Public Health Scotland

National benchmarking report on implementation of the medication assisted treatment (MAT) standards: Scotland 2022/23

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MAT standards summary

Medication assisted treatment (MAT) is used to refer to the use of medication, such as opioids, together with psychological and social support, in the treatment and care of individuals who experience problems with their drug use.

The **MAT standards document** was published in May 2021.

The standards aim to improve access, choice and care and to ensure that MAT is safe and effective.

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence-based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically informed (tier one); routinely delivers evidence-based low-intensity psychosocial interventions (tier two); and supports individuals to grow social networks.
7. All people have the option of MAT shared with primary care.
8. All people have access to independent advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma-informed care.

Foreword from Elena Whitham, MSP, Minister for Drugs and Alcohol Policy

In January 2021, the Scottish Government announced a five-year National Mission on Drugs, with the aim of reducing drug-related deaths and harms. A central part of achieving this is implementation of the medication assisted treatment (MAT) standards, which were published in May 2021.

Since publication of the last benchmarking report, tremendous progress has been made right across the country and I am extremely proud and heartened by all the work that has been undertaken and highlighted in this new report.

The progress over the last year is something that I would not have expected to see having spent a lot of my career campaigning for the support the MAT standards offer. In many areas, there has been real innovation and flexibility and challenging the norm of how things have been traditionally done.

I have spoken to a lot of groups, service providers and people accessing services over the last few months. I have both seen and heard of the progress being made and what the future plans are for full and sustained implementation of the standards.

This report details the progress which has been made by local areas to April 2023 and is down to the hard work and dedication of the people commissioning and delivering services. It shines a spotlight on some case studies, putting into context some of the work which is happening right now and provides an update on implementation of standards 1–10. I would like to record my thanks to everyone for the hard work which has gone into implementing the standards. However, as the Report illustrates, there is still a long way to go.

It is not good enough to say the standards are implemented and in place. The change needs to be seen and felt and by what people experience, with outcomes for people accessing services improving. Collecting experiential evidence to help drive change is not something that will happen overnight. The current methodology needs to be strengthened, be embedded and given time to work. I want stigma to be challenged and those with lived and living experience to be at the heart of service

improvement, working with those who commission services so that the system can indeed be seen as wholly person centred.

Challenges remain and there is still a lot of work to do to fully implement the standards by April 2025 and for them to be sustained by April 2026. This ongoing work is very much aligned to the Scottish Government cross-government action plan which published in January 2023 and sets out how the Scottish Government is addressing a whole government, whole-Scotland approach to tackling the drugs deaths crisis.

I would like to thank the MAT Implementation Support Team (MIST) for their work supporting areas with the ongoing implementation of the standards and for the work undertaken to produce this comprehensive report. In addition, my thanks must also go to each individual area, service and organisation for the work you have done and continue to do. Similarly, I would like to thank the people with lived and living experience, their families and loved ones for their input into this process which is invaluable. Everyone involved in this work is helping to turn the tide on drug-related deaths and harms.

Foreword from people with lived and living experience of substance use

Tom Bennett, Rights in Recovery Development Officer, Scottish Recovery Consortium

People with lived experience continue to wait to see significant changes as the process of the implementation of the MAT standards continues. Lived experience recovery organisations and their members are increasingly well-versed in what the standards mean and with this comes increased expectations in terms of the care people should receive.

Unfortunately, in many localities these expectations are not yet being met and this leads, not just to frustration and disappointment but, to poor and often tragic outcomes.

Lived experience communities continue to build their awareness and understanding of the human rights-based approach and in the application of the MAT standards and their inalienable human rights, which are in no way affected, or reduced, by their illness. With this knowledge comes confidence to assertively claim their rights and make challenge when services are failing.

People with lived experience call for the redoubling of efforts to implement the MAT standards, and for sufficient resourcing so that they can start to save lives now, not just in years to come.

Suzanne Gallagher, Helpline Development Officer/Naloxone Lead, Scottish Families Affected by Alcohol and Drugs

Families were hopeful at the promises around the implementation of the MAT standards. They felt that the MAT standards were an opportunity to provide proactive support to meet the needs of their vulnerable, and often fragile, family members. It was a chance to do things differently and make a real change to the lives of their loved ones. Families understood that the 10 standards would be implemented across

Scotland. However, what they are experiencing on the ground versus what is being reported differs greatly.

They refer to this as being a significant implementation gap. Families feel there is too much focus on MAT standards 1–5 and support around all 10 MAT standards should be moving at the same pace.

They are frustrated at the level of support their loved ones, who are not using opiates, are receiving as the same focus does not seem to be given to families with loved one's experiencing issues with alcohol, cocaine and benzodiazepines.

Families feel there is no acknowledgement that 'treatment' for their loved one should not only be a medical model. People struggling with other substances for which there is no replacement medications can access psychosocial and mental health support within the context of MAT. However, this is not being offered within the same timescales as opioid substitution therapy – if it is even offered at all.

Families acknowledge that there are some pockets of good practice and progress across Scotland, however, this is not consistent and is not quick enough. They strongly feel that there is no acknowledgement of them as primary care givers.

Drugs policy highlights that families should be supported 'in their own right' yet across Scotland it is still a postcode lottery as to what level of support this consists of – if it exists at all. In order for families to continue to deliver this level of support – which comes at an emotional, physical and often, financial cost – they need to be supported. Families feel that when there is contact with treatment services, there is no consideration of how their health and wellbeing needs are being met. They are rarely considered or acknowledged.

Families recognise the intention behind the implementation of the MAT standards, however, things need to be moving quicker, be open, transparent, accountable and families need to be seen and included as key partners in supporting the delivery of MAT to keep our vulnerable individuals alive and well.

Kerryanne Clarke, National Officer MAT Implementation Support Team (MIST) and Team Leader North Lanarkshire Recovery Community

Over the past year, we can see from the data provided that there has been an enormous amount of work undertaken by the Alcohol and Drug Partnerships (ADPs areas) supported by the MAT Implementation Support Team (MIST) around the implementation of the MAT standards. We can see with MAT standards 1–5 that there are currently no areas which have not implemented any of the first five standards. This is a welcome change.

We are satisfied that this is the case due to the three streams of evidence which we are aware have been collected in order to evidence change. What is evident from the data is that there is an encouraging shift in implementation from 2022 to 2023 and we hope that, with an increase in efforts, this movement continues to ensure MAT standards are fully implemented in all of Scotland.

We also note a positive shift in evidence being collected from people accessing services, their loved ones and the staff providing these services. We would, however, note our concerns that not enough focus has been given to speaking with a wider range of people accessing services and their families, across a variety of settings. We feel that many areas did not put enough effort into collecting evidence at an early stage; and leaving it too late to fully gather the voices of people with lived experience in time for this report.

We believe that this means evidence collection should be continuous, developed and focused moving forward in order to fully understand the progress of the implementation of the MAT standards, from the perspective of those accessing services and their loved ones.

It is evident that the MAT standards are being implemented across the country; however, what is noted when speaking to people accessing services is that this varies from area to area and the ease of accessing services varies along with the medication/treatments available. People are seeking consistency across the country.

A general concern echoed in recovery communities and recovery organisations across the country is that too much focus is placed on opioid substitution therapy

prescribing. It is felt that there should be more of a focus on responding to changing drug trends and more developments and understanding is needed around stimulants and benzodiazepines; and how individuals are supported when seeking help from services.

We also believe that further focus needs to be directed towards justice and following an individual's journey through the judicial systems and back into the community. There needs to be consistency not only across all ADPs but also across all justice settings – to ensure an individual, their loved ones and services are given the same support regardless of where they present.

In conclusion, we believe that individuals with lived experience welcome the MAT standards and that their implementation is being noted within communities.

It is important that we do not lose momentum and that national leaders continue in supporting the implementation and the value of lived experience.

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List of abbreviations

ADP: Alcohol and Drug Partnership

COVID-19: coronavirus disease

DAISy: Drug and Alcohol Information System

HMP: His Majesty's Prison

MAT: medication assisted treatment

MIST: MAT implementation support team

PHS: Public Health Scotland

RADAR: Rapid Action Drug Alerts and Response

RAGB: red, amber, green, blue

WAND: wound care, assessment of Injecting risk, naloxone provision and dry blood spot testing

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- Scotland Alcohol and Drug Partnerships.
- Scottish Recovery Consortium.
- Healthcare Improvement Scotland.

Executive summary

Background

The term medication assisted treatment (MAT) is used to refer to the use of medication, such as opioids, together with psychological and social support, in the treatment and care of individuals who experience problems with their drug use.

The Drug Deaths Taskforce published 10 standards of care for medication assisted treatment in May 2021. The MAT standards aim to improve access, choice and care across Scotland.

The purpose of this document is to provide:

- an update on implementation of the MAT standards 1–10 across Scotland as of April 2023
- information that Alcohol and Drug Partnership (ADP) areas can use for benchmarking and inter-organisational support

Methods

Note that in this report, Midlothian and East Lothian are separate Integration Joint Boards (IJBs) but a single ADP. Falkirk ADP and Clackmannanshire and Stirling ADP have a history of working closely together, as do their respective IJBs, so their progress is reported jointly in this report.

The 29 ADP areas were assessed against the 10 MAT standards using three streams of evidence: process, numerical and experiential. This means that 290 individual assessments were carried out, 145 for MAT standards 1–5 and 145 for standard 6–10. The evidence required to demonstrate implementation of each MAT standard was based on the criteria and indicators in the MAT standards document.

The evidence submitted for each standard was analysed and scored by MAT Implementation Support Team (MIST) on the extent to which it complied with the agreed criteria and thresholds for each evidence stream:

- Score 0 = no compliance demonstrated or no evidence.
- Score 1 = compliance demonstrated at some settings/services.
- Score 2 = compliance demonstrated at all settings/services.

The scores for the evidence streams (three for MAT standards 1–5, two for 6–10) were combined and then all 29 ADPs were jointly reviewed and repeatedly cross checked by the MIST clinical and analytic leads to interpret the information and allocate the final evidence-based RAGB.

A key consideration in the interpretation of the data and allocation of the final RAGB was the extent to which the evidence streams, local context and clinical knowledge demonstrated benefit to people affected by problematic drug use across an ADP area.

Key findings

Over the last year ADPs have made substantial progress with implementation of the MAT standards. The 29 ADP areas were assessed against each of the 10 MAT standards.

In 2023, 66% (96/145) of MAT standards 1–5 were fully implemented (19/145, 13% green; 77/145, 53% provisional green) vs. 17% (25/145) in 2022; and 88% (127/145) of MAT standard 6–10 were partially implemented (65/145, 45% amber; 62/145, 43% provisional amber; 18/145, 12% red).

There has been a transformation in rapid access to opioid substitution therapy. In 2023, 18/29 (62%) of ADPs fully implemented this standard (3/29 green; 15/29 provisional green) compared with 1/29 (3%) offering same-day access in 2022. Likewise MAT standard 2 (choice) is now fully implemented in 27/29 (93%) of ADPs.

All ADP areas with remote and rural settings demonstrated innovation in terms of maximising the use of technology, travel and flexible models of care so that people could benefit from equitable care and treatment.

In prison settings, mapping of the process measures required to implement the MAT standards demonstrates that there is not a consistent approach to access and choice across community and justice settings and that there is a need for packages of care to be tailored to meet emerging drug trends (opioids are infrequently used in prisons).

Clinical capacity to deliver the MAT standards in prisons is insufficient. Nurses spend a disproportionate amount of time dispensing medication, leaving little time to address care needs and undertake improvement work. Although people on remand comprise approximately 70% of people in prison there is insufficient dedicated resource to ensure housing, welfare and prescribing needs are met in prisons and on liberation. The lack of coordinated data systems in justice settings and across community and justice settings are a constraint to the provision of continuity of care. Without an upgrade of data systems it will be very difficult to conduct improvement work or measure progress with implementation of the standards. To enable full implementation of the MAT standards in justice settings these structural and healthcare capacity issues need to be resolved.

An area where insufficient progress has been made is the care and treatment of people using benzodiazepines and stimulants. Over the last year implementation of MAT standards 1, 2, 3 and 4 has focused on rapid access, choice, harm reduction and anticipatory care mainly for people using opioids.

There has been a dramatic increase in capacity and capability in ADPs for evidence collection. In 2023, for the process data 79% of MAT standards 1–5 and 46% of MAT standards 6–10 was fully compliant with agreed criteria, nearly all the numerical data requested for MAT standards 1–5 were submitted (61% compliant with criteria and thresholds) and experiential data were submitted for 93% of all 10 standards.

The limitation of experiential data collection is a constraint on the ability to assess the overall impact of the standards on people. Over the coming year it is a priority to

strengthen the experiential programme because it is not possible to demonstrate full or sustained implementation of the MAT standards without documented feedback confirming this.

Chart 1: Percentage of ADP areas with RAGB score per MAT standard 1–5. Scotland 2022 and 2023

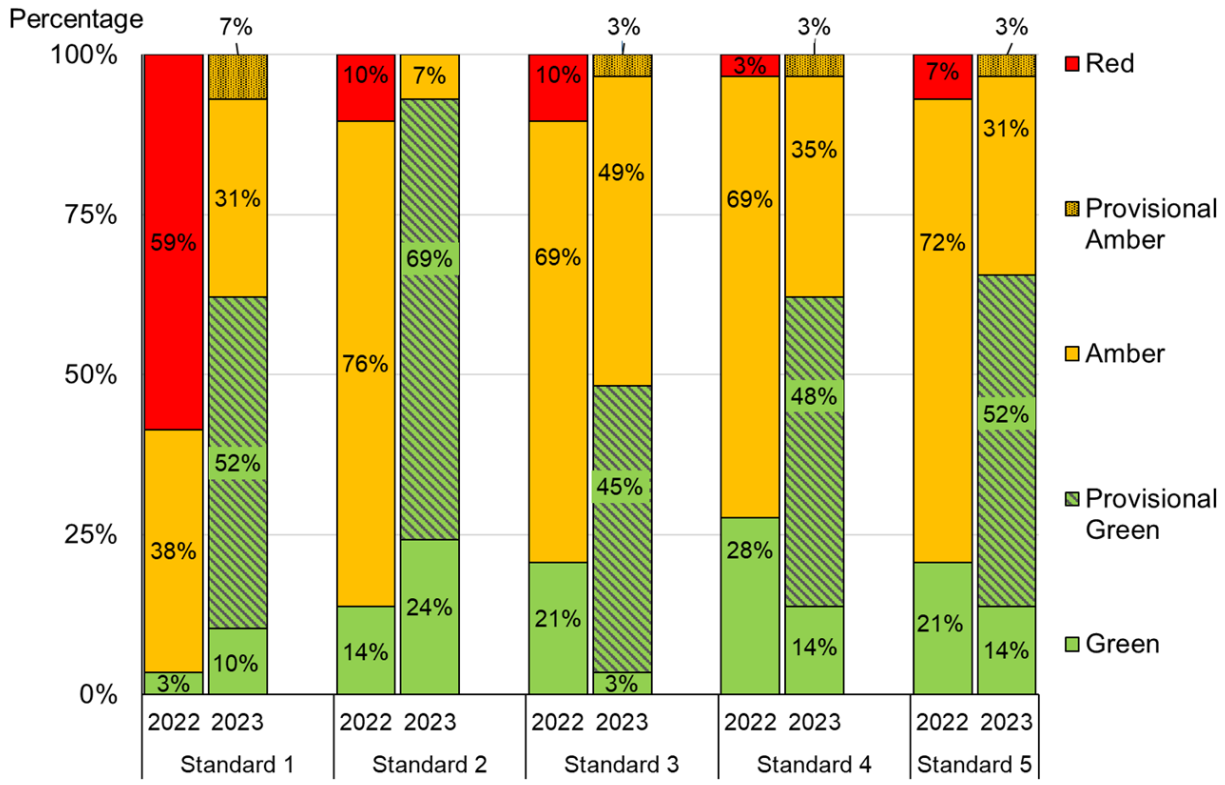


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 1: The standard is fully implemented in 18/29 (62%) ADP areas (3/29, 10% green; 15/29, 52%, provisional green). This is an increase of 17 ADP areas (up by 59%) from 2022. The standard is partially implemented in 11/29 (38%) ADP areas (9/29, 31% amber; 2/29, 7% provisional amber). This remains the same as 2022 and not implemented in no ADP areas, this is a decrease of 17 ADP areas down by 59% from 2022.

- MAT standard 2: The standard is fully implemented in 27/29 (93%) ADP areas (7/29, 24% green; 20/29, 69% provisional green), this is an increase of 23 ADP areas (up by 79%) from 2022. The standard is partially implemented in two ADP areas (2/29, 7% amber), this is a decrease of 20 ADP areas (down

by 69%) and not implemented in no ADP areas, this is a decrease of three ADP areas (down by 10%).

- MAT standard 3: The standard is fully implemented in 14/29 (48%) ADP areas (1/29, 3% green;13/29, 45% provisional green), this is an increase of eight ADP areas (up by 26%) from 2022. The standard is partially implemented in 15/29 (52%) ADP areas (14/29, 49% amber; 1/29,3% provisional amber), this is a decrease of five ADP areas (down by 16%) and not implemented in no ADP areas, this is a decrease of three ADP areas (down by 10%).

- MAT standard 4: The standard is fully implemented in 18/29 (62%) ADP areas (4/29, 14% green; 14/29, 48% provisional green), this is an increase of 10 ADP areas (up by 34%) from 2022. The standard is partially implemented in 11/29 (38%) ADP areas (10/29, 35% amber; 1/29, 3% provisional amber), this is a decrease of nine ADP areas (down by 31%) and not implemented in no ADP areas, a decrease of one ADP area (down by 3%).

- MAT standard 5: The standard is fully implemented in 19/29 (66%) ADP areas (4/29,14% green; 15/29, 52% provisional green), this is an increase of 13 ADP areas (up by 45%) from 2022. The standard is partially implemented in 10/29 (34%) ADP areas (9/29, 33% amber; 1/29, 3% provisional amber), this is a decrease of 10 ADP areas (down by 38%) and not implemented in no ADP areas, this is a decrease of two ADP areas (down by 7%).

- The RAGB score blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard, this remains the same as 2022.

Chart 2: Percentage of ADPs with RAGB score per MAT standards 6–10. Scotland 2023

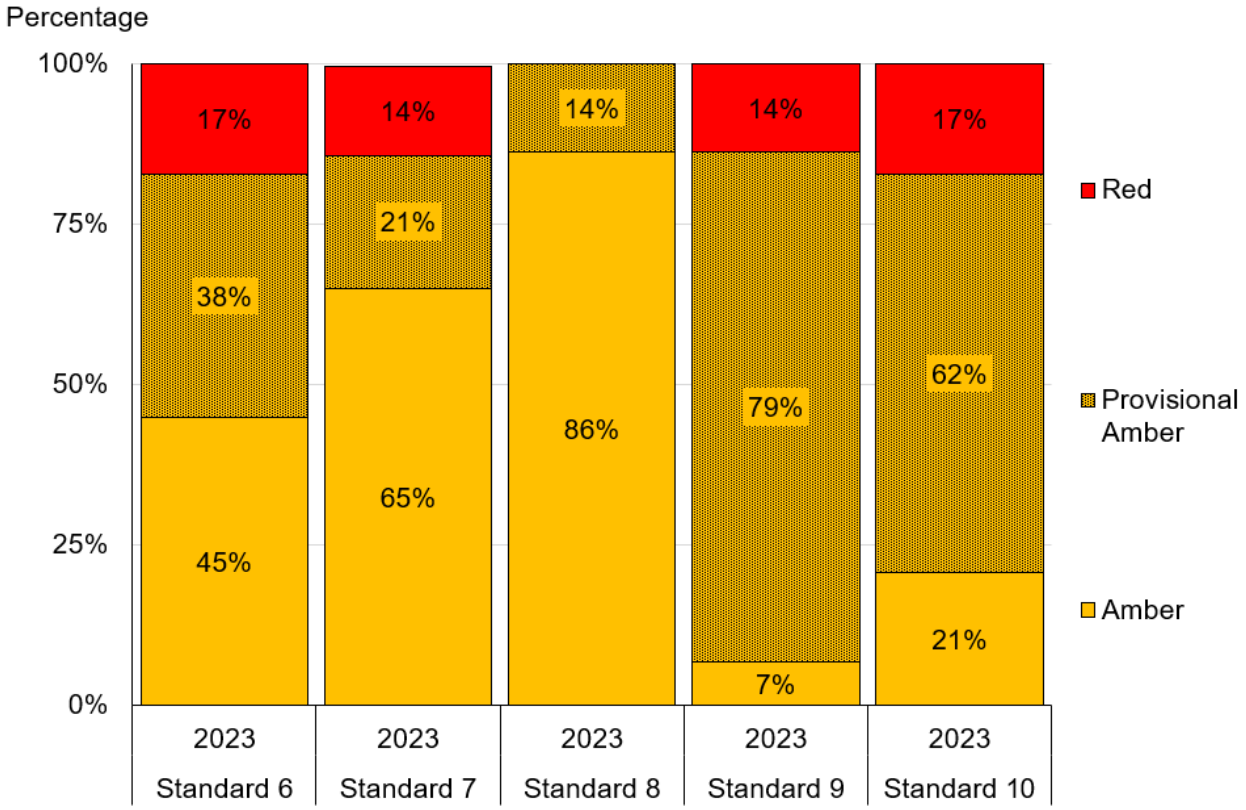


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 6: The standard is partially implemented in 24/29 (83%) ADP areas (13/29, 45% amber; 11/29, 38% provisional amber) and not implemented in five ADP areas (17%).
- MAT standard 7: The standard is partially implemented in 25/29 (86%) ADP areas (19/29; 65% amber; 6/29, 21% provisional amber) and not implemented in four ADP areas (14%).
- MAT standard 8: The standard is partially implemented in all 29/29 (100%) ADP areas (25/29, 86% amber; 4/29, 14% provisional amber).
- MAT standard 9: The standard is partially implemented in 25/29 (86%) ADP areas (2/29, 7% amber; 23/29, 79% provisional amber) and not implemented in four ADP areas (14%).

- MAT standard 10: The standard is partially implemented in 24/29 (83%) ADP areas (6/29, 21% amber; 18/29, 62% provisional amber) and not implemented in five ADP areas (17%).

Conclusions

There has been a transformational change in improved access (MAT standard 1) and choice of treatment (MAT standard 2) for people with problematic drug use in the last 12 months, and significant improvement in the other MAT standards. This is a direct result of hard work and collaboration within and between ADPs (including clinical, third sector, and lived and living experience partners) and of a shift in culture that has overcome many barriers to change.

But implementation of the MAT standards is a vehicle for change and not a sufficient end in itself. Over the coming year the priority will be full, equitable and sustained implementation of the MAT standards in all ADP areas and ensuring that all people affected by problematic drug use benefit; including women, young people, people who live in remote and rural areas and people who use benzodiazepines and stimulants.

To do this the focus needs to be on ensuring that there is benefit to people as a result of the changes implemented and to sustain improvement requires an ongoing dialogue with people using and providing services so that meaningful change can happen.

Recommendations for the Public Health Scotland MAT programme

The Public Health Scotland (PHS) MAT programme will work with partners to complete the following actions.

Establish national systems for direct support and benchmarking to implement the MAT standards

a) Refresh ADP improvement plans based on 2023 benchmarking report**.**

b) Take an NHS Board approach for improvement work across multiple ADP areas to ensure consistency in planning, implementation and the experiences of people using services.

c) Develop local capacity to collect and use data across NHS Boards to update improvement plans, target areas of highest need and maximise staff capacity.

d) Strengthen processes for learning when someone dies as a result of drugs, particularly those not in contact with treatment services and ensure that this learning is used to strengthen implementation of the standards.

e) Strengthen the MAT standards implementation network, JUSTICE IN, the remote and rural group and the Health Improvement Scotland learning system to share learning and good practice.

f) Continue the programme of ‘support to report’ with ADPs to offer clinical advice, provide online and face-to-face training and workshops, field visits and continuous support for ADPs to collect, repot and use data throughout the year.

g) Expand ways to increase third sector contributions to MAT improvement work for example through networks and national leadership.

h) Review and improve the national benchmarking methodology to continue to reflect the work and outputs of ADP efforts and to ensure that the focus is on benefit to people as a result of the changes implemented.

i) Refresh the MAT standards document to include an additional standard on community engagement for improvement with respect to MAT, explicit requirements for people using non-opioid drugs and refined measures of progress.

j) Strengthen the national thematic groups on MAT standards 4, 6/10, 7, 8, 9 and 'remote and rural' to develop operational guidance, measures for progress and disseminate good practice.

Specific standards, populations and settings

a) MAT standard 3 – Develop national guidance for MAT standard 3 across community and justice settings for drug-related harm, including recommendations on data sources, out-of-hours working, drug liaison nurses, third sector commissioning, primary care contributions, data sharing, how to link to the Chief Officers Public Safety Groups and clarity on interventions such as screening, risk assessment, assertive outreach and anticipatory care planning.

b) MAT standard 3 – Develop a specification for a national evaluation of MAT standard 3 to determine the impact and effective components of the MAT 3 from a person-centred perspective and seek a commission from the Scottish Government to conduct the evaluation.

c) MAT standard 4 – Revise guidance on implementation and assessment to include sexual health and immunisation and to ensure effective harm reduction for polysubstance use.

d) MAT standard 5 – Collaborate with ADP teams to investigate and understand the reasons for the relatively high proportion of unsupported and early discharges and to find ways to move towards a majority of discharges being supported and after greater than six months in care.

e) MAT standard 8 – Review approaches to implementation and assessment to include support for housing, welfare and income needs and to ensure that feedback from people can confirm benefit.

f) MAT standard 9 – Develop national guidance for MAT standard 9 in line with the Mental Health and Welfare Commission recommendations.

g) Justice – Develop a toolkit on implementation of the MAT standards in justice settings and provide support to implement and measure them subject to local improvement initiatives and national action taken under section 7.2.

h) Justice – Conduct improvement work on MAT standard 3 across ADPs incorporating elements of justice into the integrated pathways so that people who have been within the justice system will be highlighted as someone at potential risk of drug harm and trigger a multiagency assertive outreach response and anticipatory care planning as required.

i) Justice – Expand the national system established in ADPs to collect experiential data on the MAT standards, to ensure the voices of staff, prisons residents and their families is used to inform improvement work.

j) Justice – Continue engagement at national level on data system updates that will be required to report on the implementation of the MAT standards in the 2025 benchmarking report.

k) Conduct further analysis with respect to age, gender, setting or service of the numerical and raw experiential data submitted and use this for improvement work that meets the needs of all populations.

l) Collaborate with ADPs to review approaches to implementation and assessment of the MAT standards for people with problematic benzodiazepine and stimulant use.

Build sustainable numerical data systems to monitor and improve implementation of the standards

a) Revise data definitions, data sources and recording rules, including definitions of settings and services, for MAT standards 1–5 and define them for MAT standards 6–10.

b) Support data collection throughout the year so that local teams can periodically conduct mini analysis to sense check actions and that plans and methodologies are delivering the best level of implementation for the standard.

c) Develop work arounds for national data collection including automated Excel spreadsheets, clinical audit, web-based data collection strategies (such as research electronic data capture) and linkage with existing national and local data systems to record evidence on implementation in the community and justice settings.

Build sustainable experiential data systems to monitor and improve implementation of the standards

a) Plan and document a programme of experiential work for 2023 and 2024 including: update of questionnaires, sampling and analysis; training materials; requirements for interviewers and experiential leads; support to use evidence to update improvement plans.

b) Scale up ADP experiential programmes to include justice setting.

Next steps

Based on the findings of this report, the next steps to enable full and sustained implementation of the MAT standards across community and justice settings include the following.

a) Strengthen partnership and communication on the multiple streams of work to implement and measure the MAT standards, treatment targets, access to

residential rehabilitation, care for people using non-opioid drugs and work on care and treatment for people with problematic alcohol use.

b) Ensure that local and national workforce strategies and drug and alcohol service specification include: diverse models of care involving non-clinical and third sector; increased recruitment and retention of non-medical prescribers, improved accommodation and co-location of partners; targeted support to those areas not effectively utilising the workforce; career pathways including postgraduate education (e.g. public health, prescribing, improvement methodology); career pathways in substance use services for people with lived and living experience; out-of-hours working; and plans to meet the specific needs of remote and rural ADPs such as relocation fees, flexible rotation, and rural premiums.

c) Ensure that there is sufficient dedicated resource and capacity for intermediate management, project management, experiential leadership, numerical and experiential analysis in all ADP areas.

d) Ensure that dedicated resource is allocated for senior public health leadership and expertise in NHS Boards.

e) Ensure that the experiential lead is adequately resourced to have the time, support and expertise required to carry out this role and that there is dedicated resource to analyse and interpret experiential data sufficiently.

f) Develop guidance and provide support on commissioning to help ADPs include the requirements of the MAT standards into existing and new programmes and to complement Scottish Government work on a national service specification.

g) Review and scale up implementation of telemedicine technology such as ‘NEAR ME’ for assessment and monitoring for people affected by problematic drug use.

h) Complete the work on a single (Once for Scotland) service-level agreement for community pharmacy and establish in all ADP areas a local protocol between

NHS addiction services and community pharmacy to ensure that communications, prescribing, dispensing and harm reduction meet the requirements of the MAT standards.

i) Develop a sustainability plan for implementation, evidence collection, continuous quality improvement and benchmarking for the MAT standard.

j) Establish a clear strategy for the resolution of information governance at national level for justice, NHS, third sector, social care and residential rehabilitation.

k) MAT standard 2 – Explore and confirm mechanisms to sustain funding for long-acting injectable buprenorphine and other forms of opioid substitution therapy.

l) MAT standard 2 – Develop models of care and a treatment guidance consensus statement for people who use benzodiazepines, stimulants and other substances.

m) MAT standard 3 – Identify and resource a lead agency to establish a 'national audit' including process, numerical and experiential measures so that the burden of reporting passes from ADPs to the auditor and decide who commissions this audit.

n) MAT standard 7 – Develop a national strategy for the implementation of MAT standard 7 including collaboration with the Royal College of General Practitioners.

o) MAT standard 8 – Develop a national strategy for the implementation of MAT standard 8.

p) Justice – Strengthen clinical leadership to implement the MAT standards across community and prisons and to support: a consistent approach to the implementation of NHS Board clinical policies and procedures; the development of a package of care tailored to the emerging drug trends and needs of people in prisons; investment in health and social care staff capacity and capability including resolution of dispensing issues and dedicated health

and social care resource for remand prisoners; coordinated systems for data collection and information governance; establishment of an overarching plan for implementation; culture change that enables flexibility and innovation, teams that are person centred and services that are evidence based.

q) Justice – Ensure there is sufficient resource and leadership in place to establish in community and justice settings ‘Once for Scotland’ data systems updates that meet the needs of the drugs mission in general and the MAT standards in particular (e.g., Vision, Adastra, Educational Management Information System, Drug and Alcohol Information System)’

r) Remote and rural – Increase the use of formal arrangements with other Health Boards to utilise guidelines and to share expertise.

s) Remote and rural – Re-establish remote prescribing guidance (as extant during the COVID-19 pandemic) to enable same-day access to opioid substitution therapy in remote and rural.

1. Introduction

According to data from the National Records of Scotland, in 2020 there were a record 1,339 drug-related deaths, with figures for 2021 showing a decrease of nine from the year before. While the number of deaths was still five times more than those recorded in 1996 the small decline was the first drop in drug deaths since 2013.

In January 2021, the Scottish Government announced a five-year National Mission on Drugs. The aim of the national mission is to reduce drug deaths and improve the lives of those impacted by drugs. The national mission plan, published in August 2022, sets out how the mission will be delivered over the duration of this parliament.

The outcomes are:

- fewer people develop problem drug use
- risk is reduced for people who take harmful drugs
- people at most risk have access to treatment and recovery
- people receive high-quality treatment and recovery services
- quality of life is improved for people who experience multiple disadvantage
- children, families and communities affected by substance use are supported

The Public Health Scotland (PHS)-led programme to help implement the 10 MAT standards will contribute to the mission outcomes and uses a benchmarking and field support approach to do this. Benchmarking is an approach for implementing best practice and enables organisations to assess their own achievements by comparing progress and approaches with partner organisations. It is not just a comparison of indicators and evidence but a tool based on active collaboration and inter-organisational support to create a spirit of competition and apply best practices.

This report presents an evidence-based assessment of implementation of the MAT standards so that ADPs can benchmark against each other, the baseline red, amber,

green, blue (RAGB) assessment conducted in 2022 and against parameters in the MAT standards document.

This is the second national benchmarking report on implementation of the 10 MAT standards and provides an update on implementation across the 29 ADP areas in Scotland for the financial year 2022/23.

1.1. Timeline of MAT programme activities

- March 2021, the PHS MAT programme was set up and includes the MAT Implementation Support Team (MIST) and MAT mainstreaming supported by the drugs team.
- May 2021, the MAT standards were published.
- February 2022, the MAT standards implementation network was set up and met weekly to coordinate improvement work.
- June 2022, the **first benchmarking report** was published.
- August 2022 to April 2023:
    - ADPs implemented improvement plans.
    - The MAT programme set up six national expert groups to advise on how to implement and measure individual standards and how to respond to the problematic use of benzodiazepines and stimulants.
    - The MAT programme produced national guidance on experiential and numerical evidence collection and RAGB assessment, alongside spreadsheets and questionnaires for data collection and reporting. Over 150 people including health and social care staff and many with lived and living experience of problematic drug use were trained to collect experiential evidence.

- The MAT programme conducted mapping in 12/15 prisons in Scotland of the policies and processes necessary for implementation of the MAT standards.
- The 17 ADPs that had been RAGB red for MAT standard 1 in 2022 implemented rapid tests of change with support from MIST.
- MIST and all ADPs collaborated on a ‘programme of support to implement and report’ to help increase capacity to implement and collect evidence of progress. Over 100 face-to-face field visits were carried out.
- December 2022, a national justice network, JUSTICE IN, was set up and met monthly to share improvement work.
- Healthcare Improvement Scotland set up an information-sharing and learning system to support implementation.

2. Scope

This report is an evidence-based assessment of progress with the implementation of MAT standards 1–10 across all 29 ADP areas in Scotland, as of April 2023.

The results presented will be used for benchmarking across ADP areas as part of the national improvement process.

Each ADP will receive later in the year, the national and local numerical data analysed for management information.

The document does not report on the wider work ADP areas are doing such as providing care for people with problematic alcohol use.

Note that in this report, Midlothian and East Lothian are separate IJBs but a single ADP. Falkirk ADP, and Clackmannanshire and Stirling ADP have a history of working closely together, as do their respective IJBs, so their progress is reported jointly in this report.

3. Methods

The 29 ADP areas were assessed against the 10 MAT standards using three streams of evidence: process, numerical and experiential. This means that 290 individual assessments were carried out, 145 for MAT standards 1–5 and 145 for standard 6–10. The evidence required to demonstrate implementation of each MAT standard was based on the criteria and indicators in the MAT standards document.

There are three phases to the development of effective systems to collect, report and use evidence to support implementation of the MAT standards and it is expected that the quality and completeness of the evidence will improve over the three phases.

- **Phase 1** (2021–22) acknowledged that many systems were not in place and the reporting requirements for the 2022 benchmarking report were flexible and developmental. For example, MAT standards 1–5 did require limited numerical data but did not require reporting of raw experiential data, and for standards 6–10 no evidence was requested.

- **Phase 2** (2022–23) has required more detailed and complete data because local and national systems have developed to a stage that can now support this. For example, process and experiential data (raw and analysed) has been requested for standards 1–10 with stringent numerical requirements for standards 1–5.

- **Phase 3** (2023–26) anticipates established and sustained national systems to collect and use evidence for improvement and reporting at local and national levels.

To help ADPs understand what data were required for 2023, MIST developed and disseminated guidance documents on the collection of numerical and experiential data; and on how the evidence would be used to assess progress and allocate a RAGB score. National consultation groups were set up to agree what evidence to collect and how.

Throughout the five months prior to the reporting deadline MIST worked closely with all ADPs to clarify the evidence needed to demonstrate implementation of the

standards, to refine and test reporting tools and to provide training and field support to help ensure that ADPs' work was consistent and fairly reflected in evidence submissions. Targeted field support was provided to help overcome challenges in specific areas and good practice was disseminated between ADPs. This process was called support to implement and report. During this time MIST agreed with ADPs a predicted RAGB score on the understanding this may change once final evidence was submitted.

Process documentation such as care pathways and standard operating procedures were developed by local teams and templates were used for structured self-assessment in collaboration with MIST. There was a specific 'remote and rural' template to assess the extent to which the challenges of travel, technology and models of care are optimised.

There is no single national system for collecting numerical data on the MAT standards and so a combination of extracts from the Drug and Alcohol Information System (DAISy) and bespoke spreadsheets were set up for recording and analysing numerical data. Details are recorded in the MIST numerical measures data manual which can be used to help inform the development of national systems in the future. Numerical data were collected for MAT standards 1–5 using a suite of Excel spreadsheets. Data from the Excel spreadsheets were analysed using Excel and Tableau using a range of measures such as interquartile range, median of medians and proportions.

The experiential data were collected by teams developed locally with MIST support and training. A standard MIST questionnaire was used and adapted locally as required. A question bank with additional questions on MAT standards 3,6,9 and 10 was also provided. Data were recorded on formatted spreadsheets, analysed locally and submitted along with the raw data.

Data for all evidence streams were anonymised, mostly covered the last quarter of financial year 2022/23 and were submitted to PHS by 14 April 2023. Further detail on methods is in MIST guidance.

The evidence submitted for each standard was analysed and scored by MIST on the extent to which it complied with the agreed criteria and thresholds for each evidence stream:

- Score 0 = no compliance demonstrated or no evidence.
- Score 1 = compliance demonstrated at some settings/services.
- Score 2 = compliance demonstrated at all settings/services.

The scores for the evidence streams (three for MAT standards 1–5, two for 6–10) were combined and then all 29 ADPs were jointly reviewed and repeatedly cross checked by the MIST clinical and analytic leads to interpret the information and allocate the final evidence-based RAGB.

A key consideration in the interpretation of the data and allocation of the final RAGB was the extent to which the evidence streams, local context and clinical knowledge demonstrated benefit to people affected by problematic drug use across an ADP area.

The definitions of the RAGB are below.

- **Red:** There is no or limited evidence of implementation of the standard in MAT services.
- **Provisional amber:** There is evidence that implementation is beginning but no evidence of benefit to people.
- **Amber:** There is evidence of partial implementation of the standard in MAT services including benefit to people.
- **Provisional green:** There is evidence of implementation and benefit to people, however, full implementation is not confirmed by all three evidence streams – usually the experiential stream is lacking.
- **Green:** There is evidence of full implementation and benefit to people in all unique combinations of setting and service that offer MAT and opioid substitution therapy across the ADP area.

- **Blue**: There is evidence of sustained implementation and benefit to people plus ongoing monitoring of the standard across all MAT services.

