

# Enhanced Drug Treatment Service Evaluation Report

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## Introduction

This is the report of a service evaluation of the Enhanced Drug Treatment Service (EDTS), which is a part of Glasgow City Alcohol and Drug Recovery Services (GADRS).

EDTS has been subject to extensive evaluation comprising two strands:

1. An internal service evaluation led by NHS Greater Glasgow and Clyde (NHSGGC), which is the subject of this report, and
2. An evaluation led by Glasgow Caledonian University with Chief Scientist Office (CSO) funding. The purpose of this was to understand the barriers to and facilitators of implementing Scotland's first heroin assisted treatment service, exploring the views and experiences of patients, staff and other key stakeholders. The report of this evaluation was published in April 2023 and is available at: <https://www.cso.scot.nhs.uk/wp-content/uploads/HIPS1919report.pdf>.

## Background

The Glasgow EDTS provides medication-assisted treatment in the form of prescribed injectable diamorphine and enhanced support to people whose problem drug use persists even after they have received conventional treatment and care services.

The service was implemented in December 2019 as a recommendation following a health needs assessment of people who inject drugs (PWID) in public places in Glasgow city centre conducted by NHSGGC and Glasgow City Alcohol & Drugs Partnership<sup>1</sup> (ADP).

[https://www.nhsggc.org.uk/media/238302/nhsggc\\_health\\_needs\\_drug\\_injectors\\_full.pdf](https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf).

Diamorphine Assisted Treatment (often described as heroin assisted treatment or HAT but referred to as DAT in this report) is a well-established, evidence-based treatment for people with long-standing heroin use who have been unable to respond to / engage with conventional Opioid Agonist Therapy (OAT) treatments such as methadone and buprenorphine<sup>2</sup>. Treatment involves prescribed pharmaceutical grade diamorphine (pharmacologically equivalent to heroin) within a controlled environment, in addition to provision of holistic interventions to respond to social, physical and mental health needs. DAT was introduced in Switzerland in the mid-1990s<sup>3</sup>, and there are established clinics throughout the world, especially in Europe and Canada. Glasgow's EDTS is the first service in Scotland to offer this treatment option.

EDTS is co-located with other relevant health and social care services in Hunter Street Health Centre, just east of the city centre. It operates daily between the hours of 9am and 5pm, 7 days per week 365 days per year, and opened to referrals on 25/11/2019, with the first doses of diamorphine supplied on 3/12/2019. Currently the service offers two injecting sessions per day, with more stable individuals only attending once a day. Those commenced on DAT self-administer all injections under the direct supervision of nursing staff with no takeaway injectable doses. Treatment is supplemented with other medication and health and social care supports. The service is staffed by a multidisciplinary team including medical, pharmacy, nursing, social care and administrative staff and is co-located with other services including GPs (General Practice), Blood Borne Virus and Sexual Health teams and housing (including access to Housing First) and welfare rights officers.

## **Service Aims and Outcomes**

The proposal for EDTS and for DAT was based upon the following service aims:

- Improving the health of people who inject drugs, e.g. reduced risk of blood-borne virus (BBV) transmission.
- Increasing recovery capital and opportunity for people who use drugs, e.g. providing routes into recovery for people who inject drugs in the city centre.
- Wider societal and economic benefits, e.g. reducing the impact on health and criminal justice systems.
- Improving the experience of residents, businesses, and visitors to Glasgow City.

The service is expected to contribute to these benefits through the following service outcomes:

- Consistent and continued attendance and engagement in treatment by people who have not responded to conventional treatments for heroin dependency.
- Reduction in illicit (street) heroin use.
- Reduction in other illicit (street) drug use.
- Reduction in public injecting.
- Positive economic benefit through a reduction in the comparatively high utilisation of a variety of public services, specifically hospitals.
- Improvement in testing rates of BBV and access to HIV and hepatitis C treatment options.

## Executive Summary of Key Findings

- **Diamorphine Assisted Treatment was implemented safely and effectively** as a treatment option for people with heroin dependency in Glasgow City.
- The number of people recruited to EDTS was lower than expected and was adversely impacted by COVID-19 (the service opened in December 2019 and COVID-19 restrictions came into place in March 2020).
- The baseline profile of people recruited to EDTS was more complex than the baseline profile of other comparable cohorts such as participants in the randomised injectable opioid treatment Randomised Injectable Opioid Treatment Trial (RIOTT) in England and the Scottish Needle Exchange Surveillance Initiative (NESI) survey.
- Nine out of fifteen people who commenced on DAT completed one year of treatment.

For those who completed one year:

- Routine laboratory drug screening indicated a reduction in street heroin use, and self-reported street heroin use reduced in terms of both the number of days injecting and the amount injected.
  - Routine laboratory drug screening indicated continued cocaine use, although self-reported cocaine use reduced in terms of both the number days injecting and the amount injected.
  - Routine laboratory drug screening indicated a reduction in etizolam (street benzodiazepine) use. Self-reported etizolam use also reduced but more so than the laboratory results demonstrated.
  - Self-reported health improved, and data linkage with acute health service data showed reductions in presentations to emergency departments (ED), with overdose and overall presentations to ED and admission to hospital decreasing.
  - Homelessness and episodes of begging reduced with a marked improvement in social functioning including housing status, reduced begging, and public injecting.
  - Self-reported illegal activity as a source of income reduced.
- There is less known about the outcomes for those who did not complete one year of treatment. However, we know that:
    - Most left treatment before six month follow-up.

- All people discharged from EDTS were transferred into community treatment for continuation of OAT and were still attending treatment services one year post DAT.
  - Two people sadly died whilst in community treatment after discharge from EDTS.
  - Although not as large as for those who remained in treatment, reductions were seen in the number of ED presentations, inpatient episodes and overall bed days following DAT.
- Overall, the number of adverse events within the service were low and incidents were appropriately managed. A cost saving analysis of acute service usage was carried out for those referred to EDTS and found that cost to acute health services for those individuals reduced by 50% in the year post DAT and by 70.9% for those who completed a year of treatment. Further cost saving analysis is intended to be undertaken utilising linked data from police and prison systems and will be included in a supplementary report at a later date.

## Methods

### Eligibility

All individuals enrolled in EDTS since the launch of the service were eligible for inclusion in the evaluation (Appendix B).

### Data Collection

Baseline data collection was carried out by an NHSGGC research assistant who was independent from EDTS. People referred to and receiving a service from EDTS were approached for consent to participate in the evaluation once they had been commenced on diamorphine assisted treatment (DAT). An information leaflet was read out by the evaluation research assistant before commencing the evaluation questions. Follow-up data collection was carried out at 3, 6 and 12 months using a shortened version of the baseline tool.

The evaluation used a mixed-methods approach, triangulating different forms of evidence including:

- Self-reported data from a self-reporting evaluation tool
- Service data from clinical information systems such as EMIS (Electronic Medical Information System) Web and Clinical Portal
- Laboratory screening data processed and reported by the Glasgow University Department of Forensic Medicine
- Administrative data from Police Scotland (PS), Scottish Prison Services (SPS) and social work services.

**Table 1 - Data Sources & Service Aims**

<b>Service Aims</b>	<b>Data Source</b>
Reduction in illicit (street) heroin use	Self-reported data Laboratory screening data
Consistent and continued attendance and engagement in the treatment intervention by individuals who have not responded to conventional treatments for heroin dependency	Service data
Improvement in testing rates of blood-borne viruses (BBVs) and access to HIV and hepatitis C treatment options	Self-reported data Service data
Reduction in the spread of BBVs such as HIV	Service data
Reduction in public injecting	Self-reported data
Positive economic benefit through a reduction in the comparatively high utilisation of a variety of public services, specifically in the acute hospitals and criminal justice systems	Self-reported data Linked service data Linked administrative data from Police Scotland and Scottish Prison Services (intended to be presented in a supplementary report)

## **Evaluation Tool**

An evaluation tool was used to collect self-reported information from the individuals who were enrolled in the treatment service (the EDTS cohort). The evaluation tool was developed in consultation with 'Randomised Injectable Opioid Treatment Trial' (RIOTT)<sup>4</sup> and NESI (Needle Exchange Surveillance Initiative)<sup>5</sup> researchers and was designed to enable comparison with both the NESI and RIOTT cohorts. The tool incorporated validated tools including the EQ5D<sup>7</sup> for health and a social functioning, which forms part of the opiate treatment index<sup>9</sup>.

From December 2019 to March 2020, data were collected using the tool via face-to-face interviews carried out by the research assistant. However due to social distancing restrictions in response to the COVID-19 pandemic, from the end of March 2020 to January 2022 these interviews were instead carried out over the telephone by the same service research assistant. Interviews were scheduled to coincide with the times people attended for treatment at EDTS to minimise disruption.

## **Impact of COVID-19 Pandemic on EDTS and Treatment Interventions**

EDTS became active in December 2019. The service was severely impacted by the COVID-19 pandemic which led to a range of restrictions coming in from 23 March 2020.

Injectable opioid treatment was suspended for a period of 6 weeks shortly after the restrictions became active. However all of the individuals maintained daily contact with EDTS throughout this period and DAT was recommenced as soon as possible.

A further consequence of infection prevention control measures and social distancing rules within the service was the impact on the initial referral model which was designed to recruit up to 20 people in the first year of service and up to 40 by the end of the second year. COVID-19 restrictions meant this was not possible as logistically those receiving a service from EDTS could not attend the clinical area at the same time, and this restricted the capacity of the service. Subsequent easing of social distancing restrictions allowed further recruitment and broadening of the inclusion criteria to consider people in any part of the ADRS system.

On reading the evaluation results the reader must keep in mind that any observed changes could be due to the EDTS intervention or the impact of COVID-19 and consequent control measures (or a combination of these).

## Case vignettes of people who were referred to EDTS

The following case vignettes are presented to describe a variety of experiences that are frequently encountered by people who are part of EDTS. The case vignettes are not based on any individual but are intended to reflect the experience of a range of people who have received a service from EDTS.

### Thomas

Thomas is in his late 40s. He started taking substances at the age of 12, initially smoking cannabis and using stimulants. Thomas moved on to smoking heroin at the age of 15 and then to injecting heroin at the age of 19. He first sought help from drug treatment services at 25 and describes being in and out of drug treatment services for the past 15 years which was further complicated by long periods of homelessness and several times in prison. He has stayed in a few different homeless accommodations but often he sleeps outdoors. Thomas sadly lost his parents in his early 30s and he struggled to cope becoming more and more isolated. All his friendship group also took substances and he found it difficult to stay in drug treatment services.

Thomas had been in contact with various health and social work services over the years and was given a drug treatment testing order which didn't work out for him. Thomas said he would beg in the city centre and when finances were a struggle he would shoplift in order to make money. Despite contact with statutory services, Thomas had never claimed any benefits or had a secure income source and Thomas disclosed that he felt the greatest sense of stability when he was in custody.

Thomas had experienced several non-fatal overdoses in the past and attributed this to an increase in street benzodiazepine use, so has tried to cut back. His most significant health issues were largely in relation to abscesses and infections from injection sites. He would hold off getting his wound treated and had a couple of stays in hospital as a result. Thomas's life is also impacted by anxiety and depression and this affects him in many of his day to day activities and his self-care.

