Public Health Scotland

National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2023/24

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Planned developments

We are continuing to develop this report and currently have plans for the report to be updated annually, with new measurements developed to evidence the implementation of MAT standards and adapt to changing trends in drug use more accurately.

Contents

Foreword from Christina McKelvie MSP, Minister for Drugs and Alcohol Policy

The implementation of the medication assisted treatment (MAT) standards is one of the key strands of our National Mission on drugs that aims to save and improve lives for people impacted by drugs.

The benchmarking report is more than just a snapshot of progress to date. It is a demonstration of what can be achieved when we identify a key issue and bring people together to design and deliver change with a view to improving outcomes. I have met with people and families who have seen significant change in services.

This is as a result of the progress made to date on implementing these standards, which are about making treatment and support available more quickly, offering more choice and ensuring the services are joined up with other care. Staff working in all areas have been innovative in providing the care needed and this has helped make a difference for people in their location.

However, everyone involved in the delivery of services knows that there is still a way to go – not everyone we speak to has noticed change and there are still individuals and families who do not have access to care and support on the day they ask for help. I remain committed to help deliver change for all and I know that this is important for everyone involved.

The report for the year up to April 2024 again shows good progress, particularly on MAT standards 1–5 as well as some really good results on standards 6–10. Local areas now have systems in place to assess the experiences reported from people using services, but we still have to demonstrate clearly that the experiential feedback is leading to change and improvement.

This work is a collaborative effort, involving numerous partners involved in delivery at both the local and national level. This report acknowledges the vital work so many partners and organisations deliver to support those in need of help, especially those working in frontline services, and it confirms our commitment to the improvement of treatment with the continued implementation of the MAT standards.

There are still challenges to overcome, notably the threats posed by synthetic drugs. There is still work to do to fully implement the standards by April 2025 and for them to be sustained by April 2026. We will continue to build on our progress, striving to reduce deaths and improve the lives of those impacted.

My thanks to the MAT Implementation Support Team (MIST) for all their work, supporting areas on implementation of the standards and for producing this comprehensive report. And to every individual working in services and organisations, and those with lived and living experience and their families throughout Scotland, for the commitment and passion that has led to the significant achievements shown in this report.

Foreword from Justin Jansen, person of lived experience and Moray ADP Coordinator

The path to effective substance use treatment is paved with dedication, collaboration, and a commitment to continuous improvement. In Scotland, the implementation of medication assisted treatment (MAT) standards by Alcohol and Drug Partnerships (ADPs) in collaboration with Public Health Scotland's MAT Implementation Team (MIST) and lived experience expresses this journey. These efforts aim to ensure treatment is not only clinically sound but also deeply informed by the lived experiences of those directly affected by substance use.

This benchmarking report offers a comprehensive overview of the current state of MAT standards, highlighting both the strides made and the challenges that remain. Central to these standards is the integration of lived experiences, which provide critical insights into the real-world impacts of substance use treatment. By embedding these narratives into the core of our approach, we can ensure that outcomes for people are compassionate and effective, resonating with the individuals and communities they are designed to serve.

The contributions from those with lived experience is invaluable. Their stories illuminate the strengths and weaknesses of our current systems, offering a perspective that data alone does not capture. These voices have guided the development of the MAT standards, ensuring they are grounded and supportive of people's recovery journeys. Yet, while significant progress has been made, this report also shows us that there is still much work to be done.

The collaboration between ADPs and MIST has laid the foundation, but the ongoing challenges highlight the need for persistent effort and innovation. Addressing these challenges requires a commitment to continuous improvement, listening to those with lived experiences, and adapting our approaches to meet evolving needs.

As we reflect on the achievements documented in this report, we are reminded of the ongoing commitment required to achieve a truly effective and inclusive system of care. There is still much work to be done, work that encompasses all substance

users, not just those struggling with opioids. We must break down stigma, remove barriers, and save lives by meeting people where they are, not where we want them to be. This is a journey of compassion, understanding, and unwavering commitment to the dignity and wellbeing of every individual.

I extend my deepest gratitude to all who have shared their experiences and insights. Your contributions are not only the cornerstone of these standards but also a guiding light for future advancements and improvement.

Foreword from Mary Ryan, Volunteer Worker in Addiction Services

This foreword provides a gathered collective voice of the community across North Lanarkshire and Forth Valley.

Drug deaths in Scotland are undeniably a national tragedy, reflecting a deep-seated societal challenge that demands urgent attention and comprehensive solutions. As a person supporting service users in North Lanarkshire and Forth Valley it is heartening to witness and report a handful of local centres, dispensaries and pharmacies increasingly providing empathetic and supportive care. However, it must be noted that this is not felt across all jurisdictions serving the community.

We have some examples of supervised administration of methadone and other medications in the treatment of chronic addiction falling short of being dignified and publicly anonymous. In some cases forcing queuing and lack of privacy for individual consultations, enhancing patient stigma and embarrassment. We would encourage dispensary and caregiving across all MAT services to be supported by increased advocacy initiatives which can be auditable, providing real-time feedback to Joint Boards and ADPs. Courage and sharing one's story is integral to the recovery journey, as people often reach their lowest points before embarking on the path to healing and support. Therefore, it is imperative that establishments providing addiction services to the community, also recognise the significant role of trauma as one of the dominating factors of addiction and endeavour to create environments where individuals feel safe and respected. While some progress is starting to become evident there is clearly still a considerable distance to cover.

On reflection of the current published data and the draft indications from the MAT standards benchmarking report, July 2024, substantial enhancements are imperative across domains. It is clear a comprehensive overhaul is needed to implement trauma-informed care practices, acknowledging and addressing the underlying trauma experienced by individuals. There is a pressing need for a cohesive approach among caregivers and services, supported by robust advocacy efforts, to ensure seamless and holistic support for individuals seeking recovery. Diversity and

inclusion must also be prioritised, with efforts directed towards fostering environments that are welcoming and supportive and inclusive of individuals from all backgrounds. Moreover, it is our belief that there is a critical necessity to expand the availability of residential rehabilitation or tailored treatment programmes to meet the growing demand. Addressing bias and stigma among caregivers is paramount, necessitating ongoing education and awareness initiatives. Lastly, securing funding for full-time resources across Scotland is essential, particularly in areas such as peer support workers, recovery cafes, and a wider consortium of addiction services, to ensure consistent and accessible support for those in need.

However, amidst this darkness, there is a glimmer of hope in the resilience and courage of those within the addiction community who bravely share their experiences to work hand in hand with the policy and standards makers in laying the foundation for a better future. Their voices provide invaluable insights into the realities of addiction, shedding light on the complexities and struggles that individuals face on a daily basis. It is crucial to put a stake in the ground, to interrupt the intergenerational cycle to ensure that future generations have access to adequate services. Recognising that individuals are frequently influenced by their environment and past traumas, it is evident that a recalibrated framework of informed care, revised standards and targeted social funding are essential to mitigate the recurrence of past adversities and stigma. As a branch of the recovery community, we welcome the empirical evidence demonstrating that being in treatment significantly reduces the risk of death. Furthermore, we fully support the introduction of standards of care for MAT programmes integrating the pharmaceutical, psychological and social support in the treatment of individuals experiencing drug use issues. We would continue to advocate ambassadorial, education learnings and from other countries with demonstrable success similar programmes and hope that the Scottish Government continually strives towards best practice and prevention.

List of abbreviations

ADP: Alcohol and Drug Partnership

ANP: advanced nurse practitioner

BBV: blood-borne virus

DAISy: Drug and Alcohol Information System

FAIR: facts, analysis, identification, review

GP: general practitioner

HMP: His Majesty's Prison

IAKP: independent advocacy Perth and Kinross

IEP: injecting equipment provision

IJB: Integration Joint Board

MAT: medication assisted treatment

MATPACT: MAT pilot at custody toolkit

MATSIN: MAT standard implementation network

MORS: management of offender at risk due to any substance

NRS: National Records of Scotland

OST: opioid substitution therapy

PANEL: participation, accountability, non-discrimination, empowerment, legality

PHS: Public Health Scotland

RAGB: red, amber, green, blue

REDCap: Research Electronic Data Capture

SPS: Scottish Prison Service

StIR: support to implement and report

THN: take-home naloxone

TFV: Transform Forth Valley

1. Introduction

In 2022, according to the **National Records of Scotland (NRS) annual report**,1,051 confirmed drug-related deaths were registered in Scotland. This is 279 deaths fewer than in 2021 and the lowest number of drug-related deaths since 2017. The NRS annual report on 2023 figures will be available in August 2024.

Overall drug harms and deaths remain high. Routine indicators published by Scotland's drugs early warning system, **RADAR (Rapid Action Drug Alerts and Response)** demonstrate that polysubstance use remains the main driver of harms. The latest **Scottish Government quarterly report on suspected drug deaths data** provided by Police Scotland reports a total of 1,197 deaths in 2023. This suggests an upward trend although these figures are based on police officers' impressions when attending scenes of death and are not directly comparable to the NRS figures. A **Public Health Scotland (PHS) national analysis of drug-related deaths over 2017 and 2018** showed that slightly over half of the cohort had ever been in prison.

Based on evidence (**PHS Drugs-related deaths rapid evidence review)** that being in treatment is protective against the risk of death, the Drugs Death Taskforce published **10 standards of care for medication assisted treatment (MAT)** in May 2021. MAT refers to the use of medication alongside psychological and social support in the treatment of people who are experiencing issues with their drug use.

The taskforce evidence paper, the Scottish Government plan for the **National Mission on Drugs (2022)** and the **National Strategy for Community Justice (2022)** have all identified access to MAT care and support as key to the reduction of drug harms. Implementation of the MAT standards in community and justice settings will be crucial to achieving the aims of these strategies.

However, problematic substance use and drug-related deaths have a clear association with residence in areas of multiple deprivation where people can experience poor housing, high crime rates, fewer opportunities, trauma in their early years and inequalities in wealth and health.

Government policy **A caring, compassionate and human rights informed drug policy for Scotland** is clear that to achieve and sustain a reduction in drug-related deaths it will also be necessary to address these social and system issues, to make sure that people know their rights and that their rights are upheld. This is complemented by two further initiatives: The 'Charter of rights for people affected by substance use', scheduled for publication in December 2024 and the' National specification for alcohol and drug recovery services', scheduled to be published in early 2025.

Alcohol and Drug Partnerships (ADPs) serve as collaborative fora for partners to come together to plan, develop and deliver alcohol and drug services in Scotland. The PHS MAT programme was set up to help ADP areas implement the standards. It is being implemented in four phases:

1. partial implementation of MAT 1–5 in the community
2. full implementation of MAT 1–5 and partial implementation of MAT 6–10 in the community
3. full implementation of MAT 1–10 in community and justice settings
4. sustained implementation of MAT 1–10 in community and justice settings

The first benchmarking report in June 2022 set the scene at programme initiation, the **second benchmarking report** described the challenges and this third report in phase 3 demonstrates the successes (and ongoing challenges).

An **executive summary of this report** is available on the PHS website.

2. Scope and clarifications

This report provides an assessment of progress with the implementation of MAT standards 1–10 as of April 2024 across all 29 ADP areas. It is based on the evidence submitted by ADP areas. This evidence is scored against defined criteria to construct the red, amber, green, blue (RAGB) assessment.

- There are limitations to the RAGB assessment. While RAGB green (fully implemented) means that the criteria agreed have been met for the year of assessment this does not mean that all people who request care receive it to the agreed standard all the time.

- In some instances the RAGB assessment of implementation is contradicted by experiential feedback. This is because the RAGB assessment uses evidence on whether an experiential programme is in place to enable feedback and participation – not on the actual feedback from people using services and whether that feedback indicates implementation is effective and benefitting people (the outcomes).

This report does not provide an assessment of the outcomes of implementation of the MAT standards, that is whether implementation has been effective and benefitted people.

- Experiential feedback is crucial to tell us what the outcomes of implementation are. However, the ADP programmes to collect experiential feedback are under development and so the feedback data are not always complete or representative and not yet a reliable indicator of outcomes.

- However, great efforts have been made by ADP areas and recovery communities this year, so the feedback data submitted by ADP areas are included in the report as an early indication of the experiences of some people using and providing services. This feedback describes the experiences of people interviewed or who participated in surveys and focus groups. It is not used to allocate the RAGB and it is not considered formal 'outcome' evidence because it is not representative of all peoples'

experiences of services. A summary of the experiential data is in Section 4.2 and feedback specific to each MAT standard is in Section 4.4

- A detailed summary of the experiential feedback submitted by ADP areas will be provided in a separate report on the experiential programme.

This report does not provide a detailed analysis of the processes, policies or numerical data for each MAT standard. The PHS MAT programme will provide the following:

- Separate management information reports with more detailed analysis of numerical data for each ADP area.
- Help for local teams to anaylse the local nuances and effectiveness of implementation.
- Support for national analysis and discussion through networks, mini conferences and workshops.