The reason for the addition of provisional amber is to enable the distinction to be drawn between an ADP that has progressed to good implementation with evidence of benefit to people but not yet in all settings and services; and an ADP that is at a very early stage of implementation. This is often in a single setting or service and where there is no or minimal evidence of patient benefit.

The reason for the addition of provisional green is to accommodate the challenge of getting all three strands of evidence to demonstrate evidence of patient benefit for all settings and services in an ADP. The biggest challenge is obtaining experiential evidence across all settings and services to confirm full implementation.

Note: where the term ‘fully implemented’ is used in this report, it includes standards with an assessed RAGB status of ‘green’ and ‘provisional green’.

There are some standards for which the proportion of ADPs assessed as RAGB green status has decreased from 2022 to 2023. This would be expected because the criteria used are stricter and more explicit in 2023 as compared with 2022. For example, in 2022 for MAT standard 1 the threshold time from referral to prescription was three days in 2022 and is one day from request to engage to prescription in 2023; and the measurement has been changed from the median to the upper quartile so that it must be achieved for 75% of people rather than 50%.

Once the evidence-based RAGB assessments were agreed, they were communicated to all 29 ADPs by email with the option for a follow-up conversation on Microsoft Teams especially where the evidence-based RAGB differed from the predicted RAGB from the support to implement and report process. In the event that agreement between MIST and an ADP was not possible, the evidence was reviewed by volunteers from the MAT measures oversight group and that decision was regarded as final.

4. Findings

4.1. Evidence collection

This report demonstrates that the capacity and capability for ADPs to provide evidence of implementation and the quality and completeness of that evidence has been transformed from 2022 to 2023.

For MAT standards 1–5, all 29 ADPs provided the required streams of evidence for the 145 standards assessed (29 ADPs, 5 standards each) with the exception of one ADP that did not provide experiential evidence. Of the evidence provided, 79% of process, 61% of numerical and 12% of experiential evidence was fully compliant with the agreed criteria to demonstrate implementation (Chart 3).

For MAT standard 6–10 process evidence was submitted for 100% and experiential evidence for 87% of the 145 standards assessed. Of the evidence provided 46% of process and 3% of the experiential evidence was fully compliant with the agreed criteria to demonstrate implementation (Chart 7).

Demographic analysis of all the experiential evidence submitted in 2023 indicates that it is broadly representative of the national case load. Analysis of gender shows 32% (122/385) female, 66% (256/385) male and 2% (7/385) other; although this latter figure may not reflect the national caseload due to lack of system to record transgender.

Analysis of age groups shows the largest group was age 25–44 (38%, 148/385), followed by 45–54, 25–34, under 25 and over 55 (28%, 20%, 9% and 7% respectively). The number of interviews conducted across the 29 ADP areas ranged between zero to 65 interviews in the reporting period with a median of 11.

Further information on the challenges of evidence collection is in Appendix 3.

Chart 3: Evidence provided by 29 ADP areas by evidence stream for MAT standards 1–5. Scotland 2022 and 2023

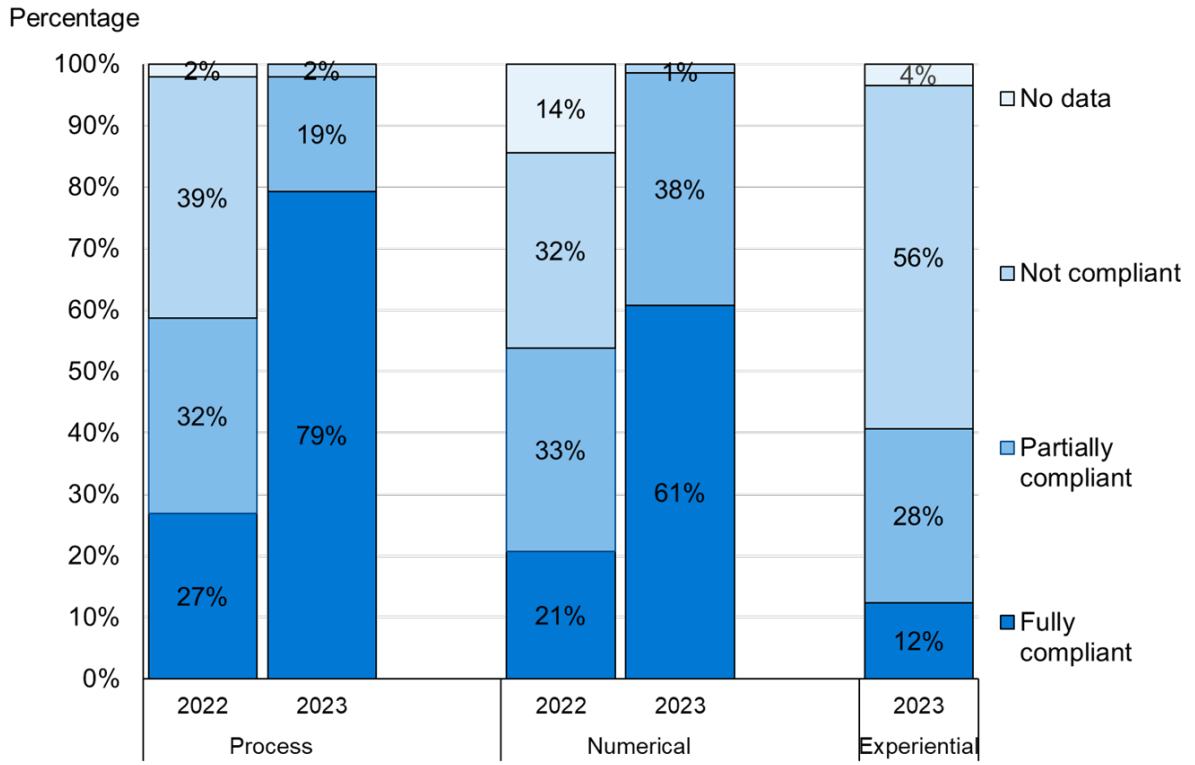


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 1–5 (five standards assessed for each of the 29 ADP areas). The data show that:

- For the process evidence stream documentation was submitted for 100% of standards in 2023 this increased from 98% in 2022. 79% of documentation was fully compliant with the agreed criteria to demonstrate implementation which is an increase from 27% in 2022. 19% was partially compliant with the criteria which has decreased from 32%. 2% of documentation was not compliant, this decreased from 39%.

- For the numerical evidence stream, data were submitted for 100% of standards in 2023, this increased from 86% in 2022. For 61% the data were fully compliant with the agreed criteria and thresholds to demonstrate implementation, this increased from 21% in 2022. 38% of data were partially

compliant, this increased from 33%. 1% of data submitted were not compliant which was a decrease from 32%.

- For the experiential evidence stream, data were submitted for 96% of standards in 2023, this is an increase from 57% in 2022. 12% of the data were fully compliant with the agreed criteria to demonstrate implementation. 28% of the data were partially compliant, with 56% not compliant. There were no data for 4% of standards. A comparison between 2022 and 2023 is not appropriate for the experiential evidence stream due to limited data in 2022.

Chart 4: Process evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 1–5. Scotland 2022 and 2023

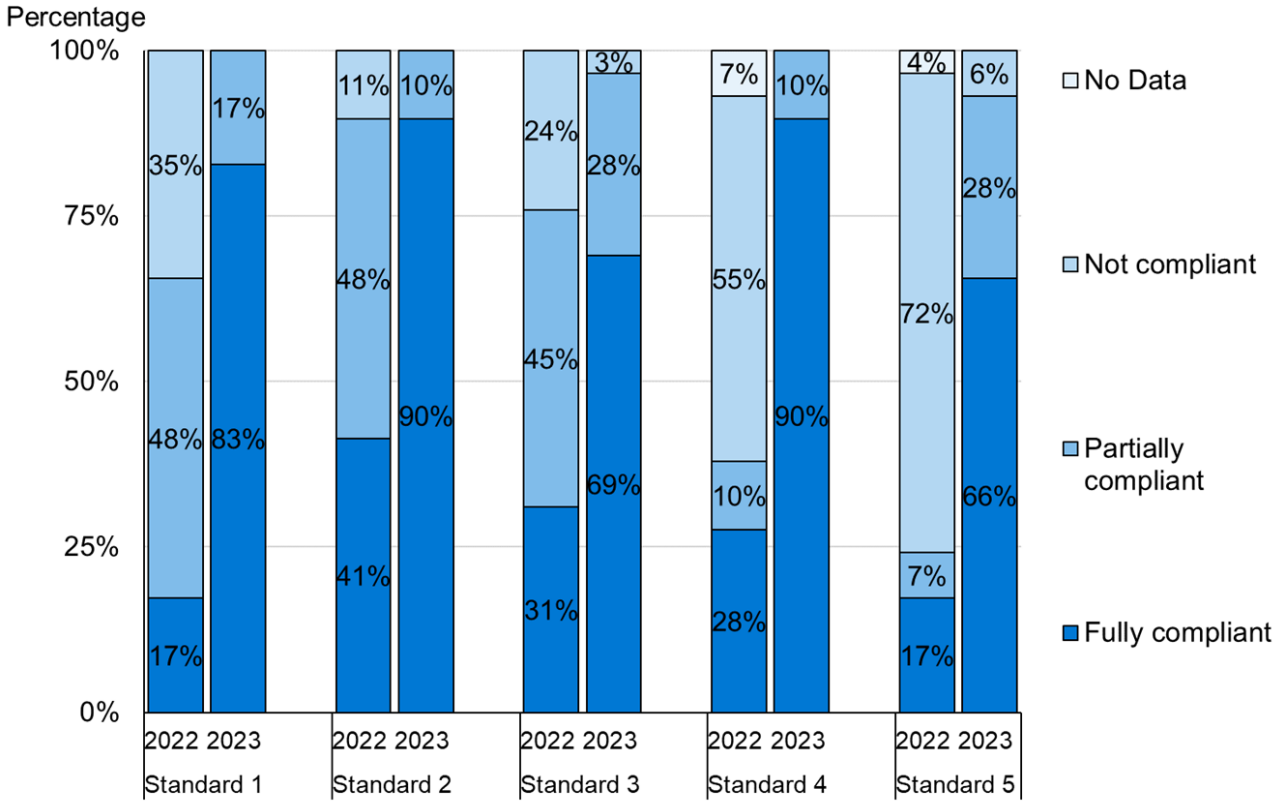


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 1–5. The data show that standards 2 and

4 were most likely to have process documentation fully compliant with the agreed criteria to demonstrate implementation (90% for both).

Chart 5: Numerical evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 1–5. Scotland 2022 and 2023

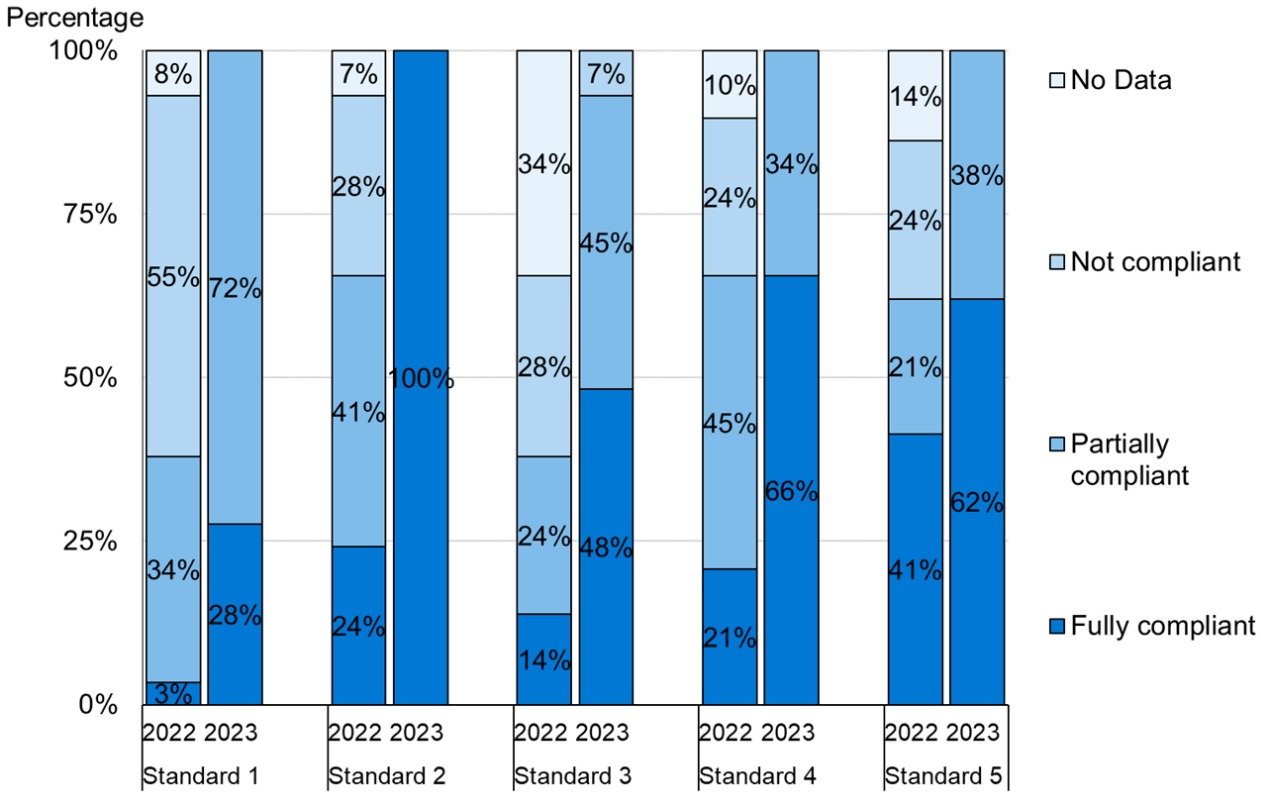


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 1–5. For the numerical evidence stream, standard 1 was least likely to have numerical data fully compliant with the agreed criteria and thresholds to demonstrate implementation (28%, this has increased from 3% in 2022) and also shows the largest proportion of where the data were partially compliant (72%, up from 34% in 2022). Standard 2 showed 100% of data provided were compliant with the criteria and thresholds to demonstrate implementation. Standard 3 was the only standard with evidence submitted that was not compliant with the agreed criteria and thresholds (7%), a decrease from 28% in 2022.

Chart 6: Experiential evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 1–5. Scotland 2023

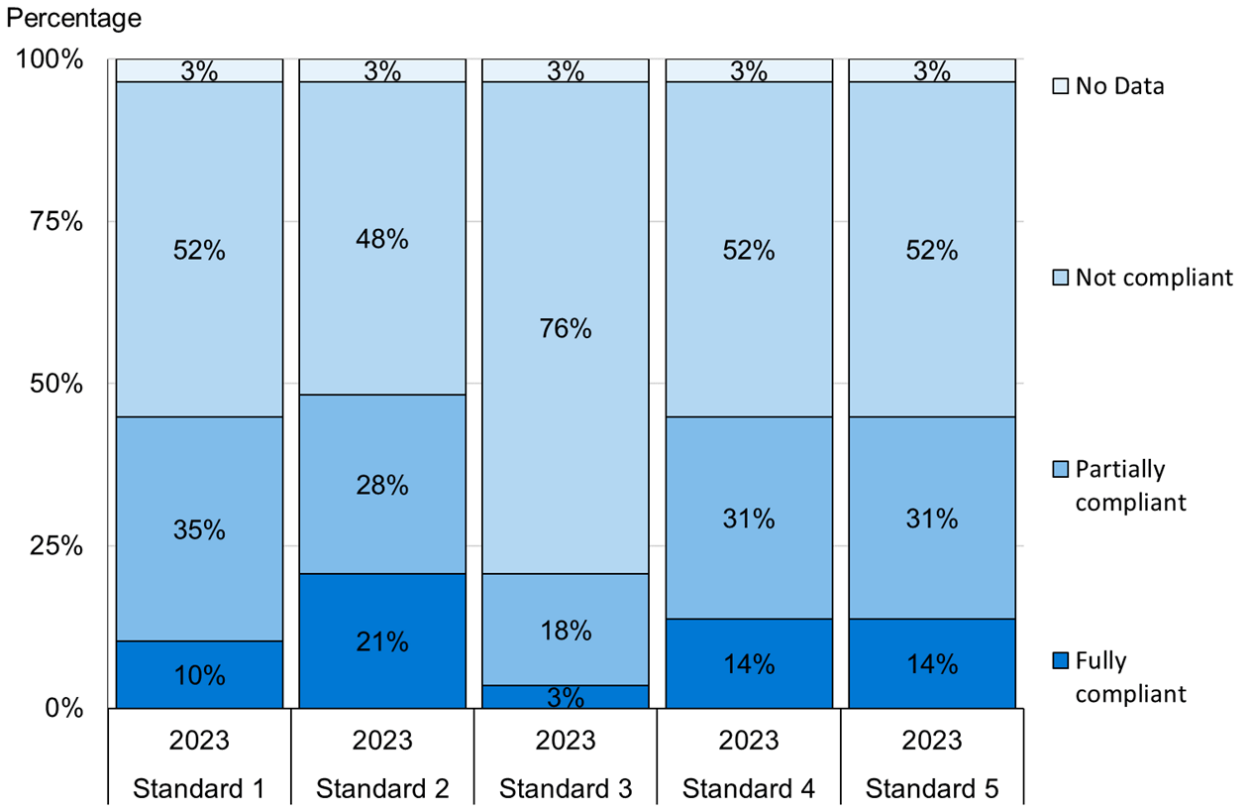


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 1–5. Experiential data were provided for MAT standards 1–5 for 97% of ADP areas. For standard 2 the evidence was compliant with agreed criteria to demonstrate implementation for 21% of ADP areas, 14% for standard 4 and 5, 10% for standard 1 and 3% for standard 3.

Demographic analysis of the 2023 evidence submitted indicates that it is broadly representative of the national case load. Analysis of gender shows 32% (122/385) female, 66% (256/385) male and 2% (7/385) other; although this latter figure may not reflect the national caseload due to lack of a system to record transgender. Analysis of age groups shows the largest group was age 25–44 (38%, 148/385), followed by 45–54, 25–34, under 25 and over 55 (28%, 20%, 9% and 7% respectively).

The number of interviews conducted across the 29 ADP areas ranged between zero to 65 interviews in the reporting period with a median of 11. Further information on the challenges of evidence collection is in Appendix 3.

Chart 7: Process and experiential evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 6–10. Scotland 2023

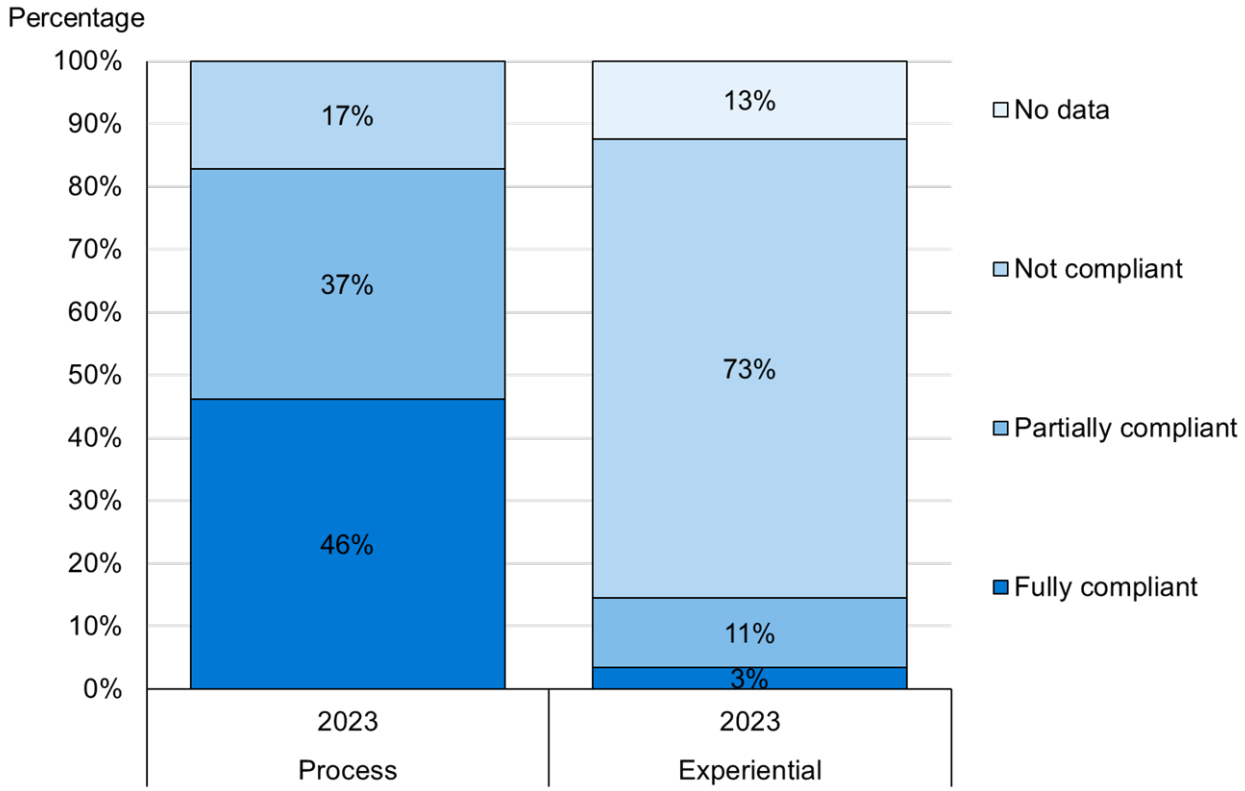


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 6–10. The data show that:

- For the process evidence stream documentation was submitted for 100% of standards in 2023. 46% of documentation was fully compliant with the agreed criteria to demonstrate implementation. 37% was partially compliant and 17% was not compliant.
- For the experiential evidence stream, data were submitted for 87% of standards in 2023. 3% of the data were fully compliant with the agreed criteria to demonstrate implementation. 11% of the data were partially compliant and 73% were not compliant with agreed criteria to demonstrate implementation. There were no data for 13% of standards assessed.

Chart 8: Process evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 6–10. Scotland 2023

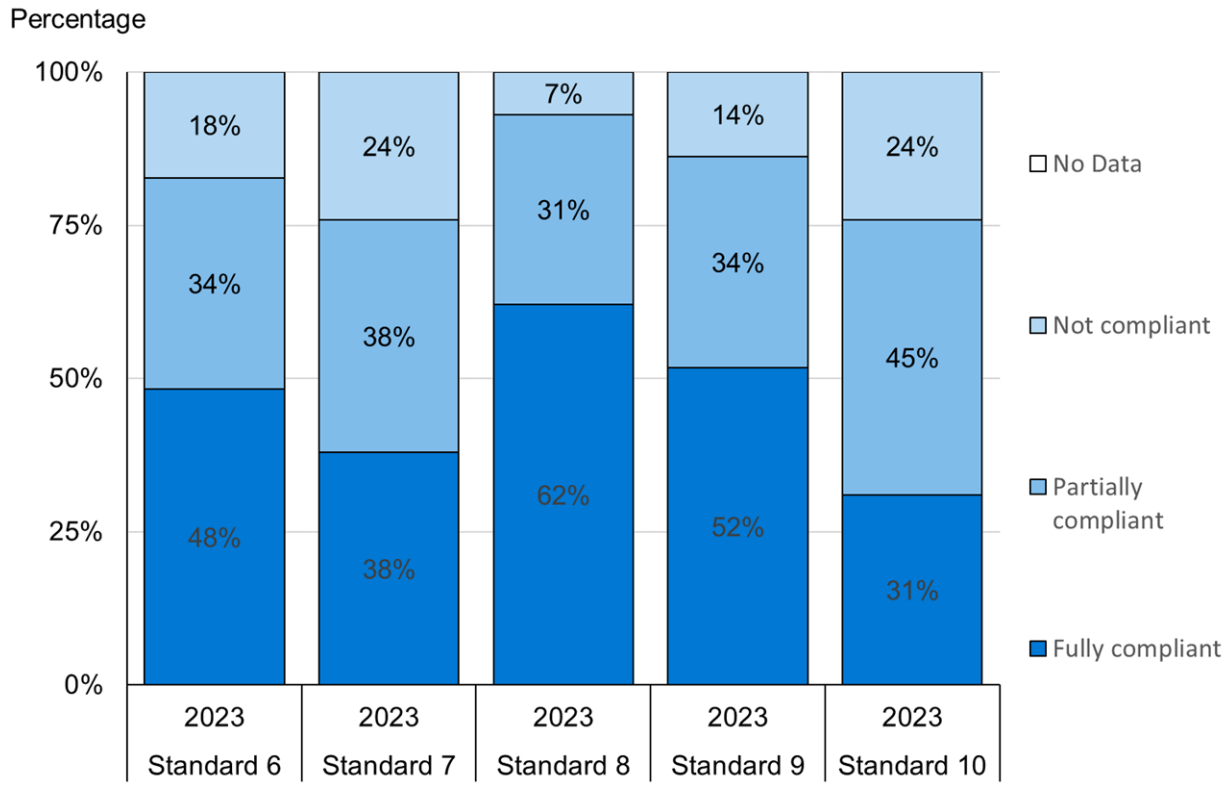


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 6–10. The data show that standards 8 and 9 were most likely to have process documentation fully compliant with the agreed criteria to demonstrate implementation (62% and 52% respectively). Standard 10 and standard 7 were least likely (31% and 38% respectively)

Chart 9: Experiential evidence provided by 29 ADP areas to demonstrate implementation of MAT standards 6–10. Scotland 2023

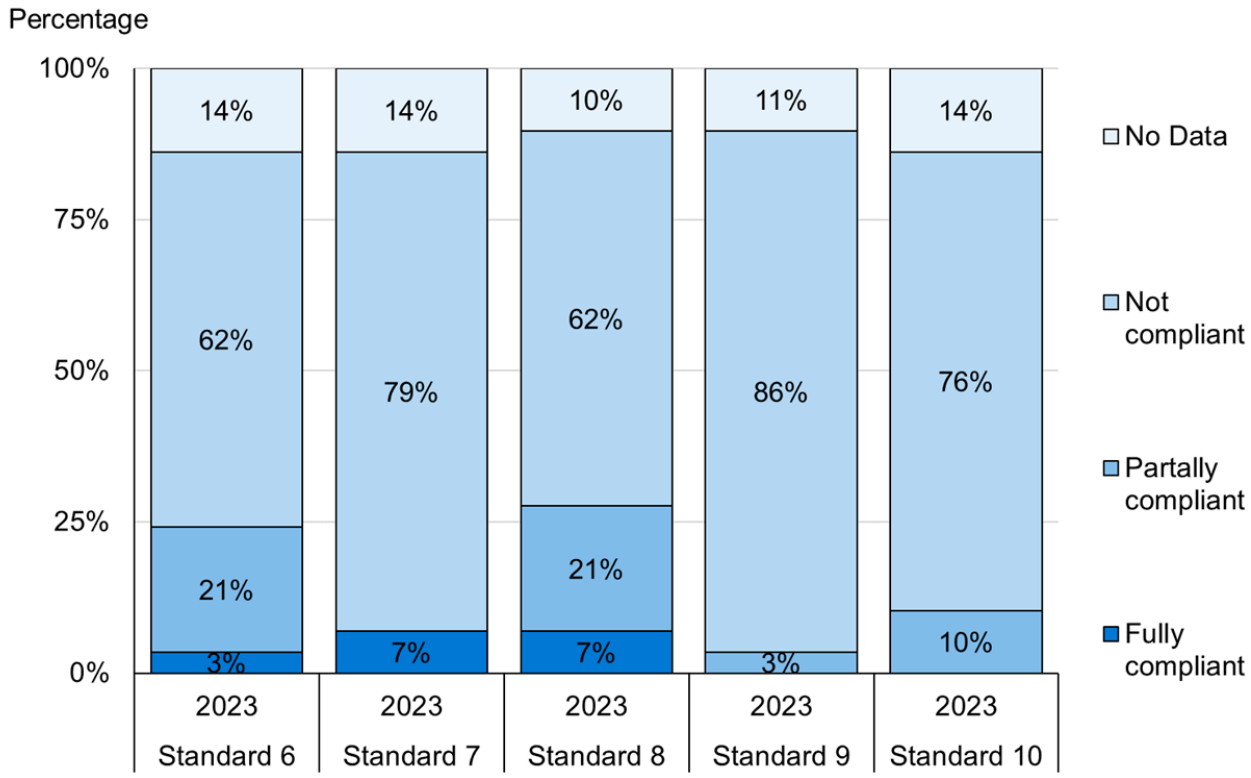


Chart description: This chart shows the evidence provided from 29 ADP areas for a total of 145 assessments of MAT standards 6–10. The data demonstrated that evidence showed compliance with the agreed criteria to demonstrate implementation was provided for standards 6, 7 and 8 (3%, 7% and 7% respectively). For standards 6 and 8 evidence was partially compliant (21% each) but for all five standards the majority of evidence submitted was not able to demonstrate implementation.

Demographic analysis of all the experiential evidence submitted in 2023 indicates that it is broadly representative of the national case load. Analysis of gender shows 32% (122/385) female, 66% (256/385) male and 2% (7/385) other; although this latter figure may not reflect the national caseload due to lack of system to record transgender. Analysis of age groups shows the largest group was age 25–44 (38%, 148/385), followed by 45–54, 25–34, under 25 and over 55 (28%, 20%, 9% and 7% respectively). The number of interviews conducted across the 29 ADP areas ranged between zero to 65 interviews in the reporting period with a median of 11.

Further information on the challenges of evidence collection is in Appendix 3.

4.2. MAT standards 1–10: Assessment of implementation

In total, 290 standards were assessed against the evidence provided, 10 standards assessed for each of the 29 ADPs. Some ADP areas (14/29) provided data by settings, services and geographical locations. This made it possible to assess whether a standard was met for people living across the entire ADP area and helped highlight gaps for improvement in some locations. However, this was not consistently reported across all ADPs.

In many cases, experiential evidence was not sufficient to confirm or deny implementation of a given standard due to low numbers of interviews, lack of information about specific standards and feedback that predated service improvements which therefore did not qualify for analysis. For this reason, many areas with process and numerical evidence of full implementation have not progressed beyond provisional green.

The assessment of MAT standards 6–10 was mainly based on documented process evidence and whether this had been converted into actions that benefit people. This is because few ADP areas were able to provide experiential evidence for these standards.

Eleven of 29 ADP areas contested RAGB scores with MAT standards 1, 3, 5 and 7 most disputed. Challenges related to discrepancies between predicted scores and final evidence-based scores. The issues most discussed for a given standard related to definitions and recording of numerical data and the interpretation overall of the combined data. For seven ADP areas RAGB scores for a given standard were amended as a result of discussions provided the data supported these adjustments. The assessment of one standard was independently reviewed and confirmed by the MAT measures oversight group.

Chart 10 describes progress with implementation of the MAT standards at national level. Appendix 4 provides a breakdown by ADP area.

Chart 10: Percentage of ADPs with RAGB score for MAT standards 1–5 and 6–10. Scotland 2023

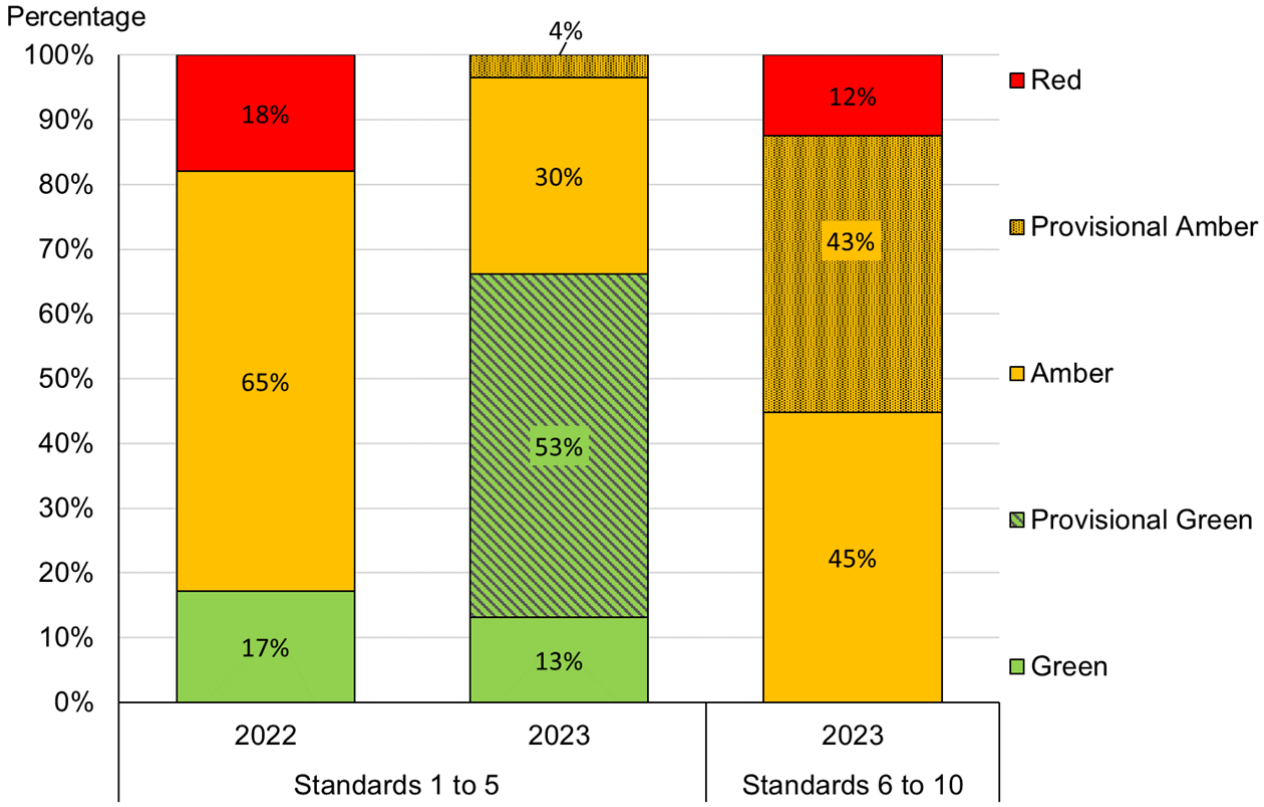


Chart description: Across all 29 ADP areas for MAT standards 1–5, 96/145 (66%) have been assessed as fully implemented (19/145, 13% green; 77/145, 53% provisional green). This is an increase from 17% (25/145 green) in 2022. Across all 29 ADP areas for MAT standards 1–5, 49/145 (34%) are partially implemented (44/145, 30% amber; 5/145, 4% provisional amber), compared with 65% (94/145) in 2022. In 2023 no standards were assessed as not implemented compared with 18% (26/145) in 2022. For MAT standards 6–10, none are assessed as fully implemented, 127/145 (88%) standards are partially implemented (65/145, 45% amber; 62/145, 43% provisional amber) with 12% (18/145) not implemented. The RAGB score blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard.

Chart 11: Percentage of ADP areas with RAGB score per MAT standard 1–5. Scotland 2022 and 2023

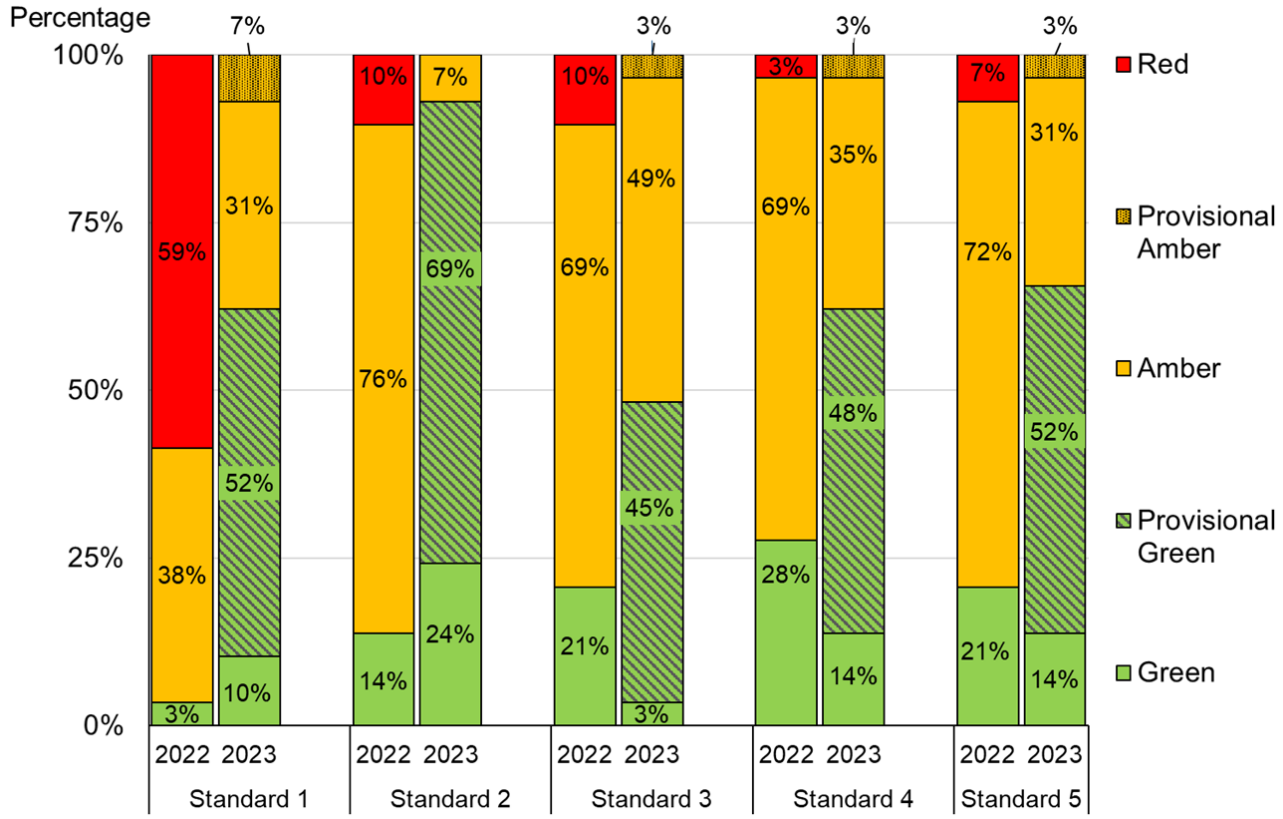


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 1: The standard is fully implemented in 18/29 (62%) ADP areas (3/29, 10% green; 15/29, 52%, provisional green). This is an increase of 17 ADP areas (up by 59%) from 2022. The standard is partially implemented in 11/29 (38%) ADP areas (9/29, 31% amber; 2/29, 7% provisional amber). This remains the same as 2022 and not implemented in no ADP areas, this is a decrease of 17 ADP areas down by 59% from 2022.

- MAT standard 2: The standard is fully implemented in 27/29 (93%) ADP areas (7/29, 24% green; 20/29, 69% provisional green), this is an increase of 23 ADP areas (up by 79%) from 2022. The standard is partially implemented in two ADP areas (2/29, 7% amber), this is a decrease of 20 ADP areas (down by 69%) and not implemented in no ADP areas, this is a decrease of three ADP areas (down by 10%).