Thomas hopes that getting treatment from EDTS will help him start on the road to becoming abstinent. That is his goal to get his own tenancy which he is able to keep for the long term. He also wants to start treatment for his hepatitis C with the help of EDTS staff, something he has been worried about but not felt able to deal with since he was diagnosed.

## **Joanne**

Joanne is in her early 30's and has spent most of her life sleeping outdoors, staying with friends a night or two or living in hostels. Joanne witnessed regular parental substance use and had an allocated children and families social worker until she was 16. Joanne started drinking alcohol and smoking cannabis at the age of 11 and begin injecting heroin at 14, having smoked heroin regularly for a few months before. Joanne was linked into alcohol and drug treatment services and had a stay in residential rehabilitation for a while but didn't complete her stay as she found it difficult to be away from her family at that time. She was linked into community drug treatment services and has been on OAT for a while, missing her medication for periods at a time and she feels that it hasn't worked for her, nothing had improved.

Joanne had frequent contact with police and had convictions for criminal damage and robbery in the past but most prison sentences spent were a result of non-compliance with criminal justice orders. Joanne has experienced physical and sexual assaults but has never had any counselling for this or had been able to process this safely. Joanne did have contact with psychiatric services at various times and she told us she had been diagnosed with a personality disorder and severe depression but was not on a long-term treatment plan. Joanne would go through periods of significant self-harm and intentional overdose.

Joanne mainly injects heroin and cocaine but will take any substance available and has had unintentional overdoses as a result. Joanne has had some short stays in residential crisis treatment in order to stabilise but when this is complete she goes back into the same level of substance use as before. Joanne was really interested when her care manager told her about EDTS and DAT. Initially she worried about the commitment to attending the service twice a day but wanted to try something different and has built up a good relationship with EDTS staff who are linking her into the different services that can work with Joanne to achieve her goals. Joanne's main goal is to obtain and maintain her own tenancy.

# Results

## Total Number of Referrals to EDTS

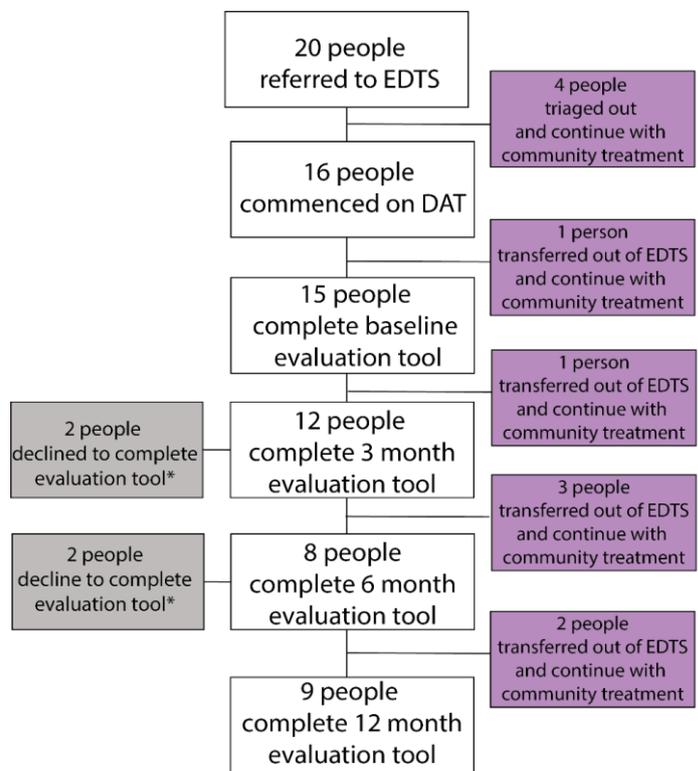
From December 2019 to December 2020, 20 people were referred to EDTS. After screening and assessment 16 people were commenced on DAT. Four people were assessed as not being eligible for the service.

In total, 15 (93%) of those who were commenced on diamorphine completed the baseline evaluation. One person did not want to continue DAT and was triaged back to community alcohol and drug treatment services in Glasgow City.

The evaluation focusses on those who completed 12 months of treatment as no further information was available once participants had left the service. It draws in particular upon data from the 9 individuals who completed 12 months of treatment and engaged with service evaluation questionnaires.

Two people who were part of the baseline cohort but who were subsequently transferred out of the service died within a year of discharge from EDTS. A brief description of outcomes for the individuals who left the service is available on Appendix A.

Figure 1 - Evaluation Pathway, new referrals from December 2019 – December 2020



\*at different time points people may have declined to complete the evaluation tool but agreed to take part at a later stage.

## Recruitment and Baseline Profile of EDTS Cohort

Most (66%) of those within the cohort were male. The mean age was 38.5 years, and all had experienced homelessness in the prior six months. All the cohort had been unemployed in the six months prior to engaging with EDTS.

**Table 2 – EDTS cohort characteristics at baseline**

Male Gender (%)	66
Age, years (mean)	38.5
Unemployed in the last 6 months (%)	100
Homeless in last 6 months (%)	100
Regular drug use, years (mean)	24.8
Injecting drug use in the past 6 months (%)	100
HIV +ve (%)	20
Hepatitis C RNA +ve (%)	47
Ever in prison (%)	100
	<i>Once</i>
	13
	<i>2-5 times</i>
	20
	<i>6-9 times</i>
	33
	<i>More than 20 times</i>
	33

All of the cohort had injected in the six months prior to engaging with the service and all had reported being in prison at least once since first injecting (with a third reporting more than 20 different incarcerations). One in 5 of the cohort were HIV positive, and just under half (47%) were HCV positive.

Service related data showed that 80% of all referrals into EDTS came from the homeless addiction team, and a smaller number of referrals from the City Centre (Glasgow) Outreach Team (13%) and the Acute Addiction Liaison Service (7%). Over a quarter (27%) of those referred into EDTS commenced treatment following a stay within the Glasgow Drug Crisis Centre or the Stabilisation Unit.

## Comparison of the EDTS Cohort Baseline Characteristics with Other Studies/Research

There is well developed evidence about the efficacy of DAT within international literature<sup>3</sup>. In DAT was first studied within a UK context through the Randomised Injectable Opioid Treatment Trial' (RIOTT). RIOTT was a randomised controlled trial which examined the role of treatment with injectable opioids (methadone and heroin) for the management of heroin dependence in patients not responding to conventional substitution treatment. The RIOTT trial found significant benefits for the patients within the heroin assisted group in comparison OAT groups<sup>4</sup>.

Despite similar eligibility criteria, there were differences between the baseline characteristics of the EDTS cohort and the patient group who were part of RIOTT. For example, the length of drug use was longer within the EDTS cohort (24.8 years vs 17.7 years) as was the overall time spent in treatment (14.1. years vs 10.5 years), and the EDTS cohort reported a higher use of cocaine and benzodiazepines (87% vs 42% and 40% vs 30% respectively). Moreover, all the EDTS cohort had been in prison at some point in their lives, with a third having been in prison more than 20 years, compared to just 16% in the RIOTT cohort. All those in the EDTS cohort were homeless at baseline (likely due to the EDTS eligibility criteria and referral pathways) compared to just under a third of the RIOTT cohort.

Caution must be taken when comparing the percentages as there is a large difference in the number of people and the methods used within the two groups, with a much larger group in the RIOTT cohort (n=43) compared to the EDTS cohort (n=15).

**Table 3 - RIOTT and EDTS Cohort Baseline Comparison**

	<i>RIOTT baseline (n = 43)</i>	<i>EDTS Baseline (n = 15)</i>
<b>Opiate (RIOTT) / Drug Use (EDTS)</b>		
Length of use (years)	17.7	24.8
<b>Previous treatment for drug use</b>		
Length in treatment (years)	10.5	14.1
<b>Regular use in past 30 days</b>		
Regular use of cocaine or crack cocaine	42%	87%
Benzodiazepine	30%	40%
<b>Homeless in the last 6 months</b>		
Yes	32%	100%
<b>Number of times in Prison</b>		
Never	35%	0%
20+ times	16%	33%

There were also differences between the EDTS cohort and those who took part in Needle Exchange Surveillance Initiative (NESI) survey, which a national survey funded by Public Health Scotland to measure and monitor the prevalence of blood-borne viruses (hepatitis C and HIV) and injecting risk behaviours among PWID in Scotland. The information in table 4 highlights the potentially higher severity of complex needs amongst the EDTS cohort compared with the GGC NESI cohort. However as with the comparison with the RIOTT cohort, caution should be applied when comparing the percentages as there is a large difference in the number of people and the methods used within the two groups and the purpose of the data collection is different.

Table 4 NESI Cohort - GGC 2019-20 Current PWID (injected in last 6m) and EDTS Cohort

	<b>NESI GGC</b>	<b>EDTS Baseline</b>
<b>Number of participants</b>	715	15
<b>Homeless in the last 6m</b>	32%	100%
<b>Unemployed</b>	25%	100%
<b>Average daily health score (n/100)</b>	45	43
<b>Skin and soft tissue infection in the last year</b>	19%	73%
<b>Overdose in the last year</b>	22%	53%
<b>Drugs injected in last 6 months (of PWID who injected in last 6 months)</b>		
<i>Heroin</i>	85%	100%
<i>Cocaine</i>	54%	93%
<i>Benzodiazepines (e.g. valium, 'blues', etizolam, etc)</i>	2%	0%
<b>Primary injection site in last 6 months - Groin</b>	41%	73%
<b>Injected in a public place in last 6 months</b>	23%	93%
<b>Number of people usually inject with:</b>		
<i>None (I normally inject on my own)</i>	42%	27%
<i>One person</i>	35%	27%
<i>2-3 people</i>	12%	40%
<i>4 or more</i>	2%	7%
<b>Average weekly income in last 6 months</b>	£188	£400
<b>Income from illegal sources in last 6 months</b>	18%	60%
<b>Average amount of money spent on drugs in last 6 months</b>	£110	£456
<b>Experienced stigma in last 6 months as a result of drug use</b>	64%	87%

A comparison of the EDTS cohort and the GGC NESI cohort is as follows:

- There was a higher self-reported prevalence of homelessness (100% vs 32%) and unemployment (100% vs 25%) within the EDTS cohort compared to NESI.
- However, the NESI cohort reported much less in the way of soft tissue infections (19% vs 73%) and overdose incidents in the past year (53% vs 22%).
- Self-reported average daily health score (out of a possible 100) was similar between the two cohorts (45 /43).
- In terms of drug use the proportion of those who had injected heroin and who had injected cocaine was slightly higher in the EDTS cohort (100% vs 85% and 93% vs 54% respectively).
- In the EDTS cohort more people injected with others (74%) than in the NESI cohort (49%) and a large majority (93%) of the EDTS cohort had injected in public in the previous 6 months compared to 22% within the NESI cohort.
- The average weekly income was also notably higher amongst the EDTS cohort (£400 vs £188) and more was spent on drug consumption (£456 vs £110) with an increased likelihood of obtaining income from illegal sources (60% vs 18%) or frequent begging to

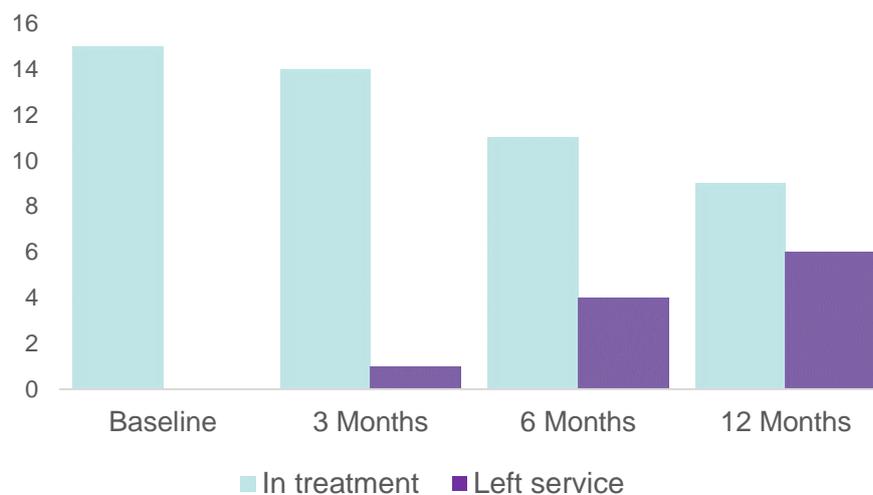
maintain the level of expenditure (see figure 19). This would be consistent with more severe drug dependency.

