

WL ADP ITEM 6: Substance Use Health Needs Assessment 2019 West Lothian

Summary of conclusions, key points & recommendations

1.0 Introduction & background

The health needs assessment aimed to assess need in relation to access and retention for drug and alcohol services, and, young people and families affected by problematic substance use.

Data was collected from service users, service providers and epidemiological sources. The findings have been collated and this summary provides an overview of the conclusions, key findings and the recommendations. The recommendations are designed to improve the patient experience of care and the health of the most vulnerable populations and are underpinned by national substance use strategy and guidance.

There have been limitations with this needs assessment due to capacity which will be addressed as part of the work going forward. For example it has not been possible to explore many factors relating to alcohol. There is specific work to be done with HMP Addiewell and the criminal justice system and there is a need to do further consultation with people affected by problematic drug and alcohol use.

Services have been working through a challenging period of changes and funding cuts. During that time it is recognised that staff have worked hard to minimise disruption to patients but there have been pressures of long and increased waiting times for most services within the partnership and where waiting times were within the targets other services have experienced the impact of this.

Progress has been made and since the information was collated for the HNA a number of improvements and changes have been implemented. Already evidenced in waiting times being on target.

2.0 Conclusions

Overall, challenges to provide continuity of care and to create a comprehensive picture of the services available and the individual journey of a person through services include:

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- (1) Difficulty collecting accurate and complete data, due partly to the large number of different systems for recording patient information;
- (2) The incomplete and complex process of health and social care integration e.g. components of the service pathway are not always aware of the remit/role of partners or the best way to share information;
- (3) Gaps in workforce development
- (4) A gap in staff resource dedicated to co-ordinate or manage West Lothian ADP resulting in limited time and opportunities to lead on strategic development for the area.

Streamlining of assessment and data recording will improve the patient experience, improve data quality and enable innovation and evaluation of services.

There is a legacy of insufficient capacity to provide prevention, assertive outreach and low threshold treatment to the population in need. This has improved with recent investment but there is still a lack of resource to fund youth work, the need for more IEP and THN provision in outlying areas, insufficient access within the Police custody setting and a vulnerable homeless population that needs more targeted support.

Frequent admission for drug and alcohol problems account for 1,000s of bed days at SJH and increased investment in community prevention and support along with improved access to inpatient detox could help to reduce and shorten admissions.

Feedback from patients, carers, family members and service providers highlights key areas of unmet need such as provision of mental health services and ready access to treatment. Ongoing inclusion of these groups in service developments is essential and new approaches to this should be considered.

Although challenging, it is important that services have the space to look beyond the pressures of the waiting times and have the flexibility to try innovative approaches to improving person centred care and refocus some attention on prevention and early intervention.

3.0 Adult Treatment

Summary of Key points

There are comprehensive drug and alcohol services for adults in West Lothian; of the estimated 1100 – 1400 problem drug users in West Lothian, 499 people entered specialist treatment in 2016/17 and as of June 2019 there were 389 in the GP National Enhanced Service 2019.

Meeting the Scottish Government target for ‘Clients waiting 3 weeks or less for treatment’ has been a challenge over the past 3 years but additional investment from the West Lothian Integrated Joint Board and changes to how patient care is provided is proving successful in reducing waits. In this assessment, long waits to access treatment was reported as the most common reason for people disengaging from services and access was an important unmet need. However there is already progress and waiting times have increased from 61% of people being seen within 21 days in the last quarter of 2018 and first quarter of 2019, to 74% in the second quarter of 2019 with the third quarter looking to exceed the target.

Other factors referred to in relation to disengaging from services were personal circumstances, including access to money for travel, homelessness, chaotic lifestyles and the influence of social networks all involved in drugs and alcohol. Lack of options for throughcare or links into the community beyond discharge was felt to “limit hope, aspirations and wider opportunities” and once a person disengages they find it hard to re-engage.

A partnership approach to care is essential to manage the patients clinically but also support patient flow. Senior Third sector key workers play a vital role in this case coordination and intensive psychosocial support for a holistic approach to care but also as drug type is changing with a move away from heroin to cocaine and benzodiazepines. Assertive outreach to settings such as police custody, prisons, hospital emergency departments and the community are also key. All of these interventions are provided currently by Third sector but there is insufficient capacity. Feedback was that not all external partners are clear about routes into these services.