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

For justice settings this report provides descriptive case studies of implementation known to or supported by the PHS MAT programme. The case studies are written by the teams that did the work. The document does not report on wider work done across the prison estate, police custody suites, social work, drug testing and treatment orders or the national justice networks.

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 as Forth Valley.

3. Methods

The 29 ADP areas were assessed against the 10 MAT standards in the community using three streams of evidence: process, numerical and experiential. All three streams are given equal weight. The evidence streams are scored and triangulated to allocate a RAGB status for the implementation of the standard. A total of 290 standards (10 for each of the 29 ADP areas) were assessed and each allocated a RAGB score.

For example, with a given standard in an ADP:

- the process evidence sets out whether the local policies and procedures are in place for service delivery in line with the MAT standards criteria
- the numerical evidence demonstrates whether service activity reflects key aspects of the policies and procedures
- the experiential programme evidence demonstrates whether policies and procedures are in place to enable people to provide feedback and participate in service improvement

If all these three streams are scored high the RAGB status is green for implementation. If any evidence stream scores low then the RAGB status is less than green. The evidence stream criteria are chosen to reflect key aspects of a standard – they do not assess all aspects of a given standard especially for complex interventions such as standards 6–10.

The RAGB status reflects the stage of implementation of a standard but does not reflect whether the implementation is effective and benefitting people – that is RAGB status does not reflect the outcome of implementation. To do that experiential feedback is required.

Further detail on methods is available in the **2022/23 benchmarking report**.

The definitions of the RAGB are:

- **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 (OST) 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.

Note: MAT standards 6–10 are very complex and difficult to measure. For this reason, it was agreed with ADP areas that numerical indicators would be developed in phases. In 2023–24 the numerical indicators chosen were those that were considered more amenable to measurement and most likely to provide information to help improvement work. It was also agreed that as the evidence requested would not be sufficient to demonstrate 'full implementation' provisional green would be the highest score attainable for standards 6–10.

Experiential

The PHS MAT programme takes the patient and user experience approach to data collection, a method commonly carried out across the NHS. This method has the advantage that near real-time experiences can feed into service improvement. The intention is that this is a sustained approach, not a time-limited exercise like a one-off

survey and is not formal research. The programme supports the methodology of semi-structured interviews and the approach can be complemented and added to by a mix of methods such as online or face-to-face surveys, public meetings, focus groups, lived and living experience panels, complaints and compliments, patient stories, critical incidents and short conversations in clinical settings.

In 2023/24 the ADP experiential programme changed to align with feedback from partners. This was because the experiential data available from ADP areas were not yet complete, representative or timely enough to be used to assess implementation and the effectiveness of implementation.

This report assesses the extent to which an experiential programme is in place. This was done using evidence to demonstrate that the planning, infrastructure, capacity, culture and engagement with the recovery community was in place to ensure that all people can realise their right to provide feedback and participate in decisions for their care.

This means that the single score for the experiential programme will contribute to the RAGB score for each of the MAT standards. This is a change from the previous year when the analysed feedback on experiences of care for each standard contributed to the RAGB score for that standard. Analysis of the experiential programme data is not included in this report, just the score.

However, in addition to experiential programme data, each ADP area submitted an analysis of experiential feedback. These data are included in the report as an early indication of peoples' experiences with implementation. The feedback data were based on four areas:

1. access, options and choice
2. shared care and advocacy
3. staying and being involved in treatment
4. mental health and wellbeing

Feedback was from three groups: people accessing treatment; family members or nominated people; and service providers.

There was some variation between ADP areas in their method of analysis because this was tailored to local needs, capacity and expertise. Some areas gave quotes while others summarised what was generally stated across staff members, people accessing treatment and family member groups.

The data were grouped together by the four areas and thematic analysis were used to identify, analyse and interpret patterns. While considering thematic analysis it is important to be reflective as the themes pulled out are interpretations from researchers and analysis in local areas. This is important with this data set because we are interpreting data which have been interpreted by others already.

Justice

The standard of care in justice settings should be consistent with that in the community, but the PHS MAT programme has not conducted a systematic assessment of implementation in justice settings. This is because the programme is at a much earlier stage and there are no systems in place for systematic evidence gathering and reporting on the MAT standards. Instead, the programme has worked with innovators and early adopters in some justice settings to collect evidence of implementation of specific standards. Once systems are more developed, it is expected that this approach will scale up and the justice programme can better align with the community methods.

All the justice data presented are from case studies conducted and reported on by colleagues in justice healthcare. The work was supported by the PHS MAT programme, but data and processes have not all been independently verified by PHS.

4. Findings

4.1. Evidence collection

MAT standards 1–5

Process and numerical evidence were submitted by all 29 ADP areas for a total of 145 standards 1–5 (that is five standards for each ADP area). A total of 97% and 94% of numerical evidence submitted was fully compliant with agreed criteria compared with 27% of process and 21% of numerical evidence in 2021/22.

MAT standards 6–10

Process and numerical evidence were submitted for 137/145 standards 6–10. Nationally 67% of process and 94% of numerical evidence submitted were fully compliant with agreed criteria. In 2022/23, 46% of process evidence was fully compliant and numerical evidence was not requested for MAT standards 6–10.

Experiential data

There has been a step change in the collection and use of experiential evidence in 2024. All 29 ADP areas submitted experiential evidence and all but one met agreed criteria. It is not possible to directly compare the evidence submission with previous years because of this change in the evidence requested. This year we assessed the structure and function of each ADP's experiential programme, whereas last year we assessed the actual feedback from people on their experiences under each MAT standard.

However, the agreed criteria for 2023/24 includes evidence that people's experiences have been collected and used for improvement. In total 1074 interviews were carried out across the 29 ADP areas: 584 with people accessing treatment, 342 with service providers and 148 with family members or nominated persons. A further 474 people (295 people accessing treatment, 133 service providers and 46 family members or

nominated persons provided feedback though other methods such as short questionnaires, online surveys and group work. In addition, 60 documented case studies were provided to demonstrate participation and the translation of feedback into service improvement. Case studies and analysis of the interviews will be shared with ADP areas in a separate report.

All ADP areas were requested to sense check their experiential work with local lived and living experience representation. This was requested at short notice so it was a challenge for many areas. However, nine areas did so through means such as existing lived and living experience panels, people embedded in local groups responsible for oversight of the standards and meetings set up specifically to do the sense check. Most ADP areas also included the strengthening of mechanisms such as a panel in their plans for 2024–25 experiential programmes.

Benzodiazepines and stimulants

In 2023/24 all ADP areas have updated protocols to include people affected by benzodiazepines and stimulant use. However specific data on access, choice and care were not requested for this group of people: for example, the time from initial presentation to assessment and care for people using benzodiazepines was not assessed for MAT 1 nor uptake of psychosocial or prescribing assessment as a choice of care for this group under MAT 2.

Justice

Justice data are presented as case studies submitted from eight prisons, two police partnerships and a community partnership.

4.2. Experiential feedback on implementation of MAT 1–10: community

This section summarises feedback submitted by ADP areas from three groups: people accessing treatment; family members and nominated people; and service providers. Experiential programmes are under development and feedback is not considered complete or representative of all peoples' views. But it does give an early indication of peoples' experiences of care. Feedback specific to individual standards is provided in Section 4.3.

People accessing services said:

- there have been fewer delays in accessing treatment
- they felt there was more support to choose different types of OST
- there was good access to harm reduction at the MAT appointment
- they felt cared for and supported by their workers to stay in treatment for as long as they needed

However, there is variation in these experiences between areas and individuals, and several gaps are identified by all groups who provided feedback: family members wanted to be more involved in choice, harm reduction and support for retention; some people still report waiting two weeks for a MAT appointment and lags between assessment and prescription for OST; there is a lack of staff training and resource to support acute crises as part of MAT 3; harm reduction interventions for sexual health and immunisation are often lacking; effective shared care with general practitioners (GPs) and community pharmacy is limited; there is a need for a greater understanding of the role of independent advocacy for all groups; mental health care can be difficult to access; and although most service users felt they were treated with dignity and respect this was not always the case. Feedback indicates that culture, care and infrastructure needs to be more trauma informed.

Some of the feedback also highlighted the local nuances that numerical data cannot capture. For example even in areas where 75% of people access a MAT assessment

within one day of presentation, some people reported a lag between access to a MAT assessment and the OST and script. One person reported waiting two weeks for their first appointment, having no option but to keep using illicit drug in the meantime and becoming ill as a result.

The lack of trauma-informed spaces and care is a recurrent theme. Spaces are often not fit for the people or the purpose and without suitable transport, support may not be accessible. Many people felt they were not offered trauma-informed care sometimes feeling threatened, misunderstood, judged, stigmatised and like a statistic. There was a feeling that care was not patient-centred or holistic and that a lack of continuity of workers could be difficult.

Feedback from services highlighted that there is a shortage of staff, caseloads are too high, appointments are too short, flexible appointment systems are not matched by flexible working patterns, and that some staff feel burnt out or stigmatised.

Effective care depends on the synergy between people accessing services, their family members or nominated persons, their service providers and the setting. The feedback indicates that for care to be effective there needs to be flexibility, time to build relationships, clear information, involvement of families, good communication between the multiagency teams, trauma-informed environments and better links to the recovery community to help reduce isolation and stigma; but that a lack of infrastructure, staff time, resource, information-sharing and training is a significant challenge to achieving this.

Some of this feedback is reflected in the National Collaborative: Charter of Rights for People Affected by Substance Use community conversations which are summarised in the **National collaborative call for evidence – analysis report**.

4.3. RAGB assessment of implementation: community

Across all 29 ADP areas for MAT standards 1–5, 90% (131/145) have been assessed as fully implemented (RAGB green) which is an increase from 66% (96/145) in 2023 and 17% (25/145) in 2022.

For MAT standards 6–10 the evidence requested by the programme was not sufficient to demonstrate full implementation but 91% (132/145) were assessed as provisional green. This is an improvement from 2023 when 45% (65/145) of standards were assessed as amber and 12% (18/145) had no evidence of implementation (RAGB red).

The RAGB score blue (evidence of sustained implementation and ongoing monitoring) was allocated to two ADP areas for MAT 4 and one for MAT 3.

Chart 1: Percentage of ADP areas with RAGB score per MAT standard 1–5 – Scotland 2022, 2023 and 2024.