- The EDTS group also reported experiencing higher levels of stigma because of their drug use than the NESI cohort (87% vs 64%).

### EDTS Service Engagement and Prescribing

From the number of people in treatment at baseline (n=15), 14 of the cohort were still in treatment with EDTS at the three-month stage.

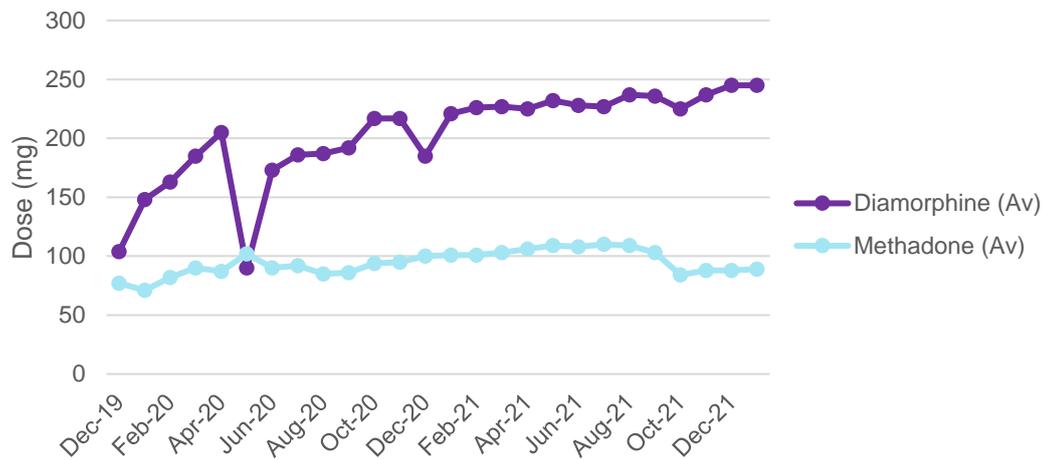
Figure 2 - Retention in Service



At the six month stage 11 people remained in treatment and at 12 months nine people were still in treatment. There were no unplanned discharges from EDTS and all of those who left treatment before the 12-month stage subsequently engaged with community opioid substitute treatment services.

Figure 3 shows the average individual diamorphine and methadone dose provided by EDTS from December 2019 to February 2022.

**Figure 3 - Average individual Diamorphine and Methadone doses by Month, Dec 2019 - Jan 2022**



The average dose of diamorphine (mg) dispensed within the service increased over time and was comparable to RIOTT and international literature, whilst the average amount of methadone (in ml) dispensed remained largely stable throughout with all methadone doses at therapeutic levels.

The impact of the cessation of injectable opiate treatment due to COVID-19 can be seen between April and May 2020, when there was also a small increase in the average amount of methadone dispensed. Trayner et al (2022)<sup>6</sup> found the same effect at national level.

### Adverse Events In-Service

Datix is the reporting system for recording clinical incidents or ‘adverse events’ within NHS GGC. It allows for the sharing of details of incidents to allow for reviewing of systems and processes along with any learning which can contribute to improvement where necessary. EDTS staff use this system to record incidents.

A total of 22 datix incidents were recorded between December 2019 and February 2022. The majority (64%) of these incidents were categorised as minor. Two incidents were due to over-sedation which was managed within the service and did not require further medical intervention.

### Injecting Illicit Heroin and Cocaine

Figure 4 demonstrates the number of people included in the full cohort (n=15) who self-reported injecting street heroin and cocaine in the previous 30 days across the different time periods of the evaluation, including those who subsequently declined to participate further in the evaluation and those who had been discharged from treatment.

**Figure 4 Self-reported injecting of street heroin and cocaine in past 30 days – baseline cohort (n=15)**

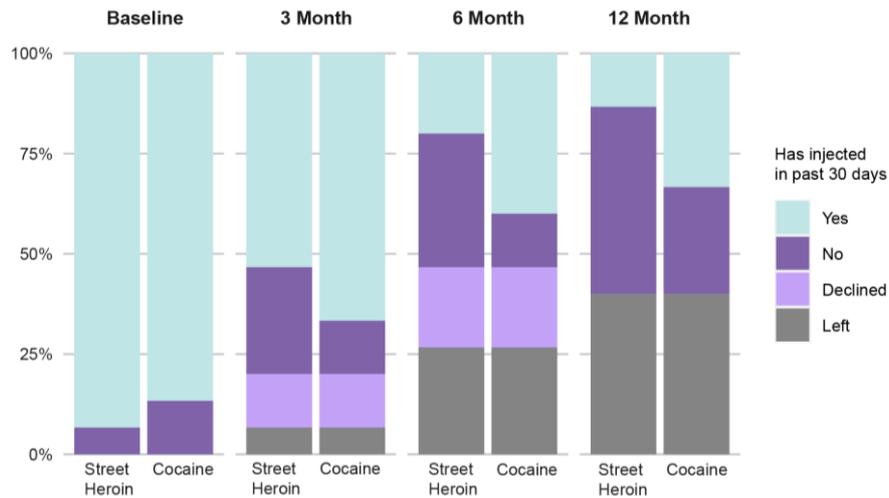


Figure 5 considers those who completed 12 months of treatment. At baseline, a majority of the cohort (89%) reported that they had injected street heroin in the previous 30 days which reduced to 22% at the 12-month evaluation period. Similarly, most people (89%) reported injecting cocaine in the previous 30 days at baseline which reduced to 44% at 12 months.

**Figure 5 Self-reported injecting of street heroin and cocaine in past 30 days. Completed 12m evaluation tool (n=9)**

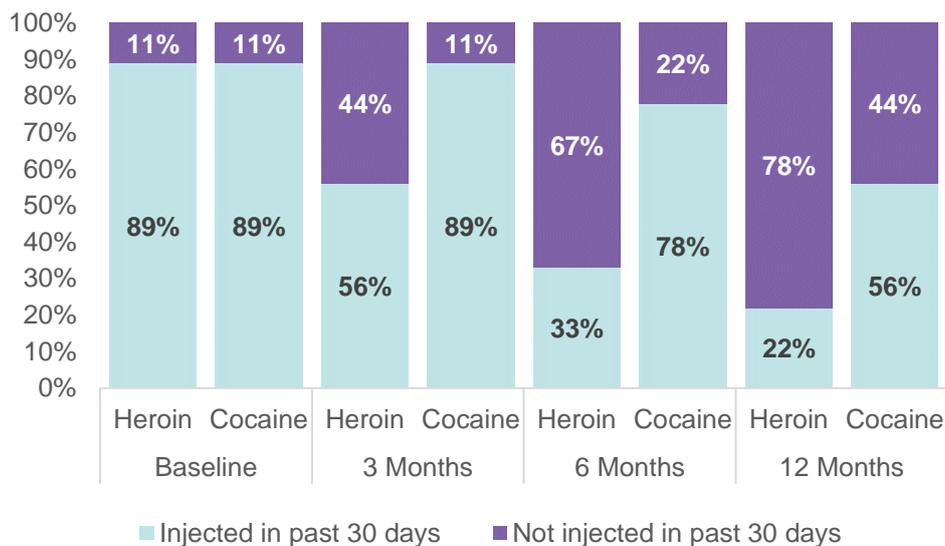


Figure 6 demonstrates the results for the labs screens undertaken at baseline and 3 month, 6 month and 12-month reporting periods. Overall the lab screen findings exhibit a similar pattern of use to the self-reported information and provide evidence that the use of street heroin decreased over time within this cohort. However from the lab data cocaine use remained the same throughout all time periods, in contrast to the self-reported data which indicated a reduction at the 6- and 12-month points.

**Figure 6 Lab Screen Results from evaluation reporting period – Street Heroin and Cocaine Detected. Completed 12m Treatment (n=9)**

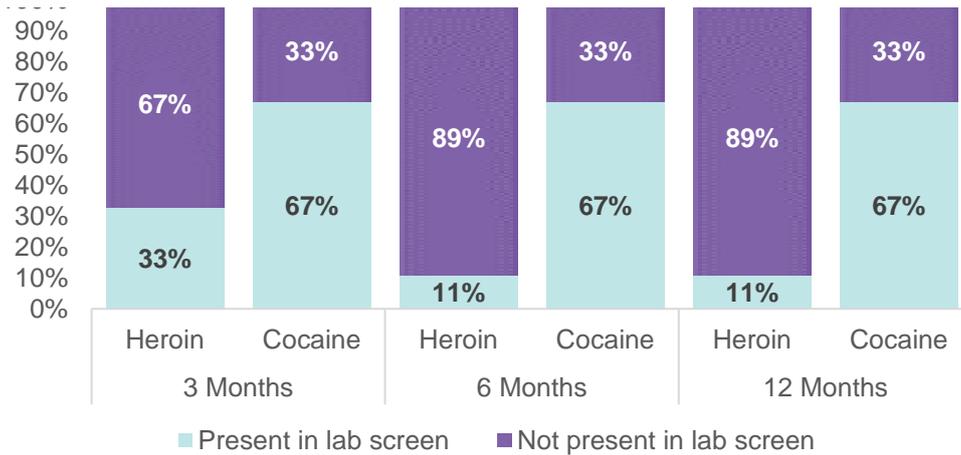


Table 5 sets out the results from the self-report evaluation tool. This shows a substantial reduction in the mean number of days in the past month on which street heroin was injected reported by people in the cohort (26.67 days to 1.89 days), and also in the mean amount of money spent on heroin in the past month (from £138.30 to £1.11).