- MAT standard 3: The standard is fully implemented in 14/29 (48%) ADP areas (1/29, 3% green;13/29, 45% provisional green), this is an increase of eight ADP areas (up by 26%) from 2022. The standard is partially implemented in 15/29 (52%) ADP areas (14/29, 49% amber; 1/29,3% provisional amber), this is a decrease of five ADP areas (down by 16%) and not implemented in no ADP areas, this is a decrease of three ADP areas (down by 10%).

- MAT standard 4: The standard is fully implemented in 18/29 (62%) ADP areas (4/29, 14% green; 14/29, 48% provisional green), this is an increase of 10 ADP areas (up by 34%) from 2022. The standard is partially implemented in 11/29 (38%) ADP areas (10/29, 35% amber; 1/29, 3% provisional amber), this is a decrease of nine ADP areas (down by 31%) and not implemented in no ADP areas, a decrease of one ADP area (down by 3%).

- MAT standard 5: The standard is fully implemented in 19/29(66%) ADP areas (4/29,14% green; 15/29, 52% provisional green), this is an increase of 13 ADP areas (up by 45%) from 2022. The standard is partially implemented in 10/29 (34%) ADP areas (9/29, 33% amber; 1/29, 3% provisional amber), this is a decrease of 10 ADP areas (down by 38%) and not implemented in no ADP areas, this is a decrease of two ADP areas (down by 7%).

- The RAGB score blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard, this remains the same as 2022.

Chart 12: Percentage of ADPs with RAGB score per MAT standards 6–10. Scotland 2023

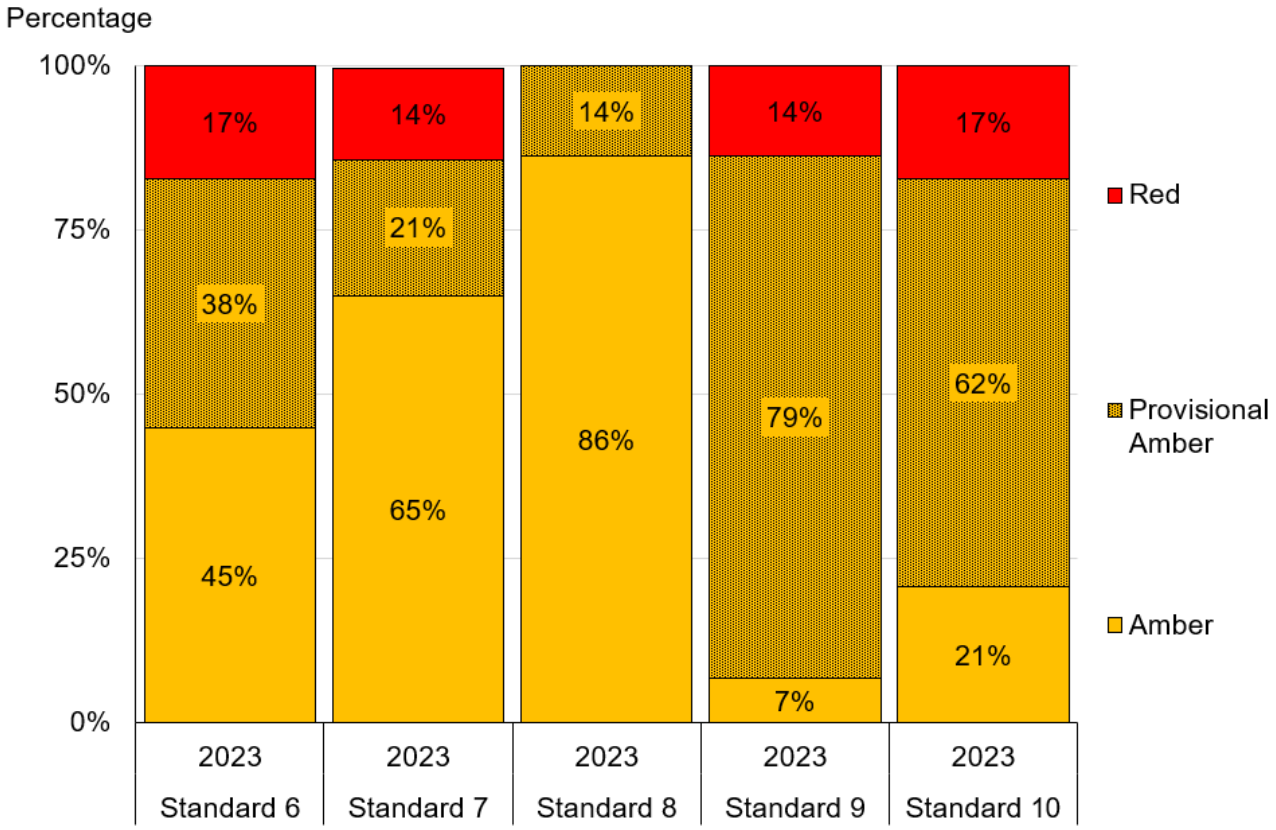


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 6: The standard is partially implemented in 24/29 (83%) ADP areas (13/29, 45% amber; 11/29, 38% provisional amber) and not implemented in five ADP areas (17%).
- MAT standard 7: The standard is partially implemented in 25/29 (86%) ADP areas (19/29; 65% amber; 6/29, 21% provisional amber) and not implemented in four ADP areas (14%).
- MAT standard 8: The standard is partially implemented in all 29/29 (100%) ADP areas (25/29, 86% amber; 4/29, 14% provisional amber).
- MAT standard 9: The standard is partially implemented in 25/29 (86%) ADP areas (2/29, 7% amber; 23/29, 79% provisional amber) and not implemented in four ADP areas (14%).

- MAT standard 10: The standard is partially implemented in 24/29 (83%) ADP areas (6/29, 21% amber; 18/29, 62% provisional amber) and not implemented in five ADP areas (17%).

4.3. MAT standards: Detailed assessment

MAT standard 1: Same-day access

All Health Boards now have prescribing guidance that allows practitioners to prescribe opioid substitution therapy on the day of presentation. In many places multiple referral routes have been established so that people can choose self-referral by phone, referral by third sector or primary care partners, walking into a service ('drop-ins') or booked appointments. Examples of improvement work include the following.

West Dunbartonshire ADP have undertaken quality improvement work in collaboration with partners from the third sector, health, social work, justice, people with lived and living experience and family members. The accessibility of the pathways into treatment were explored and it was agreed to prioritise self-referral by phone or walk-in and referral by primary care and third sector. A pathway for rapid access to MAT was also established for people identified as being at very high risk of drug harm. The improvement work includes the development of information leaflets and welcome packs advising people how to access services and what to expect.

In North and South Lanarkshire ADPs, the urgent care response team provide a single phone number that people can call to access opioid substitution therapy, harm reduction or psychosocial support. If people struggle to engage and concerns are raised, there is an assertive outreach response being ratified to support people into care. This approach will allow family members or nominated persons to have a single point of contact should they need to raise concerns or seek advice.

Perth and Kinross ADP, substance use services have limited prescribing capacity and do not have a high number of new referrals for same-day prescribing outside Perth City. To ensure rapid access and to offer opportunities to people out with Perth

City five days a week, clinical teams to prioritise a prescribing appointment in the diary every day. A triage prescribing assessment is often completed in advance of the prescribing appointment to make best use of capacity.

In October 2022, the East Lothian Substance Use Service began to offer same-day access to opioid substitution therapy. This service is delivered by one member of the nursing team over three appointment slots every weekday. Referrals are generally seen on the same day unless the person requests a later date to suit their own preferences. Referrals into the service are from a range of partners including an additional route opened in December 2022 through the new assertive outreach team. This team is well placed to facilitate entry into the same-day treatment programme and do so at every opportunity.

There are excellent examples of holistic guidance that enables people to be assessed for wider health needs such as respiratory conditions, blood-borne viruses and polydrug use at the point of prescribing. In most settings and services there are documented disengagement pathways in place so that people who are not currently in care and at risk of serious drug-related harm can have rapid access to a prescribing assessment. For example, in Greater Glasgow and Clyde and Ayrshire and Arran NHS Boards, when someone has self-referred for opioid substitution therapy assessment and fails to attend, this triggers an assertive outreach response to engage with the person. Treatment is offered because it is possible they are at high risk of overdose or other harm.

While all areas are implementing MAT standard 1, models of care are not always resilient and multiple challenges remain. Recruitment and retention of staff is difficult nationally with posts remaining unfilled despite several recruitment attempts. There are a limited number of prescribers and not enough opportunities to complete prescribing courses for nurses and pharmacists. This is a priority for workforce planning at local and national levels.

Out-of-hours provision for people to access MAT through community addiction teams is not usually available. In Lanarkshire there are plans in place to have the urgent care response team operate seven days per week, although current recruitment challenges mean they are still delivering Monday to Friday at present.

It is challenging for remote and rural areas to provide same-day prescribing five days per week due to limited prescribing capacity in small teams covering large geographical areas. Innovative and effective solutions offered in rural areas include ‘drop-in’ clinics in different community settings across an area once per week, booked prescriber appointments, the use of telehealth (e.g. NEAR ME) to complete risk assessments with people prior to face-to-face appointments, ready access to transport (e.g. taxis, bus passes) and third sector support workers to support someone to be seen out with their own locality.

In some areas there are few pharmacy providers and not all offer supervision of opioid substitution therapy. This can result in people having to travel to other areas for supervision of their medication. Innovative pharmacy models, including remote prescribing (where a provider can convey a prescription by email to a dispensing pharmacy), are crucial to sustain MAT standard 1 across all areas in Scotland.

The developments noted have resulted in greatly improved access to MAT and this is demonstrated by the numerical data.

Across all ADPs in 2023, 75% of people who requested a prescription received it within four days. Chart 13 shows the median time from initial presentation to receiving a prescription for opioid substitution therapy and this indicates that 50% of people who requested a prescription received it within one day with a range of 0–14 days. While these figures are not directly comparable with the 2022 data due to differences in data measurement and quality, they do demonstrate a significant improvement from 2022 where 50% of people who requested a prescription received it within a much longer six days with a range of 4–23 days.

In the 10 remote and rural ADP areas, 50% of people received an opioid substitution therapy prescription within two days. This was assessed as reasonable in areas that demonstrate maximisation of technology, travel and multiagency staff resources to ensure rapid and safe access to treatment and care.

Further analysis shows no significant difference between two time categories (one day or less, greater than one day) by age and gender.

Chart 13: Number of days from engagement to prescription for 50% of people by ADP area. Scotland 2023

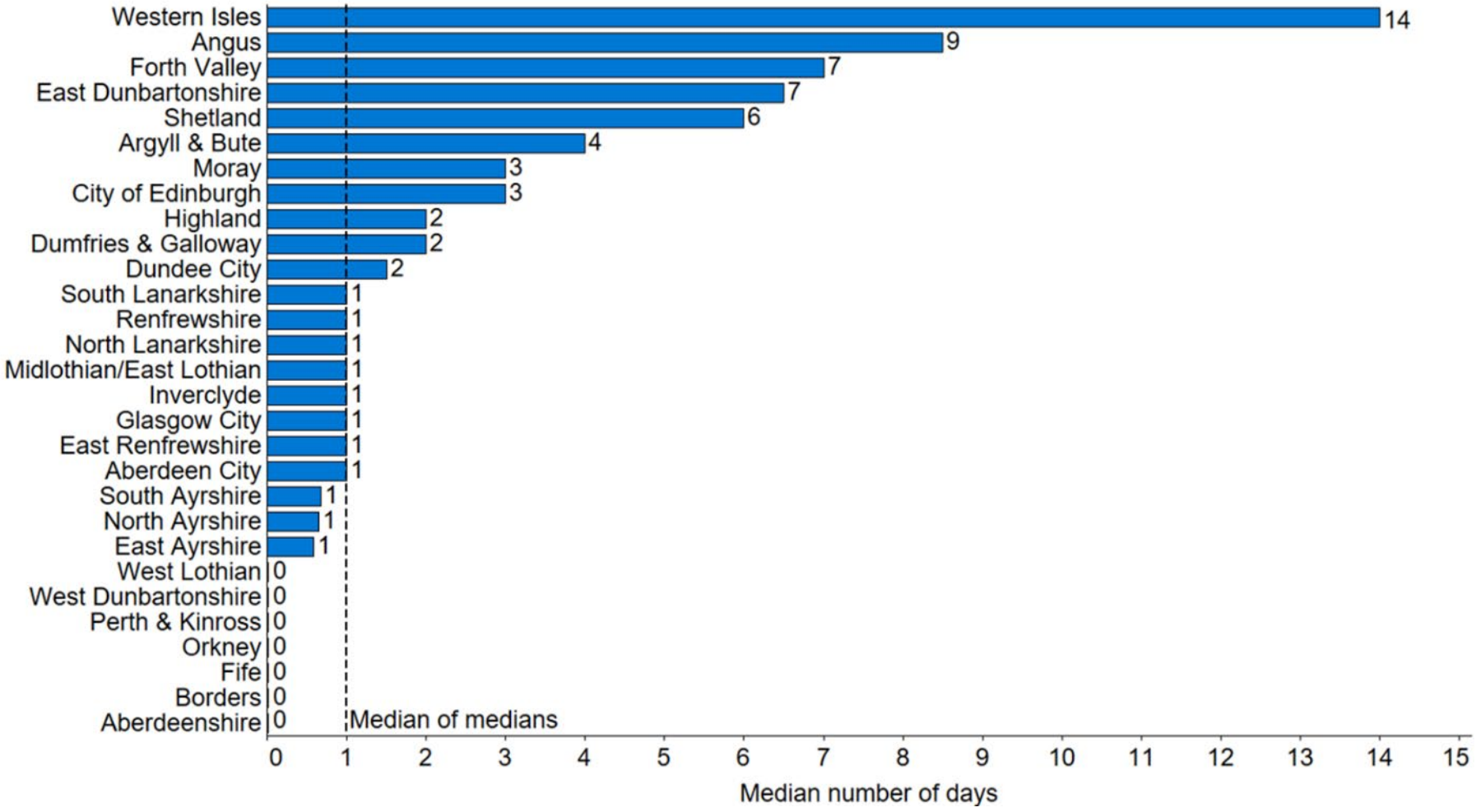


Chart description: From January 2023 to March 2023, seven ADP areas report a median of receiving a prescription on the same day, while one ADP area reports a median of 14 days. Eleven ADP areas have a median of one day.

MAT standard 2: Choice

All 14 Health Boards across Scotland now have methadone, short-acting oral buprenorphine and long-acting injectable buprenorphine on their prescribing formularies.

Long-acting injectable buprenorphine requires a UK Home Office licence to allow storage and administration on site and nearly all ADPs now have this licence or are using a named patient standard operating procedure that provides a written means to instruct employees on how to administer long-acting injectable buprenorphine. Due to licencing and product restrictions, this treatment option is rarely available for those receiving care in general practice.

There are good examples of work to overcome challenges. In NHS Dumfries and Galloway, the service has built multidisciplinary teams, including roles such as support workers and clinical psychiatrists alongside nurses, GPs, pharmacy technicians and pharmacists. Investing in staff training can help people make informed choices as it enables staff to provide clear and up-to-date information. Since the launch of the pilot in December 2020, continuous growth and investment has enabled the service to expand the number of patients they can treat with buprenorphine from 30 to 210 people.

In Aberdeenshire ADP a pilot in five community pharmacies involved dispensing and administration of long-acting injectable buprenorphine by the pharmacist. This approach is now established in Aberdeenshire, Lothian NHS Board and Glasgow City ADPs. There are good examples of accessible information for people and their families to enable informed choice, for example both Greater Glasgow and Clyde NHS Board and Lanarkshire NHS Board use leaflets which were developed by the European Network of People Who Use Drugs project in partnership with the Scottish Drug Death Task Force, Scottish Specialist Pharmacists in Substance Misuse, and advocates from Germany, Sweden and the UK.

The Argyll and Bute addiction team is an integrated team comprising specialist staff from NHS Highland and Argyll and Bute Council. Cowal is an area that has the highest number of drug-related deaths in the area and high numbers of people seeking support for domestic abuse and mental health. In March 2023 the Cowal service started an open-door approach offering a range of treatment choices for people affected by substance use including long-acting injectable buprenorphine. The team considers this new way of working as a significant change in culture for the communities it serves. Feedback so far indicates that people have found buprenorphine to be a life-changing treatment option. Some people had been attending their local pharmacy for methadone every day for years. The availability of buprenorphine treatment now offers them more opportunities, flexibility, privacy and dignity.

The numerical data demonstrate that all three options for opioid substitution therapy are available in all ADPs (NB: Western Isles had no new requests for opioid substitution therapy in the reporting period) and that there is an increased proportion of people choosing long-acting buprenorphine in 2023 (13%) versus 2022 (6%) (Chart 14).

There is, however, variation between ADP areas (Chart 15) and age groups (Chart 16). The proportion of the ADP caseload being prescribed long-acting injectable buprenorphine varies from 20–34% in nine ADPs to 5% or less in 10 ADPs with a median of 12.5%.

Across ascending age groups there is a clear increase in the proportion being prescribed methadone with a decrease in people being prescribed oral and long-acting injectable buprenorphine (Chart 16). There is no evidence of a significant difference in uptake of choices between males and females.

Chart 14: Percentage of caseload prescribed opioid substitution therapy by type. Scotland 2023

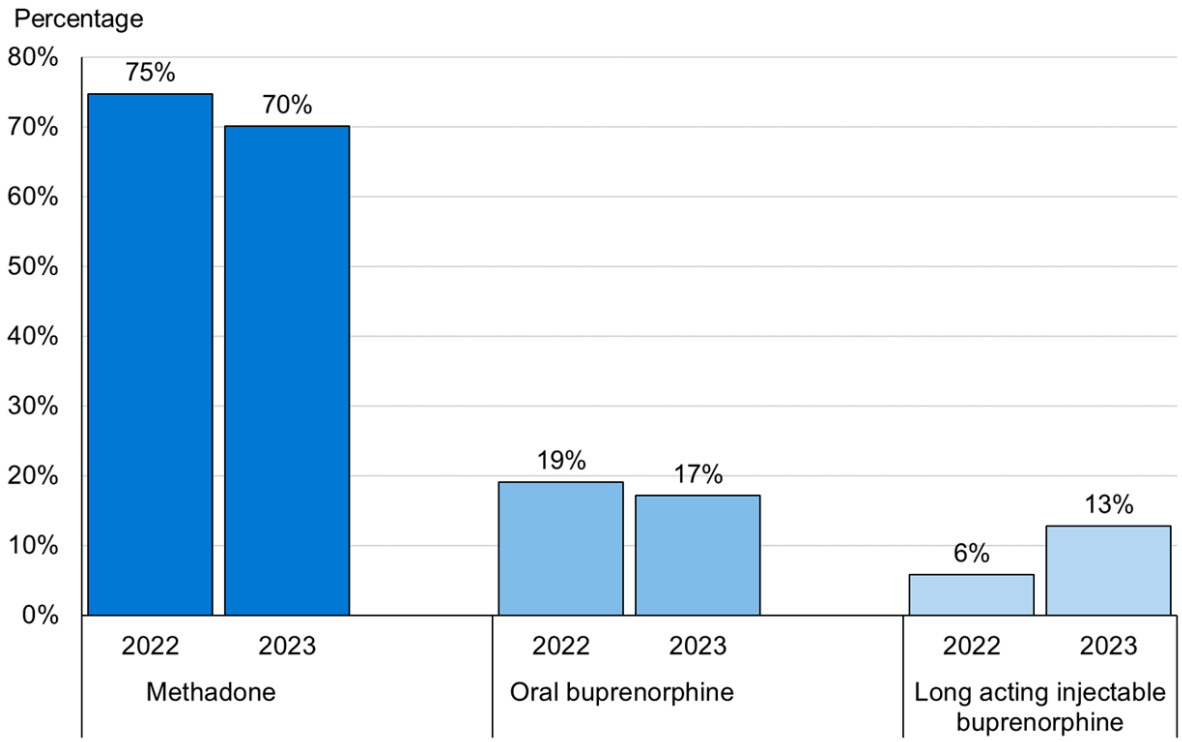


Chart description: Data were submitted by all 29 ADP areas, an increase of three areas from 2022. Data represent a snapshot date – a single point in time for 2022 and 2023. The proportion of people reported as currently prescribed methadone has reduced by 5% from 2022, (2022 n = 19,022 compared to 2023 n = 15,560). There is a slight reduction in those prescribed oral buprenorphine, 2% from 2022 to 2023 (2022 n = 4,859 compared to 2023 n = 3,796). Most notably there is a 52% percentage change increase for those prescribed long-acting injectable buprenorphine. This is from 6% of all opioid substitution therapy prescribed (n = 1,474 in 2022) to 13% (n = 2,836) in 2023. The overall caseload prescribed opioid substitution therapy shows a 13% change decrease, 22,204 in 2023 down from 25,456 in 2023. Due to restrictions in data collation, some ADP areas reported prescriptions as opposed to people.

Chart 15: Percentage of caseload prescribed long-acting injectable buprenorphine by ADP area. Scotland 2023

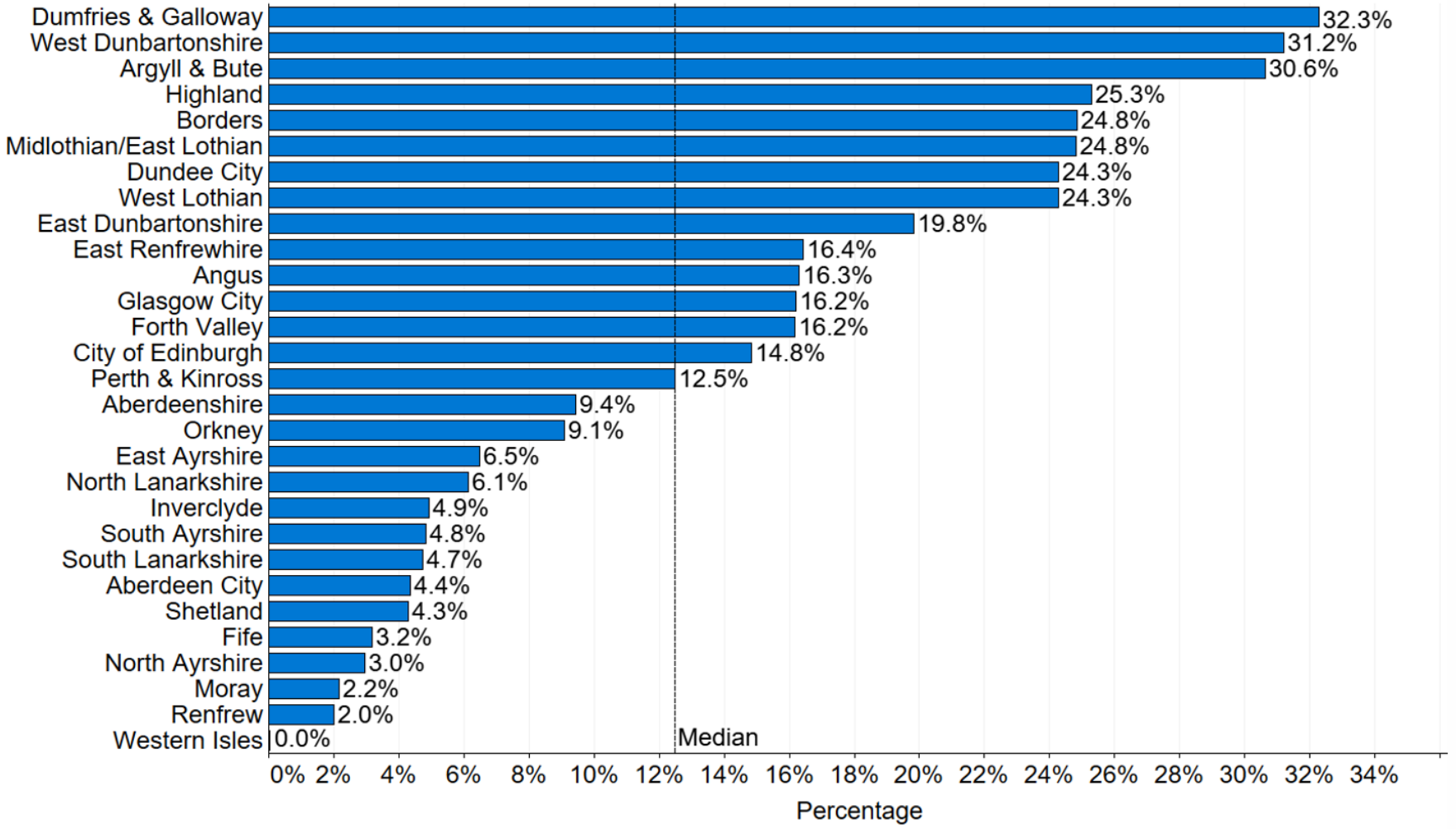


Chart description: 28 of the 29 ADP areas reported individuals currently on their MAT opioid substitution therapy caseload with a prescription for long-acting injectable buprenorphine. The percentage of the current caseload per ADP currently prescribed long-acting injectable buprenorphine varies from 0% to 32.3%, with a median of 12.5% across Scotland. Opioid substitution therapy prescribing by gender shows a very similar picture. For males prescribed opioid substitution therapy, methadone accounted for 69% (n = 10,292) and females 72% (n = 5,264). For males prescribed opioid substitution therapy, oral buprenorphine accounted for 18% (n = 2,658) and females 16% (n = 1,138). For both males and females prescribed opioid substitution therapy, long-acting injectable buprenorphine accounted for 13% (n = 1,920 for males and n = 916 for females).

Across ascending age groups there is a clear increase in the proportion being prescribed methadone with a decrease in people being prescribed oral and long-acting injectable buprenorphine (Chart 16). There is no evidence of a significant difference in uptake of choices between males and females.

Chart 16: Percentage of caseload prescribed opioid substitution therapy by type and age group. Scotland 2023

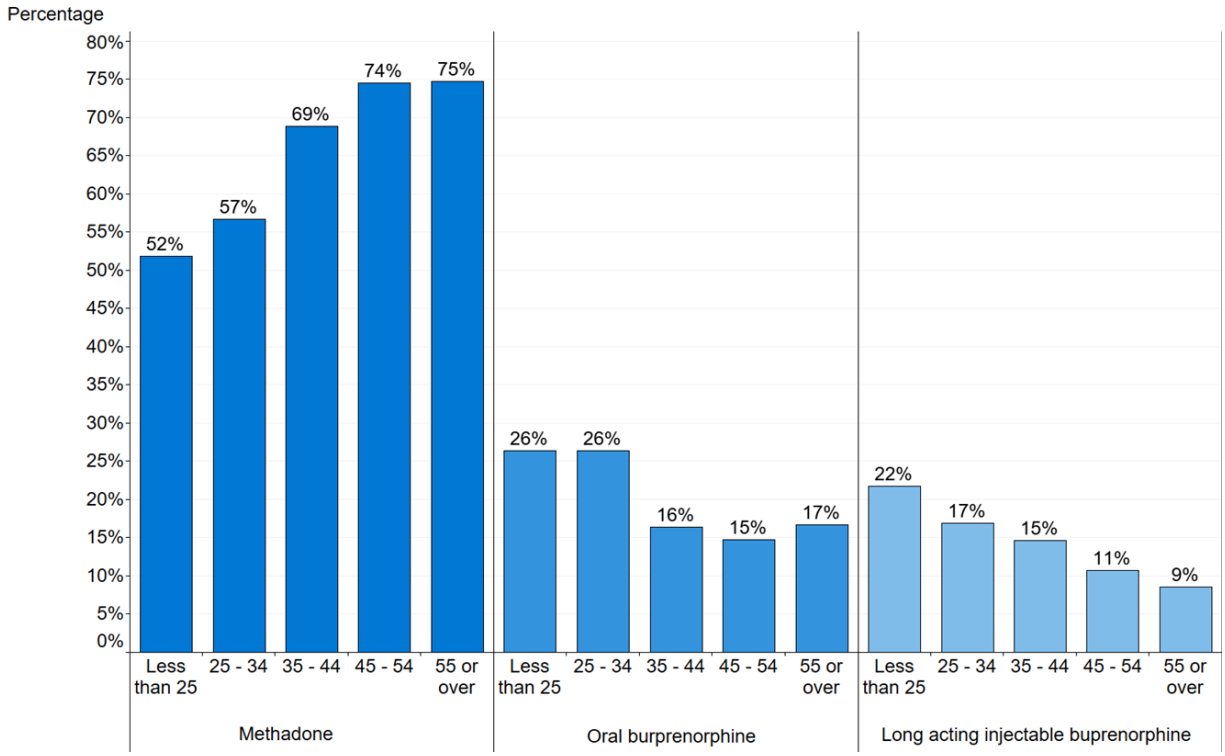


Chart description: Overall the proportion of the current MAT opioid substitution therapy caseload prescribed methadone increases in line with age advancing. For those aged under 25, methadone accounts for 52% (n = 110) rising to 74% (n = 6,171) and 75% (n = 1,990) for those aged 45 and over. There are slightly larger proportions of the caseload prescribed oral buprenorphine in the age groups aged 34 and under with the 35 and over age groups roughly the same. Those prescribed long-acting injectable buprenorphine show almost the opposite pattern from methadone with the largest proportion of 22% (n = 46) prescribed within the under 25 age group, this then decreases slightly with each advancing age group until 9% (n = 227) for those aged 55 or over.

MAT standard 3: Assertive outreach and anticipatory care

All ADPs now have documented pathways for MAT standard 3 and information sharing agreements with the Scottish Ambulance Service to follow up people who have experienced a non-fatal overdose. Pathways indicate that people need to be

followed up between 24 and 72 hours from notification of a high-risk event and that they should have rapid access to a prescribing assessment.

Risk assessment is a major challenge for services because people at risk of drug-related harm often experience multiple concurrent risk factors. This makes it difficult to recognise the level of risk a person is experiencing due to not all agencies having the necessary information. Even where multiple risks are known about, they can be assessed as the norm rather than the exception, i.e. risk can often be underestimated.

Multiple risks also mean that the criteria to initiate an assertive outreach response and anticipatory care planning should not be based only on the single presenting factor (such as a non-fatal overdose) or solely on data from the Scottish Ambulance Service or the emergency department. Information needs to be sought from partners such as police, prisons, housing, social care, secondary care and primary care.

NHS Greater Glasgow and Clyde Health Board is an example where guidance for multiagency risk assessment has been developed to support practitioners, which will be shared across ADPs as an example of good practice. The Aberdeenshire responsive engagement team also demonstrates a successful partnership model for multiagency identification, assessment and response. The team was developed in October 2020 with health taking the lead to develop pathways for all referrals requiring an assertive outreach response. The team have a morning ‘huddle’ which is held virtually on Microsoft Teams and is a protected space where partners can discuss anyone who may be at risk of harm and complete a multi-agency risk assessment. The model has now expanded beyond the Scottish Ambulance Service data to include the drug and alcohol team, social work, Police Scotland, emergency departments, psychiatric liaison services, the Department of Work and Pensions, housing services, Scottish Fire and Rescue and third sector partners. There is a target to see all referrals within 24–72 hours and provide early intervention to avoid further crisis.

An example of innovative and successful practice in a remote and rural area is the drug and alcohol recovery service for Caithness and Sutherland. The service was already delivering MAT and harm reduction support through drop-in and open referral

clinics but after review of local and national data, an assertive outreach test of change was started in January 2023. The team received guidance and permissions on data sharing from the NHS Board Caldicott Guardian, which then allowed them to develop a checklist to help partners identify people at risk and trigger an outreach response. The local police service now include the checklist as part of their information recording system. The information collected is added to their vulnerable persons database which enables quicker information sharing to the drug and alcohol recovery service for Caithness and Sutherland team. Feedback from the people receiving outreach has been positive with thanks expressed to the team for their consistent and proactive care. The team's method of evaluating staff experience has been particularly successful. Based in two separate offices they use electronic record keeping to capture what is impacting staff. Each day staff members choose from five scored emojis which tracks their ongoing experience.

The Pan Ayrshire collaboration has also achieved success with the non-fatal overdose pathways with a joint protocol to implement a service response, within 24–72 hours, to offer increased drug and alcohol support to both individuals known and not known to services.

There is a lot to do for this standard to be sustained across all ADP areas.

- Interorganisational visits to share learning are crucial. Examples include the successful collaborations between Highland ADP, Aberdeenshire responsive engagement team, the Turning Point Scotland overdose response team and NHS Lothian where a multiagency 'community inclusion huddle' conducts risk assessments.

- The use of local data can help target services to meet local needs. For example, Fife ADP have used their local non-fatal overdose data to target work in Methil where they are using a café style model delivered by third sector, health, and volunteers whereby people can drop-in to access social support, opioid substitution therapy, harm reduction, family support and mental health support. This model offers support to people regardless of the substance they are using.

- The Rapid Action Drug Alerts and Response (RADAR) is Scotland's drugs early warning system which can provide specific and bespoke intelligence about emerging threats. This includes how to best respond to new substances and identification of clusters of harms that might require a targeted response. To make best use of this intelligence, local areas will need capacity to feed information into RADAR and to respond to these instances.

- Out-of-hours services are needed. Where these exist, they are usually provided through third sector partners without access to clinical and prescribing services for substance use. This places pressure on acute services such as accident and emergency that are not always equipped to manage complex cases.

- Pathways to involve families and carers are required to enable people to raise concerns about a person and be involved in the response.

- There is a need for guidance on how risk assessment, assertive outreach and anticipatory care planning is done. For example, in some ADP areas, people already in service who are identified as being at further risk of harms are offered follow up through the next routine appointment rather than timely outreach. In other areas if a person on opioid substitution therapy has a non-fatal overdose the prescription will be withheld at the pharmacy until the person makes contact with the prescribing service, while in some areas eligibility restrictions such as use of benzodiazepines or stimulants prevent people at risk of drug harm from being followed up.

- There is a need for stronger acute sector liaison. For example, in some ADP areas such as Glasgow and Edinburgh acute sector drug and alcohol liaison nurses play a key role to: identify people admitted with drug harm; support ward staff to provide appropriate care (including the initiation or continuation of opioid substitution therapy); facilitate a planned discharge; and to work with the community teams to ensure appropriate outreach and anticipatory care planning where discharges are unsupported – which is common.

- Data sharing agreements need to be in place. This facilitates the timely sharing of information and enables the multi-agency team to agree who can take responsibility for follow-up. The evidence shows that lack of data sharing agreements, such as reliance on the Adult Protection Act 2007, can result in delays in the transfer of information, for example between NHS and third sector assertive outreach teams.

The numerical data submitted for MAT standard 3 assessment demonstrate that nationally there are multiple sources of referrals for assertive outreach and anticipatory care planning with most (78%) coming from Scottish Ambulance Services (34%), NHS specialist services (24%) and accident and emergency (20%) (Chart 17).

Chart 18 indicates that across Scotland a high proportion (72%) of referrals result in assertive outreach. However, a significant proportion result in no further action (13%) and onward referral (15%) which may have a similar outcome if not followed through by the person affected or the services involved. The local definition and recording of key points such as screening, risk assessment and assertive outreach varies between ADP areas. For example, depending on local policies an unanswered phone call can be recorded as an assertive outreach outcome as can multiple calls and a face-to-face consultation. It is a priority in the coming year to clarify these definitions and establish recording of multiagency anticipatory care planning as a key outcome.

Across 16 ADPs that submitted data (62%), 75% of high-risk people undergo risk assessment within three days (Chart 20). There is variation in response times for the remaining 10 (38%) ADPs and reasons for this include rurality, differences in recording (e.g. some areas record a face-to-face meeting as risk assessment, others a phone call), delays in sharing data between partners and incomplete or incorrect contact details.

Analysis of aggregate data by age did not show any significant differences although people under 25 years appeared to wait longer for a response; this will be further investigated and may be due to small numbers, recording and the complexity of follow up of younger people with other systems. There were no differences between

genders and only two ADPs reported transgender data which may reflect the inability of reporting systems to detect this group.

Chart 17: Number of high-risk events by notification source. Scotland 2023

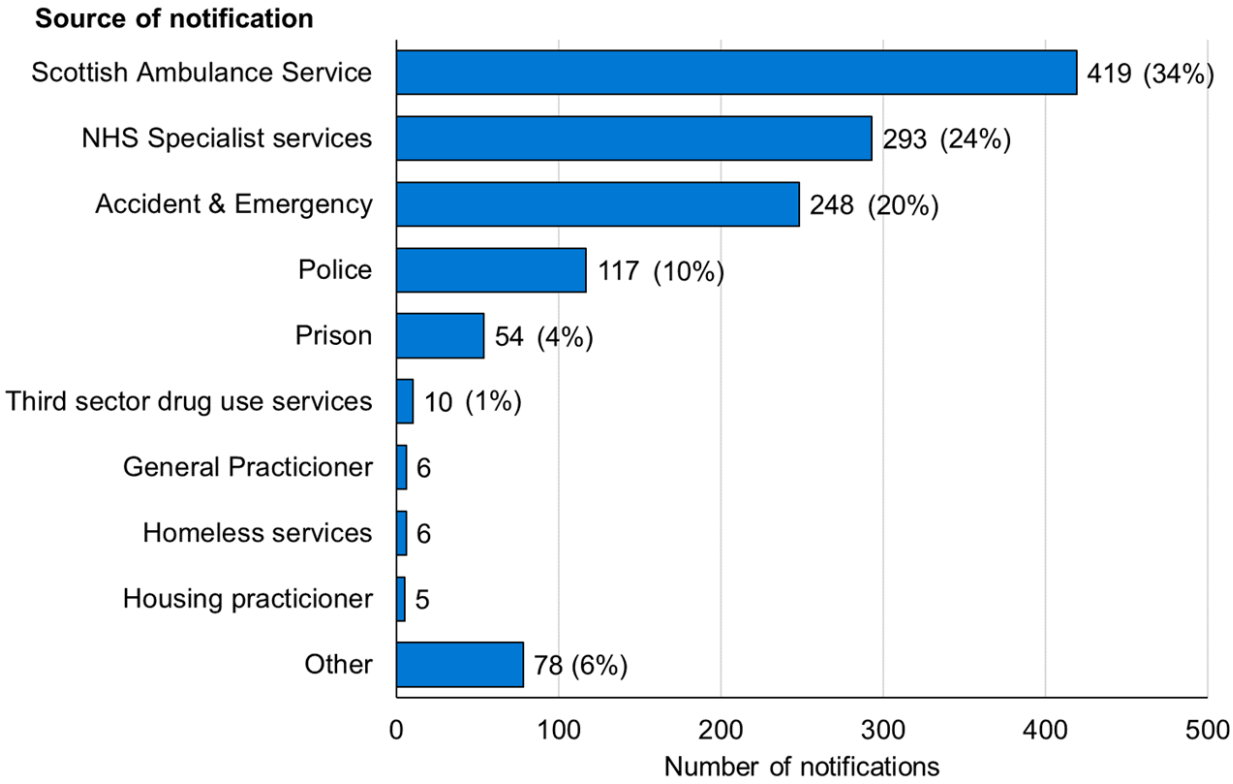


Chart description: During the reporting period between November 2022 and February 2023 there were 1,236 high-risk events notified across 26 ADP areas. The highest proportion of those were from the Scottish Ambulance Service, 34% (n = 419). The other two sources making up 44% of notifications between them were NHS specialist services (24%, n = 293) and accident and emergency (20%, n = 248). Other sources of notification accounted for 10% (n = 117) or less. Three notifications did not have a source recorded; these have been added to 'other' for completeness.