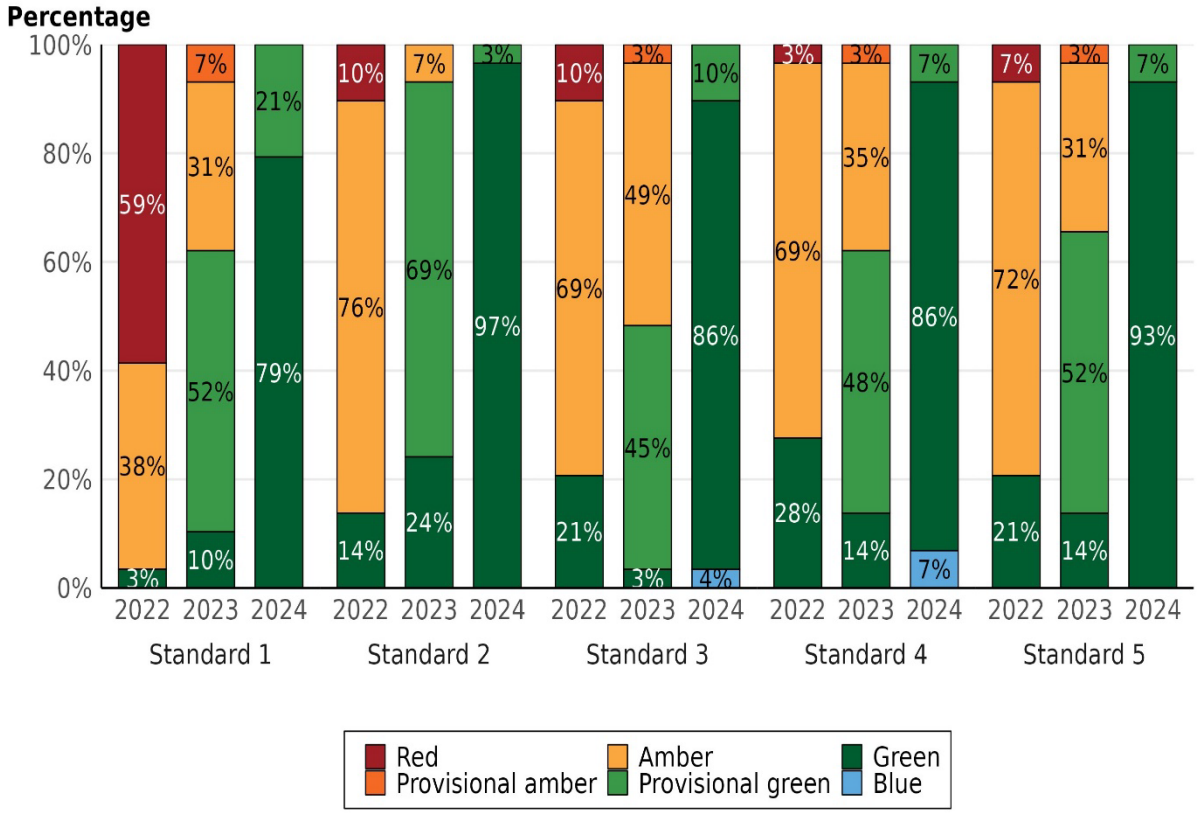
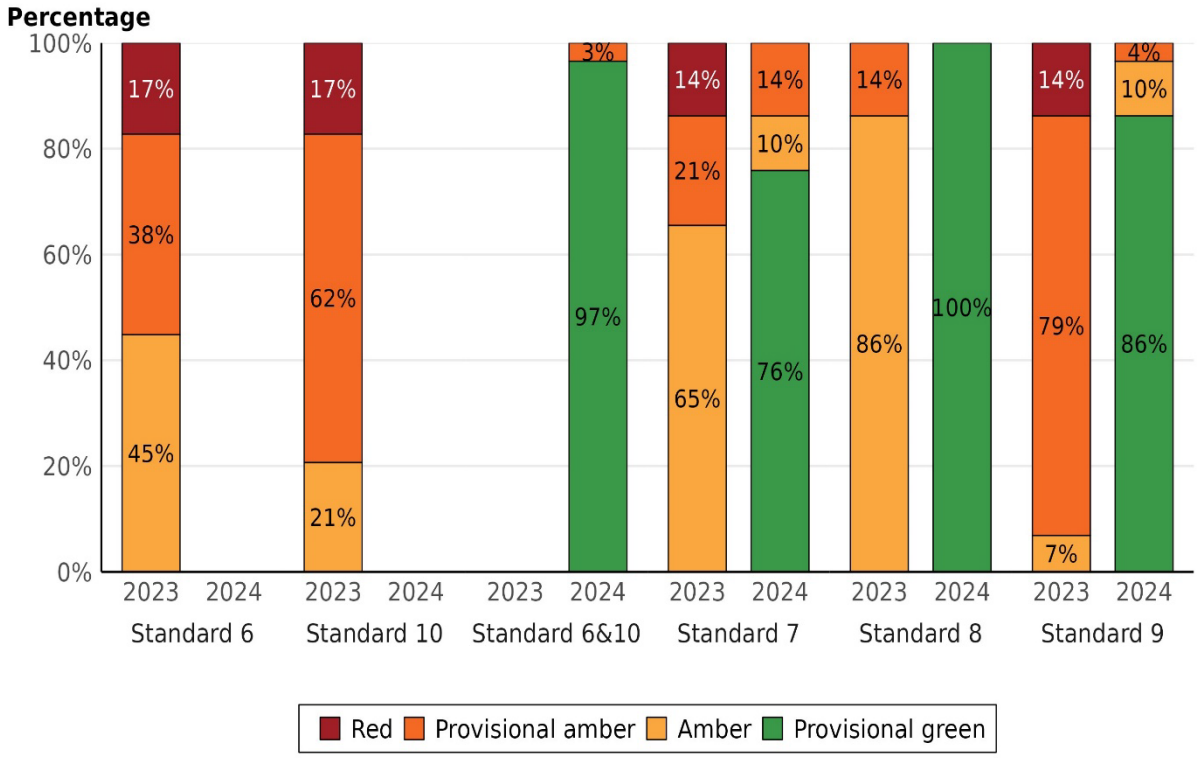


Chart 2: Percentage of ADP areas with RAGB score per MAT standard 6–10 – Scotland 2023 and 2024*



* Note: in 2023 MAT 6 and 10 were assessed separately. In 2024 they were assessed jointly.

4.4. Assessment of MAT standard 1–10: community

MAT standard 1: Same-day access

The intention of MAT standard 1 is to ensure that all people accessing services have the option to start MAT from the same day of presentation and that options should include psychosocial care as well as pharmacological care if appropriate.

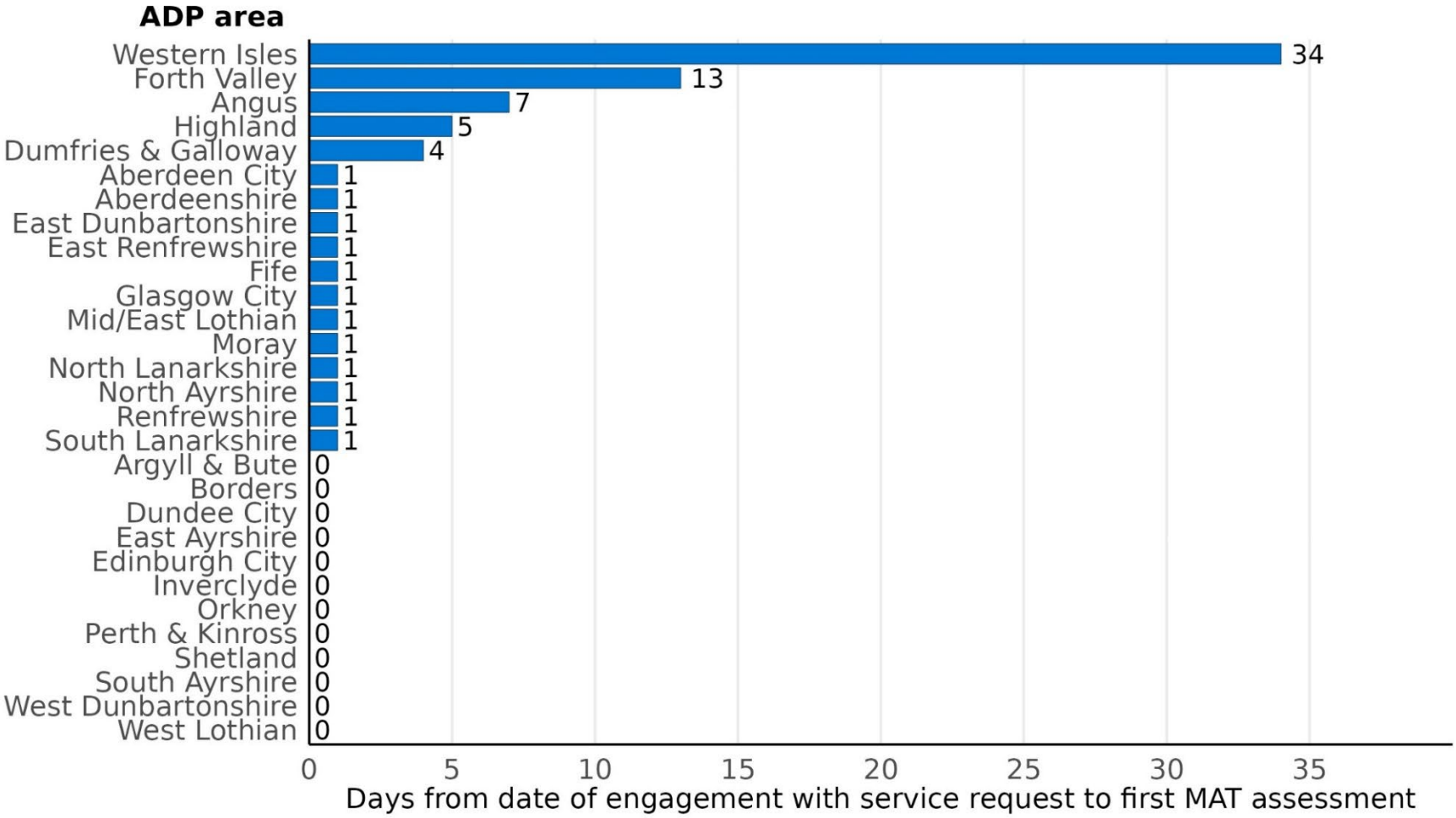
The standard was assessed as fully implemented (RAGB green) in 24/29 ADP areas. In these areas 75% of people received their MAT assessment ('first date the service offers for MAT assessment and where treatment can be initiated if appropriate') either on the same day of initial presentation or the next day. In five areas (Dumfries and Galloway, Forth Valley, Highland, Western Isles and Angus) the numerical

benchmark was not achieved because of delays of between four and 34 days from initial presentation to first MAT assessment. This is due to a combination of resource, geographical and system constraints. In Shetland ADP 75% of people received an assessment on the day of presentation but the standard was assessed as RAGB provisional green because the experiential programme was not fully implemented.

The data shows no significant gender difference in time to MAT assessment.

The methods of measurement have changed since 2021/22 but are sufficiently similar to demonstrate year on year improvement from the 2022 assessment where 50% of people received OST on the same day in eight ADP areas and in 18 ADP areas in 2023.

Chart 3: Number of days from date of engagement with service requested to date of first MAT assessment for 75 % of people by ADP area– Scotland 2024



Most feedback submitted from people using services said there was no delay in starting treatment although in some areas there were still waiting times. People felt that their treatment started on the day they requested help even if no prescription was given because the reason for not starting a prescription was explained to them. Those with historical involvement with services noticed an improvement in access to care from their past experiences.

Experiential feedback gathered by other partners do not always support these themes and some of the feedback gather by ADPs highlighted the local nuances that numerical data cannot capture. For example some people reported a lag between access to a MAT assessment and the OST and script. This was perceived as often being due to a lack of staff and hurried implementation of direct access. One person reported waiting two weeks for their first appointment, having no option but to keep using illicit drug in the meantime and becoming ill as a result.

'The process was easy and there weren't any issues' (person accessing treatment)

'They couldn't prescribe me medication as they needed a clean drug screen, so I had to wait three days and then I was prescribed methadone and diazepam.' (person accessing treatment)

'Angry it took 10 years to get there … glad of MAT Standards, making a big difference' (service provider)

MAT standard 2: Choice

The intention of MAT standard 2 is to ensure that all people are supported to make an informed choice on what medication to use (if any) along with psychosocial interventions as part of MAT.

The standard was assessed as implemented in 28/29 ADP areas because process documentation is clear that all pharmacological options, as set out in the agreed criteria, are available and numerical evidence demonstrates that there is uptake.

Shetland ADP is provisional green because the experiential programme is not fully established.

The aggregate national results (Chart 4) show a 10% decrease in methadone prescribing from 75% in 2022 to 65% in 2024 and an increase of 12% in prescribing of long-acting injectable buprenorphine from 6% in 2022 to 18% in 2024. The data shows no difference in uptake between males and females. In addition to choice there are many possible factors that could contribute to these changes in uptake. All 29 ADP areas in Scotland have methadone, short-acting oral buprenorphine and long-acting injectable buprenorphine on their prescribing formularies and all have documented processes in place to enable people to choose medication. However other factors such as demographics, organisational culture and patterns of drug use can influence what type of OST is offered. This may explain some of the variation in the proportion of the caseload prescribed long-acting injectable buprenorphine across all ADP areas which ranges from 1.4% in Highland ADP to 42.9% in Dumfries and Galloway ADP. Note that in some areas such as the Western Isles the small number of cases can impact their data. Data on treatment options such as psychological and social interventions was not requested.