**Table 5 - Self reported days of use and amount of use: Street Heroin and Cocaine amongst those who completed 12 months of treatment (n=9)**

<b>12 Month Complete - Number of days street heroin injected in the last 30 days (n)</b>			
	Min	Mean	Max
<b>Baseline</b>	0.00	26.67	30.00
<b>12 months</b>	0.00	1.89	10.00

<b>12 Month Complete - Amount of street heroin injected in the last 30 days (£)</b>			
	Min	Mean	Max
<b>Baseline</b>	15.00	138.3	300.00
<b>12 months</b>	0.00	1.111	10.00

<b>12 Month Complete - Number of days cocaine injected in the last 30 days (n)</b>			
	Min	Mean	Max
<b>Baseline</b>	0.00	21.67	30.00
<b>12 months</b>	0.00	6.44	20.00

<b>12 Month Complete - Amount of cocaine injected in the last 30 days (£)</b>			
	Min	Mean	Max
<b>Baseline</b>	0.00	121.1	300.00
<b>12 months</b>	0.00	23.33	100.00

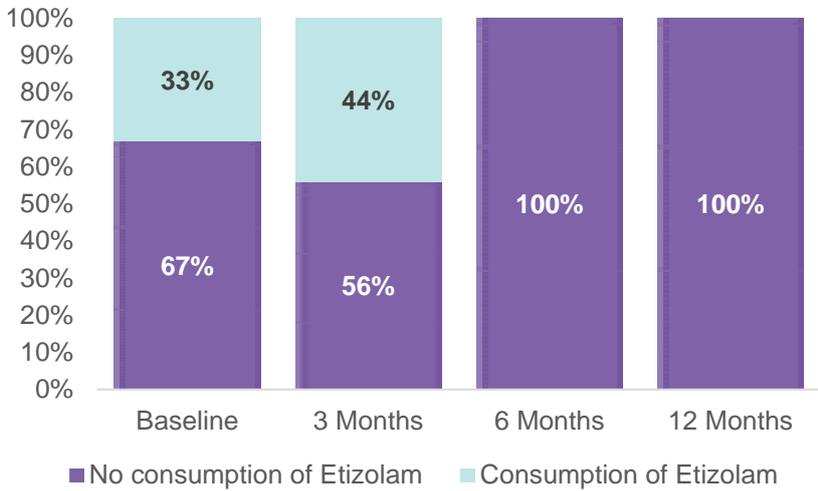
Similarly, the mean number of days on which cocaine had been injected reduced over time (from baseline mean of 21.67 days to 6.4 days at 12 months), although this degree of reduction

was less than for heroin. The mean amount spent on cocaine in the past month also reduced from £121.10 to £23.33.

**Oral Etizolam**

**Self-reported data show an initial increase in etizolam use at the 3-month stage, but no etizolam was reported at the 6- and 12-month stage.**

**Figure 7 Self-reported oral etizolam use in past 30 days. Completed 12m evaluation tool (n=9)**



The self-reported information was not reflected in the lab screen results with 78% of the cohort testing positive for etizolam at 6 months, reducing to a third at 12 months. This could be because people are not aware of what they are taking, and further investigation would be needed to clarify this. EDTS co-prescribes benzodiazepines if clinically appropriate with frequent medication reviews and liaison with the in-house pharmacy.

**Figure 8 Lab Screen Results evaluation reporting period - etizolam detected. Completed 12m Treatment (n=9)**

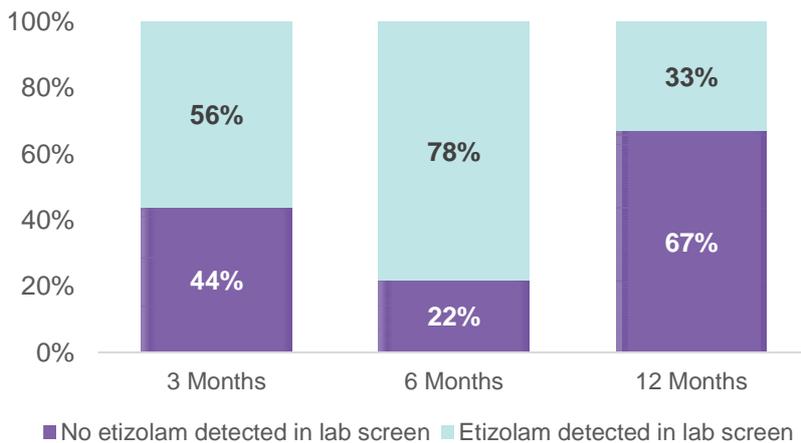
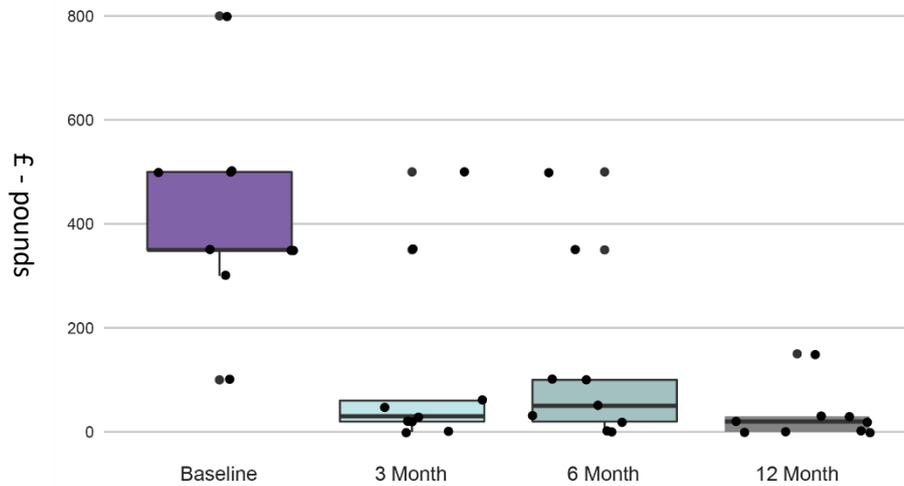


Figure 9 represents the average weekly spend on drugs from the self-reported data. The boxes at each time period within figure 9 represent the lower and upper quartile of the values (money spent) and the line represents the median of those values. At baseline, the average self-

reported weekly spend on drugs was around £350 with some individuals reporting spending up to £800 pounds a week in total. This reduced over time with much of the cohort spending well under £100 by 3-months into follow-up.

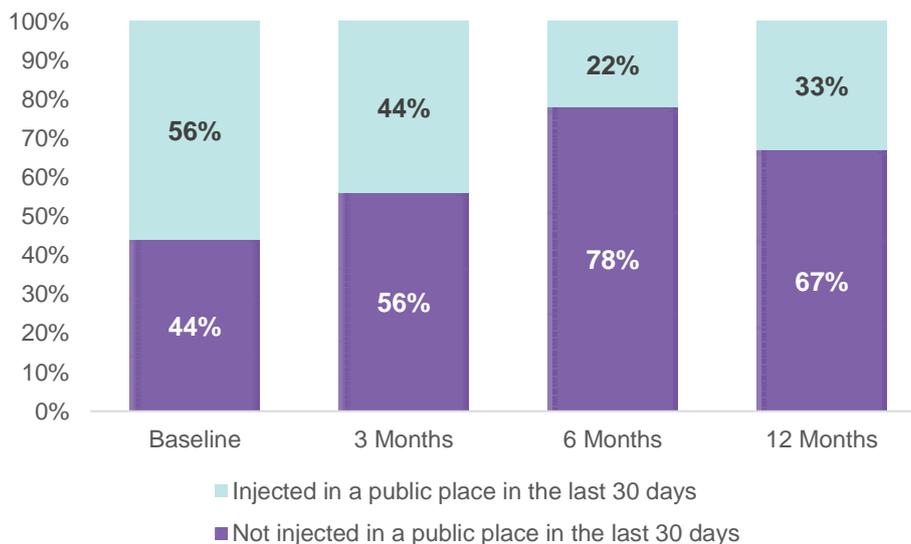
**Figure 9 Average weekly spend on drugs. Completed 12m Treatment**



### Public Injecting

At baseline, over half (56%) of the cohort self-reported injecting in a public place in the past 30 days, and there was a decrease in injecting in public by the cohort from baseline to 33% at 12 months. As both self-reported and lab confirmed street heroin use fell considerably, it is likely that the smaller change in public injecting is related to ongoing injection of cocaine for which there was no decrease in laboratory screening data.

**Figure 10 - Injected in a public place in the past 30 days**

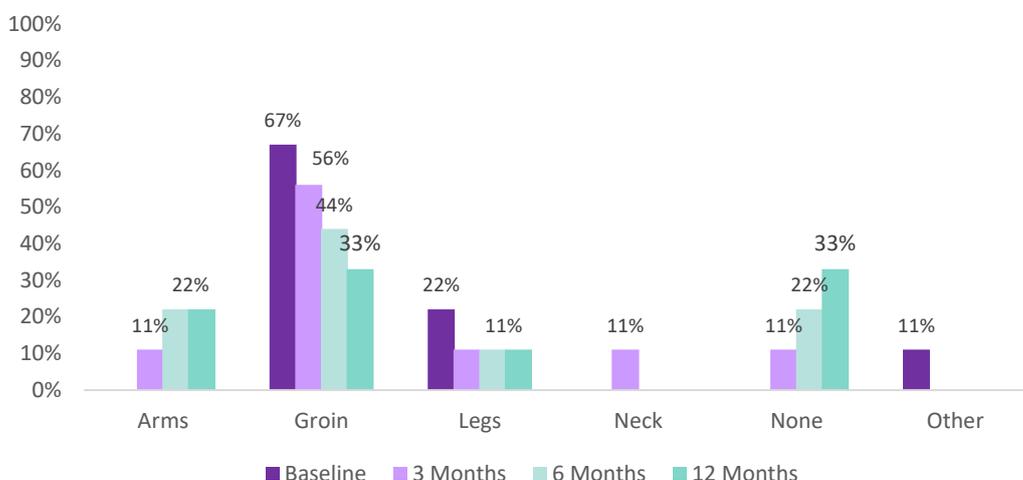


### Injecting Behaviour

The groin was the most common self-reported injecting site throughout the evaluation period however this notably reduced over time. Other injecting sites were much less common. From

the self-report information available it would appear that there was overall fall in injecting, but those who continued to inject reduced the use of higher risk sites (groin, legs, neck) in favour of lower risk sites (arms).

**Figure 11 Most common injecting site in past 30 days.**



### Alcohol Use

Self-reported alcohol use by the cohort was variable at different time periods. The mean number of weekly units consumed reduced, although the maximum units consumed increased.

**Table 6 - Alcohol units (Completed 12m treatment, n=9)**

	<i>Alcohol Units</i>		
	Min	Mean	Max
<i>Baseline</i>	0	3.7	13
<i>12 months</i>	0	2.6	20

It is unclear whether DAT made an impact on alcohol consumption by the EDTS participants or if this reflects the wider increase in home drinking over the period of COVID-19 restrictions, or a divergence from street drugs. Further study would be required to explore this.

