CHIEF SCIENTIST OFFICE

CODE:HIPS/19/19

RESEARCH PROJECT BRIEFING

An implementation science evaluation of Scotland's first Heroin Assisted Treatment (HAT) facility

AIMS

Heroin assisted treatment (HAT) is the provision of prescribed heroin ('diamorphine') under medical supervision. Clinical trials have shown that HAT is effective in reducing illicit drug use, criminal activity, and improving the health and wellbeing of patients who have not responded well to traditional treatments such as methadone. Little is known about how best to implement HAT in the real world, outside of a clinical trial setting; that is, the effective delivery of the collection of people, processes, interactions and systems that are needed to ensure that prescribed heroin can address opioid dependence. We aimed to understand engagement and the barriers to, and facilitators for, implementing Scotland's first HAT service, through exploration of the views and experiences of patients and staff, and other key stakeholders. These findings were used to develop recommendations that will guide the establishment, development and maintenance of HAT services across Scotland and the UK.

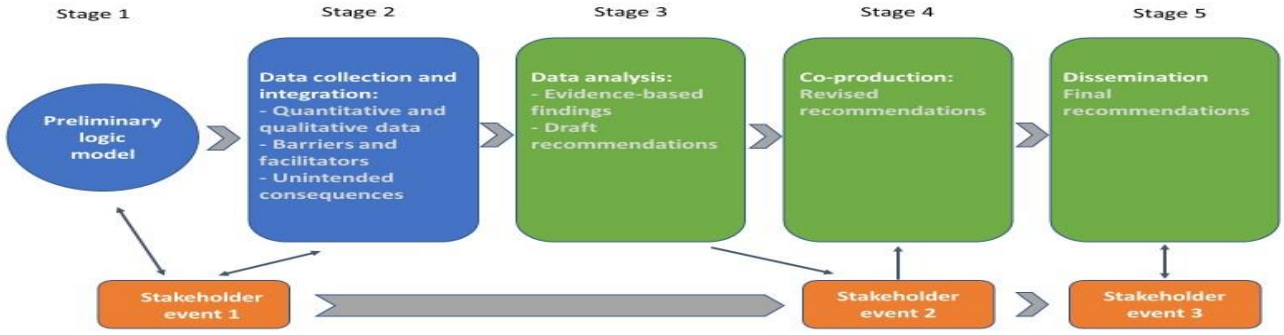
KEY FINDINGS

- The majority of people who used the HAT service in its first year engaged with services much better than they had done previously.
- Those who were still engaged after one year had reduced their illicit heroin use and had improved health and social functioning.
- Uptake was facilitated by broadening referral routes, tailoring care to individual needs, relationship building between patients and staff, and a flexible approach to treatment which did not involve punishment.
- The Covid-19 pandemic impacted the service in various ways, including limitations on capacity, referral pathways, staff availability and community support.
- Other barriers to implementation included the location and layout of the service, the intensity of the treatment, complex needs of patients, and high levels of drug use.
- Service commissioners investing in HAT must consider individual, service and environmental level contexts and factors when designing and implementing services.

WHAT DID THE STUDY INVOLVE?

The study was conducted across 5 stages (see below) and involved the following methods:

- **Logic modelling** to develop a diagram of key processes within the HAT service patient pathway and factors that might affect them.
- **Qualitative interviews** with 9 HAT patients (11 interviews in total) and 7 HAT staff (16 interviews in total). These interviews were conducted online around the time the service was opening and then again 12 months later.
- **Qualitative interviews** with 6 external staff working closely with the HAT service (e.g. criminal justice, social work, and third sector staff), were conducted online a year after the service first opened.
- **Focus groups** with 6 HAT staff (2 groups in total) were conducted online shortly after the first Covid-19 lockdown had been lifted in the summer of 2020.
- **Descriptive analysis** of routine quantitative data collected by the HAT service on measures such as attendance, drug use, and health and social functioning.
- **Stakeholder engagement** throughout the study (from design to dissemination) comprised of local and national stakeholders, and people currently or formerly using heroin (excluding HAT patients).



WHAT WERE THE RESULTS AND WHAT DO THEY MEAN?

ENGAGEMENT

In total, nine out of fifteen people who commenced HAT in its first year were still engaged with the service after one year, a substantial improvement on levels of previous service engagement. Of these individuals:

- Heroin use decreased, but other drug use (e.g. cocaine and benzodiazepines) did not decrease to the same extent.
- Health and well-being improved including reductions in overdose and presentations to hospital emergency departments.
- Social functioning improved including reductions in begging, homelessness and injecting in public places.

Six of the fifteen were no longer engaged with HAT after a year. Of these individuals:

- Most had left within six months of commencing treatment.
- All were discharged back to community treatment for continuation on other treatments such as methadone and buprenorphine.
- Two subsequently died.

WHAT WERE THE RESULTS AND WHAT DO THEY MEAN? ctd.