Chart 18: Percentage of high-risk notifications by screening outcome by ADP area. Scotland 2023

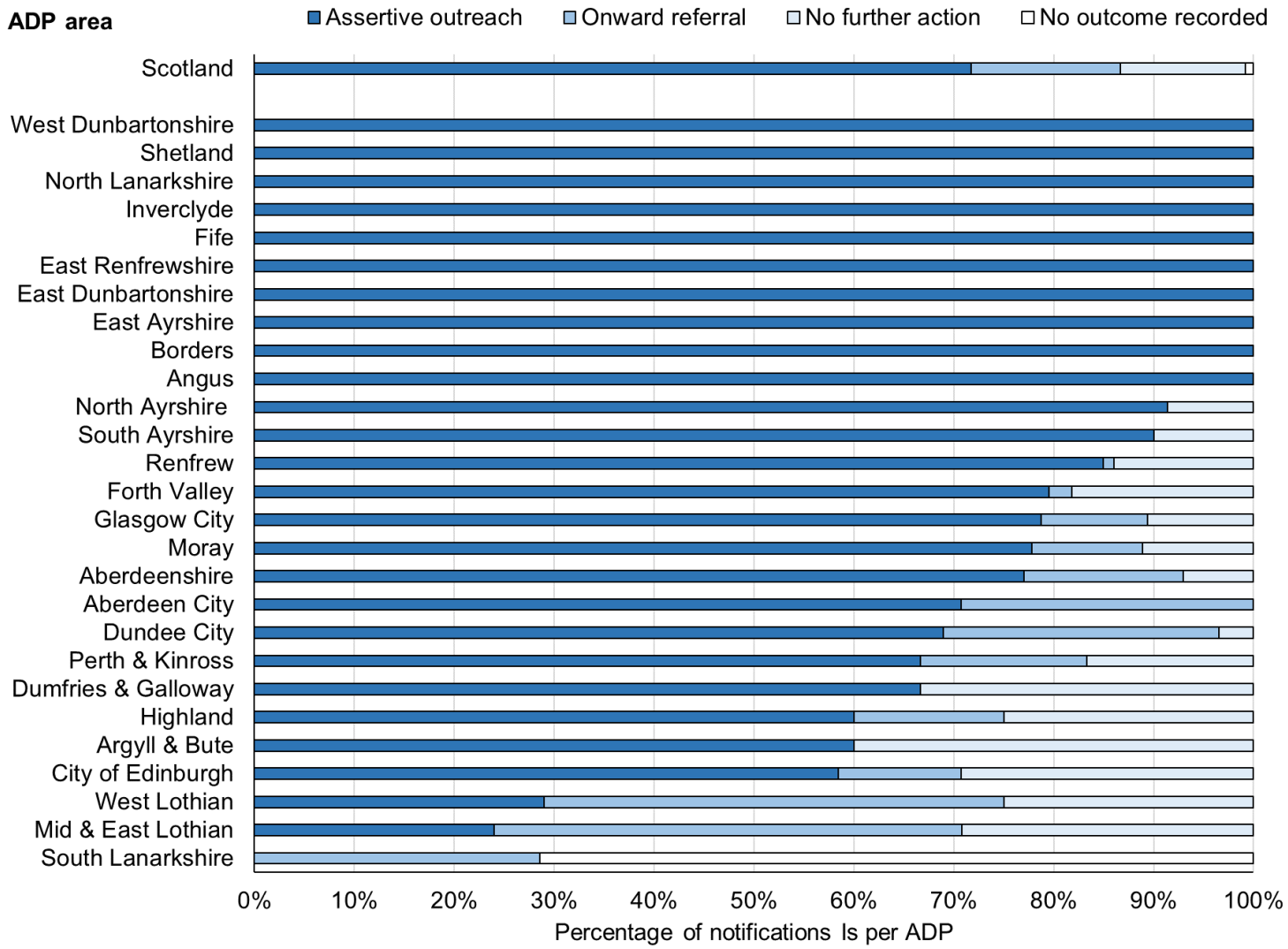


Chart description: All 1,236 high-risk events notified were screened and allocated to either assertive outreach, onward referral, no further action or no outcome recorded categories during the reporting period between November 2022 and February 2023. Ten ADP areas allocated 100% of high-risk events to assertive outreach. In 13 ADP areas 60% of people identified at high risk were offered assertive outreach. In three areas less than 60% of those at high risk were offered outreach. Two ADP areas allocated a higher proportion of screening to onward referral compared to other ADP areas (46%, n = 46 and 47%, n = 45). 11 ADP areas allocated none of the screening to no further action, with three ADPs allocating around 30% (numbers are individual to each ADP) of screening to no further action. Full data could not be reported from one ADP area and has been excluded.

Chart 19: Number of ADP areas in which 75% of people had an outreach assessment, grouped by the number of days from notification of a high-risk event. Scotland 2023

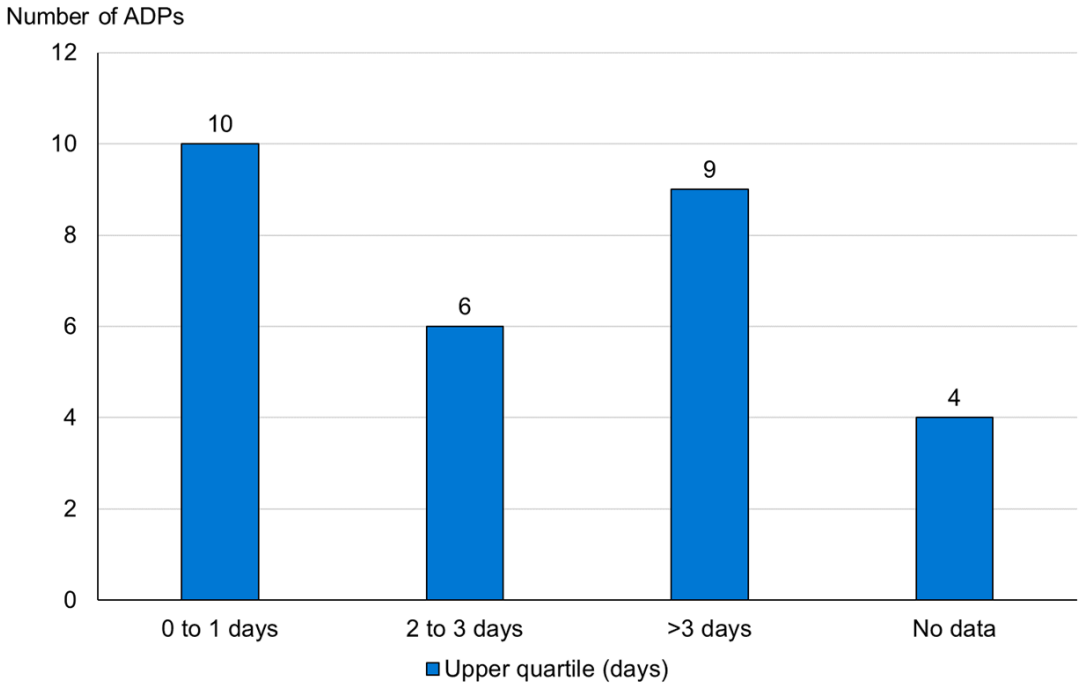


Chart description: 25 ADP areas reported high-risk events which led to an initial outreach risk assessment reporting during period between November 2022 and February 2023. 10 ADP areas had an upper quartile (75% of data points) of one day or less and a further six ADP areas conducted the initial outreach risk assessment within three days. Nine ADP areas had an upper quartile of more than three days.

Chart 20: Number of days between notification of a high-risk event and outreach assessment by the multi-agency team for 75% of people by ADP area. Scotland 2023

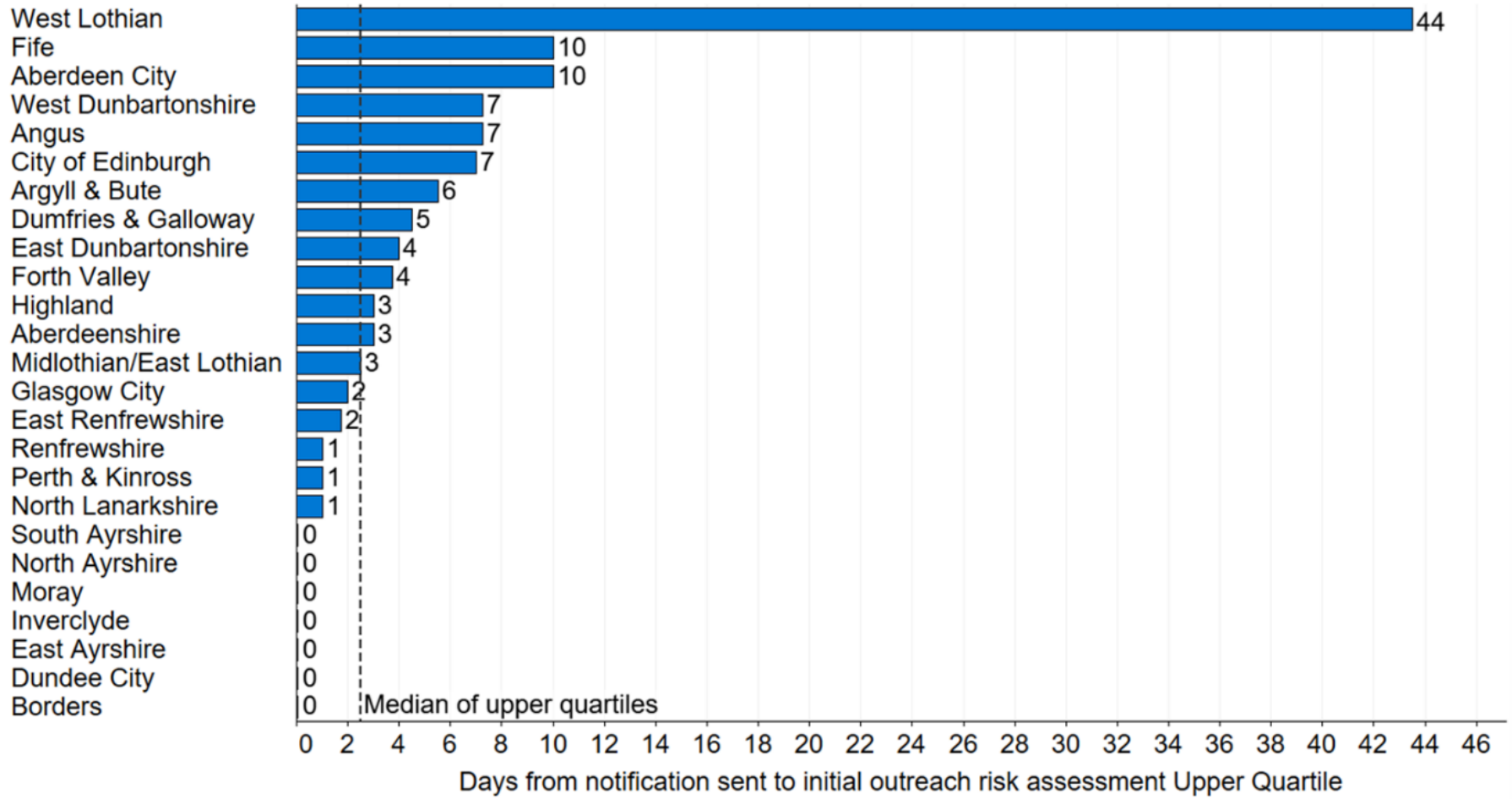


Chart description: Out of 29 ADP areas, 25 areas screened high-risk events occurring within the reporting period between November 2022 and February 2023, allocating them to assertive outreach. The time taken between notification sent and the initial outreach risk assessment varies from same day for seven ADP areas to 44 days for one ADP area. 60% of ADP areas (n = 15) provided the initial outreach risk assessment within the 72 hours stated in MAT standard 3. A median of upper quartiles provides an estimate of 2.5 days across Scotland.

MAT standard 4: Harm reduction

All areas have developed standard operating procedures and training plans to ensure new and existing staff offering MAT and opioid substitution therapy can provide core harm reduction at the same time and place as the appointment. There are fewer areas signposting for these interventions than last year, and this will likely reduce further as training plans become fully implemented and delivery models are adapted to meet the standards.

Adaptions in ADPs such as Renfrewshire, Aberdeenshire, East Lothian, and Edinburgh Northeast hub include harm reduction checklists for non-specialists as a prompt for staff when delivering MAT. Equipment inventory checklists have been developed in several areas such as Western Isles ADP and East Lothian ADP to ensure the requisite amount of core supplies are always available in all sites. Care pathways to specialist wound infection treatment have been established and documented in areas such as Aberdeenshire ADP and Orkney ADP.

An increase in the choice of venues for people to attend for care and treatment including home visits and community appointments, has resulted in innovative ways of delivering core harm reduction. In ADP areas such as East Lothian, Moray and Ayrshire and Arran staff have access to harm reduction bags or boxes containing the requisite amount of injection equipment provision and basic wound care supplies. This approach has also been taken by areas such as Orkney ADP where rooms have limited space for storing harm reduction equipment or are not suitable for delivering all interventions.

The wound care, assessment of injecting risk, naloxone provision and dry blood spot testing (WAND) initiative employs a contingency management approach using psychological techniques to encourage compliance with harm reduction initiatives for people who are affected by substance use in Glasgow City. It encourages people to engage with the four key WAND harm reduction interventions. Specialist staff from NHS Greater Glasgow and Clyde deliver the service with their third sector partners. They encourage people to attend every three months so they can support them over time. While this model does not directly correspond to MAT standard 4, because there is less focus on opportunistic intervention by all staff and more on targeted support by specialist staff, it is an excellent complement. It can create learning on how to empower staff to feel confident to offer interventions and how to empower people using services to feel confident to request and accept interventions.

The assessment of implementation of MAT standard 4 comprised structured self-assessment against agreed criteria. This is recognised as good clinical practice and is focused on whether the service meets the standard from the patient perspective. ADPs reported on the proportion of the caseload for whom four core harm reduction interventions (WAND) were available during the consultation, by appointment or drop-in, by referral or by signposting.

MAT standard 4 is reported as implemented in 18/29 (62%) ADP areas (4/29 green; 14/29 provisional green). The data in Chart 21 demonstrate that as a proportion of the national caseload all four harm reduction interventions were reported to be opportunistically available during the MAT consultation for 79% of people. Injection equipment provision was most likely to be only available through appointment, drop in, referral or signposting (21%).

Chart 21: Percentage of people able to receive core harm reduction by access categories. Scotland 2023

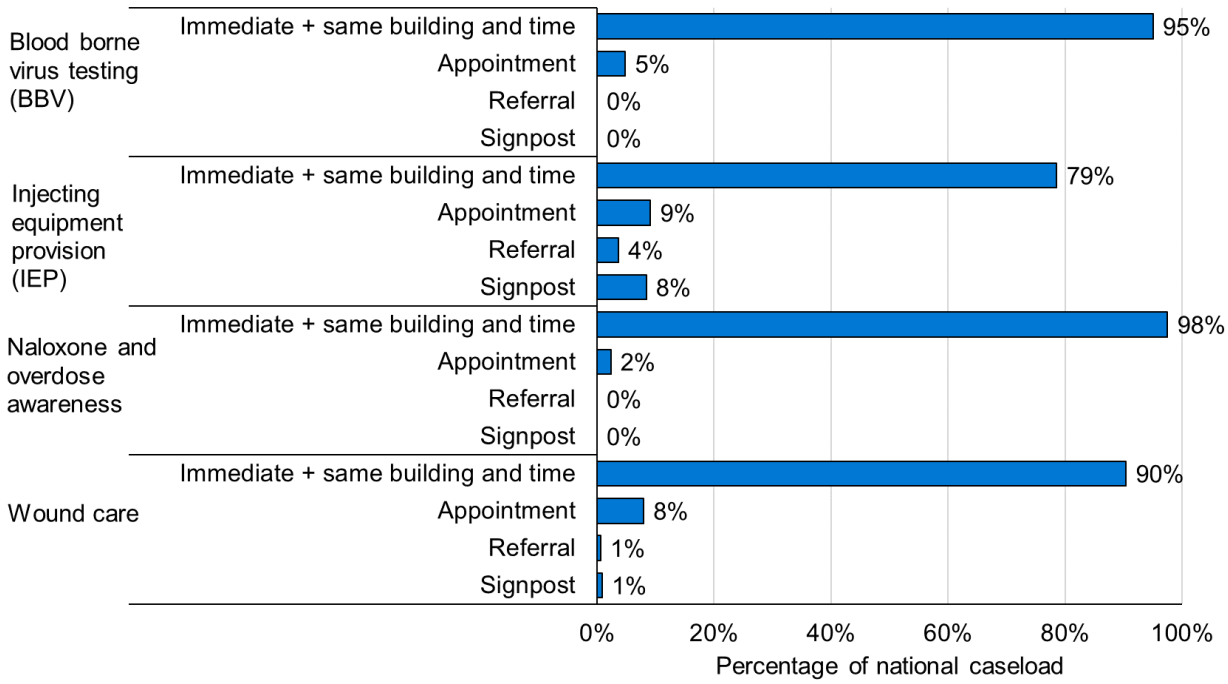


Chart description: The total reported MAT opioid substitution therapy caseload with access to the four core harm reduction measures as part of MAT appointments was 22,758. Of the four measures, naloxone and overdose awareness was available either, immediately and in the same room or available at the same time but with a different worker or room for 98% (n = 22,222) of the caseload. Blood-borne virus testing was available either, immediately and in the same room or available at the same time but with a different worker or room for 95% (n = 21,650) of the caseload. Wound care was available either, immediately and in the same room or available at the same time but with a different worker or room for 90% (n = 20,600) of the caseload. Injecting and equipment provision was available either, immediately and in the same room or available at the same time but with a different worker or room to a lower proportion of the caseload, 79% (n = 17,909) and conversely was also the harm reduction measure which had the largest proportion for signposting for access, at 8% (n = 1,920) of the caseload.

MAT standard 5: Retention as long as needed

ADP areas have begun to map how care is managed across multidisciplinary and cross-sectoral teams and most have established pathways and policies, with 66% fully and 28% partially compliant with agreed criteria to demonstrate implementation. Multiple models of care are offered through third sector, pharmacy and general practice to enable people to step up and down levels of care if requested or needed.

As noted, innovations to promote retention include the use of community pharmacy to offer choices such as long-acting injectable buprenorphine (MAT standard 2). In both West Lothian and Dumfries and Galloway ADP areas, community pharmacies collaborate with third sector partners for additional support with prescriptions.

Argyll and Bute ADP have developed a family inclusive pathway in Dunoon. Mapping of existing services identified gaps and opportunities to improve connectivity for adults, young people, children, carers and peer support.

Aberdeenshire ADP is currently carrying out a ‘test of change’ to assess the role of an occupational therapist working within substance use teams**.** The rationale is that people often fail to meet existing mental health or disability criteria for referral to occupational therapy, so for example there is nowhere to go for occupational therapy services after prison. The improvement work aims to find out what value occupational therapy could add to community teams and how it may best be delivered (e.g. in a one-to-one or group setting, at home, in a clinic, in the community or by video call).

Many areas are now discussing anticipatory care planning at assessment and have developed disengagement pathways. For example, in Fife, the ADAPT KY8 community group seeks, identifies and engages with people who are not in treatment or have fallen out of care; to offer rapid access to opioid substitution therapy prescribing, harm reduction and social support for individuals and families.

Both small teams and those in remote and rural settings have particular challenges due to a lack of third sector drug services, recovery groups, venues for assessment and generic services to support specialist teams.

The numerical data show that in 90% (26/29) of ADPs 75% of the MAT caseload are retained in treatment for six months (Chart 22).

However, when people are discharged from care there is a predominance of unsupported discharges and over the two-month reporting period comprising a total of 406 discharges nationally, 63% (255) were unsupported and 37% (151) supported. Although a slightly greater proportion of both supported and unsupported discharge occurred after six months (59% and 52%) the number of unsupported discharges is too high (Chart 23).

There is a lot of variation between ADPs with respect to supported vs unsupported discharges as a proportion of the caseload; this varies from 0.2% for two ADP areas (n = 1,073 and 1,153) to 3.4% for one ADP area (n = 383) (Chart 24). There is also variation in the proportion of these that occur prior to six months duration in MAT. Variation may be due to differences in demographics and in the definition and recording of data but requires further investigation locally and nationally to understand what this means in terms of patient experience and ways to improve models of care.

There is no clear difference in retention in treatment by reported genders nor by older age groups (35 and above) with over 85% being in treatment for six months or more for all of these. The figure is 77% for the age group 25 to 34 (n = 2546) and 66% for those under 25 (n = 165), suggesting that retention in treatment may be more difficult for younger people. For both supported and unsupported discharges, there are no clear differences of time in treatment by gender or age group from the overall figures.

Chart 22: Percentage of caseload retained in treatment for six months or more by ADP area. Scotland 2023

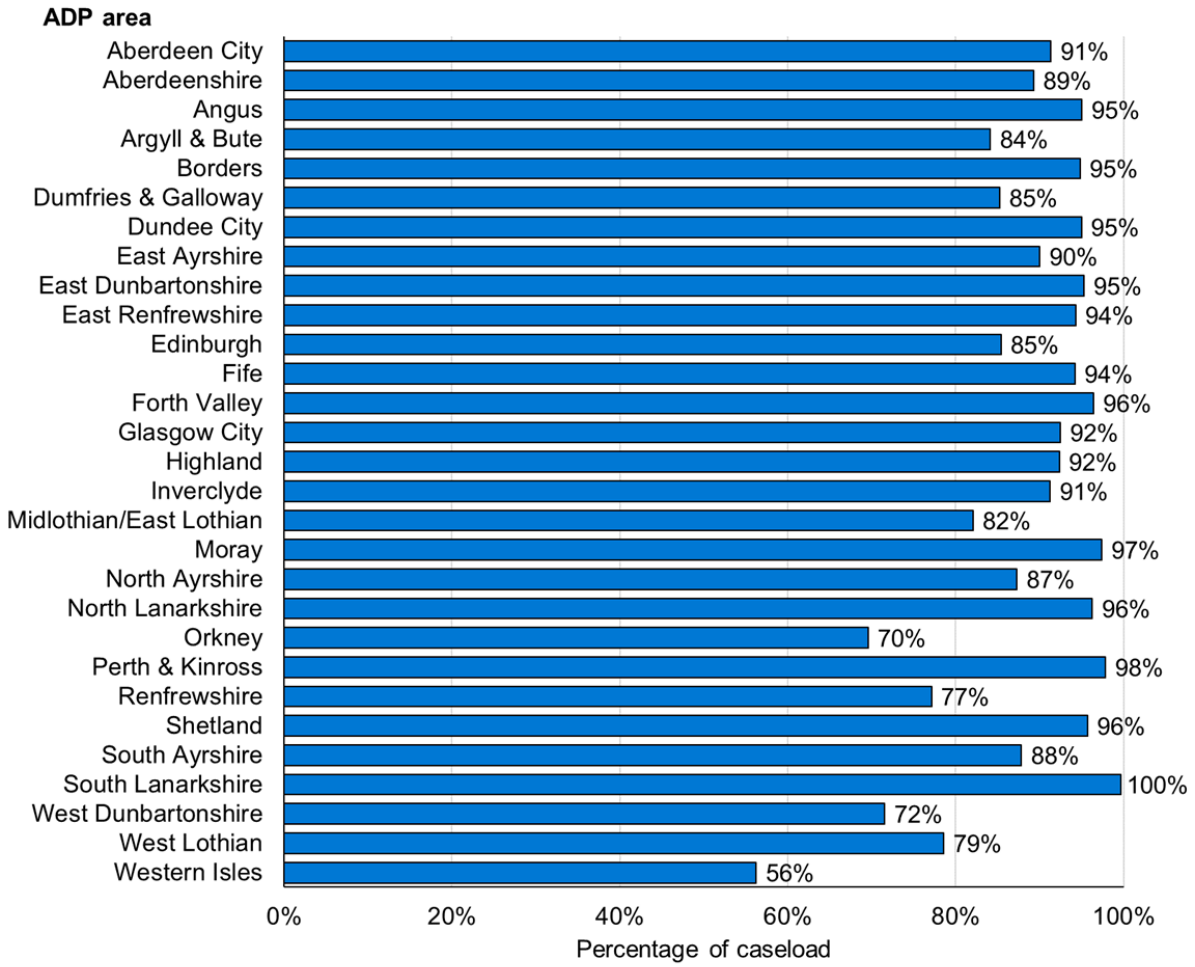


Chart description: The total reported MAT opioid substitution therapy caseload was 22,078 with 91% (n = 20,114) retained in treatment for at least six months at the point of the reporting snapshot date. 26 ADP areas had 75% or more of their current caseload retained in treatment for at least six months, with one ADP area reporting 100% (n = 934). Three ADP areas had less than 75% of their current caseload retained in treatment for at least six months.

Chart 23: Number of supported and unsupported discharges (as per DAISy definitions) by length of time in treatment. Scotland 2023

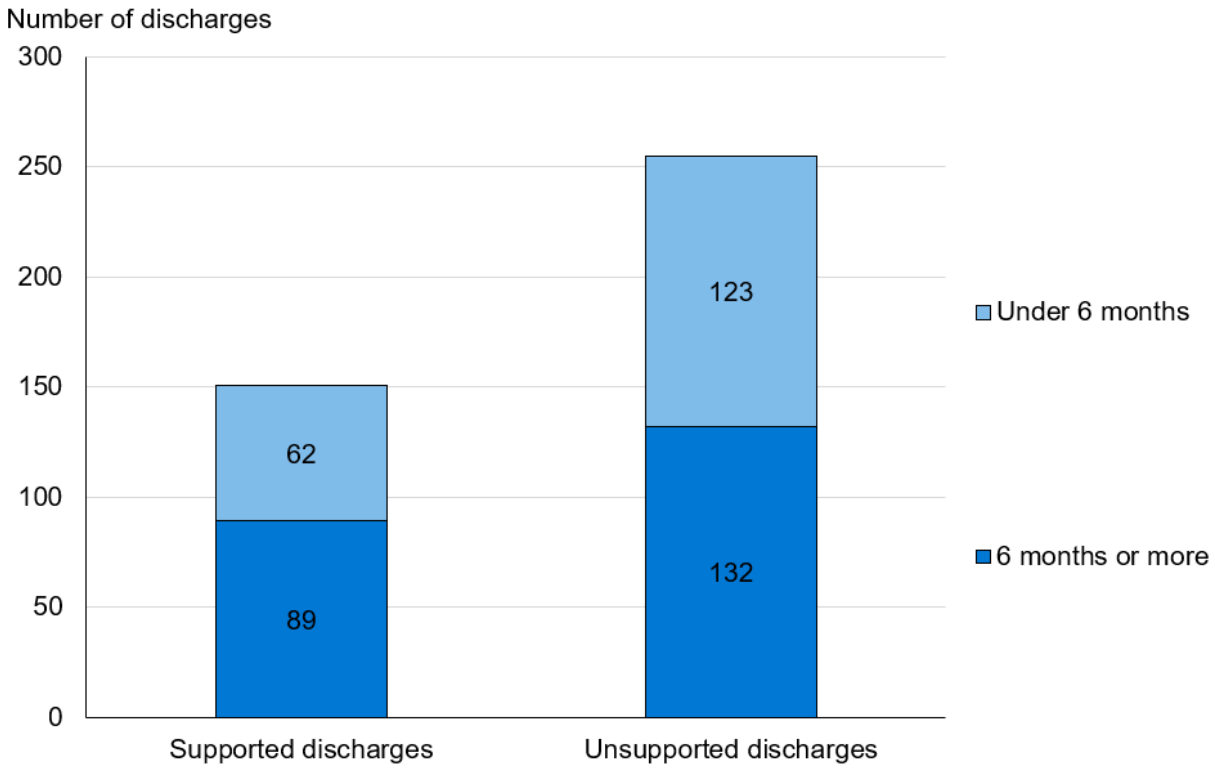


Chart description: Over the reporting period, January and February 2023 there were a total of 406 discharges. 37% (n = 151) were supported and 63% (n = 255) were unsupported. For supported discharges 59% (n = 89) were in treatment for at least six months prior to discharge. For unsupported discharges 52% were in treatment for at least six months prior to discharge.

Chart 24: Discharges as a percentage of caseload by type and ADP area. Scotland 2023

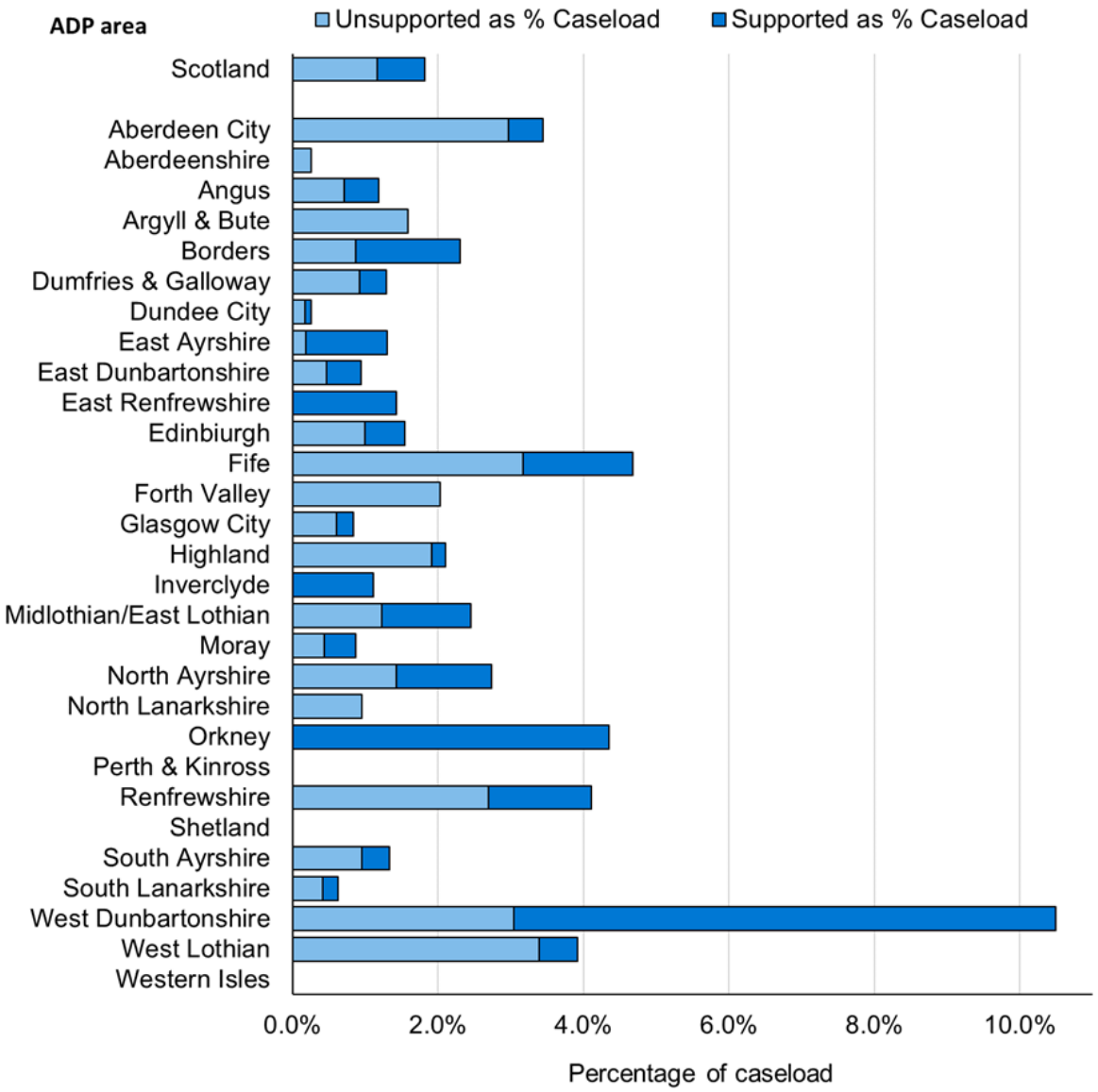


Chart description: The average percentage of caseload for unsupported discharges across Scotland was 1.2% The percentage per ADP area varies from 0.2% for two ADP areas (n = 1,073 and 1,153) to 3.4% (n = 383). During the period between January and February 2023, six ADP areas reported no unsupported discharges. Ten ADP areas had unsupported discharges less than 1% of their caseload. Seven ADP areas had unsupported discharges between 1% and 1.9% of their caseload and six ADP areas had unsupported discharges 2% or more of their caseload. The average percentage of caseload for supported discharges across Scotland was 0.7%

The percentage per ADP area varies from 0.1% (n = 1,153) to 7.5% (n = 362). Seven ADP areas reported no supported discharges. Twelve ADP areas had supported discharges less than 1% of their caseload. Eight ADP areas had supported discharges between 1% and 1.5% of their caseload and two ADP areas supported discharges greater than 4% of their caseload.

MAT standards 6: Psychological support

An important first step to implementation is the establishment of an NHS Board-wide steering group. Process evidence submitted by ADP areas demonstrates that these have been set up in Grampian, Fife, Forth Valley, Lothian, Tayside and Ayrshire and Arran with terms of reference to oversee delivery plans, documented referral pathways and frameworks to deliver psychological therapies. Where documentation has not yet been converted into actions that benefit people ADP areas were assessed as provisional amber. Other areas such as Angus ADP were assessed as amber because there are very clear delivery processes in place as part of the NHS Tayside ‘psychological interventions for substance use group’; and experiential evidence that psychology interventions are being delivered to people.

An example of good practice is in Forth Valley ADP where the substance use psychological therapies team in NHS Forth Valley partnered with the Forth Valley recovery community. In October 2020, two recovery development workers were recruited to support people in their recovery through practical day-to-day activities. This could be, for example, by encouraging people to step out of their home, take a short walk, go for a bus ride, a coffee or join a walking group. Partnership between the substance use psychological therapies and Forth Valley recovery community was developed in response to the fact that some people can struggle to put psychological learning into practice in between appointments. This is a result of anxiety, trauma symptoms and lack of social supports.

Areas that remain RAGB red for this report often have no specialist psychology.

MAT standard 7: Primary care

The process evidence submitted demonstrates that ADP areas are exploring various models to implement this standard and some community pharmacy models are described above. Further examples are below.

Substance use services in the Scottish Borders have recruited an advanced nurse practitioner to deliver health checks at the point of MAT delivery in Eyemouth. The pilot started in 2022 and makes the most of existing resources through collaboration with GP practice staff for information sharing and use of the well-established substance use drop-in service to carry out health checks. Joint working and clear communication with practice staff were significant factors in the pilot's success in providing shared care. But resilience is a concern as the process relies mainly on one GP to highlight risks and a single advanced nurse practitioner to offer physical health checks. Support workers are being trained to assist with health checks.

Aberdeenshire (Fraserburgh) have embedded a non-medical prescriber in a general practice to prescribe opioid substitution therapy and improve links for people to other primary care services.

Primary care facilitation teams is one of the criteria for implementation of this standard set out in the MAT standards document. Lothian NHS Board has a well-established team and other areas are considering how this function can be established. Other options to promote joint working with primary care colleagues are 'meet drug and alcohol services' sessions in Borders ADP and 'MAT standards awareness' sessions in East Lothian ADP areas.

Ayrshire and Arran NHS Board have approached MAT standard 7 jointly across all three ADP areas. This approach has been enabled through a network of groups both locally and Ayrshire-wide including the Pan-Ayrshire chief officer's group, the Pan-Ayrshire MAT oversight group and the partnership MAT implementation group. The model has facilitated buy-in to new initiatives through co-production of a collective case for change and overarching vision. It has also supported operational implementation by combining resources and approaches to accelerate change and

improvement. Where appropriate, IT systems, funding streams and staffing resources have been combined to set up services.

MAT standard 8: Independent advocacy and social support

The MAT standard 8 national consultation group was formed in August 2022. The initial focus for process evidence on whether independent advocacy was being commissioned and on whether there are documented workforce development plans in place for staff to access training on independent advocacy. For 2023 indicators to measure access to housing and welfare rights were not assessed.

Most ADPs were able to evidence that they had commissioned independent advocacy. Fifteen areas reported they had completed the rights-based advocacy training provided by REACH Advocacy with the remaining 14 areas having plans to do so. Due to small numbers, the islands do not commission independent advocacy but provide this via social work and Citizens Advice Bureau.

West Lothian ADP is an example of a system-wide human rights-based approach. Reach Advocacy has been commissioned to deliver 20 human rights-based workshops to approximately 360 people. All services, both statutory and non-statutory, will be offered places at the sessions as will people with lived and living experience of problematic drug use and their families. Reach Advocacy will provide the Rights Advocacy Practice Award accredited at SCQF Level 7 qualifications for staff that attend.

In Argyll and Bute, the Recovery Advocacy Project was set up in 2019 and is delivered by Lomond and Argyll Advocacy Service. It covers Helensburgh and Lomond, Cowal, and Bute and Kintyre. The Recovery Advocacy Project now provides a voice to people impacted by alcohol and substance use. With no judgement or stigma, they ensure individuals are treated with dignity and respect and support them to access services. With someone on their side, people are given the confidence to challenge barriers or discrimination when they feel they are not being heard. Satisfaction rates are good and the team continue to monitor these to review and refine their services. They also receive repeat referrals which demonstrates the confidence people and partners have in their service.

MAT standard 9: Mental health

Twenty-four ADP areas provided process evidence that they have started to establish steering groups and pathways for care, with some areas taking this forward at NHS Board level. One example, Aberdeen City ADP, has provided evidence that clinical leadership, governance structures and workforce development plans are in place and that services are benefitting people. However, other than through some pathways for MAT standard 3, very few areas have operational plans to deliver this standard and most people who have problematic substance use do not meet the existing threshold to access mental health services.

Models of care that support implementation, need to be mapped out and/or developed, that encompass the recommendations from the recently published Scottish Government report ‘Substance use and mental health concerns – the way ahead; rapid review recommendations’ and the Mental Welfare Commission ‘Ending the exclusion: care, treatment and support for people with mental ill health and problem substance use in Scotland’, and share any learning from the Health Improvement Scotland Pathfinder projects.

MAT standard 10: Trauma informed

As with MAT standard 6, an important first step to implementation is the establishment of an NHS Board-wide steering group and these have been set up in Grampian, Fife, Forth Valley, Lothian, Tayside and Ayrshire and Arran NHS Boards with terms of reference to oversee delivery plans. Most steering groups cover MAT standards 6 and 10 together.

