0			
	Involve peer workers	-0.078	0.262	-0.299	0.383
Space allocation	No inhalation space (Ref.)	Constrained to be 0			
	Provide inhalation space	-0.412	0.275	-1.496	0.067
Drug checking service	No drug checking service (Ref.)	Constrained to be 0			
	Provide drug checking service	-0.299	0.249	-1.199	0.115
Operation time	Daytime (e.g., 8am-4pm) (Ref.)	Constrained to be 0			
	Overnight (e.g., 7pm-9am)	0.441	0.359	1.228	0.110
	24 hours	-0.535	0.257	-2.084	0.019
Travel time	Continuous variable (per 1 minute)	-0.011	0.015	-0.745	0.228

**P* value was at 10% significant level, due to a small sample size of this polit study. **ASC: referred as alternative specific constant, that represented the constant term captured the inherent preference for or against choosing a SDCF in the choice set, which independent of the other explanatory variables in the model.

Conclusion

This pilot study provides initial evidence that a large majority of PWUD, and who use the types of facilities where recruitments took place, would prefer SDCF provision to the status quo and would be willing to use such a facility. Statistically significant results indicate that the sampled population tend to prefer a facility that operates in the daytime to one operating 24-hours a day, though with no significant preference between day and overnight operation. Also, compared to a SDCF with both injection and inhalation spaces, they showed a tendency to prefer injection spaces only. Although

the study results are limited due to the small sample size, they provide key insights into preferences for design features within the sampled population. This information will now be used to adapt the choice sets for wider roll out of the questionnaire. Further participants will now be recruited from other Scottish cities to achieve a larger sample size and greater statistical power, which will enable further conclusions to be made.

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