Chart 4: Percentage of caseload prescribed OST by type – Scotland 2022, 2023 and 2024

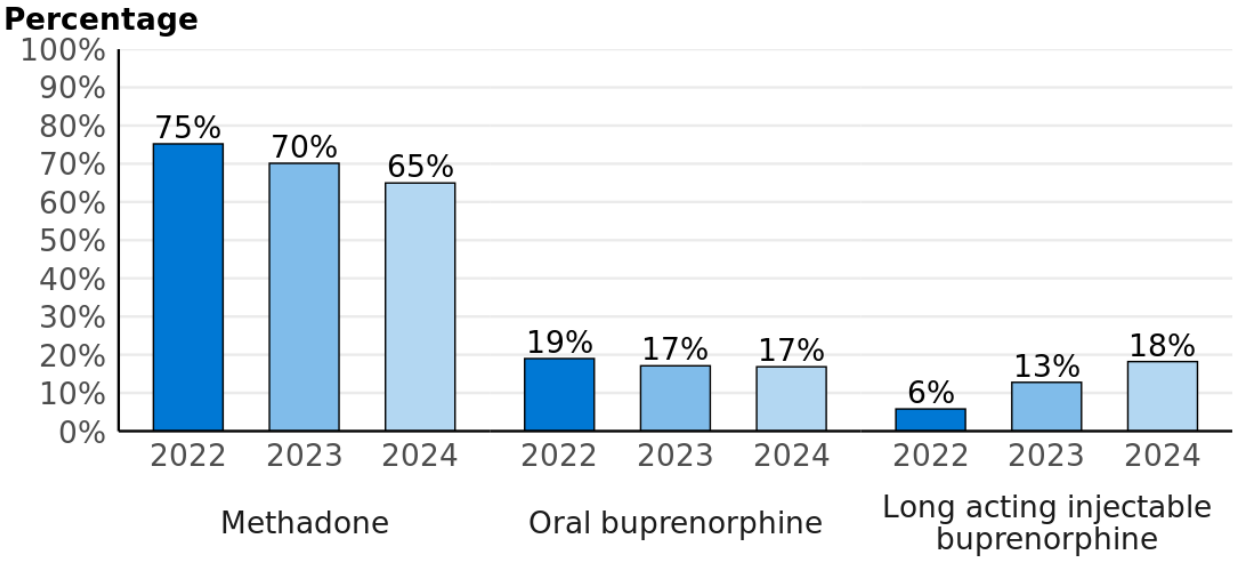
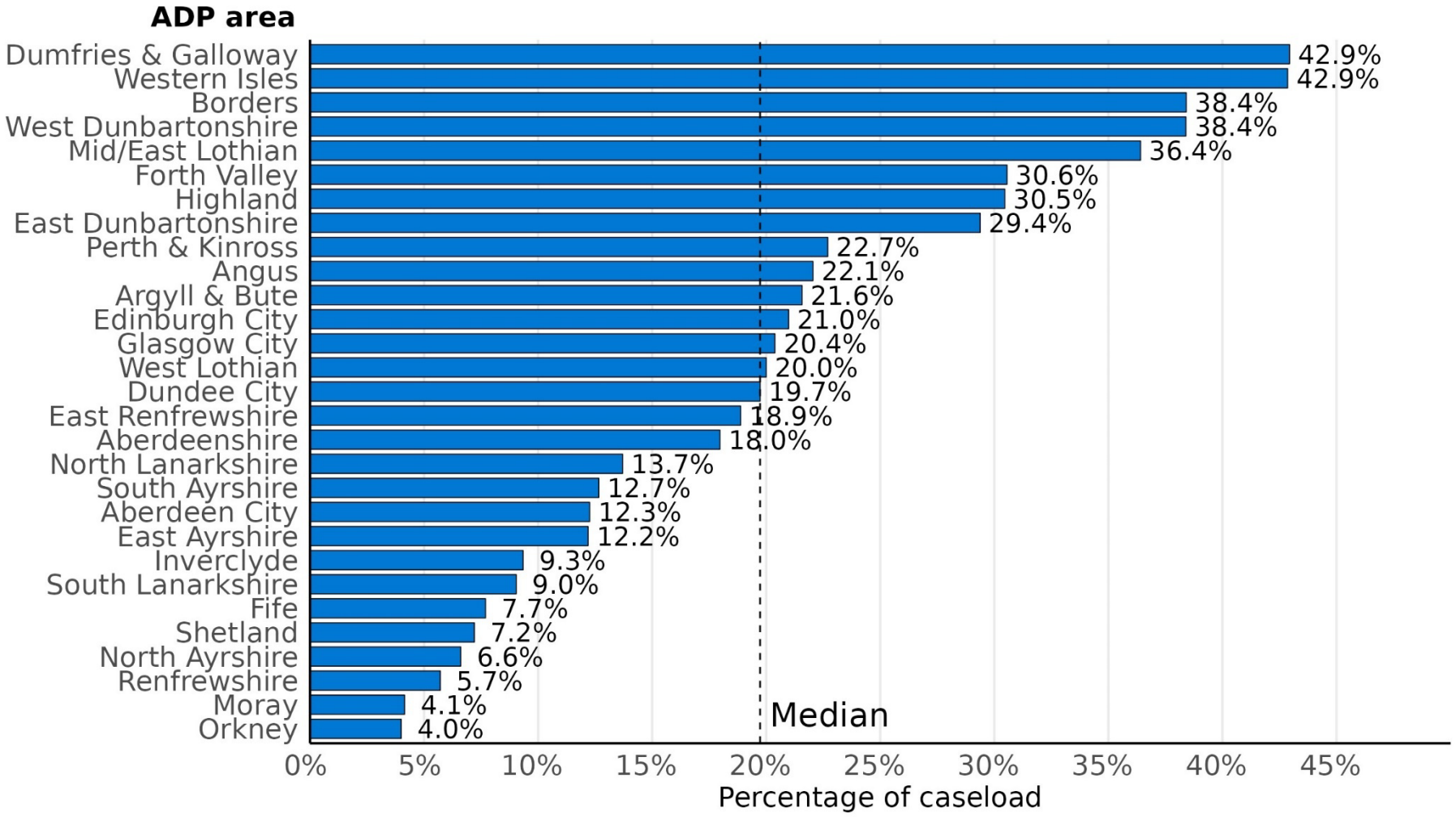


Chart 5: Percentage of caseload prescribed long-acting injectable buprenorphine by ADP area – Scotland 2024



Experiences of people using services are required to assess choice. In general the experiential feedback received indicated that people feel they are able to make an informed choice on the OST available. Individuals from 14 ADP areas expressed positive views on choice of medication and their confidence in making a supported decision that suited them. People from two areas specifically mentioned the positive impact long-acting injectable buprenorphine had on improving their lives but the majority of respondents talked more widely about discussions with workers around the right choice for them. This was backed up by family members from three areas who felt their loved ones had a range of options available to them.

There was a lack of choice felt by those people who had been in treatment for a long time. Often those people were on methadone and felt their request for a change went unheard.

Staff from six areas commented on having a full range of treatment options available to them and felt there were more options available than in the past. Please note that this does not mean there are not options available in other areas, just that they did not comment, though there are comments on restrictions to treatment options in some areas. There was no feedback on choice of non-pharmacological interventions.

'More information about what to expect when someone is accessing the service for support. It would be good to have someone to call and check if we have any worries or concerns or questions.' (family member)

'I've been on methadone since the late 80's, before Caley Court was Caley Court, I had to go to a place in Saltcoats for my script. So, whenever I've fallen away and re-engaged it's always been methadone I've been offered, nobody has spoken to me about the other options.' (person accessing treatment)

'I definitely felt involved in my options. I mind the lassie discussed all available options I could choose from and I think it was 'espranor' (a freeze-dried wafer containing buprenorphine and which dissolves rapidly on the tongue) she recommended for me, due to it having a blocker effect,

so if I used on top of it there would be no effects. I decided to go for methadone though and my choice was respected.' (person accessing treatment)

MAT standard 3: Assertive outreach and anticipatory care

The intention of MAT standard 3 is to ensure that all people at high risk of any drug-related harm are proactively identified and offered support to commence or continue MAT or other treatment of their choice. The high-risk harms include non-fatal overdose, serious skin and soft tissue infections and high-risk transitions including unscheduled discharge from hospital, community treatment or prison.

The standard was assessed as sustained implementation (RAGB blue) in one ADP area, fully implemented (green) in 25 and provisional green in two ADP areas.

There has been a year-on-year improvement in reducing the time between the identification of an event and the initial response. In 2023 16/29 ADP areas responded within three days for 75% of people and in 2024 this increased to 28/29 ADP areas. Note these figures are not directly comparable because in 2023 time to initial risk assessment was assessed whereas in 2024 it was time to first attempted contact. The 2024 data shows no significant difference between gender groups.

Overall, the notification of high-risk events by source is similar to 2022/23. Notifications from Scottish Ambulance Service SAS predominate (696, 39%). Which is partly because all ADP areas now benefit from a national data sharing agreement with Scottish Ambulance Service which makes it easier to receive and act swiftly on notifications of non-fatal overdoses. There is an increase in notifications from prisons from 54 (4%) in 2023 to 185 (10%) in 2024. This may be due to factors such as increased events or improved information sharing.

There is no national data sharing agreement in place with police or prisons and work is required on data sharing and pathways to increase collaboration with family members, homeless and housing services, third sector services and primary care because as well as early notification of events, these partners can have a crucial role

in the initial response and future care planning. It may be that the category 'other' includes notifications from these sources (14%).

Chart 6: Number of high-risk events by notification source in 29 ADP areas – Scotland 2024

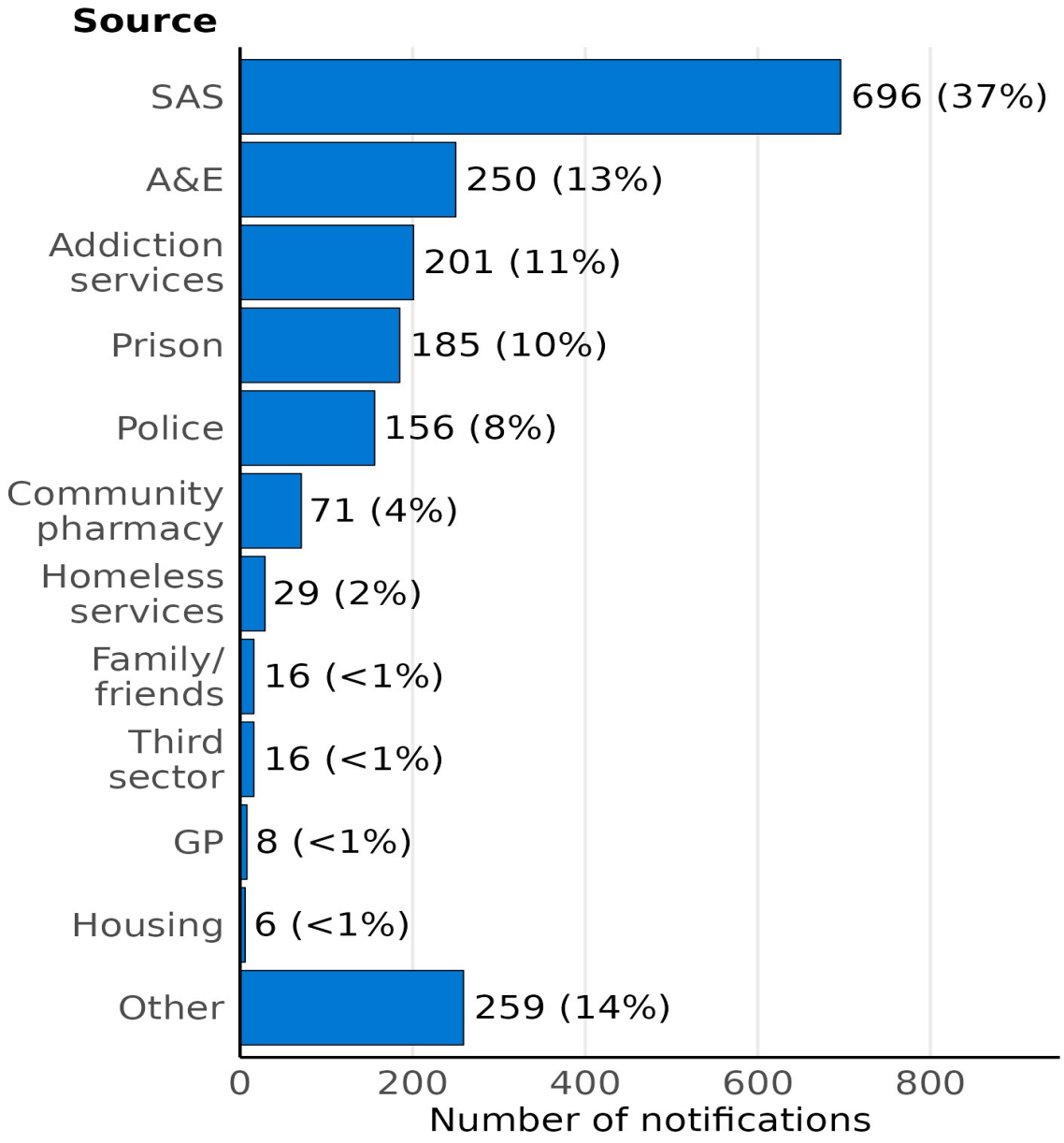
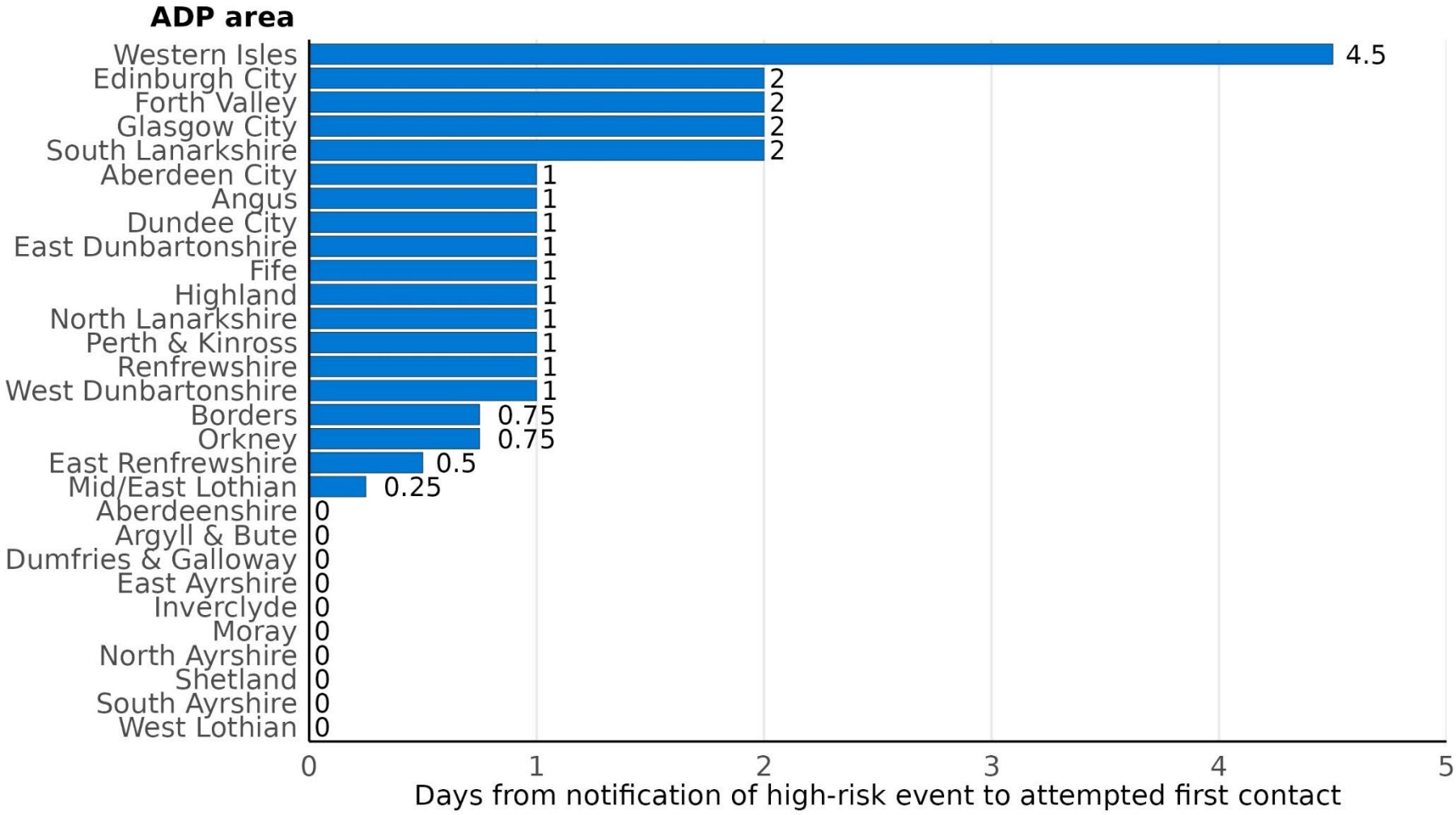