### Health

There were fewer self-reported instances of abscess or open wounds over time with no-one reporting them at 12-month follow-up despite two-thirds (67%) reporting them at baseline. EDTS provides enhanced care and treatment to those using the service with access to nursing staff for wound and dressing care along with guidance on safer injecting practices (for example the use of the vein finder equipment), which may have had an effect on a lower incidence of abscess and injection site wounds.

**Figure 12 Self-reported abscess or open wound at injection site. Completed 12m Treatment (n=9)**

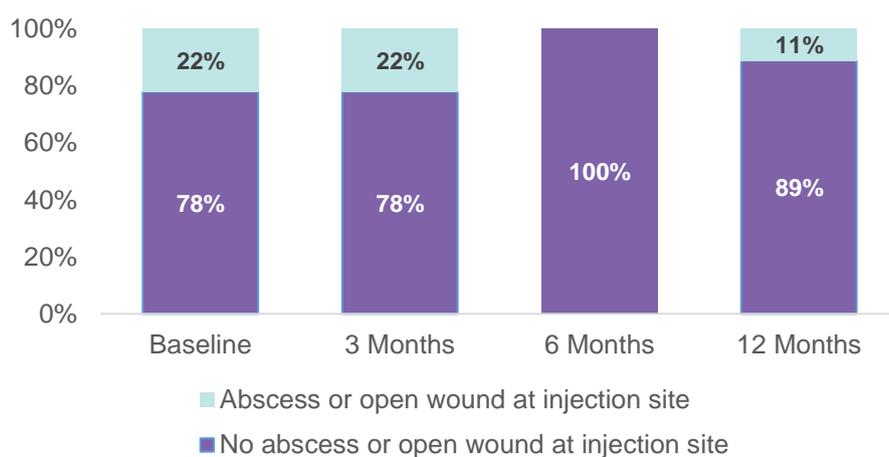
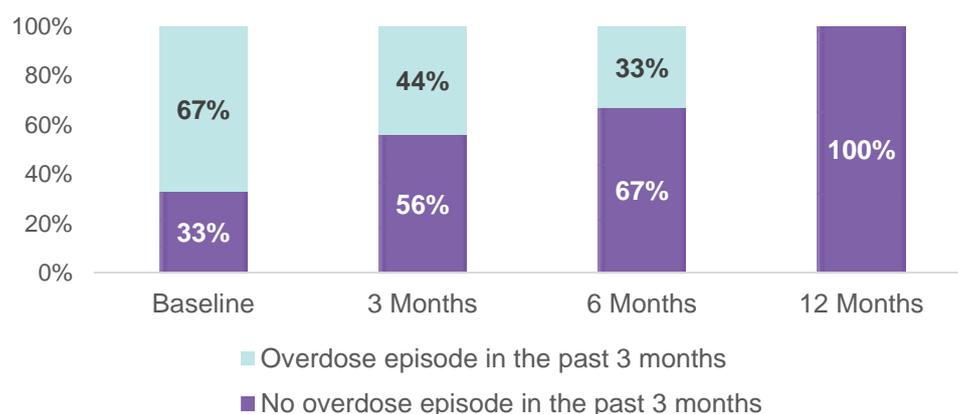


Figure 13 indicates that instances of self-reported overdose in the previous three months also reduced over time from 22% at baseline to 11% at 12 months. This aligns with the findings from emergency department (ED) data (see figure 14).

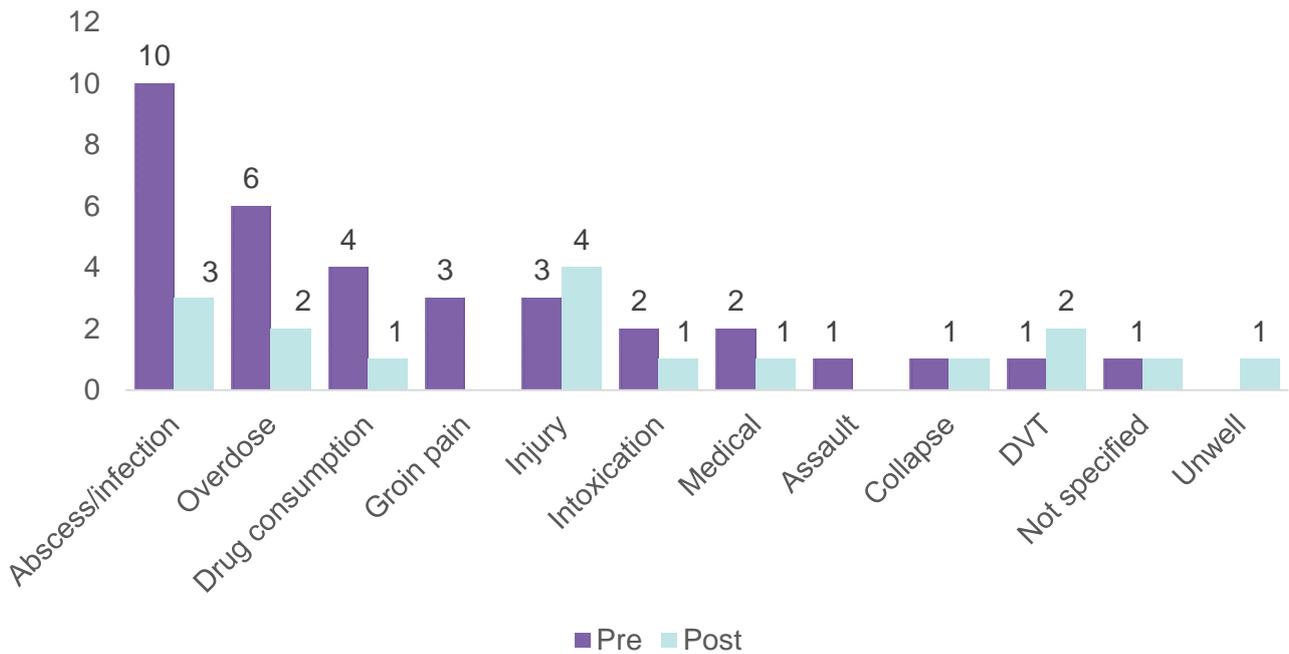
**Figure 13 Self-reported overdose episode in the past 3 months. Completed 12m Treatment (n=9)**



### Emergency Department Presentations

Figure 14 shows the comparison of ED presentations one year before and one year post commencing on DAT for the EDTS cohort, derived from data linkage. Overall presentations to emergency departments reduced from a total of 37 presentations in the year before DAT to 17 in the year since DAT commenced, a reduction of over 50%. Presentations relating to overdose reduced by 31% whilst episodes relating to abscess and infection reduced by 70%, reflecting the self-reported trend in figures 12 and 13.

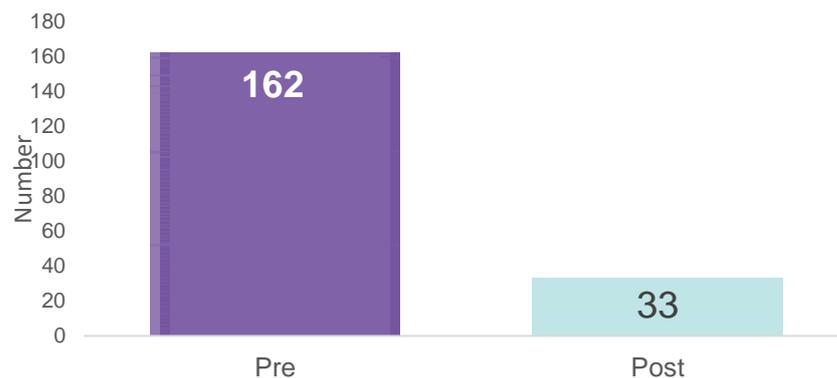
**Figure 14 ED Presentations 1-year pre and 1 year post DAT commencing. Completed 12m Treatment (n=9)**



### Inpatient Episodes and Bed Days

Data linkage also revealed that the total number of inpatient episodes decreased for the EDTS cohort when comparing one-year pre and one year post DAT being commenced, from 22 to 8 for those retained in service and from an average of 3.75 inpatient episodes per person to 2.75. Overall, the total number of bed days from inpatient episodes reduced from 162 in the year prior to commencing diamorphine treatment to 33 in the year after commencing DAT, a 38.5% reduction.

**Figure 15 Inpatient Bed Days 1-year pre and 1 year post DAT commencing. Completed 12m Treatment (n=9)**



The mean number of bed days decreased for those who remained in treatment for 12 months. The range of days for an inpatient episode decreased from 1-68 days to 1-11 days (table 7).

Further information relating to cost savings within acute services is included with the Health and Social Care Cost Savings section of the report (table 10).

**Table 7 - Summary - Inpatient bed days. Completed 12 months treatment (n=9)**

Bed Days	Min.	Mean	Max.
Pre	1.0	10.1	68.0
Post	1.0	4.7	11.0

### Self-reported health

Self-reported health was measured using the validated EQ 5D-5L tool which measures five dimensions of health: mobility, self-care, usual activities, pain and discomfort, and anxiety and depression on a scale of levels from 1 (no problems) to 5 (extreme) problems.

The output of the EQ-5D is a 5-digit health status profile that represents the level of reported problems on the five EQ-5D health dimensions. These profiles are referred to as 'EQ-5D health states' and are given a numerical value as an index score, with a higher score indicating better health. Visual analogue rating (VAR) of health is from 0 (the worst imaginable health) to 100 (the best imaginable health).

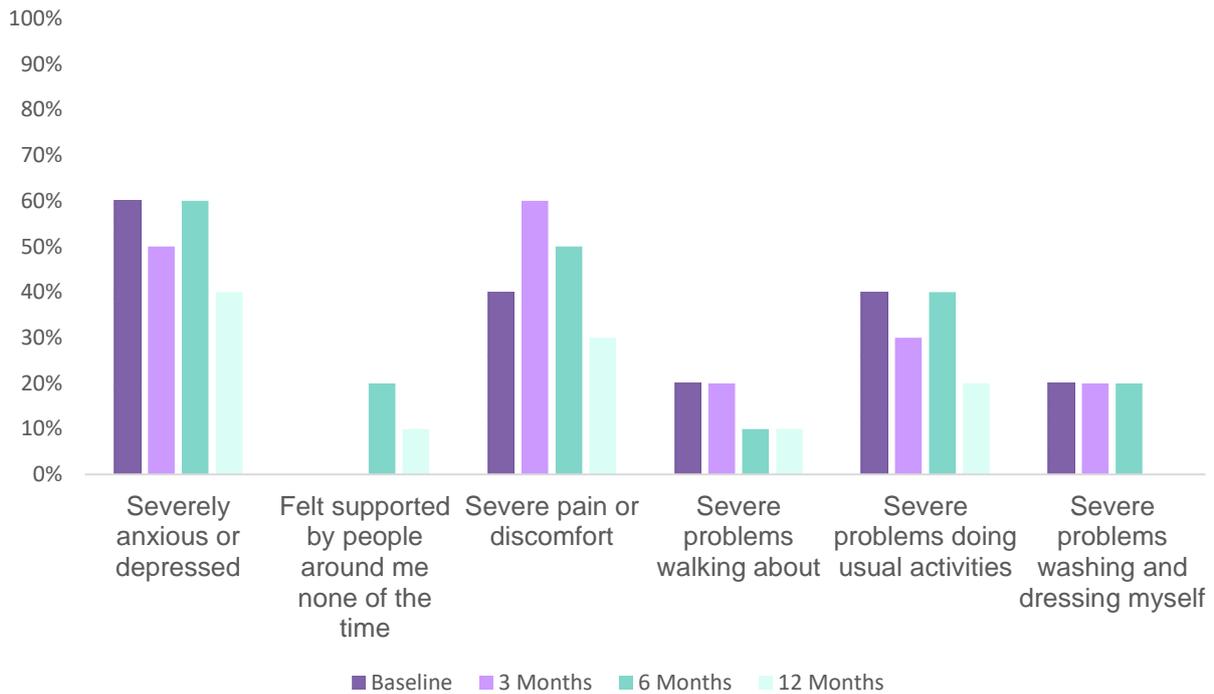
EQ 5D-5L scores improved from a mean index score of 0.23 at baseline to 0.35 at 12 months, and likewise the mean VAR increased from 41.4 at baseline to 55.0 at 12 months (table 8). Again, the impact of COVID-19 should be taken into consideration as restrictions will have had an impact on the person's abilities to carry out their usual activities and to getting support out-with EDTS from other services and from peers.