Glasgow City ADP and all Lothian ADPs were assessed as amber because they are implementing service plans for delivering trauma informed care, with Glasgow rolling out the Scottish Trauma in Leadership Training programme. However, most areas remain provisional amber because there is no evidence that documented processes have yet been converted into actions that benefit people.

The Scottish Prison Service has established a steering group for trauma-informed services and, as part of this, the service has asked all senior leaders to attend trauma-informed leadership training. Within this national approach, His Majesty's Prison (HMP) Edinburgh have established a multi-agency steering group co-chaired by the governor and an NHS Lothian consultant clinical psychologist. The group has a five-year vision with an initial focus on staff knowledge, understanding of trauma-informed practice, and understanding of staffs' own wellbeing and experiences of trauma within the workplace.

4.4. Remote and rural considerations

Seven ADP areas (Western Isles, Orkney, Shetland, Dumfries and Galloway, Borders, Argyll and Bute, Highland) have submitted a structured assessment of how they are trying to overcome the challenges of rurality and three (Moray, Angus, Aberdeenshire) have had discussions with MIST. The assessment covers the extent to which teams have maximised access choice and care through technology, travel and models of care.

Approaches include: high use of self-referral and telephone, 'tele-health' technology such as NEAR ME; wide use of bus passes, taxis, and third sector to take people to appointments; offering a choice of venues to be seen at such as GP practice, home, community hubs; and utilisation of generic primary and secondary care staff and settings to deliver care for example when weather disrupts usual access. There has been an increased use of non-statutory services and peers to engage and support people thus freeing up capacity to deliver rapid access and ensuring that staff can work at highest level within their banding. There has also been development of more generic pathways for all drugs and alcohol referrals (given in many places the same staff deal with these issues) and flexible working where staff learn new skills and take on extra responsibilities, although this means systems are fragile and may lack sustainability.

A strength in many areas is the utilisation of informal local networks and relationships to respond to urgent presentations even when no formal arrangements are in place. Some areas now have formal arrangements with other Health Boards to utilise

guidelines (Shetland and NHS Grampian), and to share expertise (Western Isles and Borders).

Examples of good practice include ‘The Shed’ in Stornoway which is a community-based project that supports young people and adults affected by problematic drug and alcohol use. There is a drop-in every Monday daytime and evening and this provides informal time for meeting others, playing recreational games and taking part in various trips and activities. Another example is the delivery of long-acting injectable buprenorphine through primary care pharmacy in Orkney as cover, in case a person misses an appointment to receive a dose and the prescribing GP is not available.

In Orkney ADP area, substance use support is provided by the community mental health team. This is a small team in Kirkwall on the main island of Orkney, made up of community psychiatric nurses, advance nurse practitioners, a prescribing pharmacist with GP support twice a week and a visiting consultant. Orkney and the outer isles have seen a significant change in drug use and heroin is now readily available which has seen a spike in those requiring opioid substitution therapy. The nursing team have built positive relationships with the GP practices on the outer isles and established a model whereby any individual looking to start MAT will have an assessment set up remotely with one of the nurses from the community mental health team. Following the assessment, the nurse will advise the prescriber in the outer isles on agreed medication and dose. The medication is then arranged to be delivered to the island via boat so that the individual has the opportunity to be started on opioid substitution therapy that day.

Significant challenges remain in remote and rural areas. Some of these are listed below.

- Lack of prescribing capacity and the legislative framework that restricts remote prescribing.
- The logistics of delivering same-day prescribing such as getting prescriptions to a pharmacy and medication to a patient is time consuming and resource intensive.

- Lack of GP shared care.
- Lack of workforce resilience. For example:
    - if a member of the workforce is off sick or leaves post, there is no one to cover their role; and services are sometimes reliant on arrangements with other Health Boards for continuity of care
    - lack of expert supervision can be a risk for non-medical prescribers
    - recruitment to a small workforce can be difficult where people may have multiple remits and need to move to a remote location with a lack of affordable or suitable accommodation and limited moving incentives
    - ADPs staffed by only one or two key individuals, or sometimes no one
- Technological barriers such as poor Wi-Fi and telephone signals.
- The diverse caseload can be difficult for a small (sometimes single person) workforce to manage: for example in Western Isles ADP area opioid dependence is a small part of the caseload with benzodiazepines, stimulants and alcohol the majority.
- There can be difficulty accessing sufficient analytical expertise to capture, analyse and report data and often this responsibility falls to the ADP lead.
- Lack of willingness to engage in experiential evidence gathering, resulting in little or limited evidence to submit.

4.5. Justice and custodial settings

There are some good examples of collaborative working in Scottish prisons.

In Greater Glasgow and Clyde's 'sustainable interventions supporting change outside' (SISCO) multiple pathways to recovery programme identifies gaps in service provision by listening to the experiences of people in prison. Since 2017, the service has evolved and now supports people in prison, at liberation and within the

community. Over the past two years, 83% of the men supported by the service have not returned to prison. The 17% that have returned have predominantly been younger prisoners between the ages of 23 and 29. The people they support often have complex needs and have experienced trauma. Collaborative working with over 30 partners is a significant factor in the success of this programme. The biggest barrier faced by the service is helping people after liberation. Information on outcomes shows that people often lose access to the support they need after leaving prison.

HMP Perth runs a daily meeting to co-ordinate targeted and joined-up support for 'persons of concern' identified as at risk of drug-related harms. The persons of concern group have been meeting since April 2021 with multidisciplinary representation from NHS Tayside and the Scottish Prison Service, including the prison chaplaincy. The persons of concern group receives referrals from staff who have identified concerns about a person during the previous night's report. Input from all members of the group creates a person-centred plan for each person at risk. If a person does not wish to take up the offer of support, the group always reviews and considers what more they can do to offer the right support at the right time. The persons of concern group has supported 1,622 people since April 2021, with 45 people currently in receipt of their services. At time of writing, 90% of the people in their care are experiencing challenges with substance use.

During the last year the MAT programme has worked with partners in HMP Perth and HMP Inverness to start improvement work, hosted a monthly justice network to support implementation of the MAT standards; and conducted mapping of the processes that are in place to enable implementation of the MAT standards in 13 out of the 15 prisons in Scotland. Themes that have emerged from this work are below.

- **Access and choice.** There is not a consistent approach to prescribing and choice across the 15 prison establishments; and although all local NHS Boards have documented prescribing guidelines and standard operating procedures delivering rapid access to opioid substitution therapy (MAT standard 1) and a choice of treatment (MAT standard 2) in the community, these are not implemented in most prison establishments. This means that

continuity of care is often not possible as people move between justice and community settings – which poses a significant risk of drug-related harm.

- **Drug trends.** Data collected by PHS (through the RADAR) indicate that opiate use represents less than 10% of substances identified in prison settings; with benzodiazepines and synthetic cannabinoids being the main drugs used. This means that packages of support need to be tailored to meet these emerging trends within prisons.

- **Healthcare staff.** Capacity, capability, recruitment and retention is a challenge in all prisons: the specialist nursing capacity that does exist spends a disproportionate amount of time dispensing medication leaving little time to address care needs and undertake improvement work or personal development. Some prisons report no known psychology input for residents. Prisons do not have sufficient capacity to care for people on remand.

- **Coordinated systems for data collection and analysis.** This is a huge challenge for the justice system, with multiple data systems (e.g. VISION, ADASTRA, EMIS PCs, TrakCare®) that are not set up to record the data required to enable implementation and measurement of the MAT standards and that do not communicate across the justice system or community systems. The mapping identified no capacity for data collection and analysis within the current workforce.

- **Information governance.** There are a lack of systems and agreements for information governance and data sharing between diverse partners across justice and community settings. For example, NHS prison health care cannot access prescribing information from primary or secondary care in the community. This means that it is difficult to obtain prescribing information to enable continuation or initiation of opioid substitution therapy on the same day as admission because community partners may not be able to provide the necessary information in time. It can also be difficult for police custody, courts or prisons to provide timely information about a person's release to community partners where there is an identified risk of overdose or other harm.

- **Culture change.** There is a lot of enthusiasm among partners in the justice and community systems to find ways to implement the MAT standards. However, the potential for progress and innovation is limited by: no overarching implementation plan for the MAT standards in prisons or police custody and a lack of clarity on the direction of senior leadership; the tension that exists between managing safe and secure custodial environments and the flexibility and innovation required in health and social care; and received wisdom and entrenched behaviours that can lead to organisational and team behaviours that are not person centred or evidence based.

5. Discussion

This report provides information on the extent to which the recommendations from 2022 have been met. Over the financial year 2022–23, all ADPs implemented MAT improvement plans. This, together with an enormous amount of work from frontline teams, means that most of the 2022 recommendations have been fully implemented and the remainder at least partially implemented.

5.1. Implementation

Over the last year ADPs have made very substantial progress with implementation of the MAT standards. The 29 ADP areas were assessed against each of the 10 MAT standards. This means that 290 separate assessments were carried out, 145 for MAT standards 1–5 and 145 for standard 6–10.

In 2023, 66% (96/145) of MAT standards 1–5 were fully implemented (19/145, 13% green; 77/145, 53% provisional green) vs. 17% (25/145) in 2022: and 2023 88% (127/145) of MAT standard 6–10 were partially implemented (65/145, 45% amber; 62/145, 43% provisional amber; 18/145, 12% red)

There has been a transformation in rapid access to opioid substitution therapy. In 2023, 18/29 (62%) of ADPs fully implemented this standard (3/29 green; 15/29 provisional green) compared with 1/29 (3%) offering same-day access in 2022. Likewise MAT standard 2 (choice) is now fully implemented in 27/29 (93%) of ADPs (7/29 green; 20/29 provisional green) compared to 14% in 2022.

MAT standard 3 has the highest proportion of ADPs allocated RAGB amber 15/29 (52%) in 2023. This is not unexpected given the challenge of getting multiagency working right, delays and gaps in the sharing of information, insufficient dedicated resources and the challenge of obtaining experiential evidence to confirm implementation. The standard is fully implemented in 14/29 (48%) ADP areas (1/29 green; 13/29 provisional green) and confirmed RAGB green in one ADP by comprehensive experiential data. This compares with full implementation in 6/29

(21%) ADPs in 2022 (although note that the data are not directly comparable with a stricter measure of assessment in 2023 as compared with 2022).

National data collected by PHS through the RADAR indicate that between September 2021 and February 2023, between 60 and 70 naloxone administration incidents were reported by the Scottish Ambulance Service each week; and in the same time period 130 hospital admissions per week were due to serious drug-related harm. However, the numerical data submitted for the MAT standard 3 assessment demonstrate that although there are multiple sources of referrals for assertive outreach and anticipatory care planning, most come from Scottish Ambulance Services (314, 34%), NHS specialist services (293, 24%) and accident and emergency (248, 20%). Despite MAT operating procedures – including pathways between secondary care, justice, housing and primary care – the proportion of referrals from these sources is very low. This suggests a lack of effective operational pathways and data sharing agreements between some partners and the need for stronger links with hospital admissions.

Key elements to successful implementation of standard 3 include: interorganisational visits; the use of local data to target areas of need; out-of-hours provision; pathways to involve families and carers; guidance for multiagency risk assessment; effective information sharing agreements; and dedicated resource for acute sector liaison. There is a need for national ‘Once for Scotland’ guidance for MAT standard 3. The guidance should include learning to date and be developed with statutory and third sector partners working with people affected by problematic drug use in community and justice settings. The aim of the guidance would be to ensure that when it is highlighted by agencies that someone is at potential risk of drug harm, this triggers a multiagency risk assessment. This is then followed up by assertive outreach and an anticipatory care plan; with a clear lead agency and a named person nominated to do the assertive outreach and follow up care planning.

Most ADP areas have dedicated harm-reduction teams providing flexible and responsive delivery of harm-reduction interventions such as injection equipment provision, blood-borne virus testing, immunisation and wound care. These programmes are essential to national programmes to eliminate the hepatitis C virus

and human immunodeficiency virus to reduce infections such as tetanus, anthrax, streptococcus pyogenes and staphylococcus aureus.

MAT standard 4 is about not missing opportunities to prevent, identify, manage or refer risks around injecting drugs during routine care and is reported as implemented in 18/29 (62%) ADP areas (4/29 green; 14/29 provisional green). As a proportion of the national caseload, all four harm-reduction interventions were reported to be opportunistically available during the MAT consultation for 79% of people. Injection equipment provision was most likely to be only available through appointment, drop-in, referral or signposting (21%). This may reflect the established 'needle exchange' services offered by specialist harm reduction services, but it does not meet the standard for opportunistic availability during MAT consultation and represents potential missed opportunities to reduce harm. Thirteen percent of wound care was also not available at the time of consultation; this may be due to lack of staff confidence or training, but appointment (8%) and referral (1%) rates may also reflect clinical need for more specialist treatment. There was a challenge to consistently apply definitions for assessment of standard 4 but the overall picture does demonstrate a high level of access to the core harm-reduction measures.

Although most areas now have systems and policies in place for standard 4, experiential evidence is necessary to confirm benefit to people using services and their families. Assessment of this standard needs to extend to other harm-reduction interventions such as sexual and reproductive health and immunisation. Obtaining data to reliably demonstrate implementation is difficult and future assessments may include direct external observation and links to other data systems such as the Needle Exchange Surveillance Initiative, Vaccination Management Tool, National System for Sexual Health, TrakCare® Patient Management System and the Educational Management Information System.

Great progress has been made in the implementation of MAT standard 5 which is implemented in 19/29 (66%) of ADPs (4/29 green; 15/29 provisional green) compared with 21% in 2022. The evidence base indicates that the risk of drug-related death is reduced when people are in treatment for six months or more and if they experience a supported discharge when needed. In the reporting period in 26/29 (90%) of ADP areas 75% of MAT caseload were retained in treatment for six months

or more but 255 (63%) of discharges in Scotland were unsupported. More work needs to be done to investigate and understand the reasons for the relatively high proportion of unsupported and early discharges and to find ways to move towards a majority of discharges being supported and after greater than 6 months in care.

A challenge with implementing standard 5 is that the focus on developing rapid access (MAT standard 1) and anticipatory care pathways (MAT standard 3) has the consequence of increasing the caseload and workload of small teams; so there is less capacity to develop and improve models of care to enable retention. Key areas for development are shared care with general practice, community pharmacy and the third sector because, if effectively implemented, these pathways can support the more stable segment of the caseload and enable specialist services to maintain access and support new, complex and high-risk cases. There is a need to strengthen professional trust and relationships between statutory and third sector partners and to ensure that systems and agreements are in place to ensure information sharing.

To implement MAT standards 1–5, ADPs have retained the necessary flexibility and innovation in models of care; and there is much less unwarranted variation in clinical policies and practice with 79% fully and 19% partially compliant with agreed criteria compared with 39% not compliant in 2022. However, there is still some variation within and between ADP areas. For example, the proportion of the ADP caseload being prescribed long-acting injectable buprenorphine varies from 20–34% in nine ADPs to 5% or less in 10 ADPs with a median of 12.5%; and the number of days to receive a prescription for opioid substitution therapy ranges from 5–16 days in 10 ADPs with the remaining demonstrating less than five days wait. In some instances, this variation is due to challenges such as rurality and difficulties with workforce recruitment and retention.

One of the key objectives of the MAT standards is to improve access to MAT so that once engaged with services people can choose the treatment, care and support they need. This is beginning to happen although in 2023 evidence did not demonstrate full implementation of standards 6–10 in any ADP areas.

MAT standard 8 is most advanced and was assessed as partially implemented in all 29 ADP areas (2/25 amber; 4/29 provisional amber) with all but four ADP areas

demonstrating that independent advocacy is in place. However, assessment was based on whether services are commissioned, and this does not necessarily mean that people can access and benefit from services. Over 2023 the measurements for this standard need to be developed to include support for housing, welfare and income needs; and to ensure that feedback from people can confirm benefit.

Progress with MAT standards 6, 9 and 10 has been slower. Standard 6 (psychological therapy) is not implemented in six ADPs and for standards 9 (mental health care) and 10 (trauma-informed care) the majority of ADPs did not provide evidence that systems are in place to benefit people. Reported challenges to implementation of these standards include gaps in senior clinical leadership with limited or no access to addiction psychiatrists in the islands and rural areas and workforce recruitment, retention and development challenges across mental health teams and substance use teams. Models of care that support implementation, need to be mapped out and/or developed, that encompass the recommendations from the recently published Scottish Government report ‘Substance use and mental health concerns – the way ahead; rapid review recommendations’ and the Mental Welfare Commission report ‘Ending the exclusion: care, treatment and support for people with mental ill health and problem substance use in Scotland’, and share any learning from the Healthcare Improvement Scotland Pathfinder projects,

MAT standard 7 was assessed as partially implemented in 25 (86%) ADP areas (19/29 amber; 6/29 provisional amber) and not implemented in four ADP areas. General practice and community pharmacy face multiple challenges to implement this standard: there is sometimes a lack of knowledge and understanding of the MAT standards or the role primary care has to implement them; there are many competing priorities, scarce resources and lack of space for shared care. In addition, many GPs and community pharmacists lack confidence, training and experience in dealing with problematic drug use and many feel it requires a specialist service due to the complexity of supporting people; and, especially in remote and rural areas, GP numbers are reducing, often replaced by locums, and practices are withdrawing from contracts to provide MAT services. These challenges can be compounded by weak systems for communication and data sharing between addiction teams and primary care.

All ADP areas with remote and rural settings demonstrated innovation in terms of maximising the use of technology, travel and flexible models of care so that people could benefit from equitable care and treatment. To fully implement MAT standards 1–10 in remote and rural settings, further work is needed to build on the existing models. For example: expand the use of tele-medicine such as ‘NEAR ME’; task shifting across multiagency teams to free up clinical expertise to support new referrals and those at highest risk; commissioning of third sector expertise to support statutory services; and ‘national expertise’ posts so that psychologists, psychiatrists or experienced specialist drug workers can support rural areas through formal arrangements.

In prison settings, mapping of the process measures required to implement the MAT standards demonstrates that there is not a consistent approach to access and choice across community and justice settings and that there is a need for packages of care to be tailored to meet emerging drug trends. New psychoactive substances are more readily available as they are less detectable than opioids, therefore opioids are infrequently used in prisons.

Clinical capacity to deliver the MAT standards in prisons is insufficient. Nurses spend a disproportionate amount of time dispensing medication leaving little time to address care needs and undertake improvement work. People on remand comprise approximately 70% of people in prison, have lower access and lower uptake of support services and it can be difficult to ensure housing, welfare and prescribing needs are met in prison and on liberation. Implementation of the MAT standards requires sufficient staff resource across health, social care, third sector and Scottish Prison Services in order to offer effective care and treatment to this population.

The lack of coordinated data systems in justice settings and across community and justice settings are a constraint to the provision of continuity of care. Without an upgrade of data systems it will be very difficult to conduct improvement work or measure progress with implementation of the standards.

To enable full implementation of the MAT standards in justice settings these structural and healthcare capacity issues need to be resolved. The Scottish Prison Service is writing a new drug and alcohol strategy with a focus on health

care and this may be an opportunity to include direction on implementation of the MAT standards.

An area where insufficient progress has been made is the care and treatment of people using benzodiazepines and stimulants. Over the last year implementation of MAT standards 1, 2, 3 and 4 has focused on rapid access, choice, harm reduction and anticipatory care mainly for people using opioids, but the picture of problematic drug use in Scotland is one of polysubstance use. For example, in October and November 2022 the most common drug types detected in post-mortem toxicology were opioids (75%) and benzodiazepines (63%) (**RADAR quarterly report**, PHS, 2023). While evidence may be limited on medication substitutes for non-opioid drugs, there is evidence that people with problematic stimulant and benzodiazepine use benefit from psychological therapies (MAT standard 6), mental health support (MAT standards 9), trauma-informed care (MAT standard 10) and harm reduction (MAT standard 4) interventions. Note that injection of stimulants is highly destructive and a factor in recent human immunodeficiency virus transmission.

More work is needed on surveillance to set out the scale of unmet needs for groups such as women, young people and people using benzodiazepines and stimulants (this is something PHS is progressing through the RADAR). Data can be used to identify some of the gaps in implementation of the standards and to ensure that care for people in these groups is included in improvement work.

5.2. Intelligence-led services

The processes of collecting and submitting data for process, numerical and experiential data are extremely complex and time consuming and a lot of the additional work falls to frontline practitioners. Nevertheless, in 2023 for the process data – 79% of MAT standards 1–5 and 46% of MAT standards 6–10 was fully compliant with agreed criteria, nearly all the numerical data requested for MAT standards 1–5 were submitted (61% compliant with criteria and thresholds) and experiential data were submitted for 93% of all 10 standards. This demonstrates a dramatic increase in capacity and capability in ADPs for evidence collection. An important caveat is that the data do not always fully represent local achievements

because in some places the pace of change and innovation has outstripped the ability to measure activity.

National systems for collection of numerical evidence have not yet been developed to support MAT, so as a temporary workaround the MAT programme – with analytical leads from ADPs – developed automated Excel spreadsheets and a detailed data dictionary to enable national reporting from local systems. This approach has resulted in good-quality data but is not yet fully representative because there is variation in services, interpretation of definitions, data quality and a lack of capacity to review and sense check data prior to reporting.

This has been the first year for the systematic collection of experiential evidence for the MAT standards and a lot of time and effort has been put into building teams of interviewers, carrying out interviews, analysing data and reporting to PHS. Standardised systems to enable collection, collation and reporting of raw and aggregate data have started in most ADP areas supported by guidance, training, questionnaires and field support from the MAT programme.

Demographic analysis of the 2023 evidence submitted indicates that it is broadly representative of the national case load. Analysis of gender shows 32% female, 66% male and 2% other; although this latter figure may not reflect the national caseload due to lack of systems to record transgender. Analysis of age groups shows the largest group was age 25–44 (38%) followed by 45–54, 25–34, under 25 and over 55 (28%, 20%, 9% and 7% respectively).

However, in this phase the quantity, quality, representativeness and utility of the information varies across ADP areas and different standards. This is because different ADP areas are at different stages of developing their programmes. This is demonstrated by the variation in the number of interviews conducted across the ADP areas which range from 0 to 65 interviews in the reporting period; and by the variation in the extent to which interviews confirm implementation or not – which is often due to bias in selection and response.

The limitations of experiential data collection are a constraint on the ability to assess the overall impact of the standards on people. Over the coming year it is a priority to

strengthen the experiential programme because it is not possible to demonstrate full or sustained implementation of the MAT standards without documented feedback confirming this. There is a need to develop well-established networks, relationships and dialogues between people who provide services, people who use them and their family members and nominated persons.

Local programmes have been more successful where there is an identified experiential lead with allocated time and resources to co-ordinate evidence collection, analyse the data and work with people to use it for improvement. To sustain the experiential programme over the coming years it is necessary to allocate local resources, keep the methods and tools under constant review and refresh the MAT standards to include a standard for community engagement and improvement.

Information sharing is critical to the effective implementation of the MAT standards and especially standard 3. As well as formal data sharing agreements, people need to feel confident sharing data and to overcome cultural barriers across sectors and professions. There is a need for ‘Once for Scotland’ guidance on information sharing between community health and social care, third sector and justice partners. Where this is not in place, there is the greatest risk of missed opportunities to reduce serious harm. Data sharing and linkage is also needed to enable tracking and improvement of peoples’ journey through the whole system.

Overall ADP areas have found innovative ways to overcome local challenges to implementation and measurement of the standards. Some overarching themes to scale up for the year ahead include: taking a NHS Board-wide approach supported by public health expertise; leadership and support from third sector partners; the effective use of local data to target service development and maximise use of resources. There also needs to be investment in key roles such as analysts, qualitative researchers, experiential leads, intermediate level management and project management; effective information governance and data sharing across multiple partners; partnership with community pharmacy; and the use of quality improvement methodology to enable rapid change.

5.3. Risks

The risks from the 2022 report all stand for 2023. These are that partially implemented standards will not meet their aim of reducing drug-related harm, that unsustainable and under resourced systems for numerical and experiential evidence collection mean that improvement work cannot happen; and that funding uncertainties could lead to a decrease in the quality and quantity of care that can be provided.

Additional risks are that small ADP teams will be overwhelmed, that senior and intermediate management support will wane and that an overemphasis on achievement of RAGB scores will undermine the focus on ensuring that there is meaningful benefit to people as a result of the changes implemented.

A significant opportunity cost of implementing the MAT standards is that there is less resource available for maintaining standards of care for people with problematic alcohol use; there is a risk that this may result in increased alcohol-related harm as many local teams work through combined services and/or posts.

6. Conclusions

There has been a transformational change in improved access (MAT standard 1) and choice of treatment (MAT standard 2) for people with problematic drug use in the last 12 months, and significant improvement in the other MAT standards. This is a direct result of hard work and collaboration within and between ADPs (including clinical, third sector, and lived and living experience partners) and of a shift in culture that has overcome many barriers to change.

But implementation of the MAT standards is a vehicle for change and not a sufficient end in itself. Over the coming year the priority will be full, equitable and sustained implementation of the MAT standards in all ADP areas and ensuring that all people affected by problematic drug use benefit; including women, young people, people who live in remote and rural areas and people who use benzodiazepines and stimulants.

To do this the focus needs to be on ensuring that there is benefit to people as a result of the changes implemented and to sustain improvement requires an ongoing dialogue with people using and providing services so that meaningful change can happen.

7. Recommendations and next steps

7.1. Recommendations for the PHS MAT programme

The PHS MAT programme will work with partners to complete the following actions.

Establish national systems for direct support and benchmarking to implement the MAT standards

a) Refresh ADP improvement plans based on 2023 benchmarking report.

b) Take an NHS Board approach for improvement work across multiple ADP areas to ensure consistency in planning, implementation and the experiences of people using services.

c) Develop local capacity to collect and use data across NHS Boards to update improvement plans, target areas of highest need and maximise staff capacity.

d) Strengthen processes for learning when someone dies as a result of drugs, particularly those not in contact with treatment services and ensure that this learning is used to strengthen implementation of the standards.

e) Strengthen the MAT standards implementation network, JUSTICE IN, the remote and rural group and the Health Improvement Scotland learning system to share learning and good practice.

f) Continue the programme of ‘support to report’ with ADPs to offer clinical advice, provide online and face-to-face training and workshops, field visits and continuous support for ADPs to collect, repot and use data throughout the year.

g) Expand ways to increase third sector contributions to MAT improvement work for example through networks and national leadership.

h) Review and improve the national benchmarking methodology to continue to reflect the work and outputs of ADP efforts and to ensure that the focus is on benefit to people as a result of the changes implemented.

i) Refresh the MAT standards document to include an additional standard on community engagement for improvement with respect to MAT, explicit requirements for people using non opioid drugs and refined measures of progress.

j) Strengthen the national thematic groups on MAT standards 4, 6/10, 7, 8, 9 and 'remote and rural' to develop operational guidance, measures for progress and disseminate good practice.

Specific standards, populations and settings

a) MAT standard 3 – Develop national guidance for MAT standard 3 across community and justice settings for high-risk drug-related harm including recommendations on data sources, out-of-hours working, drug liaison nurses, third sector commissioning, primary care contributions, data sharing, how to link to the chief officers public safety groups and clarity on interventions such as screening, risk assessment, assertive outreach and anticipatory care planning.

b) MAT standard 3 – Develop a specification for a national evaluation of MAT standard 3 to determine the impact and effective components of MAT standard 3 from a person-centred perspective and seek a commission from the Scottish Government to conduct the evaluation.

c) MAT standard 4 – Revise guidance on implementation and assessment to include sexual health and immunisation and to ensure effective harm reduction for polysubstance use.

d) Mat standard 5 – Collaborate with ADP teams to investigate and understand the reasons for the relatively high proportion of unsupported and early discharges and to find ways to move towards a majority of discharges being supported and after greater than six months in care.

e) MAT standard 8 – Review approaches to implementation and assessment to include support for housing, welfare and income needs and to ensure that feedback from people can confirm benefit.

f) MAT standard 9 – Develop national guidance for MAT standard 9 in line with the Mental Health and Welfare Commission recommendations.

g) Justice – Develop a toolkit on implementation of the MAT standards in justice settings and provide support to implement and measure them subject to local improvement initiatives and national action taken under Section 7.2.

h) Justice – Conduct improvement work on MAT standard 3 across ADPs incorporating elements of justice into the integrated pathways so that people who have been within the justice system will be highlighted as someone at potential high risk of drug harm and trigger a multiagency assertive outreach response and anticipatory care planning as required.

i) Justice – Expand the national system established in ADPs to collect experiential data on the MAT standards, to ensure the voices of staff, prisons residents and their families is used to inform improvement work.

j) Justice – Continue engagement at national level on data system updates that will be required to report on the implementation of the MAT standards in the 2025 benchmarking report.

k) Conduct further analysis with respect to age, gender, setting or service of the numerical and raw experiential data submitted and use this for improvement work that meets the needs of all populations.

l) Collaborate with ADPs to review approaches to implementation and assessment of the MAT standards for people with problematic benzodiazepine and stimulant use.

Build sustainable numerical data systems to monitor and improve implementation of the standards

a) Revise data definitions, data sources and recording rules, including definitions of settings and services, for MAT standards 1–5 and define them for MAT standards 6–10.

b) Support data collection throughout the year so that local teams can periodically conduct mini analysis to sense check actions and that plans and methodologies are delivering the best level of implementation for the standard.

c) Develop work arounds for national data collection including automated Excel spreadsheets, clinical audit, web-based data collection strategies (such as research electronic data capture) and linkage with existing national and local data systems to record evidence on implementation in the community and justice settings.

Build sustainable experiential data systems to monitor and improve implementation of the standards

a) Plan and document a programme of experiential work for 2023 and 2024 including: update of questionnaires, sampling and analysis; training materials; requirements for interviewers and experiential leads; support to use evidence to update improvement plans.

b) Scale up ADP experiential programmes to include justice setting.

7.2. Next steps

Based on the findings of this report, the next steps to enable full and sustained implementation of the MAT standards across community and justice settings, including development work on the following:

a) Strengthen partnership and communication on the multiple streams of work to implement and measure the MAT standards, treatment targets, access to

residential rehabilitation, care for people using non-opioid drugs and work on care and treatment for people with problematic alcohol use.

b) Ensure that local and national workforce strategies and drug and alcohol service specification include: diverse models of care involving non-clinical and third sector; increased recruitment and retention of non-medical prescribers, improved accommodation and co-location of partners; targeted support to those areas not effectively utilising the workforce; career pathways including postgraduate education (e.g. public health, prescribing, improvement methodology); career pathways in substance use services for people with lived and living experience; out-of-hours working; and plans to meet the specific needs of remote and rural ADPs such as relocation fees, flexible rotation, and rural premiums.

c) Ensure that there is sufficient dedicated resource and capacity for intermediate management, project management, experiential leadership, numerical and experiential analysis in all ADP areas.

d) Ensure that dedicated resource is allocated for senior public health leadership and expertise in NHS Boards.

e) Ensure that the experiential lead is adequately resourced to have the time, support and expertise required to carry out this role and that there is dedicated resource to analyse and interpret experiential data sufficiently.

f) Develop guidance and provide support on commissioning to help ADPs include the requirements of the MAT standards into existing and new programmes and to complement Scottish Government work on a national service specification.

g) Review and scale up implementation of telemedicine technology such as ‘NEAR ME’ for assessment and monitoring for people affected by problematic drug use.

h) Complete the work on a single (Once for Scotland) service-level agreement for community pharmacy and establish in all ADP areas a local protocol between

NHS addiction services and community pharmacy to ensure that communications, prescribing, dispensing and harm reduction meet the requirements of the MAT standards.

i) Develop a sustainability plan for implementation, evidence collection, continuous quality improvement and benchmarking for the MAT standard.

j) Establish a clear strategy for the resolution of information governance at national level for justice, NHS primary and secondary care services, third sector, social care and residential rehabilitation.

k) MAT standard 2 – Explore and confirm mechanisms to sustain funding for long-acting injectable buprenorphine and other forms of opioid substitution therapy.

l) MAT standard 2 – Develop models of care and a treatment guidance consensus statement for people who use benzodiazepines, stimulants and other substances.

m) MAT standard 3 – Identify and resource a lead agency to establish a 'national audit' including process, numerical and experiential measures so that the burden of reporting passes from ADPs to the auditor and decide who commissions this audit.

n) MAT standard 7 – Develop a national strategy for the implementation of MAT standard 7 including collaboration with the Royal College of General Practitioners.

o) MAT standard 8 – Develop a national strategy for the implementation of MAT standard 8.

p) Justice – Strengthen clinical leadership to implement the MAT standards across community and prisons and to support: a consistent approach to the implementation of NHS Board clinical policies and procedures; the development of a package of care tailored to the emerging drug trends and needs of people in prisons; investment in health and social care staff capacity and capability including resolution of dispensing issues and dedicated health

and social care resource for remand prisoners; coordinated systems for data collection and information governance; establishment of an overarching plan for implementation; culture change that enables flexibility and innovation, teams that are person centred and services that are evidence based.

q) Justice – Ensure there is sufficient resource and leadership in place to establish in community and justice settings ‘Once for Scotland’ data systems updates that meet the needs of the drugs mission in general and the MAT standards in particular (e.g., Vision, Adastra, Educational Management Information System, Drug and Alcohol Information System)’

r) Remote and rural – Increase the use of formal arrangements with other Health Boards to utilise guidelines and to share expertise.

s) Remote and rural – Re-establish remote prescribing guidance (as extant during the COVID-19 pandemic) to enable same-day access to opioid substitution therapy in remote and rural.

8. Implementation

Table 1: Phases of implementation of the MAT standards

Note: Shaded areas shaded correspond to work completed and work due for completion between April 2022–April 2026.

Phase	April 2022	April 2023	April 2024	April 2025	April 2026
Phase 1 • Partially implement MAT standards 1–5 in community services.	✓				
Phase 2 • Fully implement MAT standards 1–5. • Partially implement MAT standards 6–10 in community services.	✓	✓			
Phase 3 • Fully implement MAT standards 1–10 in community and justice settings. • Fully establish the experiential evidence programme. • Fully establish numerical measurement systems. • Agree sustainability plans for MAT standards 1–10.	✓	✓	✓	✓	
Phase 4 • Sustained implementation of MAT standards 1–10 in community and justice settings, including for women, young people and people who use other drugs (benzodiazepines, stimulants)	✓	✓	✓	✓	✓
Ongoing • Evidence collection capacity building. • Support to implement and report (MIST). Annual benchmarking report (MIST)	✓	✓	✓	✓	✓

Note: implementation of MAT standards other than MAT standard 3 in justice settings is subject to current local and national developments in clinical leadership, data recording, data sharing, clinical resource for remand, institutional culture and cross sectoral collaboration.

Appendix 1: Definition of RAGB status

- The aim of the MAT programme is to demonstrate, through evidence, continuous improvement of peoples' experiences in the areas identified by the 10 MAT standards. The aim of the RAGB status is to use the evidence to enable benchmarking of ADP progress against themselves and each other.
- The RAGB status is based on evidence of improvement and patient benefit across the three evidence areas (process, numerical and experiential).
- To attain green all the evidence needs to indicate ongoing improvement and patient benefit in all settings/services in an ADP area.
- Improvement and patient benefit should continue through all the RAGB stages and the ultimate goal, RAGB blue (sustained implementation), requires evidence to demonstrate full implementation with ongoing improvement and patient benefit in all ADP areas for at least two years.
- Addition of 'provisional amber' and 'provisional green':
    - The reason for provisional amber is to enable the distinction to be drawn between an ADP that has progressed to good implementation but not yet in all settings/services, and an ADP that is at a very early stage of implementation, often in a single setting/service (this situation is usually linked to recruitment difficulties) and where there is as yet no or minimal evidence of patient benefit.
    - The reason for provisional green is to accommodate the challenge of getting all three strands of evidence to demonstrate evidence of patient benefit for all settings/services in an ADP; even where there is other evidence of full implementation. The biggest challenge will be experiential evidence across all settings/services including in remote and rural areas.
- Red: There is no or limited evidence of implementation of the standard in MAT services.

- The transition from red to amber requires evidence that work has started and is expected to continue.

- Provisional amber: Where one or more evidence stream is lacking, where the scale is still very small, and there is no or minimal evidence of patient benefit; but where clinical intelligence indicates that work is started and set up to continue. This is most likely to occur where an ADP has only a small and early test of change in place, or a standard operating procedure but as yet no or minimal evidence of patient benefit.

- Amber: There is evidence of partial implementation of the standard in MAT services.

    - Amber is a broad category that can include a situation where an area has just started to implement a standard in one MAT setting/service of the ADP area with no or minimal evidence of patient benefit (Provisional Amber), or a situation where an ADP area has well established implementation and evidence of patient benefit across most, but not all, MAT settings/services.

    - The transition from amber to green requires process, numerical and experiential evidence that the standard is equitably implemented and that there is patient benefit across all unique combinations of settings/services that offer MAT and opioid substitution therapy across the ADP area.

    - In remote and rural areas the assessment will consider small numbers, local challenges and the extent to which the assessment indicates maximisation of local resource (the remote and rural process template can help this discussion).

    - For MAT standards 6–10 transition from amber to green will require numerical evidence from local audits. For financial year 2022–23 this will be discussed between the ADP and MIST on a case-by-case basis for 2022/23. The MIST and ADPs have not yet agreed formal numerical

measures for MAT standard 6–10. This will be done in financial year 2023–24.

- **Provisional green:** Where one evidence stream is lacking and it is not possible to demonstrate patient benefit across all settings/services in an ADP area, but clinical and local intelligence and the other two evidence streams indicate that work is set up and delivering across all settings/services in an ADP area**.**
    - This is most likely to occur due to a lack of experiential data. A lack of process or numerical data in a given setting/service may occur in small areas but mostly this will come under the remote and rural assessment.
- **Green:** There is evidence of full implementation of the standard in all unique combinations of setting and service that offer MAT and opioid substitution therapy across the ADP area.
    - The transition from green to blue requires process, numerical and experiential evidence to demonstrate full implementation and patient benefit across an ADP area for at least two years.
    - If ongoing assessment indicates that the standard is no longer met and patient benefit is not sustained then the RAGB status may need to be reviewed downward.
- Blue: There is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services.

The evidence to support ongoing full implementation needs to be kept under review annually. This is to mitigate against risks such as re-commissioning of a partner that may reduce resources essential to sustained improvement. For example, if ongoing assessment indicates that the standard is no longer met and patient benefit is not sustained then the RAGB status may need to be reviewed downward.

The details of what form ongoing assessment will take is to be worked out with ADPs in financial year 2023–24 but will likely include support to report updates and annual benchmarking reviews.