Chart 7: Number of days between notification of a high-risk event and first attempted contact by the multi-agency team for 75% of people by ADP area – Scotland 2024



Many people accessing services fed back that they noticed change for the better. However, there is variation in this standard of care across ADP areas. Some people were contacted quickly after an overdose and offered welfare checks and appointments with assertive outreach teams. Other people said they wanted more phone contact and wished they had more support from workers after a non-fatal overdose.

Crisis support was mentioned several times by all three groups - staff, people accessing services and family members. In some areas there was no dedicated service for crises, some areas offer staff training in recognising crisis, self-harm and withdrawal and other areas work with community pharmacists or an overdose response team to respond to crises.

> 'I will also sit with the patient at their first appointment with me after a non-fatal overdose to discuss what caused it and if there have been any significant changes to their circumstances that could have potentially triggered it. This allows us to make a plan together to put preventative measures in place.' (service provider)

Staff in some areas said they worked well with police and social workers to give support and see individuals as soon as possible. A lot of staff felt they did a lot of crisis intervention work and this took away from them doing prevention work.

Family members said they did not know how to access crisis services and a lot of feedback indicated a lack of information about what to do in a crisis.

This is a very challenging area of work for staff because outreach in difficult situations can pose risks, it is difficult to know how to respond to the whole range of drug harms and experiences can be emotionally draining. For example, some service providers felt they were not qualified to provide care after a suicide attempt and that rapid follow-up support or specific staff training, for example around post-traumatic stress disorder (PTSD) awareness, would have been beneficial.

MAT standard 4: Harm reduction

The aim of MAT standard 4 is to ensure that all people are offered evidence-based harm reduction at the point of MAT delivery, to minimise missed opportunities and to reduce stigma.

The standard was assessed as sustained implementation (RAGB blue) in two ADP areas, fully implemented (RAGB green) in 25 and provisional green in two ADP areas.

All ADP areas conducted a structured self-assessment for this standard and all but one report that blood-borne virus (BBV) testing, injection equipment provision (IEP), naloxone and overdose awareness and wound care are available for at least 75% of the caseload at all MAT appointments, either immediately in the room or in the same building at the same time as the appointment (but in a different room or from a different worker) the benchmark for MAT 4. Limiting factors for availability include physical infrastructure and systems. Immunisation for hepatitis, tetanus, influenza and COVID-19 were not assessed.

The self-reported evidence has not been validated with existing harm reduction data from routine IEP, naloxone, BBV reporting and immunisation reporting or the Needle Exchange Surveillance Initiative (NESI) surveillance data.

Most people accessing services who were interviewed said they had seen positive changes and felt they had access to harm reduction measures at the time of their appointment. However, people in some areas reported that there was no IEP available at the point of contact and felt that things like sexual health support were a gap. Family members felt they wanted more information on harm reduction, access to naloxone and IEP and wanted us to know that recovery communities and third sector organisations can be better and safer places to receive information on harm reduction.

Service providers said there were gaps in offering hepatitis B vaccinations and noted that the WAND (wound care, assessment of injecting, naloxone, and dried blood-spot test) contingency management approach increased uptake of other interventions (safe injecting provision, dry blood-spot BBV testing, and naloxone provision).

When discussing harm reduction one individual found naloxone training helpful as they were not aware they 'could overdose when using opiates orally'.

MAT standard 5: Retention as long as needed

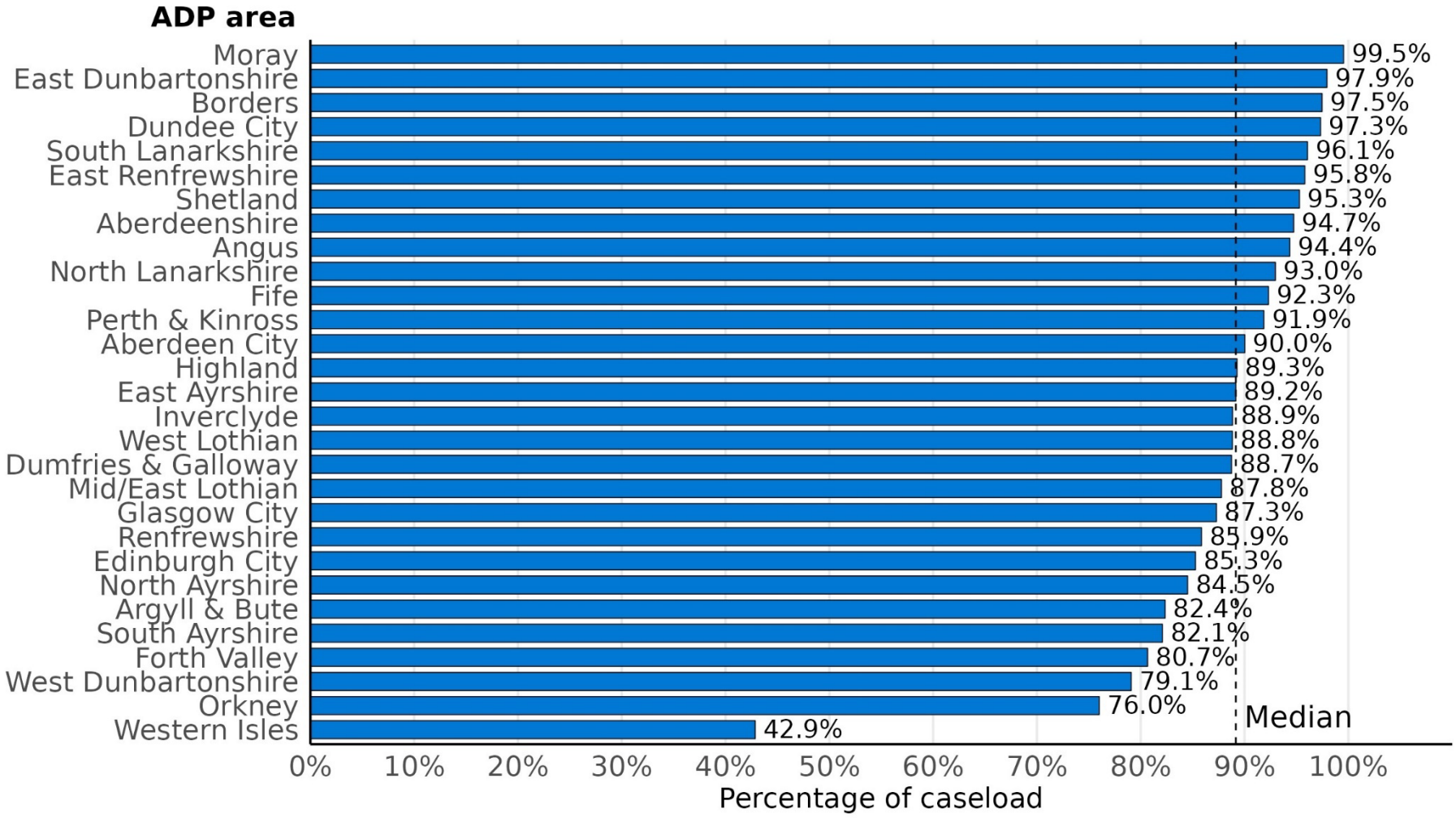
MAT standard 5 aims to ensure all people will receive support to remain in treatment for as long as requested. This standard was assessed as fully implemented (RAGB green) in 27/29 ADP areas.

A key intention of this standard is to help reduce unplanned discharge because this can pose an increased risk of harm if people are not supported in the transition from care. Data on discharges are difficult to collect consistently and to analyse and interpret. But for the RAGB benchmarking the proportion of the caseload in treatment for six months is used as a proxy for effective support for retention in care.

A total of 28 ADP areas achieved the benchmark of 75% of people retained in care for six months. Western Isles ADP was 50% but this is difficult to interpret as a different approach was used for data collection and there are small numbers on the caseload.

Aggregate data across all ADP areas indicates that there is no significant gender difference for time in care with 89% of women and 87% of men staying in treatment for more than 181 days. However, the caseload for men is about twice that for women (14,469 vs 7,095).

Chart 8: Percentage of caseload retained in treatment for six months or more by ADP area – Scotland 2024



Feedback from people accessing services indicates that they felt they had more choices and were more supported to stay in treatment if they had good relationships with the addiction team. However, staff from several areas felt they did not always have enough time to build relationships due to staff shortages and high caseloads.

People said that the following factors meant they were more able to stay in services: flexibility including appointment times; telephone calls; help with transportation, for example, bus passes; good links with other organizations; having referrals back to GPs; having knowledge of their rights; having lots of options; clear information and signposting; being spoken in a language that is understood; being sensitive to things like gender; being encouraged to engage fully; community detox; recovery cafes; and peer support. Family members specifically mentioned home visits.

A crisis can have a negative impact on someone staying in treatment and some family members felt their loved ones were treated differently if they fell out of service which made it hard to get back into service - especially if they missed appointments. People said it was important to be supported by staff to help them move on and that sometimes this did not happen and there was a lack of clear information or signposting.

> 'Things like travel distance and if they have money to get here is also a massive barrier. We have things in place to try and help assist people with these issues, so for example our recovery development workers could support them to an appointment and we have clinics in all the localities so I could meet the client there, but again, this is restricted by clinic opening times as they don't open over the 5 days a week.' (service provider)
>
> 'I think it would be beneficial to have more time to sit down and speak with my worker. I totally understand that they have loads of folk to support but 20–30minutes is not enough time... In doing that as well I think it would allow me to sit down and discuss with my worker why I was using drugs in the first place, and it could allow me to address the main issue.' (person accessing treatment)

'No. Due to staff meetings and having to complete a lot of paperwork I do not feel that I get enough time with my patients to give them the time that they deserve. I would say that I spend around 30% of the job seeing patients and the other 70% completing paperwork and patients should always come above that in my eyes.' (service provider)

'Getting a taxi (for person accessing treatment) has been well received and reduced risk and increased attendance' (service provider)

'Outside of building is very unwelcoming. Waiting room is too small and patients cannot space themselves out so many feel very anxious about meeting others' (service provider)

'It would have been good to involve my dad too at times as I think he felt like he didn't know what to say to me [about mum].' (family)

'Childcare should be provided and more things to bring women into service' (service provider)

MAT standards 6 and 10: Psychological support and trauma-informed care

MAT standard 6 aims to ensure that the system that provides MAT is psychologically informed, provides psychosocial interventions and supports individuals to grow social networks. MAT standard 10 aims to ensure all people receive trauma-informed care.