**Table 8 - EQ 5D Mean Index Score and VAR for those who completed 12m Treatment (n=9)**

	<i>Mean Index Score<sup>2</sup></i>	<i>Mean VAR<sup>3</sup></i>
<i>Baseline</i>	<i>0.23</i>	<i>41.4</i>
<i>3 Month</i>	<i>0.16</i>	<i>49.4</i>
<i>6 Month</i>	<i>0.31</i>	<i>60.0</i>
<i>12 Month</i>	<i>0.35</i>	<i>55.0</i>

There was a reduction across most severe problems in mental health, mobility and doing usual activities and self-care in washing and dressing when comparing the baseline and 12 month reporting period (figure 16). The perception of having no support increased at 6 months from baseline and was also still noted, although reduced, at 12 months from the baseline period, this may have been an impact of COVID-19.

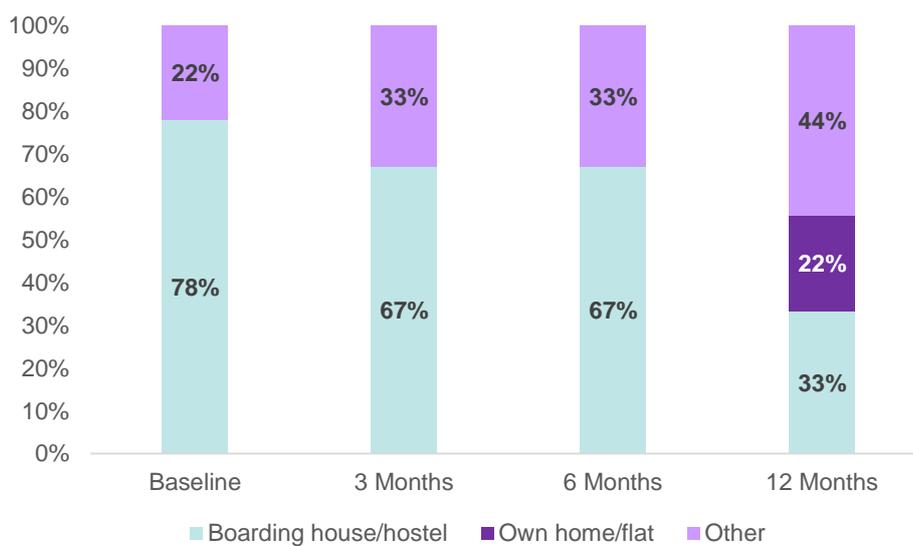
**Figure 16 EQ5L Severity of health problems**



### Homelessness and Accommodation

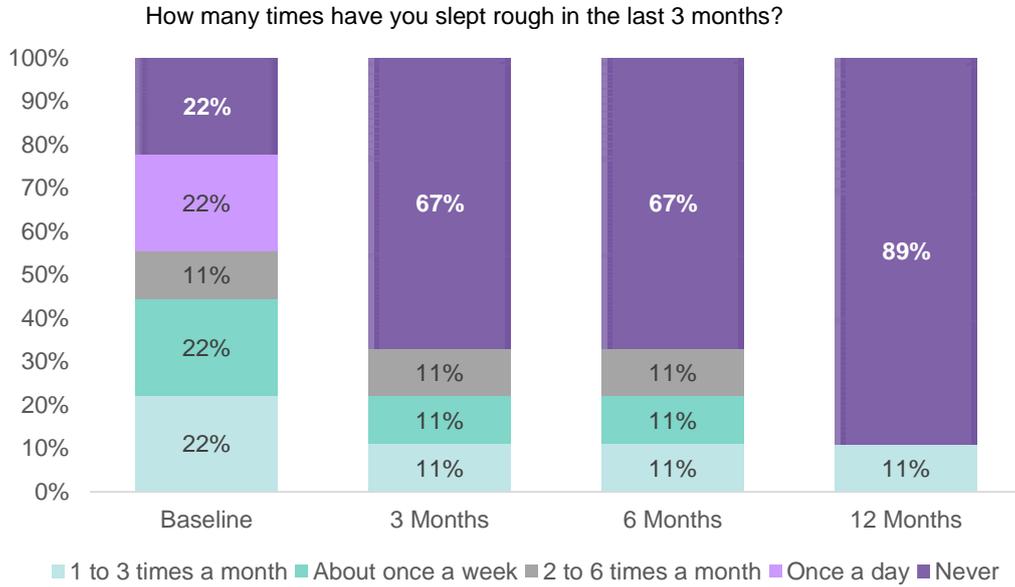
At baseline, all individuals had self-reported experience of homelessness in the previous 3 months and most individuals resided within a boarding house / hostel at the time of the evaluation. However, over time, some of the cohort moved on from boarding house or hostel accommodation to other accommodation such as supported accommodation, temporary furnished flat or their own accommodation.

**Figure 17 Lived in homeless accommodation in last 3 months. Completed 12 months Treatment (n=9)**



Self-reported rough sleeping also reduced over the course of treatment, from baseline where just 22% reported having never slept rough in the past 3 months to the vast majority (89%) reporting the same at 12 months.

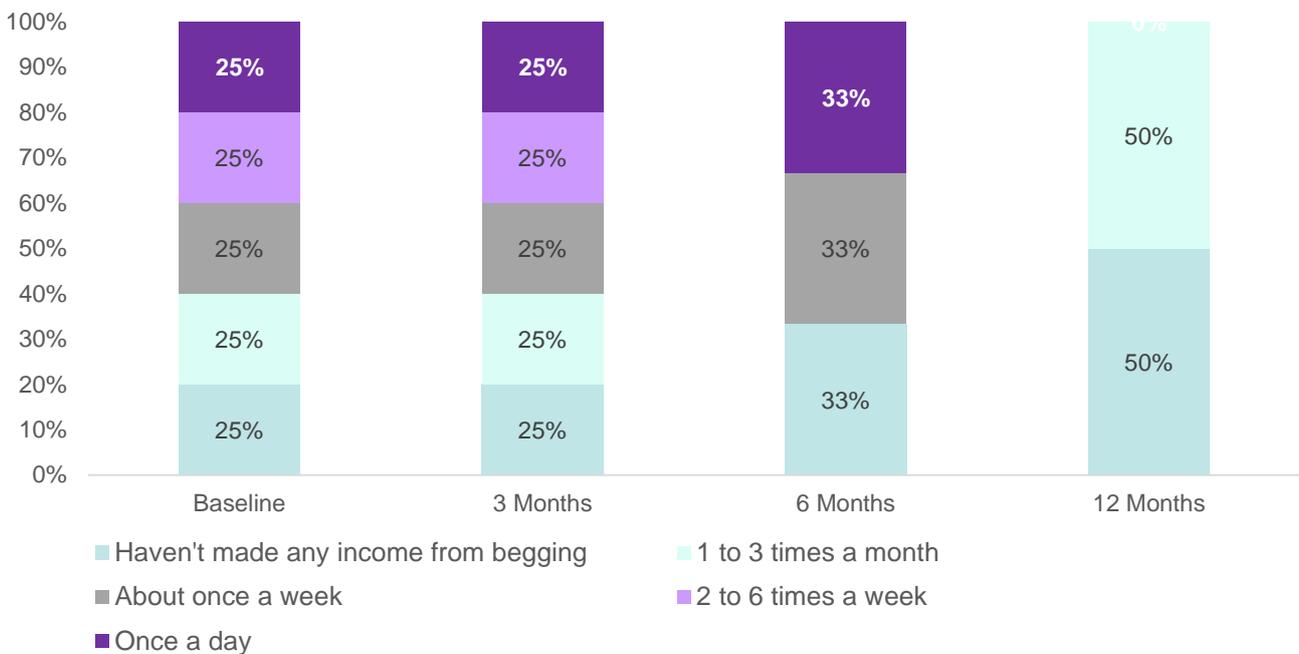
**Figure 18 – Rough sleeping. Completed 12 months treatment (n=9)**



### Begging

There was also a notable decrease in begging from a quarter of the cohort at baseline to half of the cohort at 12 months reporting not begging at all in the last 3 months (figure 19). Those who did report begging reduced the number of times they begged.

**Figure 19 How often did you make an income from begging. Completed 12 months treatment (n=9)**



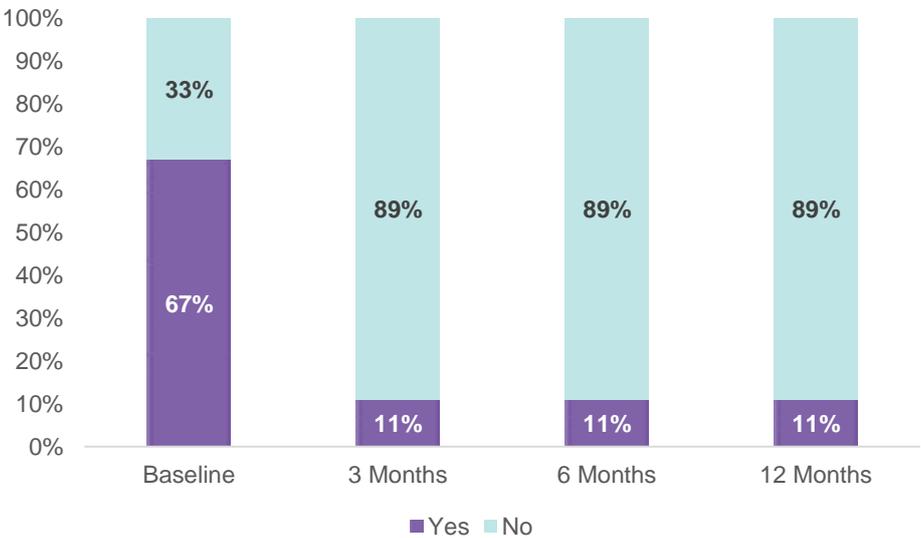
On average, the number of months begging reduced from a majority reporting that they would beg at least once in every month of the past three months at baseline to just one month in three at the 12-month period.