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The Community Addictions Service (CAS) aims to provide an integrated health and social care approach. This integration of teams has the potential to enrich the patient experience. However, for the two components (NHS Addictions and SWAT) the respective roles and responsibilities are not always clear. There is some development required to improve the integration of the teams and enhance working relationships. Reviewing skill sets and better matching them to patient care would ensure clearer roles and responsibilities in the team as well as exploring a shared system and streamlining assessments.

The 'recovery service' provider changed during the HNA. CGL have been commissioned and is working to address some of the gaps and challenges that were identified with the previous service provision. This includes more drop in clinics in local areas, the recruitment of peers and clearer boundaries for people accessing the service which makes it a safer and more supportive space for recovery.

Coordinated care for poor mental health and a history of trauma was identified as a major unmet health need by staff for drug and alcohol patients. Patients frequently present to services with anxiety and trauma which can impact on how they engage with treatment and stay with services.

There have been long waits to see specialist psychology services (up to 26 weeks for some). A gradual move to a new model of providing an assessment appointment within 4 weeks has gone some way to manage the demand. Additional Psychology capacity could add value through working with and through the wider addictions partnership, offering a psychological perspective on clients, supporting all frontline staff to work safely & effectively with trauma and providing regular training for CPNs/other addiction workers and reception & admin staff to work in a psychologically informed way and to offer lower intensity psychological interventions at point of need. This is in line with NHS Education for Scotland (NES) transforming psychological trauma knowledge & skills framework (2017).

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Specialist addictions services are not configured to provide care for co-morbidities, and other services that come into contact with problem drug users are not usually configured for provision or referral to addictions care. Secondary care staff require support from specialist staff both through in reach and the provision of staff training.

Stable housing supports the uptake and engagement with substance use treatment. Between October 2017-March 2019, 153 homeless households in WL were reported as affected by problematic substance use, 142 applicants were accommodated in B&B due to substance use for an average duration of 57days, 20 for over 100 days. The homeless health team are operating with a limited staff capacity to cover the whole area and there is no clear programme of assertive outreach to homeless people from other drug and alcohol services.

In 2018 there were 1,519 unplanned admissions to St John's Hospital for drug and/or alcohol use: 127 per month, many people with multiple admissions

- Of the 388 individuals admitted with drug use, 66% were in for more than 24hrs, bed days 2,183. Most people were discharged home and 10 people had no fixed abode
- Of the 746 unplanned admissions for chronic alcohol use, 64% stayed more than 24hrs, bed days 4,180. 92% were discharged home and 27 (4%) died in hospital.

The Drug Liaison Nurses provide an excellent service but are underutilised, with 66 referrals between July 2018 to June 2019. Staff reported the need for a similar role for people with problematic alcohol use and the need for specialist support at the hospital emergency department. This relates to the number of people accessing the emergency department in crisis.

After mental health, waiting time and access to inpatient alcohol detox was the second most unmet need for alcohol patients. Inpatient detox is provided centrally at the Ritson. In 2017 WL patients accounted for 15% of the activity. Reduced beds from 12 to 8 in 2018 has implications for CAS in relation to managing higher thresholds for community detox patients and the acuity of patients who are being

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referred into the Ritson. This can sometimes result in more patients on community detox accessing A&E with complications or those entering the Ritson being more physically compromised than in the past.

Physical health and poor nutrition was identified as the 3rd most unmet health need of alcohol patients. 50% of respondents to the staff survey said ARBD support in the community was needed. People are seeing increasing numbers of people affected by ARBD and there is a lack of knowledge in non-specialist services leading to delayed diagnosis. For those who require specialist care for ARBD WL Integrated Joint Board fund the central unit based on a % share of the occupied bed days which was calculated at 11%. Access to the specialist ARBD unit only provides treatment for people with ARBD who have been in acute hospital care.

Reasons for discharge- unknown or unplanned discharges are high across all services. It is unclear to what extent this is related to poor recording, patient drop out or the nature of the clients group. The number and reasons for service discharge is an important indicator given the links to being disengaged from services and the risk related to DRD. This needs further exploration.

Lothian is unique in Scotland in the level of primary care engagement in the care of drug users. In West Lothian 19 practices out of the total 21 are part of the GP national enhanced services programme for drug misuse (NES 2018-19). This accounts for the care of 389 patients.