MAT standards 6 and 10 were assessed separately in 2023 but assessed jointly in 2024 because there is a lot of overlap with process documentation and delivery. All but one ADP area were assessed as provisional green. This is because they were able to demonstrate a service delivery plan, training of staff and an experiential programme in place to enable feedback and participation.

However, there are limitations in the assessment of this standard. The numerical indicator used for benchmarking was the percentage of staff who completed appropriate tier 1 training in the last two years. This indicator highlights the need for

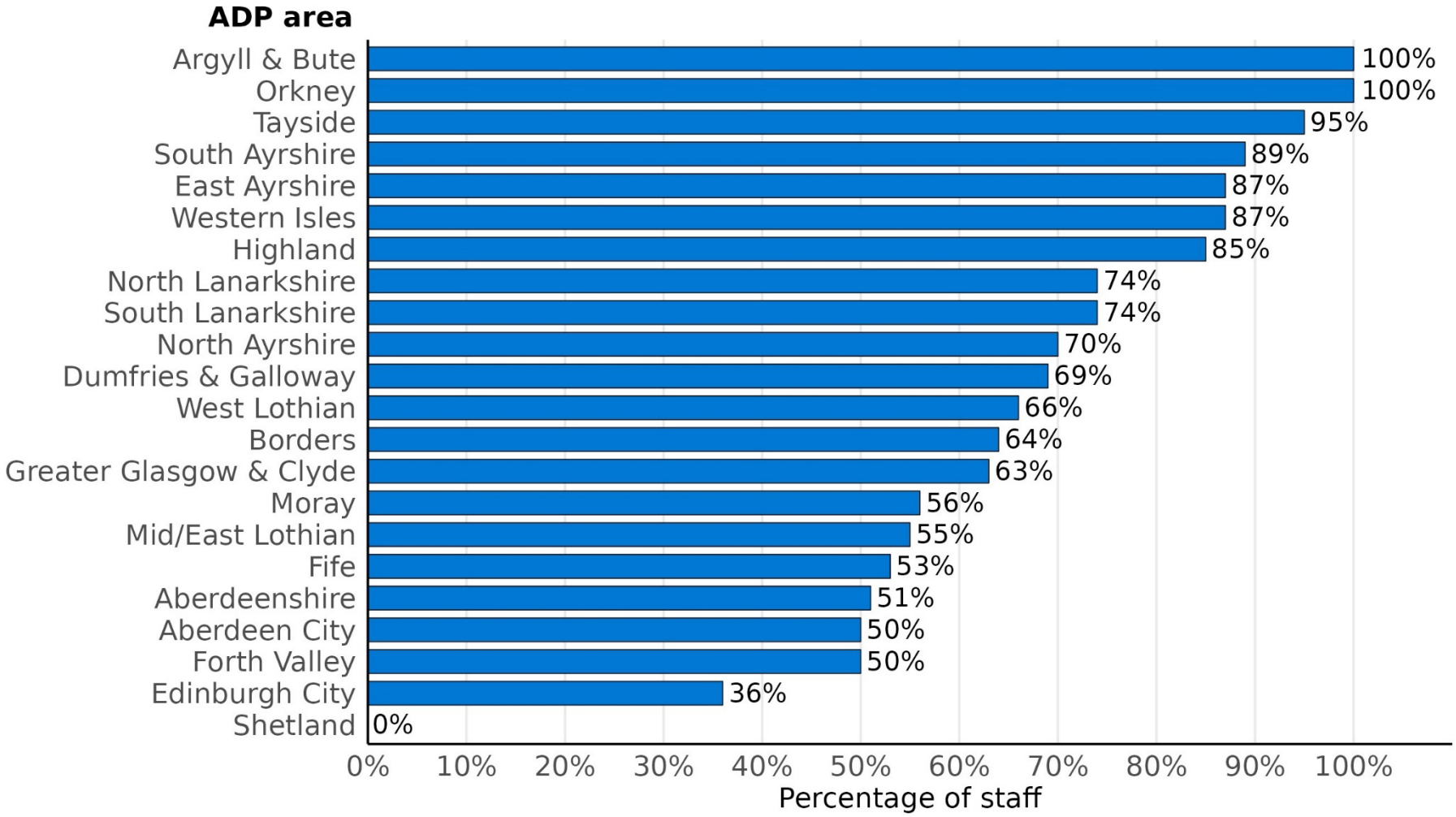
training but there is variation across ADP areas in what is considered appropriate training and there is variation in the workforce used as a denominator. For example, the third sector workforce is key to delivery but it is not clear to what extent the third sector workforce is included in the figures. This means that while all ADP areas except Edinburgh and Shetland met the benchmark for training (50% of staff trained), these figures are not directly comparable and cannot be used to demonstrate consistency. They are probably more useful as a prompt for the need to ensure appropriate workforce training.

Experiential feedback indicates that the majority of people felt they were treated with dignity and respect while accessing services. However, most people also felt they were not offered trauma-informed care and that buildings and spaces were not trauma informed.

People accessing services found that staff with lived experience of substance use were more trauma informed but also that there was a lack of continuity of support and some felt like they were a statistic. Individuals often feel like they do not have a voice but felt that their workers cared about them.

Some people accessing services felt threatened, misunderstood, judged or stigmatised, that care was not person centred and that there was an emphasis on 'treatment' over psychological needs. Some family members felt they were excluded from treatment and that home visits would be helpful.

Chart 9: Percentage of staff who have completed appropriate tier 1 training (as defined in the local training and implementation plans) in the last two years by ADP area – Scotland 2024



Perceptions of trauma-informed care differ between staff, persons accessing treatment and family members. For example some staff thought their services were for the most part fully trauma-informed (mentioning things like appointment flexibility) but many patients and family members thought there was not a lot of trauma-informed care accessible to them.

'I wanted mental health support but told to come off drugs first' (person accessing treatment)

'Yes, staff are generally great, but I don’t feel that they take the individuals mental health into consideration' (person accessing treatment)

'No one checks in on me and it makes me frequently think about leaving this job' (service provider)

'I cannot offer the standard of service I would like to' (service provider)

'I asked for trauma treatment following a bereavement, was not offered this and was never assessed' (person accessing treatment)

'The service also offers 1–1 sessions at our low-intensity clinics and can support people with loss, bereavement, anxiety management, safety and stabilisation, and responses to trauma.' (service provider)

MAT standard 7: Primary care

The aim of MAT standard 7 is to ensure that all people have the option of MAT shared with primary care and that this would help to ensure that they also receive care for general health issues. The process evidence submitted demonstrates that most ADP areas are exploring various models to implement MAT 7 and have agreed pathways and protocols. Perth and Kinross, Angus and Western Isles ADP areas are beginning to establish pathways and agreements for care but Borders, North and South Lanarkshire and Shetland have no pathways to systematically share care between specialist services, GPs, community pharmacies and others.

A total of 22 ADP areas were assessed as RAGB provisional green (four amber, three provisional amber) but this does not always mean that shared care is happening.

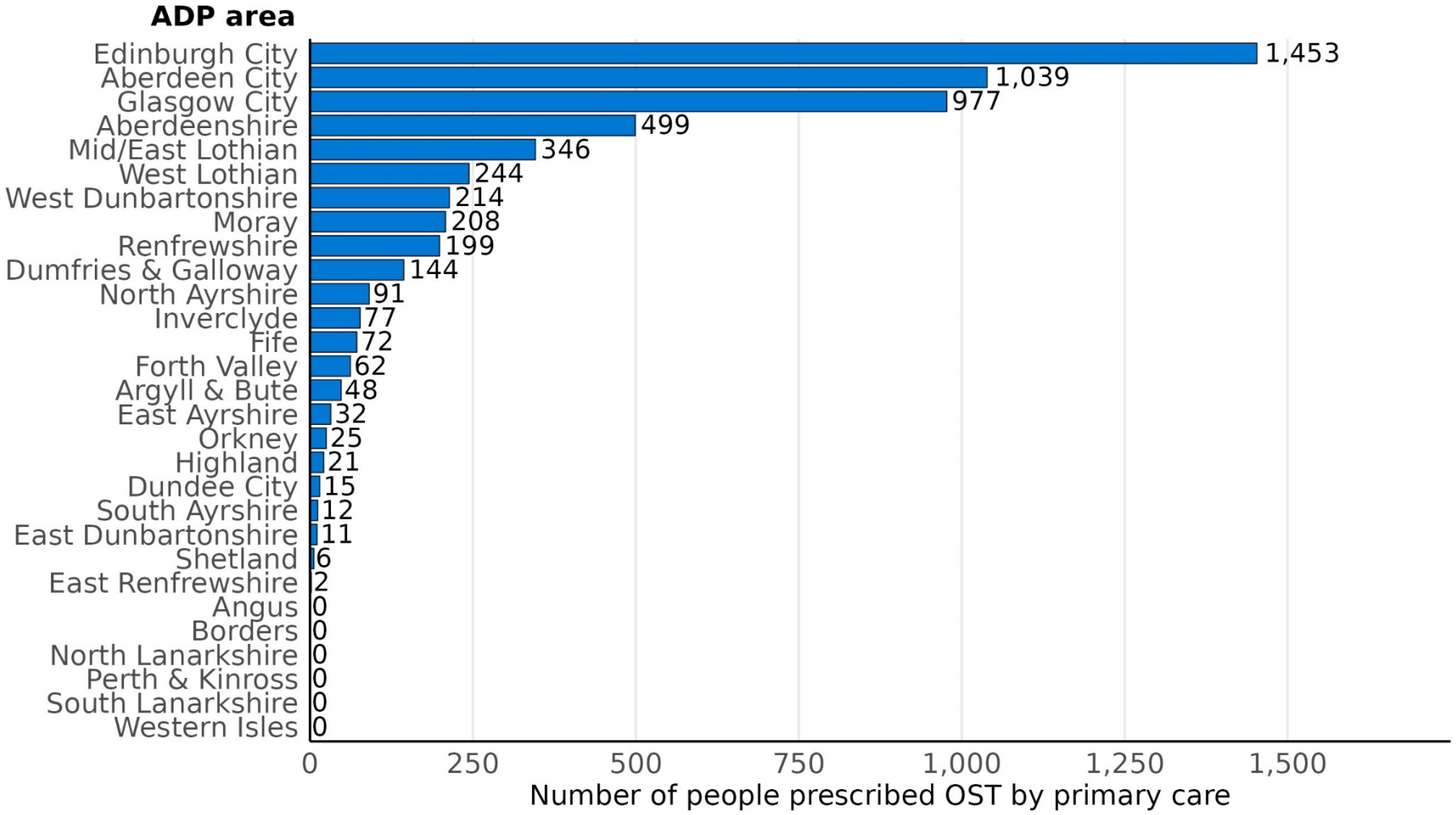
For example, in North Ayrshire there is a strategic plan to implement MAT 7, draft pathways and protocols, a steering group and data on GP prescribing as part of specialist services, but there are insufficient resources to really implement shared care as set out in the MAT standards.

This is a limitation of using the evidence available and using the RAGB system to assess such a complex intervention. The intention of MAT 7 is to ensure that people can access holistic multiagency care including drug treatment, psychosocial support and general medical services. What has been measured this year is the number of people prescribed OST by a GP which is only one small part of shared care.

Where any numbers are provided the data on OST prescribing varies from 1,453 individuals in Edinburgh ADP where there is a high uptake of GPs in the substance use enhanced service to less than 100 in areas such as Ayrshire, Highland and Dundee where enhanced services and shared care are not established.

But also numbers are not comparable and cannot demonstrate consistency. For example in Edinburgh all data reflects the enhanced service but in some areas, such as Aberdeen City, the data reflects a combination of prescribing through the GP enhanced service contract and prescribing by GPs as part of the specialist drug service caseload. In North Ayrshire all data provided are part of the specialist caseload.

Chart 10: Number of people prescribed OST by primary care by ADP area – Scotland 2024



The experiential evidence submitted indicates that shared care between substance use and primary care services is limited across the country, *'*a postcode lottery*'*. People said they wanted a range of options including contact with GP services. Some felt their GP was just for other (non-drug-related) healthcare issues and liked it; others felt there was stigma surrounding going to their GP; whereas others felt it was less stigmatising due to general practice being 'less conspicuous', as a service. Families felt that GP involvement encourages a whole family approach.

Most of the staff in substance use services commented on the unwillingness of GPs to be involved and said there was a lack of communication between services and GPs. Across all groups it was felt that GPs, community pharmacists and others who work in practices needed training on addiction. GPs themselves are often reluctant to take on patients as they have a lack of training in addiction but some GPs said that they would like to be more involved in care including treatment with long-acting injectable buprenorphine.

With regards to pharmacy some people who access long-acting injectable buprenorphine treatment in community pharmacies felt they had a good experience. However, as with GPs there can be a shortage of community pharmacists involved in substance use care.

Many services stated that they felt greater engagement with mental health service would benefit service users.