Appendix 2: Evidence scoring criteria

Table 2: Criteria for assessing whether process standards have been met

Reference	Criteria
1.1	Is there a documented care pathway that meets the MAT standards criteria?
1.2	Is there a standard operating procedure that meets the MAT standards criteria?
1.3	Are there prescribing guidelines that meet the MAT standards criteria?
2.1	Are there prescribing guidelines that offer all choices of medication?
2.2	Does the service have in place Home Office licences or a standard operating procedure for named patient prescribing?
3.1	Is there a documented care pathway that meets the MAT standards criteria?
3.2	Is there a standard operating procedure that meets the MAT standards criteria?
4.1	Is there a local protocol or improvement plan in place to enable core harm reduction services at the same time and place as MAT and opioid substitution therapy delivery?
4.2	Is there a training plan in place to ensure all staff offering MAT and opioid substitution therapy can provide the core harm reduction services at the same time and place as MAT and opioid substitution therapy delivery?
4.3	Is there a system to record the delivery of core harm reduction services at the same time and place as MAT and opioid substitution therapy delivery?

Reference	Criteria
4.4	Is all the equipment (needles, syringes, filters, foils, naloxone etc.) and documentation required to provide core harm reduction services readily available in all rooms where MAT or opioid substitution therapy are offered?
4.5	Are there an appropriate quantity, range and size of needles, syringes and equipment available so the correct equipment is used for each injection according to drug, injecting site and individual preference?
5.1	Are there documented care pathways or models of support that meets the MAT standards criteria?
5.2	Is there a standard operating procedure that meets the MAT standards criteria?
6.1	Is there a documented service plan for delivering tier one psychologically informed care and Tier two low-intensity psychological interventions?
6.2	Is there an established steering group that oversees the implementation of these plans?
7.1	Are there documented protocol(s) in place to share care between specialist services, GP and community pharmacies for people who are on MAT **OR** Is there a steering group established to oversee the development and implementation of drug treatment in primary care?
7.2	Are there documented pathways in place that enable the transfer of appropriate elements of care between specialist, mental health, GP and community pharmacy services?
8.1	Are independent advocacy services commissioned or engaged with locally?
8.2	Do staff have access to training to understand the role of independent rights-based advocacy and health inequalities training?
9.1	Is there a documented service implementation plan that includes the MAT standards criteria in mental health services?
9.2	Is there a documented service implementation plan that includes the MAT standards criteria in substance use services?

Reference	Criteria
9.3	Is there agreed care pathways in place to support any identified mental health care needs across the recovery oriented system of care, and clear governance structures to establish effective joint working arrangements to care for people with co-occurring mental health and substance use?
10.1	Is there a delivery plan in place for delivering trauma informed care that considers the five key drivers for organisational change recognised by NHS Education for Scotland?
10.2	Is there a steering group established to oversee the development and implementation of trauma informed care across MAT services?
Remote and Rural 1	Has every attempt been made to ensure all barriers have been discussed and possible solutions explored in relation to travel?
Remote and Rural 2	Has every attempt been made to ensure all barriers have been discussed and possible solutions explored in relation to use of technology?
Remote and Rural 3	Are models of care optimised to allow timely access to treatment care and support in the site/setting/locality, including models of clinical care, third sector support, and community involvement?

Table 3: Criteria for assessing whether numerical standards have been met

Reference	Criteria
1.1	Does the data show that 75% of people receive a prescription for MAT (opioid substitution therapy) are within one day?
1.2	Does the data show that 75% of people are ready for MAT (opioid substitution therapy) are within one day?
2.1	Does the data show availability of all 3 (4 where heroin assisted treatment applicable) opioid substitution therapy options?

Reference	Criteria
3.1	Does the data represent a complete assertive outreach and anticipatory care process through data recorded at all points within the process?
3.2	Does the data provide outcome of initial screening (triage process leading to onward referral, no further action or assertive outreach)?
3.3	Does the data show that 75% of notified high-risk events appropriate for assertive outreach (upper interquartile) have an initial assessment within three days of notification sent?
4.1	Does the data show that 75% of ADP MAT (opioid substitution therapy) caseload have access to the four core harm reduction measures either immediately in the same place or available in same building at same time, but different room/ worker in all settings/services?
5.1	Does the data show that 75% of MAT (opioid substitution therapy) caseload are retained in treatment for six months or more?
5.2	Does the data show that 75% of supported discharges are retained in treatment for six months or more?
5.3	Does the data show that 75% of unsupported discharges are retained in treatment for six months or more?

Table 4: Criteria for assessing whether experiential standards have been met

Compliance with criteria to demonstrate implementation of the standard	Evidence is collected from all sites and all 3 groups	Evidence is collected from some sites and 1 or 2 groups	No evidence has been collected
Fully compliant	0	0	0
Partially compliant	1	1	-
Not complaint	2	1 or 2*	-

***** A score of 1 or 2 will take into consideration the number of sites that can provide evidence and the amount of evidence that is provided, including whether this is from all three groups, that indicates the MAT standard has been met. Clear evidence that the MAT standard has been met, and/or including justification as to why evidence is not available from all sites and all three groups, will be necessary to score '2'. Otherwise, this will be scored as '1'.

Appendix 3: Evidence collection and analysis

Numerical evidence

The MAT standards numerical consultation group was formed in August 2022 with clinical, analytical and ADP co-ordinator members from a variety of local and national organisations and worked closely with clinical colleagues in national thematic groups.

Over the course of the year data definitions and recording rules were agreed. For example, in April 2022 the date of referral was the first time point used to measure standard 1 but for April 2023 it was agreed that recording for MAT standard 1 would begin at the point an individual requested to engage for treatment. The inclusion of a second measure to ready for treatment date was also agreed, though it has become clear that this requires further work due to individual interpretation and inconsistency in recording.

Definitions for MAT standard 5 were also refined and changed to categorisations of supported and unsupported discharges as a way of describing how individuals leave treatment and to be consistent with the drug and alcohol information system definitions. Once definitions were agreed bespoke data collection and analysis spreadsheets were developed to record and report on MAT standards 1–5.

Challenges and solutions

Analytical capacity both within MIST and across ADPs has been a major challenge. Much of MIST analytical time was devoted to developing and refining the data collection spreadsheets. Challenges included different levels of expertise within local areas, areas using unsupported versions of software and some equipment not compatible with the demands of the complex Excel spreadsheets. In addition, models of care and treatment pathways differ widely across Scotland and this increases the complexity of translating data definitions and recording rules for the many nuanced circumstances involved.

There were eight versions of each spreadsheet developed and disseminated to overcome the challenges. Spreadsheets do not include effective data validation resulting in recording inconsistencies and missing data though every effort was made to minimise this. The MIST recognises that although the spreadsheets provided a tool to collect the data it wasn't without difficulty and are grateful for the support and co-operation of ADP colleagues throughout this process.

Extensive communication and consultation between PHS, ADPs and other partners has enabled the numerical data collection to develop and improve vastly on last years and this would have been impossible without the dedication and patience of ADP colleagues.

Priorities for the year ahead

The first priority for the year ahead is to resolve differences in interpretation of various definitions and methods of recording to improve data quality and consistency across Scotland. For example:

- The MAT standard 1 numerical measure begins at the date when an individual requests to engage with services for treatment. The end date is the date the individual is prescribed opioid substitution therapy. Where an individual declines treatment they should be recorded as discharged and then followed up by assertive outreach and in these circumstances a new record would start from the date of successful engagement and measured until the date the individual is prescribed opioid substitution therapy. There will be cases where individuals are not deemed clinically safe to be prescribed, do not attend appointments or delay treatment due to personal choice but the standard 1 numerical measurement does not pause for these circumstances. Discussions will focus on structuring the data recording around demonstrating both the persons journey and the ability of multi-disciplinary teams to provide same-day access to treatment where appropriate.

- The MAT standard 3 numerical measure used in 2023 to benchmark the data begins at the date that notification of high-risk event was sent. The end date is when the individual was provided an initial outreach risk assessment. The

definition agreed was that this assessment must include the affected individual and within the spreadsheet options a list was supplied to record who provided the assessment and then another list for how that assessment was made e.g. home visit, phone call. As different areas use different models the time taken to provide an assessment via different methods will vary. There will be cases where individuals were not available via whatever method of attempted contact and attempts will be ongoing during the time being measured. Discussions for improving data capture will focus on improving capturing all the nuance and demonstrating the greater work involved in providing this risk assessment.

Another priority for MIST is to support data collection throughout the year so that local teams can periodically conduct mini analysis to sense check actions and that plans are delivering the best level of implementation for the standard.

A third priority is that MIST has gained approval for research electronic data capture, a web-based database platform to be developed for numerical data collection. This will replace the current spreadsheets.

Experiential evidence

This has been the first year for the collection of experiential evidence and MIST recognises the time and effort that has been put into building teams of interviewers, carrying out interviews and analysing data. It is a new process and one that has involved a considerable amount of work to get to the position when data collection can begin.

MIST is aware that some of the evidence submitted does not reflect the new services established over the past year. However, investment in the experiential work in 2023/2024 and onwards, engaging with people accessing treatment, service providers and family members will provide the detail of their experience and demonstrate how ADPs are meeting the MAT standards.

Challenges

- This past year has shown that ADPs which lack an identified experiential lead with allocated time and resources to co-ordinate and manage the experiential work, may experience difficulty in maintaining oversight across the experiential work and in sustaining momentum.

- While most ADPs have established a team of interviewers, there remains a need over the next year to ensure a broad representation across the interview teams of people with lived experience, staff, family members and researchers with qualitative experience (e.g. public health researchers). As well as training provided by MIST to support experiential evidence collection, interviewers may want to access additional training. Ongoing identification and training of interviewers is expected due to turnover of interviewers as people move on to other roles. Four ADPs commissioned a third sector organisation to identify interviewers and gather the experiential evidence and this, or a combination of local and third sector evidence collection may work for some areas.

- It is recognised that some evidence gathered from people accessing treatment is historical. Individuals may have been in services for several years and refer to experiences in the past, as opposed to current services. Where new services have been set up, some ADPs did not have time to recruit people accessing treatment or staff for interview due to the short timescale between a new service beginning and evidence submission dates.

- Recruitment of people to interview has proved difficult at times, for example, some ADPs report difficulty in recruiting family members or in gaining access to NHS services to recruit people accessing treatment. Service provider interviews have been difficult to arrange in some ADPs due to staff workloads, and as a result a few ADPs facilitated the completion of the questionnaire online. This is a good alternative to face-to-face interviews, if required, as the MIST experiential team recognise that this year has been a time for setting up a process and overcoming barriers. In a similar way, it is recognised that telephone interviews are the way forward in remote and rural areas to overcome the challenges of geography and travel.

- MIST recognises the potential for bias in recruitment, especially in this first year due to the recruitment of a small sample of interviewees in some areas. We will focus on recruitment issues in the coming year and all ADPs are encouraged to widen the scope and number of interviewees.

- Identification of an individual with experience in thematic analysis has been a challenge for some ADPs. The MIST can provide some support in this area, including thematic frameworks to support analysis and guidance, however, this is a role that requires substantial skill and experience to ensure that the evidence is analysed and presented appropriately.

- It is difficult for the core questionnaire to gather evidence to demonstrate that all the MAT standards are being met without it becoming longer than it already is. Question banks for MAT standards 3, 6, 9 and 10 were designed and disseminated in autumn 2022 for use with people accessing treatment and service providers but uptake was low last year due to time pressures for ADPs. The experiential team acknowledges feedback from ADPs on the questionnaire and issues around gathering evidence for all the MAT standards.

Solutions

- An experiential lead to co-ordinate and oversee all aspects of the experiential work is essential. The experiential lead should have the time and ability to co-ordinate and manage the experiential work. An example of where this has worked well is Dumfries and Galloway where the experiential lead has provided continuity, co-ordination and oversight of the evidence collection process which resulted in clear and robust evidence for their submission.

- The challenge of historical data is one that will be resolved naturally as more people access treatment through newer services and therefore create a larger pool of potential interviewees. Access to these individuals via NHS services has proved difficult for some ADPs this year and the alternative, directing recruitment to recovery hubs and similar in the community, has increased the likelihood of interviewees being in service for some time. Historical evidence

can be useful however, for example, evidence submitted from Renfrewshire ADP noted how service users who had been in the service for some years reported a change from very little choice of treatment 10 years ago or more, to more recently being given information on all available treatment options.

- Difficulties in recruiting from specific groups has varied across ADPs due to the local context, and it is hoped that other ADPs will share what has worked for them. The MIST experiential team will continue to offer potential solutions. Consideration is currently being given to a workshop focusing on family support organisations.

- Sharing of ideas and innovative ways of working between ADPs is key to overcoming barriers. For example, interviewers from the North Lanarkshire Recovery Community carried out telephone interviews for the island ADPs due to concerns over confidentiality in small communities where interviewers and interviewees potentially know each other, while Forth Valley ran a focus group with people accessing treatment, and Mid and East Lothian designed recruitment postcards for staff to pass to service users and to have available in waiting rooms and group settings.

- ADPs need to ensure they have an analyst with appropriate skills and experience to carry out thematic analysis. As stated above, MIST can provide some support in this area, however, ADPs are encouraged to identify an analyst with the appropriate skills and knowledge or alternatively support an individual to access the appropriate training.

- The experiential team have begun to revise the questionnaire and update training in response to feedback from ADPs. Guidance and resources will also be revised and we will consider additional resources to support ADPs.

Priorities for the year ahead

- The experiential team will support ADPs over the coming year to develop and embed their systems and teams, especially those still in the early stages of establishing experiential evidence collection processes. For a number of ADPs

this will focus on establishing a team of interviewers, for others the focus will be how they can improve the evidence collection programme in terms of identifying and recruiting interviewees or addressing evidence gaps with the use of the question banks.

- It is important to maintain the focus on experiential evidence collection and to sustain momentum. ADPs are encouraged to develop their experiential evidence collection plans for the coming year, i.e., who to interview, when and where. Aside from the evidence collection and analysis itself, this will involve continued identification of and support to interviewers.

- In the longer term the experiential team will focus on how we can support ADPs to embed and sustain experiential evidence collection on a permanent basis, for example the development of a ‘train the trainer’ package.

Appendix 4: Table of RAGB allocation for MAT standards 1–10 by NHS Board and ADP area

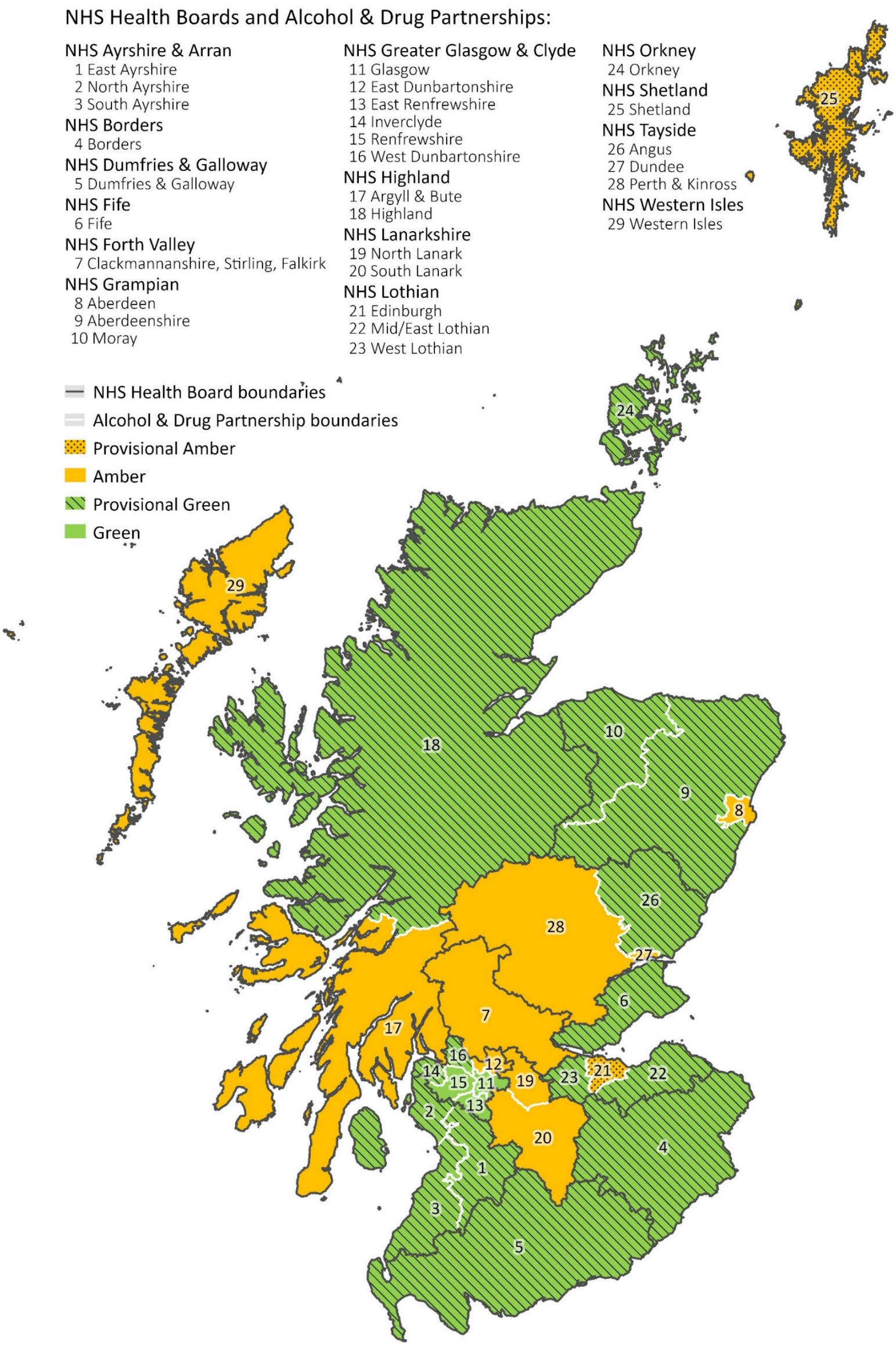
Table 5: Breakdown of implementation status (RAGB score) by Health Board and ADP area for each of the standards 1–10, 2022 –2023

NHS Board	ADP	MAT 1 2022	MAT 1 2023	MAT 2 2022	MAT 2 2023	MAT 3 2022	MAT 3 2023	MAT 4 2022	MAT 4 2023	MAT 5 2022	MAT 5 2023	MAT 6 2023	MAT 7 2023	MAT 8 2023	MAT 9 2023	MAT 10 2023
Ayrshire and Arran	East Ayrshire	Amber	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Amber	Green	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Ayrshire and Arran	North Ayrshire	Amber	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Ayrshire and Arran	South Ayrshire	Amber	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Borders	Borders	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Provisional Amber	Provisional Amber	Amber	Provisional Amber	Provisional Amber
Dumfries and Galloway	Dumfries and Galloway	Amber	Provisional Green	Amber	Green	Green	Green	Green	Green	Amber	Green	Amber	Amber	Amber	Provisional Amber	Amber
Fife	Fife	Amber	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Red	Provisional Amber
Forth Valley	Clackmannanshire, Stirling, Falkirk	Red	Amber	Amber	Provisional Green	Amber	Amber	Amber	Provisional Amber	Amber	Amber	Amber	Amber	Provisional Amber	Provisional Amber	Provisional Amber
Grampian	Aberdeen	Red	Amber	Amber	Provisional Green	Amber	Amber	Green	Provisional Green	Green	Provisional Green	Provisional Amber	Amber	Amber	Amber	Provisional Amber
Grampian	Aberdeenshire	Amber	Provisional Green	Amber	Provisional Green	Green	Provisional Green	Green	Provisional Green	Green	Provisional Green	Amber	Amber	Provisional Amber	Provisional Amber	Provisional Amber
Grampian	Moray	Red	Provisional Green	Amber	Green	Red	Provisional Green	Red	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Provisional Amber	Provisional Amber
Greater Glasgow and Clyde	East Dunbartonshire	Red	Amber	Amber	Provisional Green	Amber	Amber	Amber	Provisional Green	Amber	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Greater Glasgow and Clyde	East Renfrewshire	Amber	Green	Amber	Green	Amber	Provisional Green	Amber	Amber	Amber	Green	Amber	Provisional Amber	Amber	Provisional Amber	Provisional Amber
Greater Glasgow and Clyde	Glasgow City	Amber	Green	Amber	Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Provisional Amber	Amber
Greater Glasgow and Clyde	Inverclyde	Red	Provisional Green	Red	Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Green	Amber	Amber	Amber	Provisional Amber	Provisional Amber

NHS Board	ADP	MAT 1 2022	MAT 1 2023	MAT 2 2022	MAT 2 2023	MAT 3 2022	MAT 3 2023	MAT 4 2022	MAT 4 2023	MAT 5 2022	MAT 5 2023	MAT 6 2023	MAT 7 2023	MAT 8 2023	MAT 9 2023	MAT 10 2023
Greater Glasgow and Clyde	Renfrewshire	Amber	Green	Red	Green	Amber	Amber	Green	Green	Amber	Green	Amber	Amber	Amber	Provisional Amber	Provisional Amber
Greater Glasgow and Clyde	West Dunbartonshire	Red	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Green	Amber	Amber	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Highland	Argyll and Bute	Red	Amber	Red	Provisional Green	Red	Amber	Amber	Amber	Amber	Amber	Red	Provisional Amber	Amber	Red	Red
Highland	Highland	Red	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Provisional Green	Amber	Amber	Red	Provisional Amber	Provisional Amber	Red	Red
Lanarkshire	North Lanarkshire	Red	Amber	Amber	Provisional Green	Amber	Amber	Amber	Amber	Red	Amber	Red	Red	Amber	Red	Red
Lanarkshire	South Lanarkshire	Red	Amber	Amber	Provisional Green	Amber	Amber	Amber	Amber	Amber	Amber	Red	Red	Amber	Provisional Amber	Red
Lothian	Edinburgh	Amber	Provisional Amber	Amber	Provisional Green	Amber	Amber	Amber	Amber	Amber	Provisional Green	Amber	Amber	Amber	Provisional Amber	Amber
Lothian	Mid and East Lothian	Red	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Provisional Amber	Amber
Lothian	West Lothian	Amber	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Provisional Green	Amber	Amber	Amber	Amber	Amber	Provisional Amber	Amber
Orkney	Orkney	Red	Provisional Green	Amber	Green	Amber	Provisional Green	Amber	Amber	Red	Provisional Green	Provisional Amber	Provisional Amber	Amber	Amber	Provisional Amber
Shetland	Shetland	Red	Provisional Amber	Amber	Amber	Red	Provisional Amber	Amber	Amber	Amber	Provisional Amber	Red	Red	Provisional Amber	Provisional Amber	Red
Tayside	Angus	Red	Provisional Green	Amber	Provisional Green	Amber	Amber	Amber	Green	Amber	Provisional Green	Amber	Provisional Amber	Amber	Provisional Amber	Provisional Amber
Tayside	Dundee	Red	Amber	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Amber
Tayside	Perth and Kinross	Red	Amber	Amber	Amber	Amber	Provisional Green	Amber	Provisional Green	Amber	Provisional Green	Provisional Amber	Amber	Amber	Provisional Amber	Provisional Amber
Western Isles	Western Isles	Red	Amber	Amber	Provisional Green	Amber	Amber	Amber	Amber	Amber	Amber	Provisional Amber	Red	Amber	Provisional Amber	Provisional Amber

Appendix 5: Maps of RAGB allocation for MAT standards 1–10 by NHS Board and ADP area

MAT standard 1



MAT standard 2

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
17 Argyll & Bute
18 Highland

NHS Lanarkshire
19 North Lanark
20 South Lanark

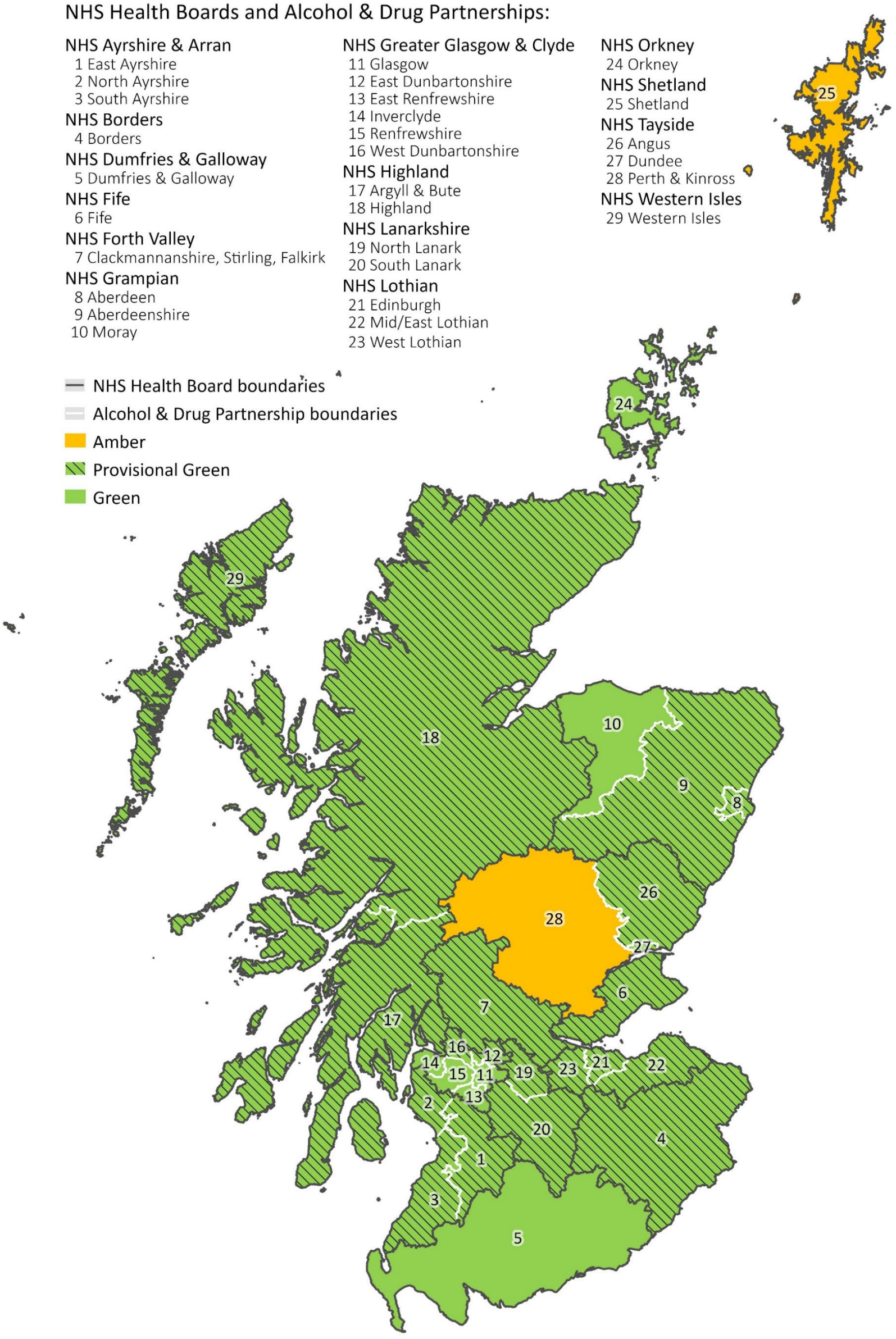
NHS Lothian
21 Edinburgh
22 Mid/East Lothian
23 West Lothian

NHS Orkney
24 Orkney

NHS Shetland
25 Shetland

NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 3

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
17 Argyll & Bute
18 Highland

NHS Lanarkshire
19 North Lanark
20 South Lanark

NHS Lothian
21 Edinburgh
22 Mid/East Lothian
23 West Lothian

NHS Orkney
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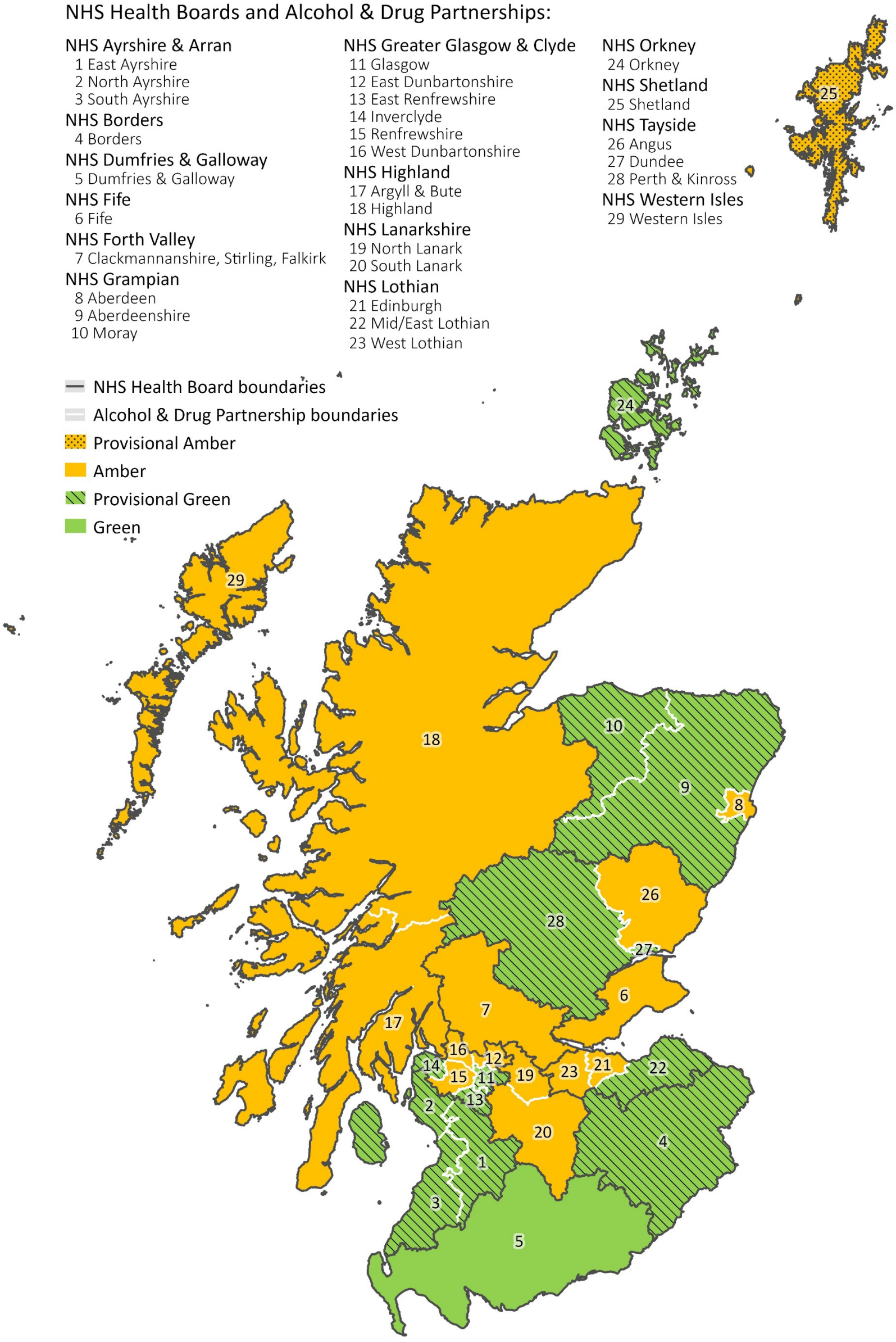
NHS Shetland
25 Shetland

NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 4

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
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12 East Dunbartonshire
13 East Renfrewshire
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15 Renfrewshire
16 West Dunbartonshire

NHS Highland
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NHS Lanarkshire
19 North Lanark
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NHS Lothian
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NHS Shetland
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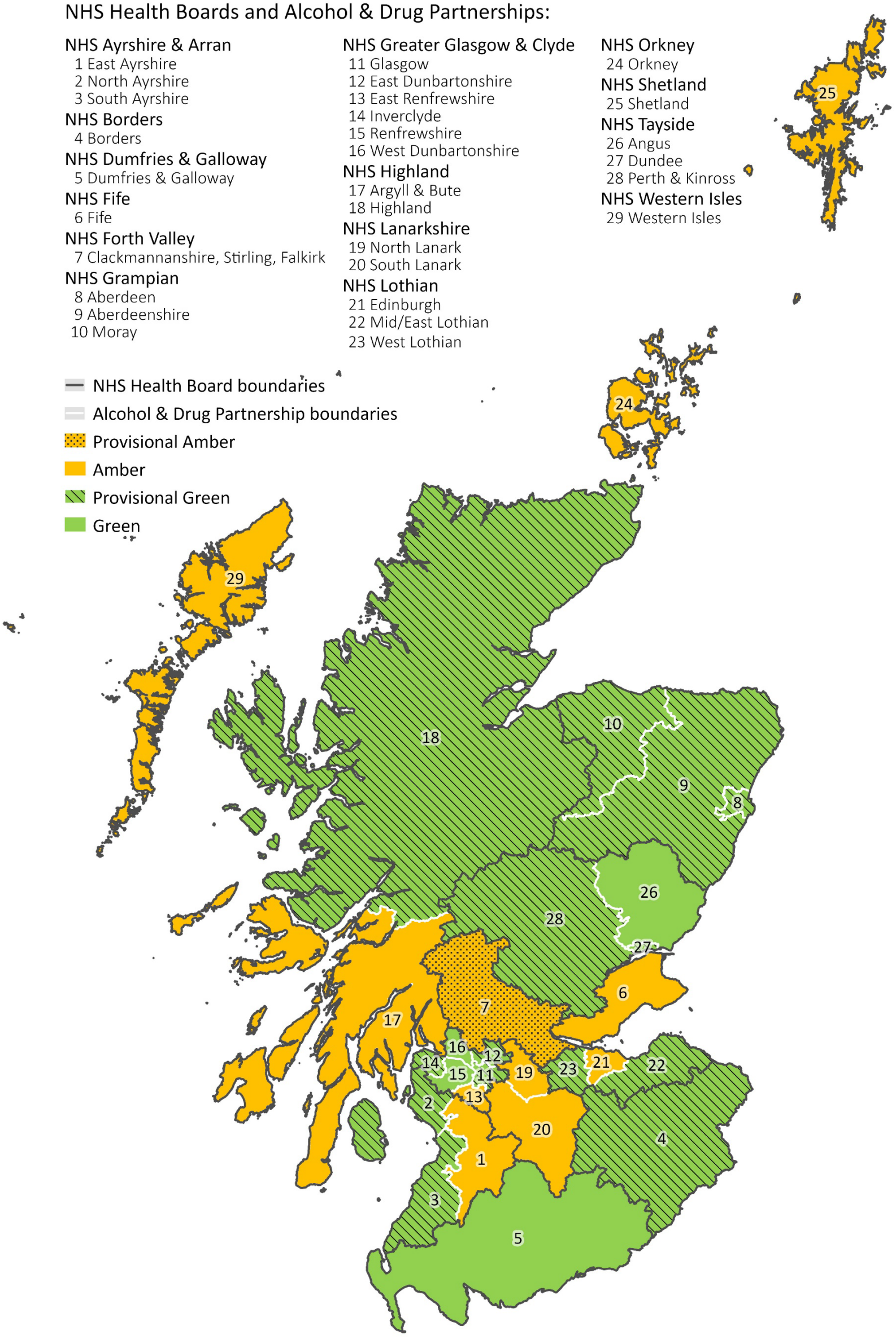
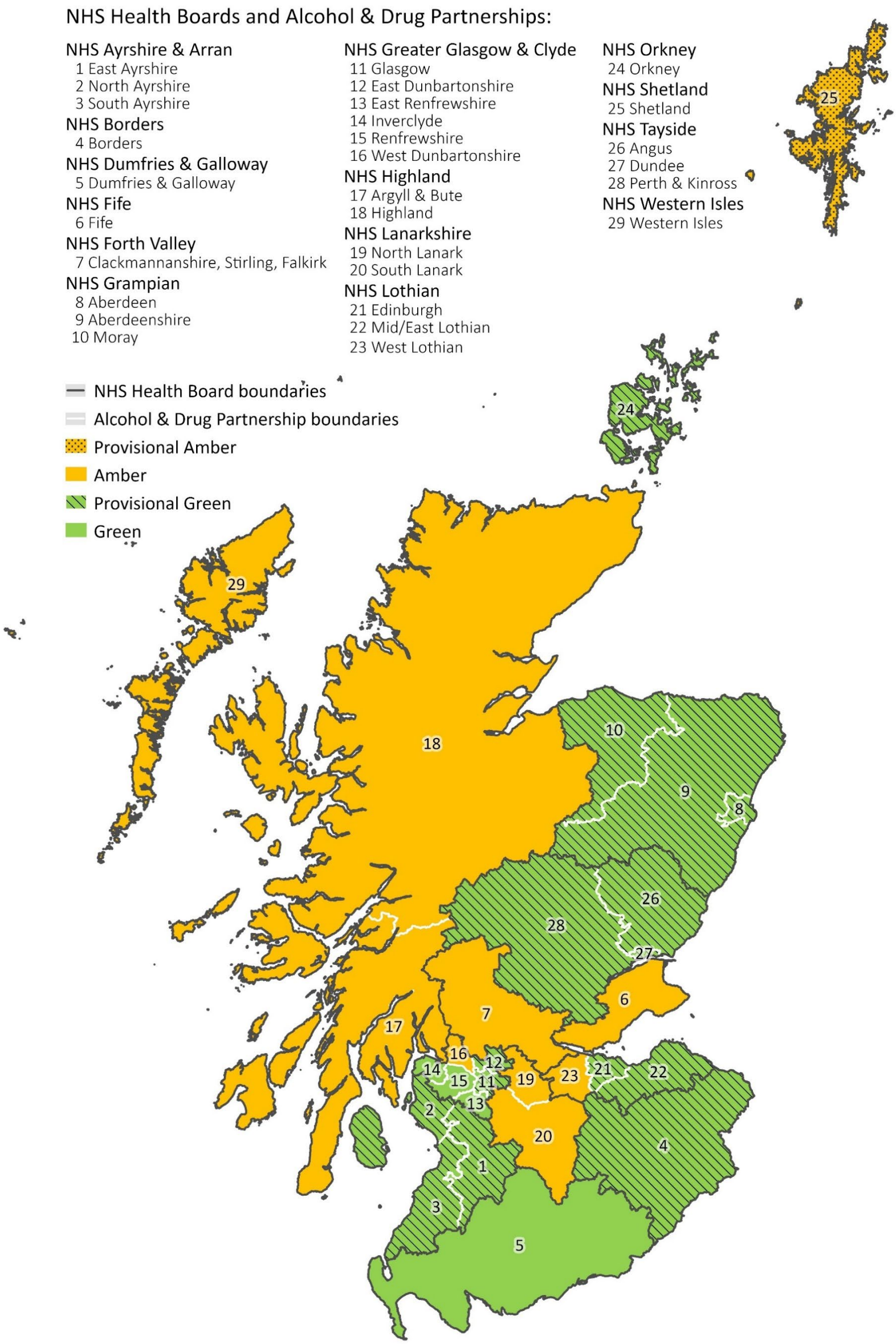
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 5



MAT standard 6

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
17 Argyll & Bute
18 Highland

NHS Lanarkshire
19 North Lanark
20 South Lanark

NHS Lothian
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22 Mid/East Lothian
23 West Lothian