Of the total patients cared for by NES GP practices, 338 are on prescriptions. Of those 75% of patients are prescribed methadone, 20% buprenorphine and 5% dihydrocodeine. Only one GP practice in West Lothian is a non-prescribing practice, which is in Whitburn. CAS work closely with this practice.

Over the last 5 years there has been an increase in age of NES patients. Males aged 45- 49 years account for the greatest number of male NES patients and females aged 35-39 years. All of the NES GPs are supported by the Primary Care Facilitation

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Team (PCFT) through training and visits and advice/ monitoring of associated care (e.g take home naloxone & BBV testing) and polypharmacy.

Approximately 47% of the NES patients are known to be previous injectors yet the number of patients tested for Hep C in the last 12 months are low.

GP responses to the survey highlighted the value that they place on specialist substance use services. All stated having good links with CAS and WLDAS with fewer knowing about referral routes or having contact with CGL Assertive outreach or the drug liaison nurse. All of the GP practices have a nurse clinic or either a CGL drop in or WLDAS drop in but there maybe potential to try out some joint clinics with Primary Care which have been successful in other parts of Lothian.

Additional training that GPs selected from the list echoed the other respondents with an interest in “Understanding and responding to client trauma” and “Childhood adversities, mental health and addictions”. In separate feedback they reported the need for training on the management of benzodiazepines and stimulants as seeing more patients using etizolam and alprazolam or cocaine.

Recommendations:

1. Increase investment to ensure adequate capacity and a skill mix that includes senior key workers, trained outreach workers and peers that can work alongside the NHS team to provide the following:
 - a. Effective care coordination
 - b. ‘step down’ support for psychological and other treatment interventions
 - c. Intensive social support including housing, financial maximisation & family involvement
 - d. Assertive outreach that can offer support for people in at high risk or in crisis. Including people experiencing near fatal overdose, people dropping out of treatment for addictions or BBV, people in transition between housing, prison, hospital etc.
2. An addictions consultant and a mental health consultant should lead a multidisciplinary group to explore ways to address the unmet need for chronic

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and enduring mental health care. This may require liaison between A&E, in patient wards, liaison psychiatry, community mental health teams and addictions psychiatry.

3. Invest in psychology support to build capacity for general staff to provide more tier 1 and tier 2 psychological interventions and support services to work in a more trauma informed way.
4. Conduct a skill mix review of the two teams that make up the Community Addictions Service to ensure an integrated team whose skills are matched to the presenting needs of the patients and enhance the flow of patients through that part of the pathway.
5. Develop a model of care that enables rapid access to OST i.e. within 3 weeks of first attending the drop in.
6. Explore the use of contingency management as a way of retaining patients in services and contributing to successful recovery or increased abstinence for those with dual diagnosis.
7. Develop capacity to identify and provide advice, treatment and referral for physical co morbidities among people presenting with addictions. This may include recruitment of Health Care Assistants to conduct physical health checks and clear referral pathways to primary and secondary care or capacity building for CPNs.
8. A system to offer support or advice for people in crisis out with office hours should be considered e.g. in partnership with Lothian Unscheduled Care Service.
9. Review and update communications and information about the addictions partnership pathway to ensure external agencies are clear about how to refer in and the most appropriate service to refer into.
10. Invest in capacity for a West Lothian Drug and Alcohol Liaison Nurse and explore options for specialist addictions support (third sector) for the Emergency Department at St John's Hospital (and LUCS if relevant/feasible).
11. Review factors affecting access to inpatient alcohol detox and the impact on patients and services in the community.
12. Continue to explore options to increase joint working with Primary care to address physical health issues alongside substance use.

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13. Establish housing models (e.g. Housing First for homeless applicants) and clearer pathways for housing options and support for those with problematic substance use.

4.0 Harm Reduction

Summary of key points

In total there were 2,534 Injecting Equipment Provision (IEP) transactions across the West Lothian sites in 2018. This relates to 883 unique clients. Around 82% of the 883 unique clients were male¹, with an average age of 39 (for female clients the average age was 34) while ethnicity was mainly white. Of all people that attended IEP 26% were Image and Performance Enhancing Drug (IPED) users. This is higher than the Lothian average of 22%. Where IEP is provided then best practice would be to offer other harm reduction interventions such as safer injecting advice, take home naloxone, discussion and testing for blood borne viruses. This is offered routinely from the NEON bus but not the pharmacy where the largest numbers of patients access injecting equipment. There are gaps in IEP provision that can be addressed by exploring the opportunities for outreach services rather than fixed times and sites.