The findings reported in figures 17, 18 and 19 could have been impacted by local and national COVID-19 policy, with Glasgow City efforts to move people experiencing homelessness into accommodation during the pandemic. However, this period of transition would also have been aided by the social support and access to housing / welfare support provided by EDTS. From the eligibility criteria we know that the people in EDTS will have been in contact but not necessarily engaged with housing and welfare services in the past as part of community interventions. Furthermore EDTS staff intensively supported individuals to engage with such services.

### Income from Illegal Sources

There was a decrease in the number of individuals who self-reported income from illegal sources in the previous 30 days. At 12-month follow-up 11% reported illegal income in the past 30 days compared to a majority (67%) at baseline.

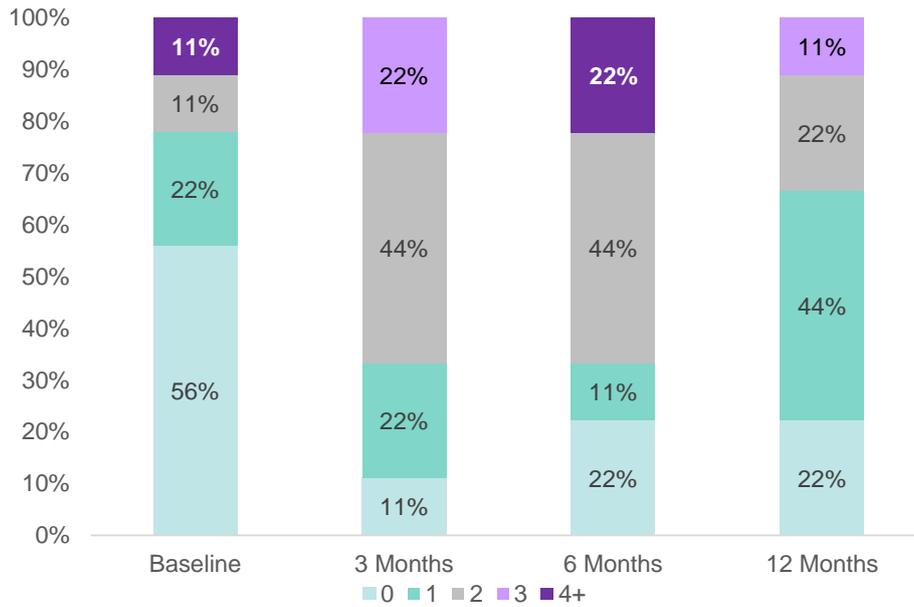
Figure 20 Self-reported income from illegal sources. Completed 12m Treatment (n=9)



### Social Functioning and Connections

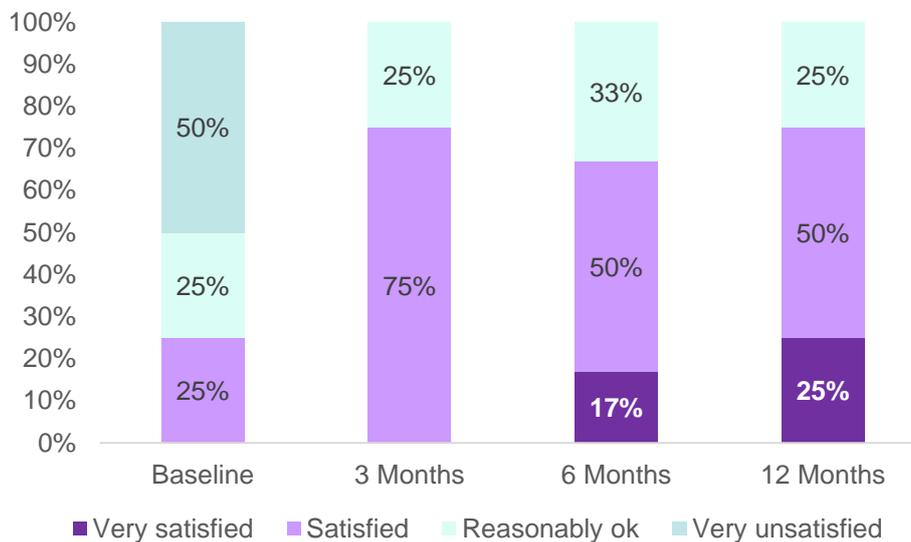
The number of close friends reported by those who completed 12 months of DAT increased over time, from over half (56%) reporting having no close friends to 78% reported having at least one close friend at 12 months (figure 21).

**Figure 21 Self-reported number of Close Friends (n=9)**



Those who completed 12 months of DAT also reported increased satisfaction in support from their friends. The data suggest that engaging in EDTS may have supported people to build meaningful friendships.

**Figure 22 Self-reported support from friends (n=9)**



A series of questions were asked within the self-report evaluation using the social functioning tool which forms part of the opiate treatment index<sup>9</sup>. Within the social functioning tool, a lower score indicates better social functioning, and table 9 demonstrates a slight improvement in the mean social functioning score for those in EDTS from baseline to the 12 month follow up period.

Again, consideration should be given to the restrictions in social mobility because of COVID-19.

**Table 9 - Social Functioning - Mean Score (n=9)**

	Mean Social Function Score
Baseline	24
12 Months	21

### Health and Social Care Cost Savings

An analysis of total costs of health services included emergency department presentations, inpatient episodes / bed days and outpatient episodes from the information presented in the earlier Health section in the report. The largest reductions in cost can be seen in those who completed one year of treatment; however a reduction in costs was also seen in the group who had not completed one year of treatment (table 10). Overall there was a 50% decrease in the cost post- DAT.

**Table 10 - Acute Services Costs - included ED, IP and OP Episodes, whole cohort**

	Completed 12 months	Did not complete 12 months	Total
One Year Pre-DAT commencement	£134,624	£124,752	£259,376
One Year Post DAT commencement	£39,121	£90,464	£129,585
Difference	£95,503	£34,288	£129,791
% difference	70.9% decrease	27.4% decrease	50.0% decrease

Source: CostsBook 2020 (April 2019 to March 2020) - Scottish health service costs Public Health Scotland

### Prison and Police Information

It is anticipated that a supplementary report on drug-related crime from Police Scotland and prison-related data from the Scottish Prison Service will be provided in due course.

### Limitations to the Evaluation

There are a number of limitations to this evaluation, namely the small sample size which was partly a result of the recruitment model and then confounded by COVID-19 restrictions. As a result it was not possible to carry out a more advanced statistical analysis of the evaluation results. Furthermore, this evaluation does not have a control/comparison group which would have assisted in better understanding the impact of the intervention. Furthermore the data has been presented as percentages in almost all of the results to protect deductive disclosure/anonymity.

## Conclusion

The evaluation concludes that **Diamorphine / Heroin Assisted Treatment was implemented safely and effectively** as a treatment option for people with heroin dependency in Glasgow City. The service model and co-location with key health and social care services was beneficial in realising the “enhanced” service offer to people. Any future decisions on the service model should, however, also be informed by the output of the CSO funded independent evaluation which explored the benefits and challenges of the service model in more detail.

This NHSGGC-led service evaluation focused on patient outcomes. We conclude that for those who have completed 12 months of treatment, the **outcomes were largely those expected from the substantial evidence base for Diamorphine / Heroin Assisted Treatment**, namely:

- Routine laboratory drug screening indicated a reduction in street heroin use, and in self-reported street heroin both in terms of the number of days injecting and the amount injected.
- Routine laboratory drug screening indicated continued cocaine use however self-reported cocaine use reduced for the number days and amount injected.
- Routine laboratory drug screening indicated a reduction in etizolam (street benzodiazepine) use. Self-reported etizolam use also reduced but more so than the laboratory results indicated.
- Self-reported health improved, with reductions in overdoses and public injecting.
- There were substantial reductions in presentations to Emergency Departments and admissions to acute hospitals.
- Homelessness and begging reduced with an improvement in social functioning including housing status.
- Self-reported illegal activity as a source of income reduced.
- Although most individuals continued to use street drugs in addition to those provided by EDTS, there was considerable improvement in their personal circumstances in relation to a number of health and social functioning outcomes. The extent of this varied between people, with profound positive change for some and less for others.
- The co-location with other relevant services was key in achieving an “enhanced” support and the inclusion of an onsite pharmacy allowed the co-ordinated supply of key

medication for the EDTS group, including treatment for mental health problems and blood borne viruses. These were important factors in achieving positive outcomes.

- There were low numbers of significant adverse events experienced in the service.

However, the evaluation also highlights that recruitment into the service was **adversely impacted by the COVID-19 pandemic**. Whilst the initial recruitment rate was promising prior to COVID-19, it was not sustained thereafter.

The evaluation also highlights the **complex needs** of the EDTS cohort compared to those from who participated in the RIOTT study or the NESI survey. The complex needs and extent of polysubstance use in the recruited population may explain the number of people who did not complete a full year's treatment. Despite the complexity and polydrug use, there were **no deaths of people retained in EDTS**, but 2 deaths in those discharged from EDTS.

Although the person centred outcomes look positive for those who completed at least a year of treatment and these themselves may justify the investment in EDTS, a cost-benefit analysis was incomplete due to lack of data on criminal justice outcomes. However, the very large reductions in ED and acute admissions (realising an estimated **70% reduction in cost to acute services** for those completing a year of treatment) are promising and suggest **the service could be economically justifiable** as well as clinically. The caseload at which the service provides as much savings as is spent on it may be calculable with more data.

A supplementary report on drug related crime from Police Scotland and prison related data from the Scottish Prison Service is anticipated in due course.

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## Appendix A

### Characteristics of those who left the service (before the 12 month evaluation period)

Most of those who left the service left before the 6-month evaluation period. There were equal numbers of male and females in the group who left treatment services and the average age was the same as those who remained in treatment.

There were no major differences between the two groups in terms of the onset of problem substance use and the length of time in treatment for drug related problems. Those who had completed 12 months in DAT had a slightly longer history of substance use over time and first started taking illicit substances at a younger age. There were also lower levels of positive laboratory results for illicit substances, with less street heroin and etizolam.

**Table 1a - Differences between those who stayed in treatment for 12 months (n=9) and those who left before 12 months (n=6)**

	Completed 12 months treatment	Did not complete 12 months treatment
Average age first started using illicit drugs	11	15
Average age at onset of problem illicit drug use	17	19
Average age first sought help	24	23
Average length of drug use	27	24
Average length of time in treatment (years)	14	15
Proportion of positive street heroin lab screens (total)	25%	34%
Proportion of positive cocaine lab screens (total)	80%	86%
Proportion of positive etizolam lab screens (total)	46%	69%

### Outcomes for those who Left the Service

Sadly, two individuals died whilst engaging with community treatment services who had been discharged from EDTS after the 12-month treatment point. All individuals were still attending community treatment services and receiving OAT one year post DAT.