'I do think this could be beneficial as I personally don't think workers in GP practices understand how complex addiction is and having GP's more involved in my care could possibly make that better as workers may see the day-to-day living with addiction.' (persons accessing treatment)

'I think if this [shared care] was to come about it would be beneficial to some clients, particularly those who are experiencing stigma as GP's are a bit more inconspicuous.' (service provider)

'I've had bad experiences with GP[s] and feel shame going' (person accessing treatment)

MAT standard 8: Independent advocacy and social support

MAT standard 8 aims to ensure that all people have access to independent advocacy and support for housing, welfare and income needs.

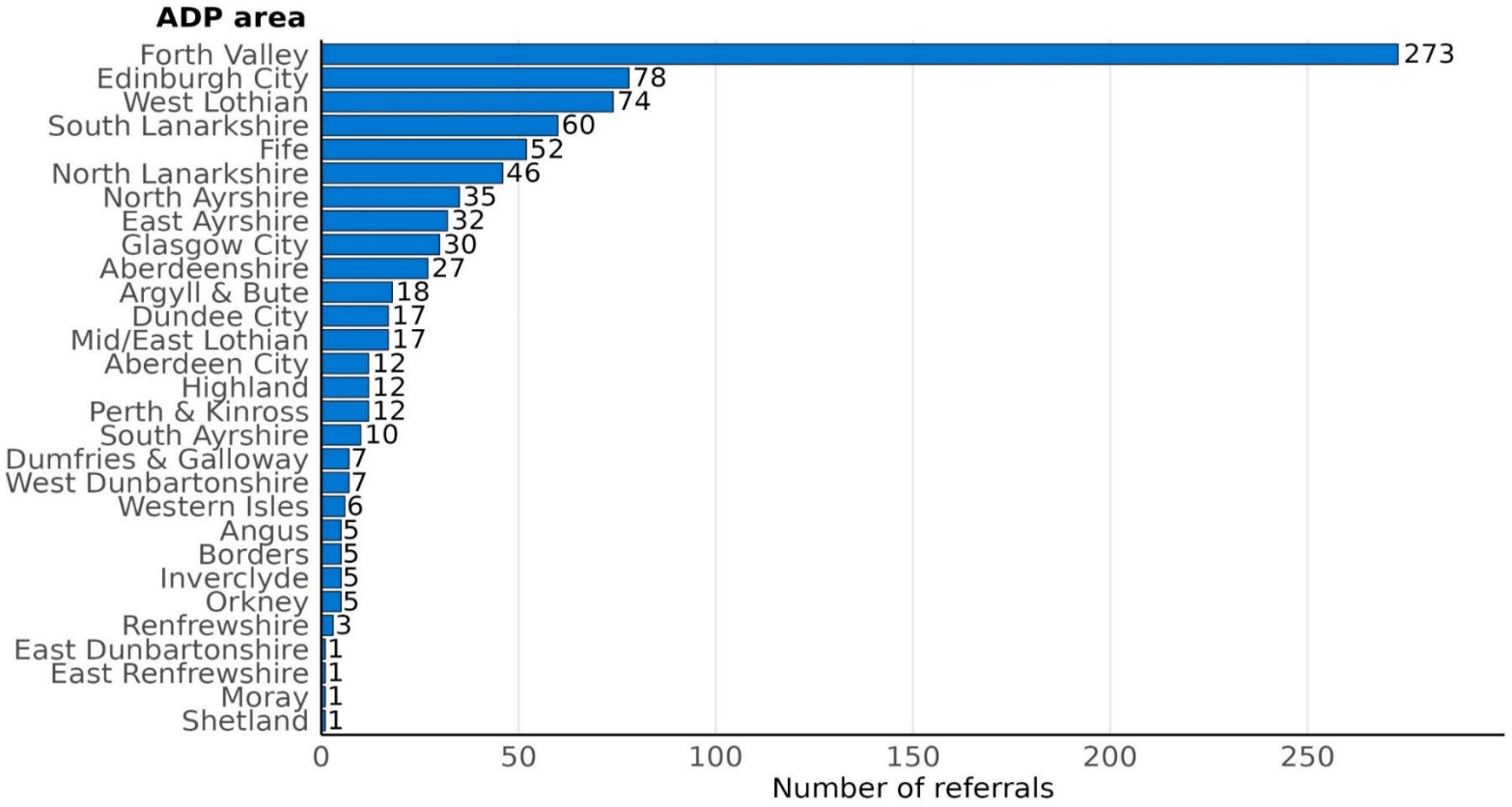
All 29 ADP areas were assessed as provisional green for this standard. This means that ADP areas have commissioned (or engage with) independent advocacy services and have advocacy training plans in place for staff.

The number of referrals varies across ADP areas from 78 in Edinburgh City to fewer than 12 referrals in half of ADP areas. As with other numerical evidence for standards 6 to 10, these numbers are not directly comparable because there are different service models involving different partners and the way in which data are collected is not clear in many instances. Also referral data does not adequately capture the extent to which people uptake and benefit from independent advocacy services.

The next key step is to ensure that advocacy services employ people with the right skills to support people to get the kind of support that is right for them with respect to housing and welfare issues. There is a need to incorporate these elements in improvement support and evidence gathering in the coming years.

Where there are independent advocacy services, peoples' experiences improved. This was reported by staff, people accessing treatment and family members. However, in many cases service users reported they did not know advocacy was available, family members often felt like they were the only advocate for their loved ones and some members of staff had a misunderstanding of what independent advocacy was – for example they felt that was their role. Some service users said there was a lack of advocacy for actual treatment and choices.

Chart 11: The referral numbers from substance use services to independent advocacy services by ADP area – Scotland 2024



Note: Forth Valley include all referrals not only those from substance use.

Where there was independent advocacy, people felt empowered by it and advocates were able to help ensure people had their rights respected. Service providers felt that if independent advocacy was more available it would free them up to do other things.

> 'If a patient is chaotic, they might not always turn up to their appointments and for this reason alone I think we need an advocacy service that is specific to addictions, where they could support people to appointments and advocate on their behalf as not every patient is confident in asking questions in relation to their treatment.' (service provider)
>
> 'I think it makes a massive difference when you are chatting to someone who knows exactly what you're going through cos' they've lived it.... I think another reason peer support would keep me engaged is because I often struggle to support myself, I can fall off the wagon easily or easily stray, whereas peer support would maybe be able to see it happening and help me get back in line.' (person accessing treatment)
>
> 'I do think that peer support is massive in keeping me engaged with the service.' (person accessing treatment)

MAT standard 9: Mental health

The intention of MAT standard 9 is to ensure that all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.

This standard was assessed as provisional green in 25/29 ADP areas and these areas 25/29 have documented procedures for joint working to care for people with co-occurring mental health and substance use issues.

Numerical data were requested by PHS from the perspective of substance use services and provided by all 29 ADP areas. This indicates that of 965 new referrals in the reporting period 765 (80%) were screened for mental health risks and needs in the reporting year. Among the screened people for whom data were available 68%

had evidence of mental health issues (62% mild to moderate mood disorders, 6% severe enduring conditions such as schizophrenia and bipolar disorder), 38% were already in care and 58% of people had continuation of existing care or referral for new care agreed in care plans. Note that issues with data quality means that these figures could include some double counting.

These figures suggest a substantial unmet need for mental health care among people presenting to substance use services: 30% of new presentations were either previously undiagnosed or had left care. It is encouraging that 58% of people had mental health care included in care plans, but we do not have data on whether these people actually received the care they need or that it was effective. The screening rate of 80% is also positive but could be improved with stronger systems and staff training.

Chart 12: Mental health difficulties identified in the initial screening by substance use services in 29 ADP areas – Scotland 2024

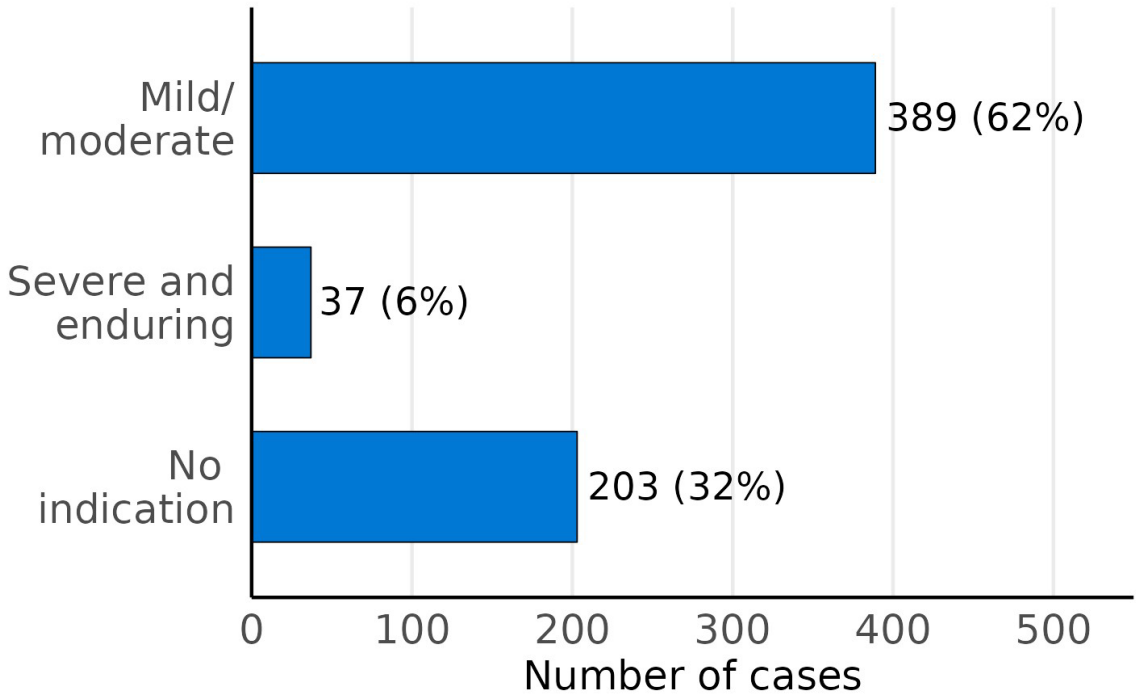


Chart 13: Existing mental health treatment at the time of screening across 29 ADP areas – Scotland 2024