There are 34 community pharmacies across West Lothian and most have good links to the Community Addictions Service. Only 5 provide injecting equipment.

Pharmacies will be seeing patients on a daily basis for opiate substitution replacement (OST). There is an opportunity to invest in pharmacies to enhance the delivery of harm reduction services for drugs and alcohol, including, naloxone distribution and DBST, anticipatory care and to review other services such as the ongoing pharmacy supervised disulfiram pilot. There is some work required with some pharmacies in relation to the patient experience and how the issue of removing access to some pharmacies can be overcome.

The recording of NEO data from IEP outlets is incomplete. E.g. use of structured treatment was poorly recorded with no answer recorded for 71% clients.

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Current capacity for assertive outreach is limited. Increasing the resource allocated to services to provide assertive outreach could extend the reach of harm reduction interventions and connect with people not engaged in services.

There is a comprehensive and effective programme for prevention testing care and treatment of Blood Borne Viruses (BBV). In West Lothian (population 181,300) there are an estimated 196 people in drug use services/prison to re-engage, and 539 people yet to be diagnosed.' Opt out' BBV testing needs to be introduced to increase case finding for hepatitis C.

Take Home Naloxone (THN) is distributed through addiction services. However, the number of kits distributed per month is quite low with an average of 16 kits/ month over the last 6 months. There is no evidence of an increase in distribution following the change in legislation in 2015 which allowed third sector to supply family/ friends to use THN. The spread of DRD and NFO from Livingston to outlying areas highlights the need for wider dissemination of THN and a change in approach of how to offer it and who to offer it to.

Recommendations:

1. Raise awareness of Image and Performance Enhancing Drug (IPED) use and the risks involved with local gyms and agencies that work with young people (e.g. colleges, schools, youth agencies, primary care), promote the Lothian Harm Reduction Team IPED training course and explore with them the possibility of providing an IPED clinic in WL.
2. Extend IEP provision through more pharmacy and assertive outreach provision.
3. Review pharmacy contracts and investment to explore the options for more enhanced pharmacy services especially those who have high numbers of patients accessing for OST. Propose a pilot in West Lothian to test these ideas.
4. Strengthen NEO data collection.
5. Implement the recommendations of the NHS Lothian hep C case-finding action plan which include all services provide opt out testing, all pharmacies

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that dispense OST or provide injecting equipment must either offer HCV testing, or have a clear pathway in to testing, treatment, and care.

6. Support services to increase the distribution of naloxone kits including GP NES, NHS and Third sector. Ensure family and friends are offered kits as well as the patients.

5.0 Young People and Families

Summary of key points

For the young people who are more vulnerable to harmful substance use the need to address the risk factors and increase the protective factors at different stages in their lives is key. Risk factors include the impact of trauma and adverse childhood experiences, addressing mental health problems, poverty, peer substance use and drug availability.

Resources for preventative activities have been withdrawn from schools and youth work over recent years. Spending on prevention is essential to improve the outcomes for the children and young people and mitigate the long term impact on adult substance use and other social services. Investing in a holistic approach allows multiple risk factors to be addressed and is more likely to be effective such as those which provide an opportunity to practise and learn a range of personal and social skills, specifically coping, decision making and resistance skills. Currently there is no coordinated programme or resource for training of school staff in substance use and care.

Alcohol and cannabis are reported as the most frequently used substances amongst young people. Tobacco use also increases for those who are smoking cannabis and tends to be in the 15+ age group.

Since April 2018 there has been a gap in specialist substance use provision in West Lothian for young people who are affected by their own or others use. Only 20% of staff surveyed had a clear referral pathway or knew where they could refer a young person onto for support. Since 2018 WLDAS were commissioned to operate with a lower age limit of 16 + and all other referrals for under 16s problematic drug or

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alcohol use were directed to the West Lothian Youth Inclusion Project (WLYIP). Staff feedback indicates that this service lacked the staff capacity and specialist knowledge to deal with the substance use issues that were being presented.

Substance use referrals for young people reduced significantly. In 12 months the previous family recovery service worked with approximately 46 young people 16 years and under compared to 11 young people being referred into the WLYIP in 2018. All referrals are now directed to the young people's mental health screening group where they are allocated to the most appropriate service.