From reviewing the acute information available for people who commenced DAT but did not remain in treatment, there were positive changes to some outcomes, such as demonstrated by table 1b which shows there was a slight decrease in the number of ED presentations in this group and a reduction in the number of inpatient episodes.

**Table 1b - Use of Acute Services – Episodes (n=6)**

Acute Episodes	1 year prior to DAT	In the year after starting DAT	change	%Change
ED Presentations	61	49	-12	-19.70%
IP Episodes	44	31	-13	-29.50%

Furthermore the overall bed days from inpatient episodes also slightly reduced as demonstrated in Table 1c.

**Table 1c Total number of bed days (n=6)**

	1 year prior to DAT	In the year after starting DAT	% Change
Total number of bed days	121	112	-7.40%

## Appendix B EDTS Eligibility Criteria

<b>Consent</b>	Patients must have the capacity to give informed consent.
<b>Residence</b>	Must be or be eligible to be patients of the Homeless Addiction Team.
<b>Age</b>	Over 18 years.
<b>Diagnosis of Dependence</b>	Based on NHS GGC ADRS ORT Guidelines
<b>History of Injecting Heroin Use</b>	Current injecting heroin use with a substantial history and evidence of ongoing drug related harms.
<b>Previous Treatment Attempts</b>	The expectation in normal circumstances would be a history of previous attempts at ORT at therapeutic doses with poor outcome.
<b>Psychiatric Condition</b>	No current condition, e.g. active psychosis, severe affective state that would preclude engagement and safe delivery of EDTS.
<b>Physical Condition</b>	No current condition, e.g. severe hepatic failure, severe renal impairment, severe respiratory disease that would preclude safe delivery of EDTS.
<b>Pregnancy</b>	Not pregnant, breastfeeding or planning to become pregnant.
<b>Concurrent Alcohol / benzodiazepine abuse</b>	Not at a level causing significant impairment or risk, or likely to cause instability within the treatment system.
<b>Treatment Requirements</b>	No predictable social, health or legal status that would prevent treatment completion, or disability that would prevent attendance, engagement of treatment or make treatment unsafe.

## Appendix C - RIOTT Comparison Table

	Injectable methadone (n=42)	Injectable heroin (n=43)	Oral methadone (n=42)	EDTS Baseline Group (n=15)
<b>Demographic indicators</b>				
<i>Age at randomisation (years)</i>	37.0 (7.0)	37.5 (6.6)	37.2 (5.9)	38.5
<i>Men (%)</i>	67%	86%	67%	67%
<b>Ethnic origin</b>				
<i>White</i>	95%	98%	95%	100%
<i>Black</i>	2%	2%	5%	0
<i>Mixed white/Asian</i>	2%	0	0	0
<b>Employment status</b>				
<i>Employed</i>	2%	2%	2%	0
<i>Unemployed / receiving sickness benefit</i>	98%	95%	93%	100%
<i>Other</i>	0	2%	5%	0
<b>Imprisonment</b>				
<i>Spent time in prison</i>	62%	77%	81%	100%
<i>Number of times in prison</i>	5.6 (5.5)	6.9 (7.3)	5.4 (7.9)	33% >20 times
<b>Treatment at baseline</b>				
<i>Optimised oral methadone</i>	38%	42%	38%	87%
<b>Previous drug use (NB figures for RIOTT are for opiate use and for EDTS are all drug use)</b>				
<i>Age of first use (years)</i>	20.6 (5.5)	19.3 (5.2)	20.6 (6.2)	13.6
<i>Length of use (years)</i>	15.9 (7.2)	17.7 (7.9)	16.0 (6.6)	24.8
<b>Injecting drug use</b>				
<i>Age at first use (years)</i>	24.0 (7.4)	21.4 (6.8)	23.6 (7.1)	18.4
<i>Length of use (years)</i>	12.4 (7.1)	15.6 (9.0)	13.0 (7.0)	20.6
<b>Previous treatment for drug use</b>				
<i>Age at first treatment (years)</i>	26.9 (7.1)	26.7 (6.3)	27.1 (7.5)	22.4
<i>Treatment for opiate use</i>	100%	100%	100%	100%
<i>Number of times in treatment</i>	4.1 (3.8)	4.7 (4.7)	4.5 (4.1)	n/a
<i>Length in treatment (years)</i>	9.5 (5.8)	10.5 (7.7)	9.5 (6.0)	14.1
<i>Abstinence-based residential rehabilitation</i>	50%	35%	38%	n/a
<i>Number of rehabilitations</i>	1.3 (0.7)	1.7 (1.8)	2.3 (2.9)	n/a
<b>Drug use in past 30 days</b>				
<i>Regular use of cocaine or crack cocaine</i>	43%	42%	43%	87%
<i>Heroin use</i>	100%	100%	100%	93%
<i>Number of days use</i>	27.0 (4.1)	28.0 (3.0)	27.5 (3.7)	28.2
<i>Crack cocaine use</i>	69%	79%	74%	n/a
<i>Number of days use</i>	15.0 (11.4)	13.2 (10.7)	14.2 (10.9)	23.8
<i>Benzodiazepine use</i>	31%	30%	43%	40%
<i>Number of days use</i>	6.2 (8.0)	5.3 (5.5)	9.7 (11.0)	20.3
<i>Alcohol use</i>	57%	44%	50%	47%
<i>Number of days use</i>	13.9 (10.4)	15.1 (10.6)	15.5 (11.6)	n/a

## Appendix D – NESI Comparison Table

	Current PWID (injected in last six months)	EDTS Baseline
N	711	15
<b>Section 1 – Demographics</b>		
<b>Gender</b>		
Male	75%	67%
Female	25%	33%
Unknown/missing	<1%	-
<b>Homeless in the last six months</b>		
Yes	32%	100%
No	68%	0%
Unknown	<1%	0%
<b>Current employment situation</b>		
Employed	5%	0%
Getting support into employment	2%	0%
Unemployed	25%	100%
Long term sick/disabled	64%	0%
Other	3%	0%
Unknown/missing	1%	0%
<b>Section 2 - Health</b>		
<b>Mobility</b>		
I have no problems in walking about	52%	13%
I have slight problems in walking about	14%	13%
I have moderate problems in walking about	18%	7%
I have severe problems in walking about	14%	60%
I am unable to walk about	<1%	7%
Unknown/missing	<1%	0%
<b>Self-care</b>		
I have no problems washing and dressing myself	64%	53%
I have slight problems washing and dressing myself	14%	13%
I have moderate problems washing and dressing myself	13%	7%
I have severe problems washing and dressing myself	8%	27%
I am unable to wash or dress myself	<1%	0%
Unknown/missing	1%	
<b>Unusual activities (e.g., work, study, housework, family, or leisure activities)</b>		
I have no problems doing my usual activities	53%	40%
I have slight problems doing my usual activities	12%	0%
I have moderate problems doing my usual activities	15%	27%
I have severe problems doing my usual activities	17%	27%
I am unable to do my usual activities	3%	7%
Unknown/missing	<1%	0%
<b>Pain/discomfort</b>		
I have no pain or discomfort	41%	20%
I have slight pain or discomfort	13%	7%
I have moderate pain or discomfort	20%	20%
I have severe pain or discomfort	20%	40%
I have extreme pain or discomfort	5%	13%
Unknown/missing	1%	0%
<b>Anxiety/depression</b>		
I am not anxious or depressed	15%	-7%
I am slightly anxious or depressed	12%	0%
I am moderately anxious or depressed	22%	13%
I am severely anxious or depressed	33%	67%
I am extremely anxious or depressed	17%	13%
Unknown/missing	1%	0%
<b>Relationships/social support</b>		
I have felt supported by the people around me all of the time	26%	13%
I have felt supported by the people around me some of the time	20%	13%
I have felt supported by the people around me a fair amount of the time	23%	33%
I have felt supported by the people around me a little of the time	17%	40%
I have felt supported by the people around me none of the time	13%	0%

Unknown/missing	1%	0%
<b>Average daily health score</b>	45	
<b>Skin and soft tissue infection in the last year</b>		
Yes	20%	73%
No	79%	27%
Unknown/missing	1%	0%
<b>Overdose in the last year</b>		
Yes	22%	53%
No	76%	40%
Unknown	2%	7%
<b>Number of times overdose in the last year (only includes those who reported an overdose, n=153)</b>		
Once	36%	20%
2-4 times	37%	13%
5 or more times	21%	20%
Unknown/missing	6%	0%
<b>Section 3 - Drug and alcohol use</b>		
<b>Drugs injected in last six months (% of 711 PWID who injected in last six months)</b>		
Heroin	85%	100%
Cocaine	54%	93%
Crack	5%	0%
Heroin and cocaine/crack together	17%	93%
Speed	2%	0%
Benzodiazepines (e.g. valium, 'blues', etizolam, etc)	2%	1%
Body building drugs (e.g. steroids)	3%	0%
Legal high	<1%	7%
Other	3%	0%
<b>Drug most commonly injected</b>		
Heroin	67%	67%
Cocaine	26%	20%
Heroin and cocaine/crack together	2%	13%
Benzodiazepines (e.g., valium, 'blues', etizolam, etc)	0%	0%
Other	4%	0%
Unknown/missing	1%	0%
<b>Primary injection site in last six months</b>		
Arms	37%	0%
Hands	7%	0%
Groin	41%	73%
Legs	10%	13%
Feet	2%	0%
Other	3%	13%
Unknown/missing	1%	
<b>Alcohol use in last 12 months above recommended guidelines (&lt;14 units per week)</b>		
Yes	19%	20%
No	81%	80%
Unknown	<1%	
<b>Section 4 - Illicit injection behaviour</b>		
<b>Injected in a public place in last six months</b>		
Yes	23%	80%
No	77%	20%
<b>Frequency of public injecting (only includes PWID who reported public injecting, n=162)</b>		
Always	23%	0%
Usually	19%	80%
Sometimes	56%	20%
Unknown/missing	1%	0%
<b>Number of people usually inject with</b>		
None (I normally inject on my own)	42%	27%
One person	35%	27%
2-3 people	12%	40%
4 or more	2%	7%
Don't know	1%	0%
Unknown/missing	8%	0%
<b>Section 5 - Crime and income</b>		
<b>Number of times in prison</b>		

Never	35%	0%
Once	10%	13%
2 to 5 times	22%	20%
6 to 19 times	17%	33%
20+ times	16%	33%
Unknown/missing	<1%	0%
<b>Average weekly income in last six months</b>	£188	£400
<b>Income from illegal sources in last six months</b>		
Yes	18%	60%
No	78%	40%
Unknown/missing	3%	0%
<b>Proportion of income from illegal sources in last six months (only includes those who reported illegal income, n=131)</b>		
All (100%)	2%	0%
Most (75-99%)	44%	40%
About half (26-74%)	34%	20%
Small part (1-25%)	13%	0%
None	2%	40%
Unknown/missing	5%	0%
<b>Average amount of money spent on drugs in last six months</b>	£110	£456
<b>Section 6 - Stigma</b>		
<b>Experienced stigma in last six months as a result of drug use</b>		
Yes	64%	87%
No	35%	13%
Unknown/missing	1%	0%