NHS Orkney
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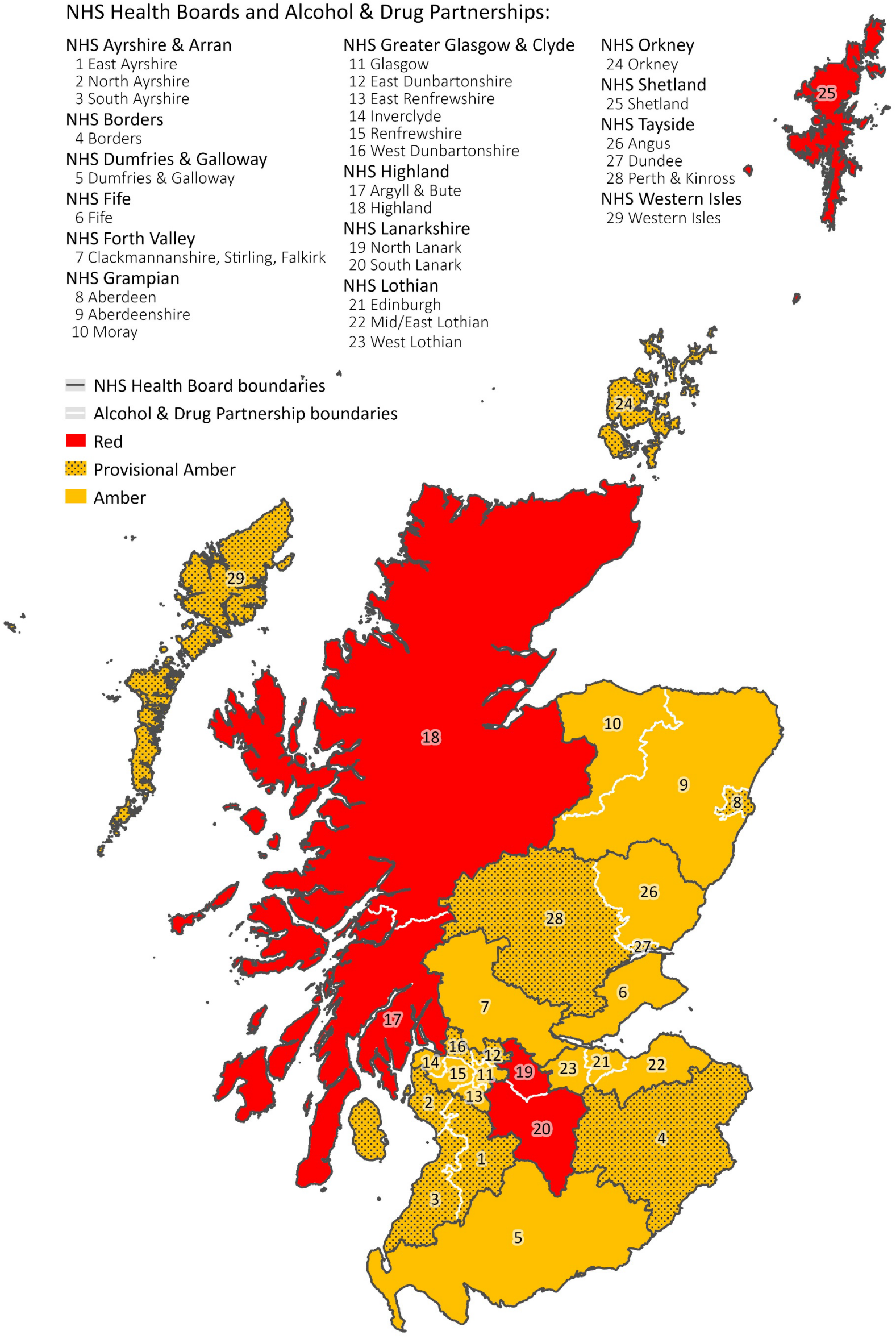
NHS Shetland
25 Shetland

NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 7

NHS Health Boards and Alcohol & Drug Partnerships:

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1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
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12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
17 Argyll & Bute
18 Highland

NHS Lanarkshire
19 North Lanark
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NHS Lothian
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23 West Lothian

NHS Orkney
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NHS Shetland
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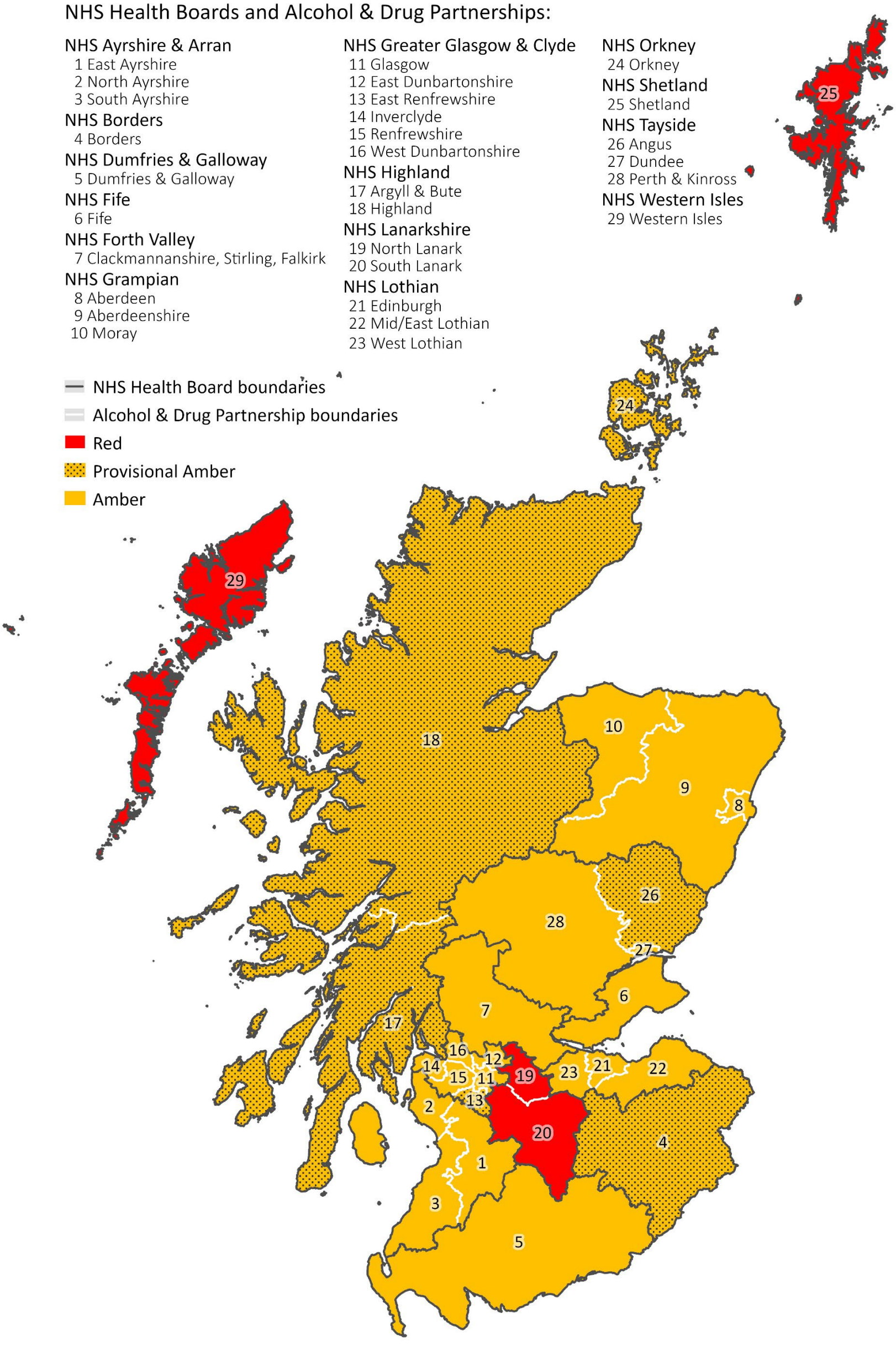
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 8

NHS Health Boards and Alcohol & Drug Partnerships:

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1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
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NHS Lanarkshire
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NHS Shetland
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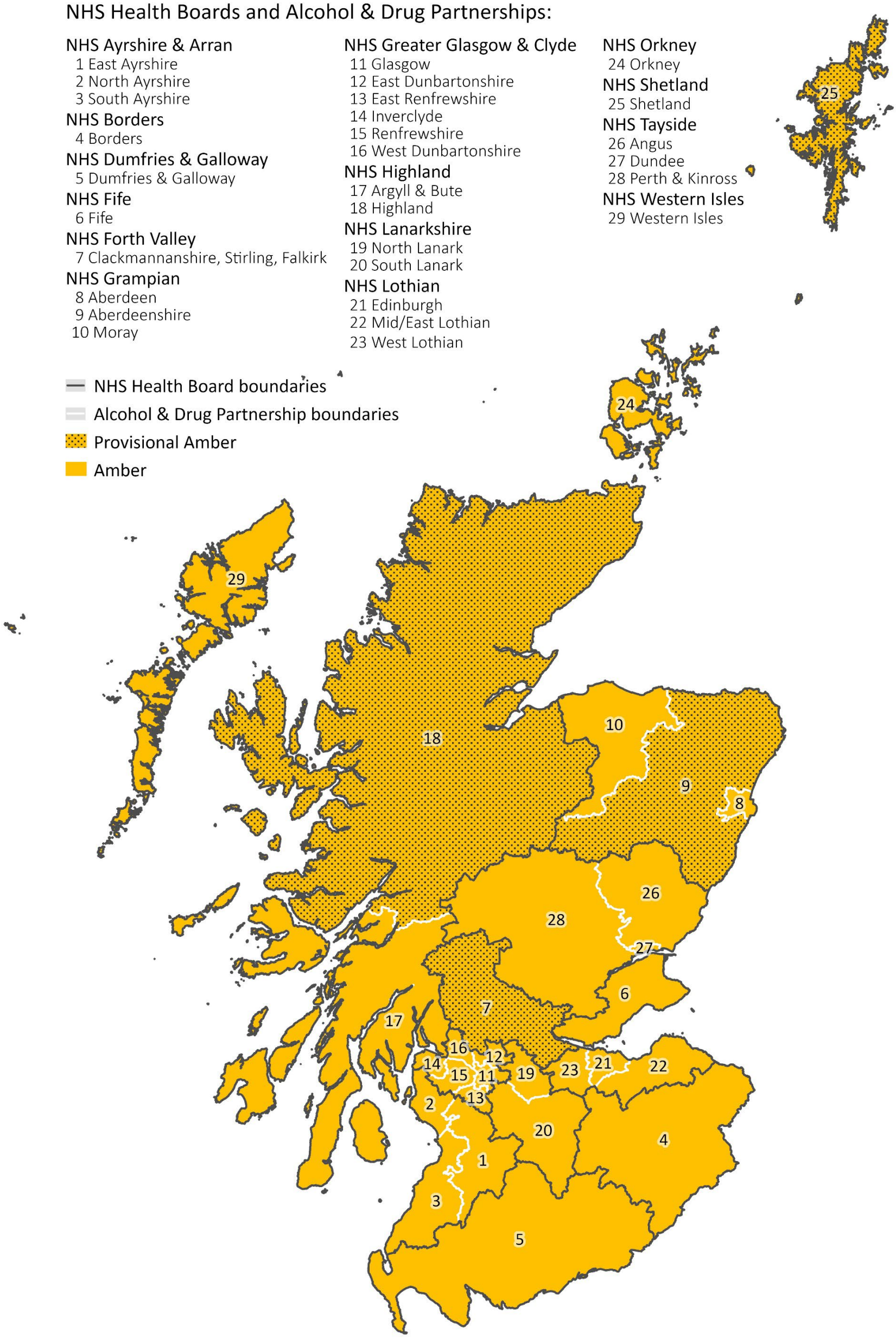
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 9

NHS Health Boards and Alcohol & Drug Partnerships:

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1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire

NHS Highland
17 Argyll & Bute
18 Highland

NHS Lanarkshire
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24 Orkney

NHS Shetland
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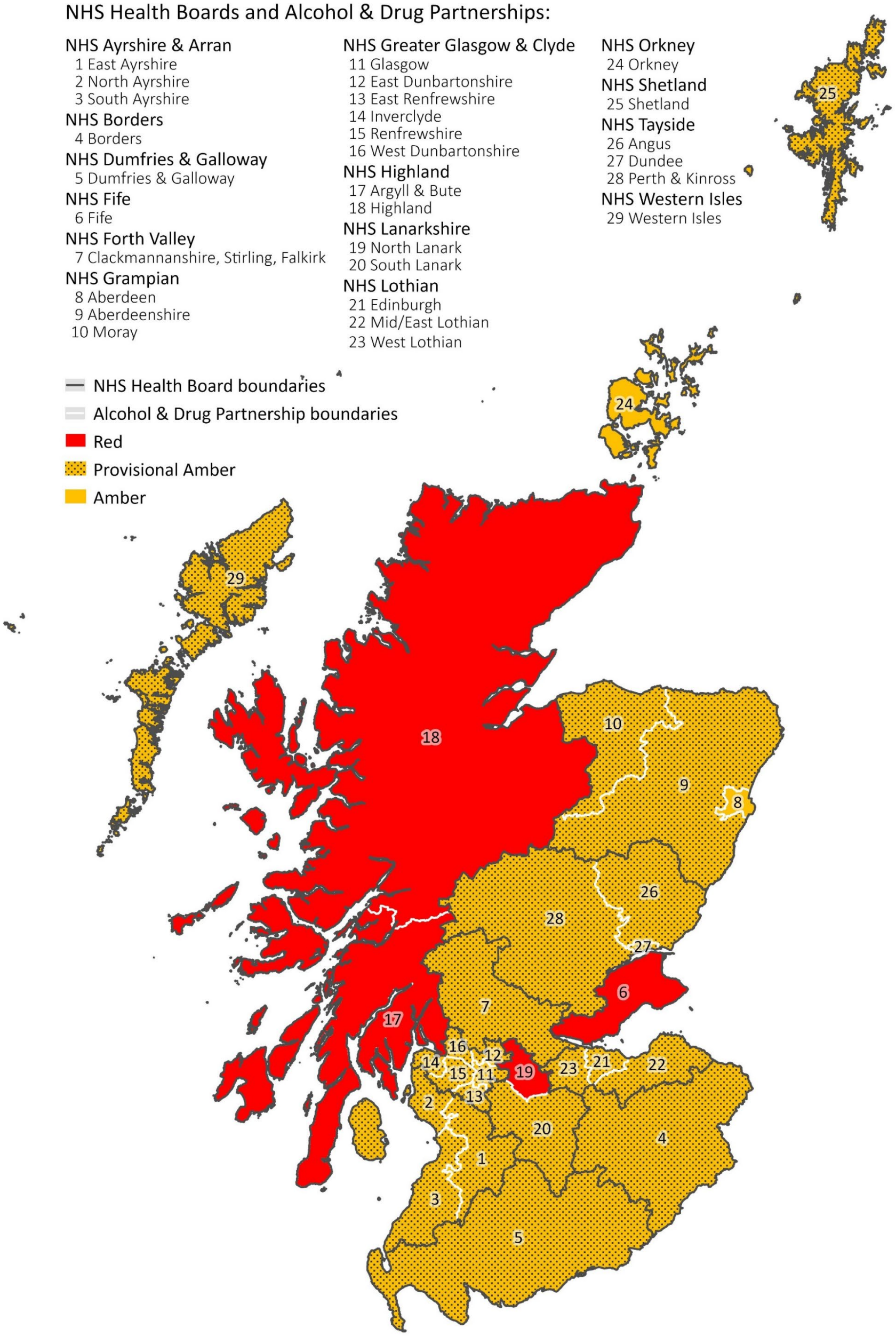
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross

NHS Western Isles
29 Western Isles



MAT standard 10

NHS Health Boards and Alcohol & Drug Partnerships:

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1 East Ayrshire
2 North Ayrshire
3 South Ayrshire

NHS Borders
4 Borders

NHS Dumfries & Galloway
5 Dumfries & Galloway

NHS Fife
6 Fife

NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk

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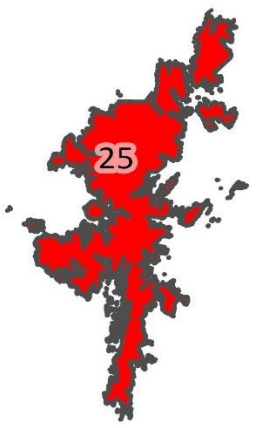
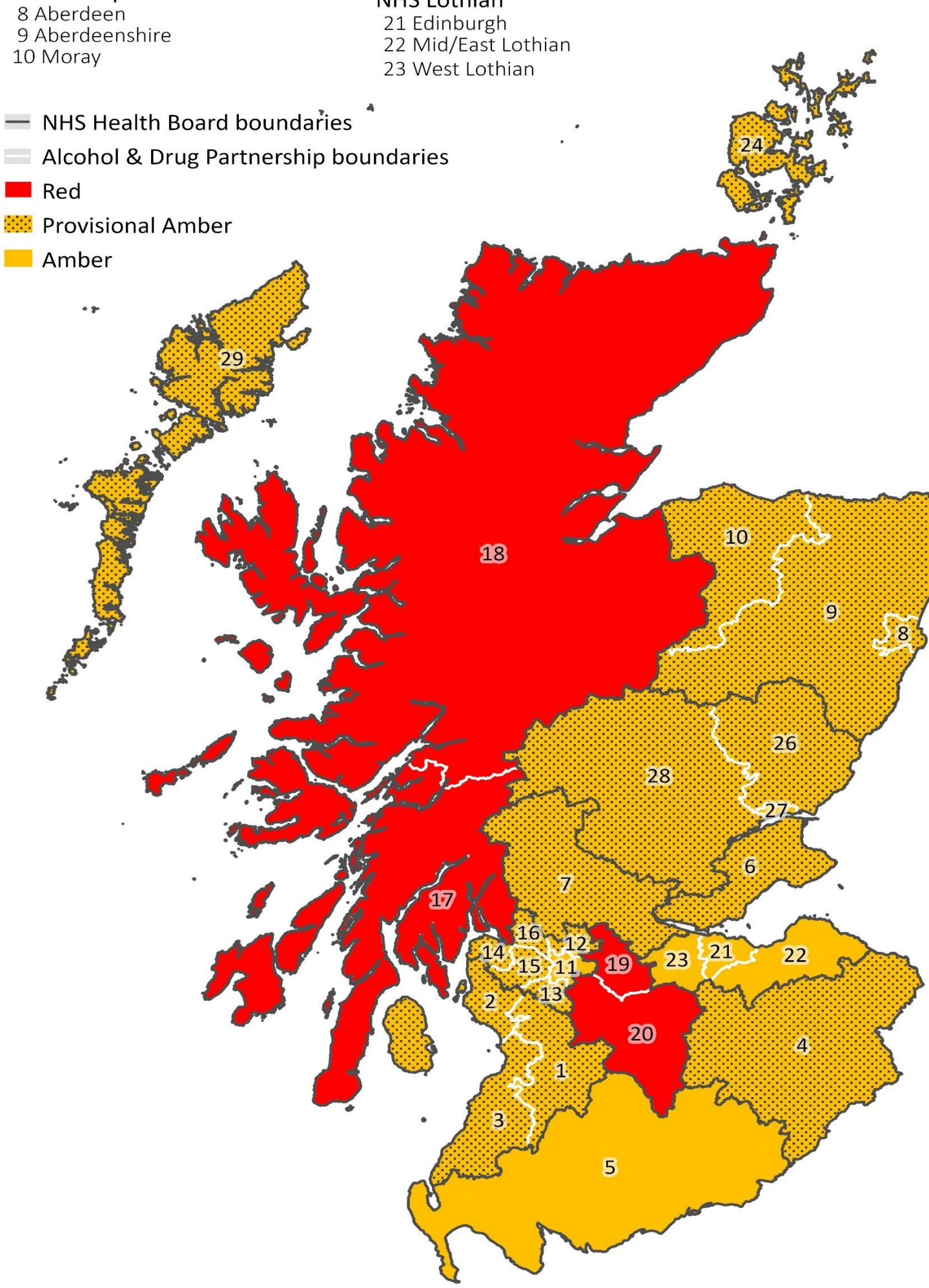
27 Dundee
28 Perth & Kinross

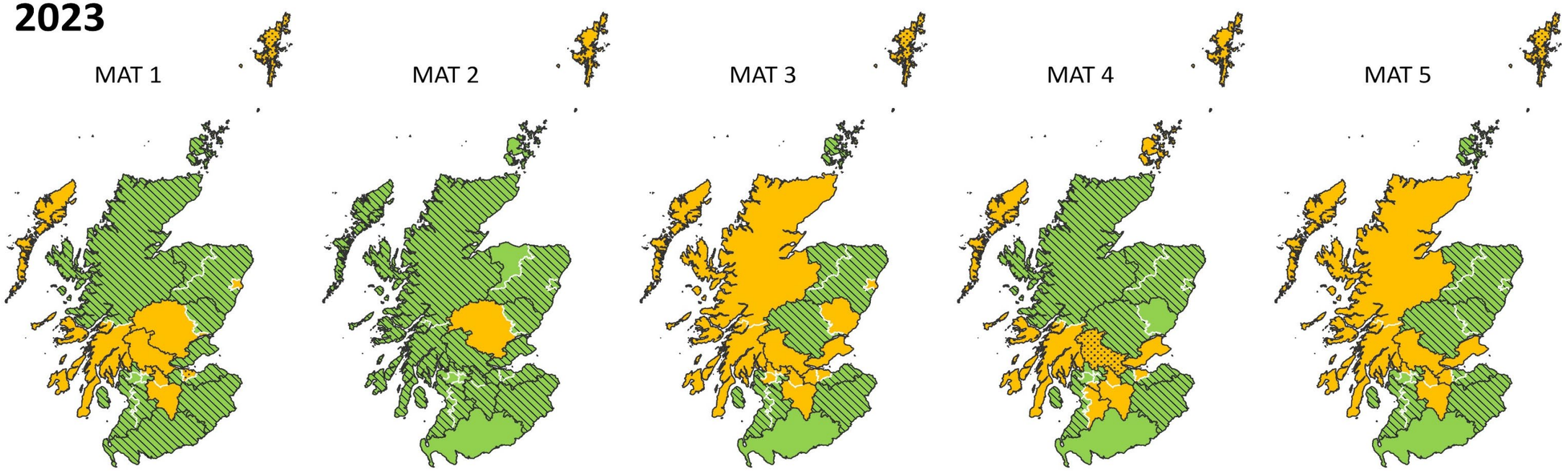
NHS Western Isles
29 Western Isles



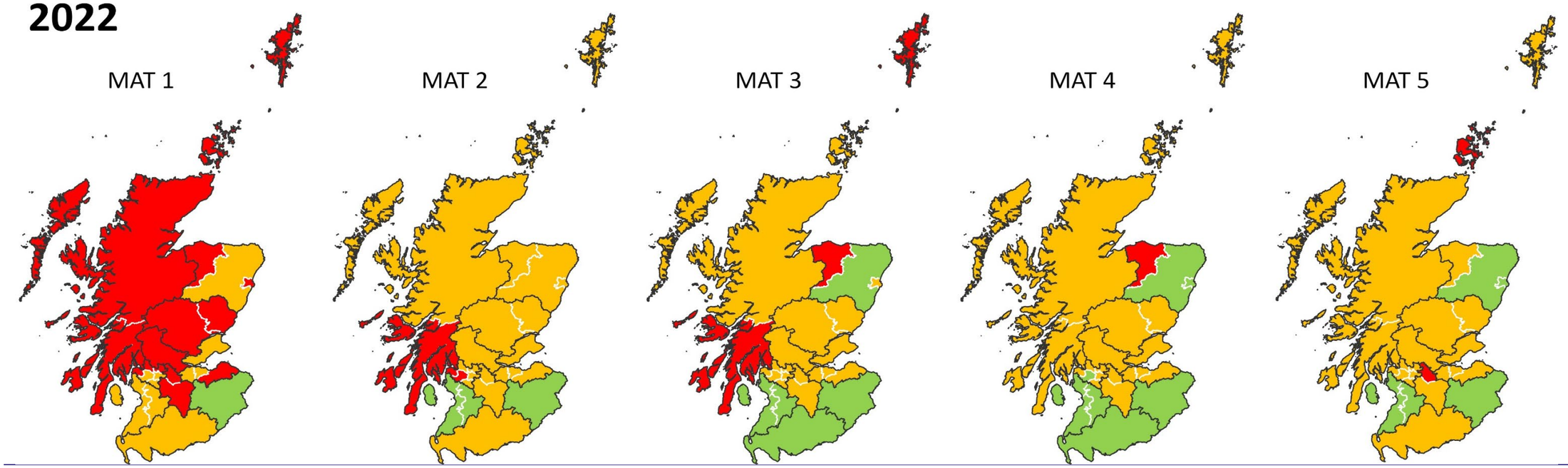


MAT standards 1–5. 2022–2023 comparison

2023



2022



Appendix 6: Case studies

Angus ADP

Background

Angus Integrated Drug and Alcohol Recovery Service is an integrated health and social care service focused on person-centred care and harm reduction interventions. AIDARS have been working on improving their referral processes to support same-day access to opioid substitution therapy.

Impact

Since January 2023, revision of the screening of referrals has improved access to care for people entering the service. When the Angus Integrated Drug and Alcohol Recovery Service now receives a referral showing opiate dependency, the person is allocated to either a non-medical prescriber or a medical prescriber. The prescriber works with them to determine what options are available to them, if they want to start opioid substitution therapy, and, if clinically safe to do so, starts them on their chosen medication as quickly as possible.

The original process involved a key worker (nurse or social worker) assessing the referral before passing on to a prescriber. Initial service data now shows a reduction in waiting times. The changes to service delivery have also been well received by team members who can see the difference it is making to people they support. Improved screening also allows better signposting to other services where appropriate.

Learning

The service has increased their team numbers by training 2 new non-medical prescribers. This has supported improved access for people and made the workload

more manageable for the team. This may also be due to a reduction in the number of opiate-related referrals. The majority of service referrals are currently for alcohol, cocaine, and benzodiazepines rather than opiates.

At the start of the project some of the team were concerned about the level of risk involved with same-day prescribing but confidence has grown with the understanding that this is only implemented when it is clinically safe to do so. IT systems have also challenged service development. Different reporting schedules and competing requirements have also been a barrier for services and require review. The service continues to monitor improvement progress through national and local data collection and analysis.

Top tips

- Ensure flexibility, making best use of the available clinical expertise according to evolving need.
- Invest in staff learning and development so they feel confident, skilled, and supported to make decisions.
- Involve people accessing services and their family in service improvement activity to ensure that planned and implemented changes align with need.

Next steps

The Angus Integrated Drug and Alcohol Recovery Service are developing workforce learning and development plans and intend to introduce virtual case review huddles soon. The service will also review data from recent surveys to assess the impact of their service provision.

Argyll and Bute ADP – case study 1

Background

In Argyll and Bute, service providers and people have identified the need for advocacy support for many years. The Recovery Advocacy Project was set up in 2019 after discussions with Argyll and Bute ADP. This is a core service delivered by Lomond andArgyll Advocacy Service. It covers Helensburgh and Lomond, Cowal, and Bute and Kintyre.

Firstly, they recruited three part-time peer advocacy workers to support the service; who all completed their Scottish Qualification Award on a Rights Based Approach. They then consulted with local community and partner agencies about their service model. This helped refine their plans and strengthened connections with stakeholders. Promotion of their service was achieved by a virtual consultation call with a range of stakeholders, seeking a range of views to guide the development of the project.

They also distributed leaflets, posters and information packs to local groups and services and introduced their peer advocacy workers via blogs and posts on social media. Further awareness raising of their service happened through their ‘Step into May’ walking challenge. This encouraged people to meet up and learn more about options available to them in their recovery journey.

Impact

The Recovery Advocacy Project now provides a voice to people impacted by alcohol and substance use. With no judgement or stigma, they ensure individuals are treated with dignity and respect and support them to access services. With someone on their side, people are given the confidence to challenge barriers or discrimination when they feel they are not being heard. Satisfaction rates are good and the team continue to monitor these to review and refine their services. They also receive repeat referrals which demonstrates the confidence people and partners have in their service.

Learning

Activities such as their Group Recovery Project have provided the team with insights into the needs of the people they support. They have fostered a culture of collaboration and trust with people and services which continues to grow. They are working to overcome challenges in trying to engage women affected by alcohol and substance use.

Top tips

- Have a clear vision of what you want to achieve.
- Include people with lived and living experience at every stage.
- Be creative when promoting your service.

Next steps

Over the coming months the team aim to secure longer term funding to embed and extend the reach of their service, publish their new advocacy ‘Book of Hope’ and trial their self-advocacy skills training pack on the Isle of Bute.

Argyll and Bute ADP – case study 2

Background

The Argyll and Bute Addiction Team is an integrated team comprising of specialist staff from NHS Highland and Argyll and Bute Council. Geography is an important factor in delivering care here. It is the fourth sparsest population of the 32 local authorities within Scotland with 47% of its population living in rural areas. One in 10 people are income deprived in this region which also includes 23 inhabited islands.

The Argyll and Bute Addiction Team's funding allocation enabled the team to focus on service delivery in Cowal. A region identified as needing more services as it is the most deprived area of Argyll and Bute. Cowal has the highest number of drug-related deaths in the area and high numbers of people seeking support from domestic violence and mental health services.

Impact

The Argyll and Bute Addiction Team response and outreach service launched in March 2023 and operates an open-door approach offering a range of treatment choices for people affected by substance use including a long-acting form of buprenorphine. This reduces the need for a referral from professional services and offers people more treatment choice.

The team considers this new way of working as a significant change in culture for the communities it serves. Feedback so far indicates that people have found buprenorphine to be a life changing treatment option. Some people had been attending their local pharmacy every day for years. The availability of buprenorphine treatment now offers them more opportunities, flexibility, privacy and dignity.

Learning

Assertive outreach has worked well in communities to reach people who may hesitate to contact support services. Forming a multi-agency group approach enabled relevant agencies to come together and develop standard operating procedures. As a result, their work was more consistent, cohesive, and everyone had a voice. The team faces ongoing challenges with recruitment, especially of response nurses, mostly due to fixed term funding for posts. Availability of equipment is also a recurring issue for those who are in post.

Top tips

- Support people in a way they are comfortable with, when they are ready to engage.
- Consider models of care such as supporting people in their own home and which open new channels of trust and support.
- Create an approach that is also sustainable for the practitioner as some treatments are more intensive than others.

Next steps

The Argyll and Bute Addiction Team will focus on promoting and building on their response service in Cowal to expand across Argyll and Bute.

Dumfries and Galloway ADP

Background

NHS Dumfries and Galloway covers a substantially rural area 110 miles wide, and holds two main hubs with 55 Specialist Drug and Alcohol Service staff members in multidisciplinary teams. Introduction of long-acting injectable buprenorphine was identified as a pilot service development to improve people's choices of treatment.

Impact

Since the launch of their pilot in December 2020, continuous growth and investment has enabled the service to expand their offering. Increased funding has expanded their capacity of patients they can treat with buprenorphine from 30 to 200 people. The service now supports 210 on buprenorphine with numbers increasing weekly. In line with MAT standard 2, buprenorphine is offered as a first line treatment for new assessments if suitable.

Increasing the medication options available to people to include buprenorphine has had considerable impact on service users. They are given more choice in treatment and enabled to make informed decisions. The impact of this service development is evaluated using the WHO's Quality of Life Index.

There is no one size fits all approach in the service. Giving people a choice of treatment and connecting them to support options has led to feedback such as:

- 'no more feelings of being ashamed'
- 'opportunity to work'
- 'family trust back'

Learning

The service has valued building multidisciplinary teams; including roles such as support workers and clinical psychiatrist alongside nurses, GPs, pharmacy technicians and pharmacists. Investing in staff training can help people make informed choices as it enables staff to provide clear and up-to-date information.

A significant barrier to implementation was the organisation and costs of the Home Office licence to store buprenorphine. Stock wastage is also a challenge due to the variability of client need. Open communication with service users has improved trust and relationships. The team reported that people understand the costs in running this service and appreciate being invested in.

Top tips

- Importance of evaluation to demonstrate impact – long-acting injectable buprenorphine embedded into service.
- Capture data and learn from it – this was vital to secure further funding.
- Adapt and innovate the service as numbers grow.
- Work in partnership with community pharmacy and general practice.

Next steps

The service plans to continue adapting their service to expand their drop-in care offering and broaden roll out to primary care.

Dundee ADP – case study 1

Background

In Dundee City, drug and alcohol treatment services are provided by the Dundee Drug and Alcohol Recovery Service which offers a mixed-model approach delivered by a multidisciplinary team in collaboration with social work, criminal justice and third sector services operating in three regional clusters across the city.

The aim of this service model is to offer the right care, in the right place, at the right time for every person. It consists of both drop-in and appointment-based services alongside an assertive outreach component and additional services for children, families and intensive input for expectant mothers. All elements of the service seek to provide same-day access to treatment (MAT standard 1) and assertive outreach to those at the most risk of harm (MAT standard 3).

Impact

What began as a small-scale test of change, prior to the start of the COVID-19 pandemic has now evolved into a service model supporting approximately 50 new referrals each month, while supporting on average 1400 people at any given time.

Learning

The development of the role of non-medical prescribers in the team has been a significant lever in improving service delivery along with the positivity and resilience of all the team members. Another enabler has been the introduction and availability of Buvidal treatment with demand for clinics now doubling and positive feedback from people choosing this form of medication.

The development and growth of the service has not been without its challenges, in particular in relation to the identification and maintenance of suitable premises, maintenance of adequate service staffing levels and logistical challenges of

prescription deliveries. Despite these obstacles, they continue to receive positive feedback from people accessing support.

Top tips

- Multi-agency leadership buy-in and support is critical to success.
- Identify the right premises for delivery of services.
- Develop a robust workforce plan to support roles such as non-medical prescribers.

Next steps

Ongoing review of the service model. Focus on demonstrating people's feedback and acting on this to support future service design and continuous improvement.

Dundee ADP – case study 2

Introduction

In Dundee City, substance use services are provided by a range of organisations, including the Dundee Drug and Alcohol Recovery Service, offering a mixed-model approach delivered by a multidisciplinary team in collaboration with social work, criminal justice and third sector services operating in three regional clusters across the city.

Background

The aim of this service model is to offer the right care, in the right place, at the right time for every person. It consists of both drop-in and appointment-based services alongside an assertive outreach component and additional services for children, families and intensive input for expectant mothers. All elements of the service seek to provide same-day access to treatment (MAT standard 1) and assertive outreach to those at the most risk of harm (MAT standard 3). The Dundee Drug and Alcohol Recovery Service faced criticism and stigma over the years which has created barriers and challenges for those accessing treatment but also for the staff working within services.

The Dundee Drug and Alcohol Recovery Service has worked tirelessly with partners to change how the service is viewed and to ensure it is as accessible as possible. The service acknowledged that change, including culture change was needed and opted for a Test of Change around MAT standard 1 to increase access to same-day prescribing in an accessible way.

Approach

Initially the Dundee Drug and Alcohol Recovery Service implemented a Test of Change in the form of a rapid access clinic (including alcohol and drugs support), which was run two full days a week. The clinic was run on a drop-in bases, with a morning session and an afternoon session offering more choice for patients. This

was also split over two locations – Constitution House and Wallacetown, which is a GP practice. The multiple locations gave individuals a choice as to where they would feel more comfortable attending. The Dundee Drug and Alcohol Recovery Service were aware that individuals often felt stigmatised attending Constitution House as it was well known for being a drug treatment centre which at times put people off attending. Therefore, it was important to include a different location as part of the Test of Change to offer choice. It was also recognised that not everyone would access a drop-in approach and a third day was established to offer planned assessment appointments at a person's choice.

There is a significant demand for treatment in Dundee, with the Dundee Drug and Alcohol Recovery Service receiving on average 25 referrals per month (individuals accessing drug treatment only). This can see up to 8 people turn up to any drop-in session, which creates significant capacity issues for Dundee Drug and Alcohol Recovery Service staff. In order to overcome this challenge and see as many individuals as possible, DDARS have implemented a triage system. This is where individuals are first seen by health care staff who take a history and key information from patients before passing to nursing staff for assessment. This model has been really successful, increasing the number of nurse prescribers has increased the number of people that are able to start on treatment on the same day.

Top tips

- Partnership working – collaborating with partners in third sector and statutory services, utilising a wide range of skills and expertise.
- Holistic Approach – working collaboratively to provide wrap around support meeting individuals need.
- Assertive Outreach – taking services to people at risk, who previously may have fallen through the cracks.

Challenges

The Dundee Drug and Alcohol Recovery Service had successfully managed to have their Test of Change up and running and were due to add an additional day to their rapid access drop-in clinics when Constitution House was impacted by significant flooding. This closed the building to staff and patients as it was not safe to be in many areas of the building. This meant that the team could only work from Wallacetown, which has limited space. However, despite the challenge the flood created, the team pulled through and continued to provide a quality service to patients. Nursing staff went above and beyond to ensure they had the items they needed to start patients on treatment that same day.

The team also co-located with a third sector provider, broadening accessibility of treatment. This also allowed for stronger relationships to be built with third sector colleagues. The Dundee Drug and Alcohol Recovery Service recognises the importance and need for multi-agency support from colleagues to ensure a truly holistic service is provided. After seven challenging weeks, the service was able to return to Constitution House, increase their rapid access clinic to 3 days a week quickly and resume normal service delivery. There was also a silver lining that came from the disaster in that the service has been exploring further co-location with third sector partners to further increase accessibility to services and holistic care.

Impact

The Dundee Drug and Alcohol Recovery Service have seen significant success with their Test of Change despite the challenges. It took longer to increase the rapid access clinics as planned due to issues around buildings, staffing resource and overcoming existing stigma. However, in spite of this the service is now flourishing. They have increased to providing same-day access to treatment 5 days per week, which includes a third sector lead drop in on Fridays, providing patients with crisis interventions and support around basic needs such as food and electricity. It also provides an opportunity for nursing staff to build relationships with patients in a neutral environment meaning those who may have been unsure about attending a drop-in clinic, feel more confident in doing so now. The third sector led drop-in has

also allowed the service to access a population that may not have previously accessed treatment services. Staff are able to provide information and dispel myths about accessing treatment in a safe, informal environment with access to lots of different services in one room.

Dundee is continually thinking one step ahead which is evidenced by the development of the Prison Liberation Pathway. Those liberated from prison are at a higher risk of overdose within the first 72 hours of release. The Dundee Drug and Alcohol Recovery Service have developed a pathway with Perth Prison to minimise those liberated falling through the cracks and missing treatment.

Through the hard work of all the staff involved in the Dundee Drug and Alcohol Recovery Service, Dundee has progressed from a red RAGB status to an Amber over a period of one year. This is an incredible achievement in a short space of time, highlighting the commitment, hard work and dedication from all of the service and third sector staff.

Enablers

One of the main drivers behind the success of the Test of Change has been Dundee Drug and Alcohol Recovery Service willingness and commitment to change. It is evident that the team endeavour to provide the highest quality of service for people and continually go above and beyond to ensure they achieve the best possible outcomes.