85% of staff surveyed agreed that a specialist young person's worker is required to reach those most at risk "to provide support including early intervention or counselling in schools to prevent the impact of childhood trauma reoccurring in adulthood". The WLADP Young people's subgroup have been successful in securing funding for a 0.8wte young person's therapeutic post within WLDAS.

Children who are looked after or accommodated are a high risk group who require more intense and assertive outreach to help engage them about substance use, mental health, relationships and sexual health. Local services reported difficulties in reaching these young people and engaging staff in workforce development opportunities.

Services for which substance use is not core business have a role in early intervention, advising and referring people to services but there is no current workforce development programme to support this.

Maternities with drug use have been statistically significantly 'worse' than the national average. This has been an issue since 2009. Currently there is no specialist midwifery or antenatal care team for women who experience problematic drug use.

Recommendations:

1. Build a strategic and operational network of support for the young person's worker to promote a tiered response to young people's substance use similar

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to that of adult services and young people's mental health. Include existing networks such as the Children's Partnership sub groups (prevention & early intervention) and Healthy Respect.

2. Provide workforce development to enable staff to respond appropriately to young people's substance use, especially those working with the most vulnerable young people (LAAC nurses, school nurses, education, youth workers, GPs, drop in staff, Police and family placement teams). This reflects a similar approach to the response to young people and mental health to enable staff to recognise their role & know how to respond.
3. Work with young people, schools and substance use services to develop the PSE toolkit for substance use education linking in with national developments and using evidence based approaches.
4. Ensure substance use is included in the work plans and agendas of specific community planning groups and others such as the WL Children and Family management group, the WL young people's sexual health group, the mental health early intervention group, the community learning and development partnership and other relevant forums.
5. Further explore the specific needs of young people from more vulnerable groups (e.g. those involved in offending, young people who are care experienced or those whose parents have substance use issues) through consultation with young people.
6. Explore the need and opportunities for improving the provision of services for women with high and complex needs, including addictions. This should be done in partnership with sexual and reproductive health services (including WISHES) and maternity services.

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Across West Lothian there are a variety of family support interventions offered which provides a comprehensive range of options to support families where multiple and complex issues including substance use are addressed. Whole Family support tends to be resourced to work with the main care giver which is often the mother. In 18-19 Circle worked with 82 parents, from those only 27 fathers. This has highlighted a gap in resource for Dads work and also the type of support which would help to sustain recovery, re-build relationships and improve outcomes for the children. This work is also supported across the partnership because of concerns relating to the health and wellbeing of Fathers who have relapsed because of issues relating to access to children, with some ending up in hospital.

Circle have capacity to work with 45 families and in 2017-18, family referrals exceeded this number with 61 families looking for support. Circle frequently works in parallel to adult services (CAS, WLDAS, and the recovery service). In 2017-18 approximately 79% of adults were also linked into one of the above services.

Family support groups are valued services from both those attending them and the staff working with the patients. Amongst staff and service users there is recognition that provision for family support has improved but not all partners and public know about the availability, role and remit of these services. There are two family support groups that run twice/ per month in West Lothian. Feedback from service users indicates that the support received is felt to be “useful and appropriate for their own specific need but that the process to access services can be too long and it would be helpful to have more options”.

Recommendations:

1. Continue to invest in family support and ensure information about access and availability is clear and shared widely.
2. Ensure services identify or consider family engagement or other support networks at key points during treatment. Where possible there should be proactive involvement of the above in care plans. Staff should be trained in how to approach this. Make links with the DHOG families, carers and young people group.

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3. Identify and implement a co-ordinated model to ensure family support tailored to individual family needs is provided. Take into account the other models that are currently used such as family group dynamics.
4. Pilot the Dads project and evaluate to measure the combined impact of service input on outcomes for parents and children.

6.0 Drug Related Deaths

Summary of key points

The number of DRDs in West Lothian residents has more than doubled from 12 in 2014 to a current plateau of 28 in 2017 and 27 in 2018.

Most DRD occur on the West side of West Lothian such as Whitburn, Armadale & Blackburn. This mirrors the hot spots for non-fatal overdoses.

In West Lothian, largest single group is males in their 30s (25%) vs. males in their 40s (25%) in NHS Lothian. This points towards a relatively younger age for DRDs in West Lothian

Opioids are the commonest contributor to death (22/27 in 2018), but the average number of drugs implicated in death is 5 (range of 1 to 10). Both alprazolam and, in particular, etizolam are commonly implicated in death although not found to be a single cause of death.