BARRIERS TO, AND FACILITATORS FOR, IMPLEMENTATION

Barriers to implementation	Facilitators for implementation
Individual level	
Complex needs of the patient group with extreme levels of trauma, severe mental and physical health, and living with high risk of: relapse, violence, unsafe housing, and coercion, all of which impacted engagement.	Individualised care packages, which were flexible to patients differing contexts and needs and supported a collaborative approach with patient choice on issues such as treatment dose, timelines and outcomes.
High levels of other drug use, especially benzodiazepines, which impacted the ability of patients to begin treatment, and the capacity of patients to maintain engagement.	Relationship building and development of trust between patients and staff that was achieved through daily contact, and a focus on an empathetic approach.
Service level	
Layout of the service which staff and patients felt was overly clinical, and increased the risk of negative incidents (e.g. same access door for entry and exit).	Optimal dosage of diamorphine alongside methadone to reduce symptoms of withdrawal and support abstinence from street heroin overnight.
The intensity of the service (i.e. twice daily attendance, seven days per week) which was challenging for some patients to maintain over the medium to longer term.	Holistic support of patients both within service and through external partners, covering a range of needs beyond substance use, such as: medicines management; physical health; housing; relationships, and life skills.
Lack of staff resource capacity and dedicated, non-clinical, physical space to address both mental health and wider holistic work with patients.	A flexible approach to treatment delivery which did not involve punishment, including a high threshold for “disruptive” patient behaviours, and agreement that the primary aim of the service was focussed on reducing harms and maintaining engagement with the patient group.
High turnover of staff which resulted in regularly restarting the critical process of trust building between patients and staff, leading to treatment fatigue in patients.	An appropriately skilled and supported staff group, that were motivated to deliver a harm reduction prioritised approach through an empathetic and patient focussed, trauma informed understanding of patient's lives, contexts, and needs.
Restrictions put in place due to the COVID-19 pandemic which limited service capacity, temporarily closed referral pathways, and increased staff shortages through sickness, shielding and redeployment.	A recognition that the HAT approach was relatively unique, and particularly demanding on staff, and required provision of appropriate staff wellbeing resources, supervision and training to avoid the high risk of burnout.
Environmental level	
The location of the service which was challenging for some people to reach and risked encounters with people from previous drug using networks, increasing risk of exposure to street drugs.	Broadening and diversifying referral pathways, and lowering thresholds, to reach a larger pool of eligible patients, including through assertive outreach and during periods of patient stability (e.g. rehab/hospital stays).
Capacity reductions in community based and other services due to COVID-19, which resulted in limited community based support within the service which had been originally planned for.	Co-location alongside other linked services such as GPs, housing officers and blood borne virus teams, allowing rapid access and collaboration with these services, and utilisation of existing professional networks.

WHAT WERE THE RESULTS AND WHAT DO THEY MEAN? ctd.

The following recommendations were developed on the basis of data collected through interviews and focus groups and in consultation sessions with stakeholder groups which included people currently or formerly using heroin.

RECOMMENDATIONS TO IMPROVE IMPLEMENTATION
Individual level
1. Referral processes to HAT should adopt an individualised approach.
2. HAT care packages should be tailored to individual needs, co-produced, flexible, and non-punitive.
3. Respectful relationships between HAT staff and patients are essential to patient engagement and outcomes; and should be formally supported.
4. Shared expectations of treatment duration should be acknowledged by staff and patients.
Service level
5. HAT services should be resourced to provide mental health care via informal support through everyday interaction; and specialist intervention where required.
6. Resources should be committed to make sure that the whole person and their needs are addressed (e.g. physical health, housing, relationships, life skills) including within HAT services and through in-reach from key external services.
7. HAT service design and built environment should be patient, rather than clinically, focussed.
8. Staff recruitment should be tailored to the unique needs and demands of working within HAT.
9. Staff wellbeing should be prioritised through appropriate resources, supervision and training.
Environmental level
11. HAT service location should be accessible, safe and close to key external services.
12. HAT services should have multiple referral pathways from statutory and non-statutory services, including via assertive outreach.

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WHAT IMPACT COULD THE FINDINGS HAVE?

- Improved understanding of the implementation of Scotland's first HAT service will put policymakers and service commissioners in a much stronger position to design services that have the best chance of success.
- Study findings will also support patients to engage with HAT more effectively and staff to maximise its potential benefits.
- Recommendations from the study are already being used to improve effectiveness of the service that was evaluated in the study.

HOW WILL THE OUTCOMES BE DISSEMINATED?

- A dissemination event in April 2023 involving people currently or formerly using heroin and other key stakeholders.
- Two academic papers will be submitted in 2023, one focussing on barriers and facilitators to implementing HAT, the other on staff/patients expectations and experiences of HAT.
- Presentations at Academic/Practitioner Conferences in 2023.
- Working with our partners, Scottish Drugs Forum, and other stakeholders to disseminate our findings and recommendations in appropriate ways for different audiences, including but not restricted to: Community drug treatment providers and those who use their services; Scottish Government; Public Health Scotland; social work and housing services; Police Scotland; other UK governments considering HAT.

CONCLUSION

- Heroin-assisted treatment was successfully implemented in Glasgow for a small group of patients with complex needs who had previously been unable to meaningfully engage in other community drug treatment services.
- Tailoring HAT to individual patients' needs is essential to their ongoing engagement.
- COVID-19 had a major impact on the original service delivery model, but other barriers to implementation were identified at individual, service and environmental levels.
- HAT is not a short-term solution for a patient group with complex needs and polydrug use, therefore policy makers, commissioners and practitioners need to consider this when planning and operating similar services.
- Future research should explore how patients can transition from HAT to less intensive treatments through planned discharges.

RESEARCH TEAM & CONTACT

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