Creativity and innovation have allowed Dundee to progress greatly. Adopting a triage approach to Rapid Access Clinics and a Third Sector led drop in has increased accessibility of treatment to a broader and increased population of people.

Collaboration is key to MAT standard implementation. Dundee Drug and Alcohol Recovery Service recognises the importance to a multi-agency approach and collaborating with third sector and statutory partners. This allows Dundee to provide authentic holistic care to the people of Dundee, increasing positive outcomes.

Fife ADP

Background

Between 2017 and 2019, 44 people lost their lives as a result of drug-related deaths in the Levenmouth area with 26 occurring in the town of Methil. Fife ADP agreed a new set of locality based strategic priorities following extensive analysis, strategic planning, and engagement with people with lived and living experience. Central to their planning was to work with all people to save lives in a non-stigmatising way. They focus on a ‘no wrong door’ approach that helps people access a range of services both universal and specialised in a safe, warm and welcoming space.

Impact

In March 2022, the ADAPT-KY8 community hub opened its doors. It opens one day a week and offers a range of statutory, third sector and lived experience informed services including:

- naloxone training and supply of kits
- access to Addiction and Fife based Recovery Services
- Blood borne virus testing
- rapid prescribing and onsite mental health support
- access to harm reduction equipment
- individual and family support, and
- housing support, welfare checks and support to attend other services

They currently welcome on average 30 people per week and offer around 20 naloxone kits to new and repeat visitors. 30 people have already started treatment from this venue. The atmosphere is informal and relaxed. People attend to have a chat, get a bite to eat, and meet with service providers and professionals to learn

more about what is available to them. The hub also runs activities such as snooker, bingo and craft sessions to encourage people to engage and reduce isolation and loneliness. Several people also attend other sessions delivered by services they first discovered at the hub.

Learning

The team at the hub soon realised the importance of a protected space for their population to help them feel safe, heard and respected. They understand how anxious people are when they first attend the hub and their support often starts outside the front door, reassuring people that they are welcome and it is safe to come in. Extensive promotion across the locality is central to the success of the hub.

Top tips

- Continual consultation where possible with communities and people with lived and living experience.
- Being prepared to adapt and modify service delivery based on peoples' feedback.
- Identifying and collaborating with partners with the same vision and ethos to build a one-stop shop approach for people.

Next steps

NHS Fife's Public Health team are conducting an evaluation of the planning involved with this approach. This will inform future locality-based provision in other areas of Fife where its inclusion is required to address inequalities.

Forth Valley ADP – case study 1

Background

The Substance Use Psychological Therapies team in NHS Forth Valley partnered with the Forth Valley Recovery Community in October 2020. This was in response to the MAT standards which highlight the importance of positive relationships and social connection in people's recovery.

Two Recovery Development Workers were recruited to work in collaboration with the psychology team. Both workers are experienced in Cognitive Behavioural Therapy and Motivational Interviewing. They also have lived experience of substance use.

Impact

The Recovery Development Workers each have a consistent caseload of 4 or 5 people with sometimes a small waiting list. They meet regularly with their colleagues in the Substance Use Psychological Therapies team to review their cases and treatment plans.

Their aim is to support people in their recovery through practical day-to-day activities that move them closer to their planned goals. This could be, for example, by encouraging people to step out of their home, take a short walk, go for a bus ride, a coffee or join a walking group.

The team know that their treatment model is having an impact from the individual progress made by the people they have worked with. They have had a number of successes with people who have achieved their person goals and progressed in their recovery.

Learning

Partnership between the Substance Use Psychological Therapies and Forth Valley Recovery Community was developed in response to the fact that some people can struggle to put psychological learning into practice in between appointments, as a

result of anxiety, trauma symptoms and lack of social supports. The MAT standards provided them with the evidence and impetus they needed to secure funds for this project.

Top tips

- Ideally Recovery Development Workers benefit from having both Cognitive Behavioural Therapy skills and Motivational Interviewing training and lived experience of substance use.
- The Recovery Development Worker role is one of a role model and mentor and these attributes should be recognised.

Next steps

The team know that their current staffing model lacks resilience and hope to address this by securing longer term funding and resources. They are also challenged by IT issues which currently limit the Recovery Development Workers' access to key records – this is also being addressed.

Forth Valley ADP – case study 2

Background

The beginning of the COVID-19 pandemic was the catalyst for the NHS Forth Valley Substance Use Service's buprenorphine pilot. Inspired by the adoption of buprenorphine prescribing within the Scottish Prison Service, they were keen to design and roll out a similar model in the community.

They developed their own service-specific clinical guidance, initially keeping it tight and focused on a small group. These were people who had shown an interest in buprenorphine and who had fewer complexities in their treatment needs. In this first phase, service leaders realised their team members required more support to adapt to their new ways of working. Training was secured from the buprenorphine suppliers and team members were supported to learn new skills and build their confidence.

Impact

Very quickly, the pilot expanded to support people with more complex needs. This rapid scaling up of the project was in response to the demands of those accessing the service. The recovery community were sharing their positive experiences and encouraging others to seek support. On occasions this increased demand has led to challenges with supply, but the team are working on streamlining processes to meet demand.

Learning

The success of the pilot has been driven by people seeking the service. Many, although not all, appreciate the freedom and dignity afforded by this treatment option. The commitment and dedication of the staff involved in the design and delivery of the service has also been a significant success factor. The need for Home Office licences for the storage of buprenorphine has posed challenges and the team are progressing applications to allow this for several of their local sites.

Top tips

- Strong senior leadership is required to secure engagement and buy-in.
- Focus your service development and team culture on patient choice.
- Promote the evidence base for this treatment option.
- Empower team members with the skills and confidence needed to deliver the service.

Next steps

While aiming to sustain the gains already achieved in this pilot the project the team aim to:

- Continue to gather and respond to feedback from people accessing their services
- expand their workforce by gaining funding for more non-medical prescribers to offer a more flexible service.
- develop formal processes to track and review their buprenorphine prescribing activity ensuring treatment options are available in all areas including primary care and community pharmacies

Glasgow City ADP – case study 1

Background

Sustainable Interventions Supporting Change Outside (SISCO)Multiple Pathways to Recovery programme was set up to offer a road to substance use recovery for prisoners in Scotland. Initially working with the Scottish Prison Service, SISCO identified gaps in service provision by listening to the experiences of prisoners. The programme aimed to ensure that prisoners could access care and support during their stay in prison. They took a whole person and trauma informed approach to ensure the model's impact was effective and sustainable.

Since 2017, the service has evolved and now supports people in prison, at liberation and within the community. They achieve this through person-centred and responsive interventions which focus on the immediate needs of the person.

Impact

The aim of the programme is to offer a meaningful support package for men in Scottish prisons and after liberation. Over the past two years, 83% of the men supported by the service have not returned to prison. The 17% that have returned have predominantly been younger prisoners between the ages of 23 to 29. The people they support often have complex needs and have experienced trauma. Meaningful engagement and consistent support from SISCO has produced positive outcomes. Feedback from people shows the importance of asking what they need during their stay in prison and what would help when they leave.

Learning

SISCO have provided the building blocks of support people in prison need when working towards recovery from substance use. Collaborative working with over 30 partners is a significant factor in their success. Their focus on harm reduction means they can refer people onto onward services and meaningful recovery.

The biggest barrier faced by the service is helping people after liberation. Information on outcomes shows that people often lose access to the support they need after leaving prison. A number of factors need to be addressed including continuing trauma informed care, safe housing, and support networks.

Top tips

- Listen to people to understand what matters to them.
- Build trust with the community you serve – service staff and volunteers make a difference.
- Work with partner organisations to help connect people to the right support they need.

Next steps

SISCO is securing funding to continue their work and obtain new, more central premises. The service is working towards expanding to a more robust and sustainable community care model.

Glasgow City ADP – case study 2

Background

The WAND initiative is an incentive-based harm reduction programme for people who are affected by substance use in Glasgow City. It encourages people to engage with four key harm reduction interventions:

- wound care
- assessment of injecting risk
- naloxone awareness and promotion
- dried blood spot testing.

Specialist staff from NHS Greater Glasgow and Clyde deliver the service with their third sector partners. They encourage people to attend every three months so they can support them over time. This helps to keep track of their progress and allows for timely identification of risk and onward referral to relevant services.

Impact

The Assessment of Injecting Risk tool is key to the service. It identifies injecting-related harms and their causes while promoting conversations about harm reduction. In the first year of the service, 831 people attended the service with 41% returning for a second round of interventions. Numbers have increased since then and the service now has a control group to further assess the service's impact. To incentivise engagement, people receive a PayPoint voucher on completion of all four interventions. Current evidence shows that people use these vouchers to support their daily lives in practical and meaningful ways.

Learning

The service identified a correlation between injecting below the waist and the development of deep vein thrombosis (DVTs) and venous ulcers. This resulted in the service purchasing a vein finder device. This device uses innovative technology to create a real-time visual map of the veins on the surface of the skin and can result in less trauma to the skin and a reduction in the development of ulcers.

The WAND initiative has also seen indicators of short-term behaviour change including:

- signs of decreased levels of main drugs used
- higher proportion of people tested for blood-borne viruses
- increased numbers of people carrying naloxone on follow-up

Top tips

- Proactive collaboration with other specialist agencies and sectors who have the required skills and expertise.
- Engage in meaningful ways with people who use the service.
- Equip and train staff to feel confident and safe delivering services.
- Develop and maintain links with partner agencies, gathering feedback to support follow-up interventions.

Next steps

Analysis and evaluation of both service and patient outcomes and the impact of the vein finder device is currently underway.

Highland ADP

Background

The Drug and Alcohol Recovery Service for Caithness and Sutherland consists of a small team based in a rural setting. The service was already delivering MAT and harm reduction support through drop-in and open referral clinics before this project, with one nurse prescriber at either end of the county. After reviewing local and national service data, the team decided to run an assertive outreach test of change in Caithness to add to their existing service offerings. Their test of change began in January 2023 after successfully recruiting additional support workers. The team engaged with their Board's Caldicott Guardian to secure guidance and permissions for the project. They then developed a checklist designed to support their partners to identify and trigger an outreach from their service.

Impact

The local police service now include the checklist as part of their information recording system. The information collected is added to their Vulnerable Persons Database supporting quicker information sharing to the Drug and Alcohol Recovery Service for Caithness and Sutherland team. Since January 2023, the service has recorded their number of weekly trigger referrals. They are applying quality improvement methodology to analyse these figures to determine whether people have previously accessed their service, are currently open to them, or are not yet known. They then focus on the outcomes of those contacts to inform their approach. Feedback from the people receiving outreach has been positive with thanks expressed to the team for their consistent and proactive care.

Learning

The main challenge identified by the service is confidentiality. The Caldicott Principles set out guidelines to protect people and their confidential information. The

Drug and Alcohol Recovery Service for Caithness and Sutherland received approval to conduct assertive outreach to those considered high risk.

The team's method of evaluating staff experience has been particularly successful. Based in two separate offices, they use electronic record keeping to capture what is impacting staff. Each day staff members choose from five scored emojis which tracks their ongoing experience.

Top tips

- Build relationships and contacts – partnership working can be a strength of rural communities.
- Consistency in outreach and team members helps build trust with people.
- Start small and grow your project from there – quality improvement tools can help with this.
- Communication helps reduce stigma and improve people's understanding of available options.

Next steps

The Drug and Alcohol Recovery Service for Caithness and Sutherland will continue measuring the impact of this project's work in Caithness with a view to expanding into other areas including inpatient and primary care.

Inverclyde ADP

Background

The Early Help in Custody Team provides a peer support approach of early help to people in police custody in Greenock police station. They work closely with police colleagues while remaining independent of the justice system. Based in Inverclyde, the service is available to people living in other local authorities who are in Greenock police custody.

The team support people all year round from 10am to 10pm with a base located within the police station to provide rapid response where required. The service delivers harm reduction interventions and wrap around support through an assertive outreach model designed to fulfil MAT standards 3, 4 and 5.

Impact

The service began in April 2022 and has supported 80 people with current data demonstrating a 20–30% increase in referrals every 6 months. First contact is usually made in custody and the team offer holistic support to people who are experiencing drug and alcohol problematic use and often committing high numbers of low level crimes. If it is the first time in police custody, the team offers support to navigate the criminal justice system.

The team, with short focused interventions, connect clients with mainstream drug and alcohol services, and also offers support for a variety of aspects of clients' lives. Examples include connecting people to legal and social services and helping them attend vital appointments. The value of the service is in its approach – ensuring people are treated with care, dignity and respect. Feedback from people is often expressed as relief and gratitude for the way in which they have been supported.

Learning

There have been challenges while setting up this service. Every new team member needs to complete Protecting Vulnerable Groups disclosure which can take up to approximately 12 weeks. The development of trust between the team and their partners has required significant effort. Now the team and their partners have a mutual understanding of each other's roles and ways of working.

Top tips

- Map the infrastructure of the area you are planning to work in.
- The 10am–10pm model, 365 days a year is important to ensure timely access.
- Maintain professional boundaries to support both people and staff.
- Develop risk assessments and appropriate policies to maintain staff safety.

Next steps

The service is currently seeking further funding to maintain this model.

Midlothian and East Lothian ADP

Background

In October 2022, the East Lothian Substance Use Service began to offer same-day access to opioid substitution therapy. This service is delivered by one member of the nursing team and provides three appointment slots every weekday. Referrals are generally seen on the same day unless the person requests a later date to suit their own preferences and availability.

Although referrals come into the service from a range of partners, an additional route opened in December 2022 through their new Assertive Outreach team. This team are well placed to facilitate entry into the same-day treatment programme and do so at every opportunity.

Impact

Feedback from both elements of the service has been positive and the linkage between them has added an extra dynamic. People identified through the assertive outreach team are supported to travel to the Musselburgh clinic, and then provided with transport options to return and attend future appointments. This helps to reduce financial barriers for those who are ready and keen to access treatment.

Learning

Both parts of the service are developing and are seeking to find ways to improve the quality of referrals into the teams and their own service promotion materials. They have both found the addition of shared clinical support helpful in freeing up their capacity to work with people seeking treatment. They are continually seeking ways to respond to the changing needs of people, particularly as substance use trends change which can impact on the type of treatment they can safely offer.

Top tips

- Make sure there are processes in place to ensure service resilience.
- Provide clear information to other services around referral requirements and pathways.
- Track your service data to identify trends in numbers and types of interventions, this helps shape future service delivery.

Next steps

The team are seeking to continue to improve contacts across partner agencies and communities to promote their services. They are also hoping to acquire a vein visualisation system to support their harm reduction activities and hope to see the development of a dedicated wound pathway over time.

Orkney ADP

Background

In Orkney substance use support is provided by the Community Mental Health Team. This is a small team, in Kirkwall mainland Orkney, made up of Community Psychiatric Nurses, Advance Nurse Practitioners, a prescribing pharmacist with GP support twice a week. They have a visiting consultant and no inpatient facilities, therefore, more often than not, nursing time can be consumed by emergency situations caring for those acutely unwell.

MAT standards

Orkney and the outer isles have seen a significant change in drug use. Previously heroin was not accessible and people who had been using heroin would come to the island thinking they would just stop. However, this has changed significantly and heroin is now readily available which has seen a spike in those requiring opioid substitution therapy.

Orkney has seen several challenges in implementing MAT standard 1 due to the rurality, access to medication and resourcing. In particular, there is a specific challenge with same-day access to MAT for those living in the outer isles. Therefore, the team needed to look at a flexible approach in order to ensure these individuals had the same opportunity to start MAT same day.

The nursing team have established positive relationships with the GP practices on the outer isles and therefore established a model whereby any individual looking to start MAT, will have an assessment set up remotely with one of the nurses from the Community Mental Health Team. Following the assessment the nurse will advise the prescriber in the outer isles on agreed medication and dose. The medication is then arranged to be delivered to the island via boat so the individual has the opportunity to be started on opioid substitution therapy that day.

Impact

Due to the arrival and sustainability of the heroin supply in Orkney and surrounding isles, there has been an increase in those requiring opioid substitution therapy. Enabling the team to remotely assess individuals and arrange delivery of medication via boat for administration that day, has had a significant impact for individuals. By utilising this model of assertive outreach, equitable access to MAT has been created, regardless of where an individual resides.

Learning

The team have had to adapt and work flexibly. There have been some practical issues relating to supplies of medication, transport i.e., if there is bad weather it may not be possible for boats to deliver medication to the outer isles. Despite this, the team have shown real innovation and creativity in their problem solving. By adopting this approach they have been able to provide authentic patient centred care, tailoring every step of assessment and treatment to meet patient need.

Top tips

- Flexibility, being able to think outside the box and use creative solutions to meet needs.
- Collaboration, this model works well due to the positive working relationships with the GP practices and nursing staff in the outer isles.

Next steps

The team are due to begin piloting a drop in with Relationship Scotland to provide additional counselling for individuals. This is from a recognition that there is a significant need for this type of support and will also encourage referrals into substance use service by providing direct access.

Pan-Ayrshire ADPs

Background

There are three Health and Social Care Partnerships (HSCPs) and associated ADPs in Ayrshire in the north, east and south of the region. To drive change across this landscape, they have taken an integrated approach to the implementation of the MAT standards.

This approach has been enabled through a network of groups both locally and Ayrshire-wide including the:

- Pan-Ayrshire Chief Officer's group
- Pan-Ayrshire MAT Oversight Group
- Partnership MAT Implementation Groups

This model has provided opportunities to work and respond at pace to emerging priorities and allowed professionals with the relevant expertise, experience and knowledge to contribute to driving change across the whole of the region.

Impact

The model has driven the strategic intent of MAT implementation. It has facilitated buy-in to new initiatives through co-production of a collective case for change and overarching vision. It has also supported operational implementation by combining resources and approaches to accelerate change and improvement. Where appropriate, IT systems, funding streams and staffing resources have been combined to set up services.

Processes, guidelines and templates have been co-designed across services and professional groups. All serving to support consistency of choice and access for people across Ayrshire. They have also achieved success in their Pan-Ayrshire work with national initiatives such as their collaboration with the Scottish Ambulance

Service on non-fatal overdose pathways. This project has resulted in the development of a joint protocol to implement a service response, within 24–72 hours, to offer increased drug and alcohol support to both individuals known and not known to services.

Learning

Service leaders recognise the value of positive relationships in their work. All developed through effective communications across all areas of their business including with external partners and those with lived and living experience. They have also valued the power of joint working within all their projects with Housing First as a particular example of collaboration. This support provides specialist addiction and mental health interventions within the Housing First model. This approach provides a single point of contact and clear pathway between housing and statutory Community Mental Health Services and Alcohol and Drug services which work in partnership to enhance and complement the housing support offered to the homeless population.

Top tips

- Use multiple communication channels to keep all relevant staff groups and partners updated.
- Focus on developing and sustaining relationships across all groups from the outset.
- Keep an eye on the strategic horizon and be prepared to react and capitalise on opportunities.

Next steps

Through their robust and joined up approach to planning, there is a clear path ahead. While focused on embedding their new ways of working for MAT standards 1–5, work is already afoot refining their plans and activity on MAT standards 6–10.

Pan-Lanarkshire ADPs

Background

A small team of 3 staff nurses cover Lanarkshire, a large area consisting of 4 localities in the South and 6 in the North. Each nurse is also a non-medical prescriber. The team trialled a Test of Change within Clydesdale area due to the high need for opioid substitution therapy. Once the team receive a referral they arrange to see the individual as quickly as possible, within a 24 hour period. In order to overcome some of the barriers that those in rural areas face, an assertive outreach model was implemented. Where a person's location is rural, the nursing team will carry out a brief telephone assessment, before carrying out a physical assessment in the person's home.

Impact

The impact of this Test of Change has been life changing for some people. Previously there had been a 21 day wait for individuals wishing to be started on Opioid substitution therapy, which has now been reduced to 24hrs. Nurses have been able to provide WAND checks at these appointments. The team have been able to access a population of people who would not have otherwise not been able to start treatment had the nursing team not been able to attend their home. People have reported their appreciation of the service.

Learning

Lanarkshire has recognised the importance of wrap around, holistic support. Based on this there has been a trial of Peer Support workers in the South. This has been beneficial to the nursing teams as it provides an additional person with additional expertise to visit people at home and provide clinical and social support. The team have also built relationships with Justice, Social work and other partners to ensure a collaborative, holistic approach is taken to treatment.

Top tips

- Planning – weekly meetings, being prepared and running a Test of Change.
- Feedback – making sure you're taking on board feedback, using it to improve service delivery and learning from others around you.
- Networking – importance of having a skills mix in the team, peer experience and collaboration to ensure individuals are receiving the best possible support.

Next steps

Lanarkshire will commence a 7 day a week service model, ensuring people can access treatment any day of the week. There are a couple of challenges to be overcome in terms of licencing, staffing and pharmacy, however, once these have been overcome, increased access to treatment will increase the positive outcomes for patients.

Perth and Kinross ADP

Background

The Integrated Drug and Alcohol Recovery Team offers a drop in clinic in Perth City. It supports people to consider and choose the most suitable recovery option for them. The service runs one day a week with the team offering same-day assessments and prescribing where appropriate. If someone is not ready to engage they are given the choice to return and offered a follow-up appointment. People are also offered information and advice of other local services and support.

Impact

Since the service opened, attendance has increased and recently reached full capacity. The team has also noted an improvement in the standard of referrals demonstrating that both people and professionals understand how to access the service and what it offers.

Work is underway to capture service feedback by:

- registering on care opinion
- collecting experience surveys via their Business Improvement Team, and
- conducting experiential interviews using an electronic booking system and offering a cash voucher for participation

Learning

The team have viewed this project as an opportunity to review and challenge their old ways of working. They quickly learned the value of targeted service promotion through social media, the production of podcasts and engagement with key partner agencies. There are still challenges around delivery of this model within

geographically large and rural communities which require further planning and support both locally and nationally.

Top tips

- Proactive collaboration with partner agencies and sectors.
- Forge trust early with people using the service.
- Target promotion of services with people and partnering services.
- Ensure adequate administrative support from the start.

Next steps

The team have raised the profile of their same-day prescribing service through a promotional campaign in May this year.

Scottish Ambulance Service

Background

The non-fatal overdose pathway enables the Scottish Ambulance Service to identify people at high risk of drug-related harm on attendance. Frontline ambulance clinicians deliver this new model. They input key data which triggers the pathway at the local Health Board. Teams also use this opportunity to talk to people about and offer take-home naloxone.

Impact

From July 2021 to January 2023 the pathway generated 10,904 referrals. Approximately 40% of these referrals were for people unknown to local services. With the person's consent, the ambulance team share information with the Health Board. Local drug treatment and support services use this information to contact the person. Examples of follow-on support include:

- allocation of keyworker
- referral for MAT
- supply of take-home naloxone
- referral to local addiction psychological therapy teams
- referral to Community Mental Health teams
- connection to local Narcotics Anonymous groups

Feedback from people has been positive. Some have experienced several non-fatal overdoses and welcome the follow-up this model offers.

‘If it was not for the kind ambulance staff that put in the referral, I would probably be dead and that is a fact. I am now addressing my drug use, have housing support and

feel in a place to change things. I wasn’t sure what "help" even meant to be honest, but this service has helped me prioritise and support me. Thank you.’

Learning

A balanced and robust national data sharing agreement was key to the pathway design. Central to this was the will and engagement of the 14 Health Boards. The service design team worked with the Boards to embed a strong harm reduction culture. Engagement with and training for frontline clinicians nurtured a person-centred approach. On completion of the training, staff highlighted the impact of hearing from people with lived and living experience.

Top tips

- Encourage open conversations with frontline teams.
- Review existing services through a fresh perspective.
- Understand your service demographic.
- Design services with people with lived and living experience.
- Develop engaging and realistic educational content to maximise learning.

Next steps

Scottish Ambulance Service is currently assessing the pathway's local impact to support continued service improvement.

Scottish Borders ADP

Background

In the Scottish Borders, the Eyemouth Health Check project aims to improve access to primary care health services for people impacted by substance use. It helps GP practices identify people with health challenges who they have been unable to follow up with. It also offers a place for people to be supported in a drop-in community setting. Following their health check at the drop-in clinic, people can be referred back into their local GP practice for further support.

The set-up of this project involved several key steps:

- developing a specific selection criteria
- identifying a partner GP practice/s
- GP practice staff identifying relevant patients they had been unable to follow up
- Advanced nurse practitioner reviewing each person's clinical record and offering appointments where appropriate, and
- following up and offering a physical health review.

Impact

Launched in August 2022, the Eyemouth pilot aimed to provide a more holistic, shared care model of support. It makes the most of existing resources through collaboration with GP practice staff for information sharing and using the well-established drop-in service in Eyemouth to carry out health checks. Joint working and clear communication with practice staff were significant factors in the pilot's success. The team has consistently received positive feedback from practice staff who have

seen benefits from the model's active outreach engaging patients who they have been unable to follow up with.

Learning

The process relied mainly on one interested GP to highlight patients that would benefit from the pilot. Clearer identification on the level of urgency for any instructions on follow up care would be useful. A traffic light system was suggested by the practice as a way of categorizing follow up processes. Relying on their single Advanced Nurse Practitioner to offer physical health checks has become increasingly time consuming. Training support workers to assist with checks is intended to support this.

Top tips

- Engage with GP practices to secure buy-in and clarify that the project intends to streamline work, not increase it.
- Build connection and trust with people and professionals through face-to-face contact and connections.
- Have shared access to IT systems and records to allow necessary information sharing.
- Provide holistic care by working with third sector and other statutory providers in informal settings.

Next steps

The team are focused on building on the current pilot by expanding to other locations in the Health Board.

Scottish Prison Service: HMP Edinburgh

Background

The Scottish Prison Service is committed to becoming a trauma informed organisation. As part of this, the service has asked all senior leaders to attend trauma-informed leadership training. A trauma-informed steering group also meets to develop several projects across the estate.

Within this national approach, HMP Edinburgh started working towards becoming a trauma informed prison in October 2021. A multi-agency steering group formed, co-chaired by the governor and NHS consultant clinical psychologist. The group includes representatives from the Scottish Prison Service, the local Health Board, local authority and third sector colleagues. External partners also attend as critical friends.

The first task of the steering group was to approve a vision for a trauma informed prison considering the needs of both residents and staff. Sub-groups for related topics including research, lived experience and implementation were also developed.

Impact

The group circulated its vision to all staff working within HMP Edinburgh with a commitment from the Governor of at least a five-year programme. Steering group members attended a trauma informed leadership training session to help inform next steps. To improve outcomes for prison residents, the group agreed to initially focus on staff's knowledge and understanding of trauma informed practice. This also included their own wellbeing and experiences of trauma within the workplace.

The group designed a staff survey including information on experiences of trauma at work, job satisfaction, vicarious trauma and burn out, overall psychological wellbeing, attitudes, knowledge and experience of trauma informed practice. They circulated the survey to around 650 staff who worked within HMP Edinburgh. Analysis of the results is currently taking place.

Learning

Sustainable, long term trauma informed change takes time. Particularly when working across multiple partner agencies. A clear strategy formed by senior leaders from representative stakeholders is key.

Top tips

- Form a steering group senior leaders with decision making power to steer change.
- Develop a vision, long term strategy and take a phased approach.
- Focus on staff and cultural change first.
- Review research and gather baseline data before starting on change.

Next steps

HMP Edinburgh will develop a strategy for improving staff wellbeing following analysis of the staff survey data. The data will also feed into the national Scottish Prison Service staff training needs analysis and will inform the national strategy for trauma informed organisational change. A prison-wide, multiagency programme of staff training and post-training support will be delivered in conjunction with the SPS National Trauma Training Strategy and the National Education for Scotland Psychological Trauma Training Plan.

Scottish Prison Service: HMP Perth – case study 1

Introduction

HMP Perth is a national receiving establishment that receives individuals direct from court, predominantly from five ADP areas (Perth and Kinross, Dundee, Angus, Forth Valley and Fife).

To understand the level of implementation across the justice settings the MAT Implementation Support Team (MIST) conducted a mapping exercise across the Scottish Prison Service estate. HMP Perth was chosen as an early improvement site concentrating on three workstreams; (1) prison pathways; (2) use of peers within custody and (3) family-inclusive practice.

Background

MAT standards have been embedded across all ADPs over the past year and the next phase is to support ADP's, Scottish Prison Service and NHS to implement these within the justice settings.

Approach

MIST visited HMP Perth to gain an understanding of prison pathways from community/court to police and prison custody as well as pathways within the setting including liberation pathways. They provided support to facilitate face-to-face workshops which were held at HMP Perth where NHS, Scottish Prison Service and partner agencies attended to ensure collaborative working.

MIST supported local teams to review and improve current ways of working based on shared experience and good practice identified in other areas.

Challenges

- NHS recruitment challenges, resulting in staff shortages within the establishment has had an impact on progressing prison pathways, however, NHS senior staff are involved and driving changes in the system. Once the substance use team have more staff in place, there will be increased staff involvement in identifying improvements from the ground level.
- Difficulty embedding family inclusive practice due to lack of capacity and resources, however, HMP Perth recognises the importance of this piece of work and is committed to progressing this in the near future. Scottish Families affected by Alcohol and Drugs (SFAD) will continue to support with this.

Self-help resource

- The Scottish Prison Service have created a detailed induction booklet for individuals entering the establishment. This has also been recorded as an audio book on the prison radio.
- The Scottish Prison Service have employed two lived experience workers within the establishment and have recognised that peers supporting the induction have a paid wage. NHS are currently recruiting to recovery workers to work closely with the Scottish Prison Service recovery team.
- The Scottish Prison Service have conducted their first Living experience Network meeting within the establishment, this will be held monthly which is facilitated by residents.
- The Scottish Prison Service have introduced a peer recovery placement person attending weekly from HMP Castle Huntly Open Estate.

Impact

The development and implementation of a recovery focussed network (workstream 2) within the establishment has resulted in better communication and access

pathways for recovery within the establishment, which has benefitted both prisoners and service providers. Key improvements are:

- The utilisation of the prison radio station to broadcast individual recovery stories and the newly developed detailed induction audio book.
- The use of peers within the induction process helping newly admitted individuals into custody with the understanding of the induction process.
- Delivery of the first living experience network meeting facilitated by individuals in custody.
- Improved links between the community and the establishment.

One of the main drivers behind the success has been the Scottish Prison Service's commitment to change and willingness to promote recovery within the establishment in partnership with NHS.

The daily multi-disciplinary Person of Concern Group meeting which discusses anyone who has been managed on the Scottish Prison Service Management of Those at Risk of a Substance policy targets conversations around recovery and harm reduction, ensuring that the right person is seeing the individual at the right time.

Scottish Families affected by Alcohol and Drugs have been instrumental in working hard to move forward with workstream 3 and their enthusiasm to drive this change has ensured the setting of foundations for this work moving forward.

Top tips

- Ownership of actions to support implementation of MAT standards to be accepted by local NHS and partner agencies with support from MIST and this must be agreed by all stakeholders from the initial stages.
- Partnership working is crucial ensuring links with community and third sector partners.

Enablers

Collaboration is key to the success of MAT standard implementation with a custodial setting, in particular the Scottish Prison Service, NHS, Partner agencies and MIST.

More information

There is a lot of good work taking place within HMP Perth and the recent workshops have strengthened the collaboration between key partners.

HMP Perth have fully committed to recovery within the establishment and they have committed to the full month of May being totally focused on recovery with collaboration from multi-agency partners to make sure this was successful.

MIST have also conducted interviews with people accessing services, service providers and family members. Evidence gathered will be used as a baseline for quality improvement and learning from these interviews will be collated into a guidance pack for using in other establishments.

It has been difficult to progress the other workstreams due to challenges noted above. However, on a positive note, NHS have now recruited staff and will continue to progress implementation of the MAT standards and ensure local pathways are strengthened.

The Scottish Prison Service and NHS are also committed to supporting the embedding of Family inclusive practice. In addition to workstream 3, Scottish Families affected by Alcohol and Drugs are also supporting the development of a family pack being available, these packs will include information of what happens within custody for family members, as it was highlighted that lack of information/knowledge of what happens within custody can cause family anxiety.

Scottish Prison Service: HMP Perth – case study 2

Background

A coordinated, person-centred approach to supporting ‘persons of concern’ in a prison setting. HMP Perth runs a daily meeting to co-ordinate targeted and joined-up support for people identified as at risk of drug-related harms. The Persons of Concern Group evolved through recognition that people in prison needed more targeted and responsive support. The group have been meeting since April 2021 with multidisciplinary representation from NHS Tayside and the Scottish Prison Service, including the prison chaplaincy.

The Persons of Concern Group receives referrals from staff who have identified concerns about a person during the previous night’s report. Input from all members of the group creates a unique level of insight from which plans offering a range of recovery focused services are then formed for each person. If a person does not wish to take up the offer of support, the group always reviews and considers what more they can do to offer the right support at the right time.

Impact

The Persons of Concern Group has supported 1,622 people since April 2021, with 45 people currently in receipt of their services. 90% of the people in their care are experiencing challenges with substance use. The group always seeks to engage with people even if they are referred on multiple occasions as it is recognised that recovery is not always a linear process.

Learning

The group’s collaborative approach results in more meaningful interventions, improving the health and wellbeing outcomes for those supported. It also improves communication across staff groups which creates a more positive working environment.

Top tips

- Strong leadership is needed to maintain an outcomes focused approach to each meeting.
- Keep meetings brief with a core membership that represents all relevant disciplines.
- Keep meeting administration to a minimum focused on capturing key personal details, agreed actions and final outcomes.
- Set up a separate meeting when a complex case arises.

Next steps

HMP Perth are now looking to increase their selection of recovery interventions to include a gym and exercise programme. They are keen to collect more data to quantify the positive outcomes they are seeing within the people they are supporting. They have recently developed a harm reduction recovery pack which they plan to launch in the coming months.

South Ayrshire ADP

Background

The team were given a small amount of funding and utilised this to focus on the area where they were seeing the highest number of referrals for opioid substitution therapy. They began a test of change using a school hub in a deprived locality within South Ayrshire, linking in with the Violence Reduction Unit. Within the team based here, they adopted a multi-disciplinary approach. Initially the service began during COVID-19 and operated on an appointment only basis, working around school times.

Impact

The test of change had a positive impact, initially designed for 6 months to be extended beyond this period. People were able to access harm reduction support as well as being linked into Recovery Support at their appointment. People were able to access ongoing support from the Recovery Community and Addiction workers out with the hub, which has had a significant impact on individuals. The team are able to work in a truly holistic manner, drawing on the mixed skills and experience within the wider team from addiction workers and peers. The test of change also allowed the team to increase their direct access across South Ayr in different venues, increasing the accessibility for people.

Learning

At the beginning of the test of change it was initially thought that in order for this test of change to be successful, there would need to be a separate MAT team. However, it was quickly realised that this was not the case and this way of working needed to become part of core business. The processes and access has been adapted to meet the needs of individuals. The team had the idea to streamline the appointments for individuals and due to COVID-19 restrictions the team opted to undertake a pre-assessment, which enabled the individual to nominate a preferred pharmacy.

Top tips

- Flexibility – being open and willing to do things differently.
- Being prepared – getting ahead with preparing the script for people and setting up a pharmacy. Allows people to start treatment the same day as being seen.
- Multi agency collaboration – working with addiction workers, and peers has been instrumental to providing holistic care.

Next steps

South Ayr would like to eventually move to a drop in model five days a week. They are also working with the prisons that feed into South Ayrshire to ensure that prison liberations on Buvidal do not fall through the cracks.

West Dunbartonshire ADP

Background

West Dunbartonshire is a rural area with three main urban regions, namely Clydebank, Dumbarton and the Vale of Leven. It has one of the highest levels of deprivation in Scotland. Around 700 people affected by substance use are supported here. In June 2022, West Dunbartonshire Addiction Service piloted a project on same-day medication assisted treatment in Clydebank. The core project team focused on four key improvement areas:

- Better patient engagement
- improved service access and choice
- reduced ‘did not attend’ rates (DNAs), and
- enhanced service experience.

Some of the new ways of working developed during the COVID-19 pandemic were maintained such as their open-door policy and telephone and self-referrals. They also introduced the following changes:

- same-day prescribing protocol
- access to virtual patient referrals
- flexible transport provision where required, and
- promotional materials developed in conjunction with people with lived and living experience.

Impact

Changes made to the service resulted in an 85% reduction in service access delays and a 65% increase in the number of people accessing treatment. Retention in treatment has also improved along with positive feedback on treatment choice and availability.

Learning

The team appreciated the value of pathway mapping in the design phase of the project. The development of a low-threshold assessment checklist supported team members to assess opiate dependence levels. This gave them more confidence in the early stages. The presence of senior clinicians also supported team members to adjust to new ways of working. Challenges for the service have been around balancing the needs and expectations of people accessing the service with safe clinical practice. Raising awareness of what to expect on the treatment journey and why is often critical to the success of interventions.

Top tips

- Close collaboration with GP services to enable treatment access and choice.
- Clinical leadership to support teams to adapt to new ways of working.
- Ongoing engagement with people accessing services to enhance therapeutic relationships.
- Deploying current team members in creative ways while offering support and guidance.

Next steps

The service is currently seeking Home Office licenses to upscale buprenorphine provision and continue to collaborate with local GPs to develop pathways between services.

West Lothian ADP

Background

Ensuring a system wide human rights-based approach is adopted is central to the approach being taken forward within West Lothian. This will ensure the workforce and people affected by substance use are aware of this approach in terms of rights holders and duty bearers. The aim of this approach is to develop a system-wide understanding of human rights and their application, contribute to workforce development, continuous service improvement and impact positively on service design, development, and delivery.

In the coming months, 20 workshops will be delivered to approximately 360 people. All services, both statutory and non-statutory, will be offered places at the sessions. People with lived and living experience and their families will also be invited to participate in the workshops. To ensure comprehensive representation at the sessions, a full evaluation of the programme will be conducted. This will inform local workforce development and MAT standards improvement plans.

Impact

Reach Advocacy has been commissioned to deliver human rights-based workshops using a cross-population approach. Learning outcomes include awareness of:

- social determinants of health
- what are human rights?
- history of human rights
- practical tools for applying a human rights-based approach
- MAT standards

Reach Advocacy will also provide Rights Advocacy Practice Award accredited at SCQF Level 7 qualifications for staff within West Lothian's Mental Health Advocacy

Project. This will ensure advocacy staff are appropriately qualified to deliver a human rights-based approach on behalf of people who require support when accessing medication assisted treatment.

Learning

Feedback from previous participants on the awareness raising workshops and qualifications has been overwhelmingly positive with a particular appreciation of both the depth of knowledge offered combined with practical examples which bring the learning to life.

Top tips

- Focus on co-production and empowerment to gain traction and buy-in.
- Participation from the workforce and people who use services minimises biases and assumptions, fosters connections and a common understanding.
- Adopt a quality improvement approach to the development and maintenance of the programme to reflect and refine throughout.

Next steps

Sessions will be held throughout the summer, followed by a full evaluation of the programme. The findings will be submitted to West ADP (ADP) to inform future planning.