Polypharmacy and having 2 or more non-fatal overdoses can be used as the strongest indicator of drug related death.

Recommendations:

1. Establish an effective anticipatory care system including for follow up of people who have had a non-fatal overdose: in line with guidance being developed by the DHOG and NHS Lothian Harm Reduction Team.
2. As part of further engagement with adults explore the use of polypharmacy.

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3. All the recommendation in this report will contribute to the prevention of DRD. For example arrangements for a safe discharge from hospital (including THN) into specialist treatment, stable housing, and low threshold access to harm reduction and assertive outreach to help retention.
4. Specific additional actions to prevent DRD are coordinated by the Lothian wide DRD and Harm Reduction Oversight Group, and it is recommended that West Lothian participate fully in this group which provides support for local implementation of pan Lothian strategy.

7.0 Workforce development (WFD)

Summary of key points

Rights, respect & recovery highlights the importance of robust workforce development planning for delivering person centred recovery. Survey responses highlighted interest in the following training to increase confidence and competence:

- Childhood adversity, substance misuse and mental health
- Understanding client trauma and how to respond
- Motivation and behaviour change skills
- Sexual health
- A programme of local harm reduction training would be beneficial, to include introductions to image and performance enhancing drug use, risks relating to groin injecting, safer injecting, BBVs and dry blood spot testing and take home naloxone.

Attendance at central Harm Reduction training is good but there is currently no-one from West Lothian who is trained as a trainer in THN.

Other suggestions for training from staff included how to identify and address physical health problems and separate training on ARBD.

Stigma towards people with problematic drug and alcohol use continues to be reported by service users and staff.

Recommendations:

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1. Progress with the ADP workforce development planning.
2. Liaise with the Harm Reduction Team and the community BBV team to bring a one day harm reduction training session for multi-agency staff to West Lothian.
3. Deliver a multi-agency quality improvement training session for staff to increase knowledge of the QI methodology and tools and support small tests of change.
4. Liaise with clinical psychology and sexual and reproductive health leads to provide trauma informed training in line with the NHS Education for Scotland (NES) trauma training framework.
5. Explore options to deliver level 1 trauma informed training for services working with children and young people and build on the young people's mental health first aid training that has been rolled out across West Lothian.
6. Liaise with the Lead Pharmacist for substance use to facilitate training for community pharmacists to support enhanced delivery of services for problematic substance use. This could include naloxone distribution, DBST, safer injecting advice and how to raise these issues effectively to support better engagement with patients.
7. Stigma training should be incorporated into generic training for example through Learnpro or be targeted at generic services for those with little experience of working with people with problematic drug and alcohol use.

Health intelligence

There was difficulty collecting accurate and complete data, due partly to the large number of different systems for the recording of patient information. For young people this was also difficult because often the primary reason for attending a service is not recorded as substance use. Currently there is no central place to record young people's substance use data.

The combined health intelligence node (CHIN) can analyse and distribute drug and alcohol related data to inform service developments and care going forward.

Recommendations:

1. Develop a scope of work to look at ways to streamline data collection across adult services to better understand and monitor developments in the patient

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journey. E.g. conduct data linkage to establish the waiting time from first entry to the addiction service to receipt of OST, to enable monitoring of system changes.

2. Improve understanding of the nature and extent of young people affected by problematic substance use. E.g. establish a system to collate data on young people at risk, review the numbers coming through the mental health screening group, conduct a case note review of families with children affected.
3. Establish a systematic approach for ongoing inclusion of the views and feedback from patients, family members, carers and staff into the development of services (e.g. pathway reviews, Quality Improvement projects, group forums).

Implementation

It is recommended that the WL ADP form a local action group with clear leadership to implement the recommendations of this report and those stemming from the Lothian wide DRD and Harm Reduction Oversight Group (DHOG). Explore the option of having a project manager provided by the Health and social care partnership.

NHS Lothian department of Public Health and Policy can provide general support for implementation and specific areas of work may include investigation of the following:

- A review of addiction services in criminal justice settings including police custody and HMP Addiewell.
- Further consultation with adults and young people who are affected by problematic substance use, especially those not in services or those who frequently disengage with services.
- The need and opportunities for the provision of specific services for women with high and complex needs, including addictions.
- Factors affecting access to alcohol detox and diagnosis and treatment for ARBD.
- Support to embed a quality improvement approach to substance use services.