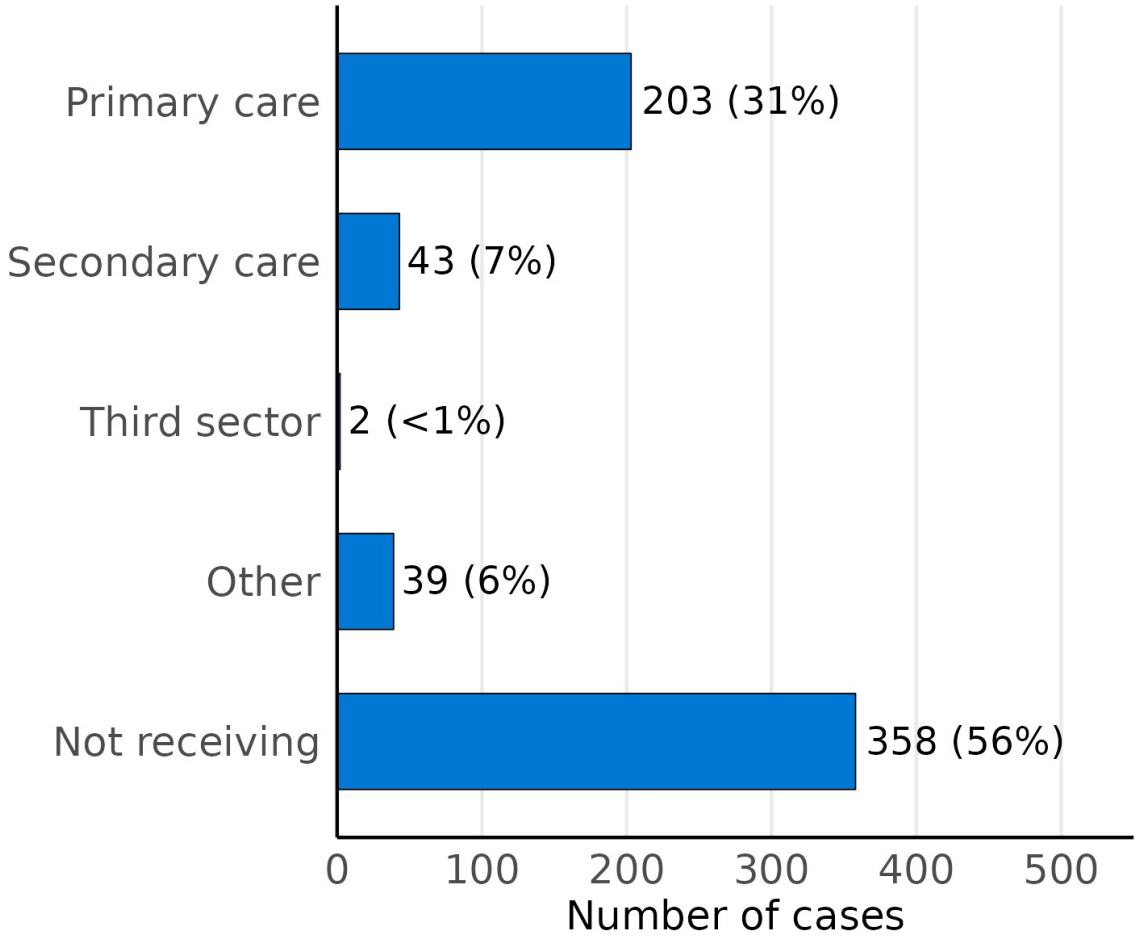
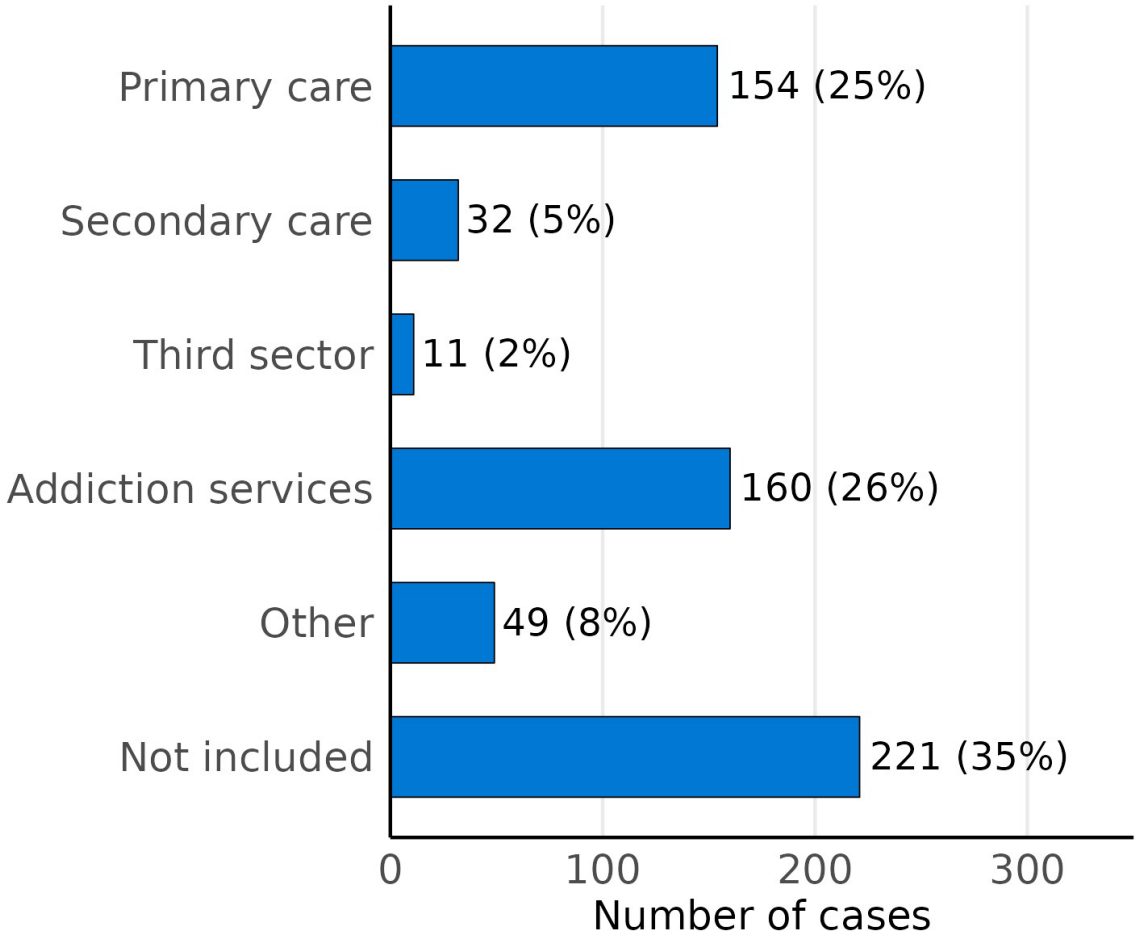


Chart 14: Mental health treatment agreed in care plan with the service user across 29 ADP areas – Scotland 2024



All groups interviewed felt there was a gap in mental health services. Staff feel there is a lack of training and a lack of psychiatrists or psychologists wanting to be involved in the addictions field and being on site. Staff pointed out that third sector services are not well linked in with addiction services leading to underuse of this helpful resource. People accessing treatment for mental health issues? found long waiting times even with a referral and staff said this results in a waste of resources as people receive treatment inappropriately or when no longer required.

The experiential and numerical data gathered so far suggests that although most ADP areas have documented procedures for joint working it is not clear that these are effectively implemented and benefit people.

'They definitely ask how I'm feeling, and don't just accept fine as a response. They really care and they want to help' (person accessing treatment)

'Yes, staff are generally great, but I don't feel that they take the individuals mental health into consideration' (person accessing treatment)

'They always ask how I am feeling as they are aware of my mental health difficulties' (persons accessing treatment)

4.5. Implementation of MAT standards 1–10 in justice settings

In January 2024, the PHS MAT programme hosted a conference to share examples of good practice implementing the MAT standards in prisons and other justice settings across Scotland. All the data presented below are from case studies conducted and reported on by colleagues in justice healthcare and demonstrate that specific standards can be implemented in justice settings. The work was supported by the PHS MAT programme, but data and processes have not all been independently verified by PHS.

MAT 1: HMP Edinburgh

The standard was implemented by changing clinical processes to ensure that people currently prescribed OST and people not currently prescribed OST in the community would have rapid access to treatment. This was enabled by additional staff recruitment.

All people admitted to the prison in the evening have an initial assessment by a registered nurse with an advanced nurse practitioner (ANP) undertaking a detailed assessment of the person's health, drug and alcohol histories the next day. Previously, residents not in receipt of OST prior to entering prison had to keep a diary

recording their drug use for at least two weeks before starting OST. Those waiting could be involved in unstable drug use, build up drug-related debts and be at much greater risk of drug overdose and BBV infection.

The process has changed and increased staff capacity have resulted in most people starting OST within 72 hours of admission and there are no reported waiting lists for substance use services.

Main components of the rapid access process map

- Following positive drug analysis, an ANP undertakes a patient review. For residents prescribed OST before admission, the ANP contacts the named worker and local pharmacy to confirm drug dosage and last dispensing date before custody. The dosage can be prescribed on the same day of confirmation, if last dispensed within three days of custody. If the time lapse was longer, the ANP seeks agreement from the named worker to continue prescribing and starts re-titration. For example, if John Smith did not pick up his daily methadone dosage (50 mg) within five days of entering custody, he could start on 30mg before titration to 50mg.

- When residents with a recent heroin or opiate history seek treatment, the ANP confirms their home address and contacts the nearest local OST service. If the service agrees to continue prescribing after future release, OST can begin on the same day with low dose titration towards an optimal dosage. If OST service agreement was not obtained, in the meantime residents will be offered drug detoxification to ease withdrawal symptoms.

- Longer-term residents with a sentence over two years can be fast-tracked on to OST in prison. On release some residents may choose to move to a different home address. In these cases a relevant community prescriber will be contacted to provide continuity of care.

- Other support options include referral to the addiction team or a local third sector provider (**Change Grow Live**) at any time, and access to dihydrocodeine detoxification for those wishing to discontinue OST.

- On liberation, the same processes would be adhered to, if the resident had been prescribed OST on entering custody. The prison addiction team would be informed of the liberation date. The person would be invited to discuss support, including continuation of a drug prescription if required.

- The addictions team, ANPs and senior charge nurses will see any residents seeking support. The addictions staff are available weekdays, senior charge nurse on weekdays except Thursday, and ANPs from Monday to Saturday. All staff are available between 7am and 5pm.

Key learning points

Timely sharing of community prescribing data can enable rapid access to OST prescribing in prisons.

Prescribing choice remains a challenge, as HMP residents are only offered methadone or long-acting injectable buprenorphine. Oral buprenorphine is not offered but it is worth noting that this has a high commodity value in prison and there may be a risk of diversion.

Workforce commitment to new ways of working, addressing staff capacity and upskilling staff through training were important factors in taking this new work forward.

MAT 2: HMP Shotts

Prison healthcare staff liaised with the MAT standards lead at NHS Lanarkshire to adapt MAT 2 standard operating procedures developed for community services. This was supported by regular staff meetings and input from the PHS MAT programme.

A survey was undertaken with 16 residents prescribed long-acting injectable buprenorphine for more than six months. Prescriptions were initiated in the community or the prison. The majority (15) of residents spoke positively about the therapeutic benefits with only one expressing negative views. People fed back that not having to take a drug each day led to positive identity changes and one person

said they 'forgot' they were on prescription drugs. One person spoke about suppressed emotions returning after decades of being prescribed methadone and another described the challenges of revisiting old memories.

The survey will be repeated over the next year with plans to share learning at the new prison recovery hub. Residents' views on the other MAT standards and care will be sought at that time.

Key learning points

Continuous feedback can help enhance service delivery by providing valuable insights into lived experiences and the impact of prescription choice on wellbeing within a prison setting.

Prison-based and community-based staff can work together by using MAT resources and learning to support the implementation of standards in prison settings.

MAT 3: Police custody suites and liberation in Inverness and Fife

Inverness – MAT pilot at custody toolkit

In 2023, the Police Custody Healthcare Team in NHS Highland identified that 52% of patients in police custody at risk of drug-related death were not referred to healthcare services for support. The MAT pilot at custody toolkit (MATPACT) was created as an innovative approach to proactively identify those at risk and offer health interventions. Burnett Road Primary Custody Centre in NHS Highland was the location for this approach. It typically has one nurse on duty per 12-and-a-half-hour shift for the 42 cells in the centre.

Prior to starting the approach during admission all people in custody who confirmed drug use during vulnerability screening were not routinely offered a referral to healthcare – a referral was generated by police for immediate health interventions only. This meant there was no focus on harm reduction, missed opportunities for early intervention or referral to specialist teams and inequitable access to care.

The aim of the change was to reduce missed opportunities for referral to the custody healthcare team. The healthcare team and the police conducted a process mapping and fish bone analysis to identify underlying causes of missed opportunities for referral and a driver diagram was developed to clarify the theory of change. A tool kit to deliver the proposed changes was developed and police and healthcare staff were offered training in the MAT standards and quality improvement methodology by the ADP strategic lead.

Results

During the test of change, there was a comparison of referral data six months prior and six months during MATPACT. There was a 12% increase in referrals to custody healthcare, the uptake of take-home naloxone increased from 4 to 75 after 14 weeks period and BBV testing increased.

The main barriers encountered were working with the multiple systems used between the police and health care and navigating different information sharing agreements so that improvements could be measured. Effective partnership working with police and healthcare helped with some of the barriers.

Feedback from people in custody and staff

'This feels like the first time anyone has bothered to talk to me about my drug use in a way that isn’t judging'.

'I never realised the police cared about treatment to get me off heroin'.

Key learning

All staff needed to be involved from the start of MATPACT to promote ownership and empower staff to continue to promote change.

It is important to take a quality improvement approach with a clear aim, service mapping, fishbone analysis, a driver diagram and outcome, process and balancing measures identified and monitored.

It is necessary to create the conditions for improvement to happen, this includes adequate staffing levels, empowering staff ownership, transparency, and a shared vision.

It is essential to get feedback from staff and people in custody about their experiences of the service.

There is great value in a skills mix – bringing different skills and experiences together. The MATPACT project involved a team of dynamic people including a drug and alcohol recovery service strategic lead or quality improvement lead, a policy custody service manager and a senior charge nurse.

Fife – Multidisciplinary liberation meeting

Supporting individuals being released from custody and reintegrated back into their communities is one of Fife ADP's strategic priorities to reduce drug-related deaths and prevent re-offending. Data from drug-related deaths in Fife in 2021 found that 73% of the 70 people who died were known or currently involved with criminal justice services. Fife does not have a prison in the local authority area and although a commissioned service does provide support to those being liberated, there is not a multi-disciplinary approach for every person on a short-term or remand sentence.

To address this gap, Fife ADP propose setting up a liberation meeting for people coming to Fife from custody to help them integrate into health and social care systems and the community. The aim is to co-ordinate support for those returning to Fife from a short-term (under four years) sentence or on remand. This could mean arranging support with housing, medication, benefits and substance use as well as support with their mental health and emotional wellbeing, as they cope with the transition back to their community. The liberation meeting would be a multi-disciplinary meeting made up of NHS addiction services, housing services, a specialist social work team supporting people who use substances (COMPASS), Scottish Prison Service (SPS), Department of Work and Pensions (DWP), Scottish Association for the Care and Resettlement of Offenders (SACRO), Criminal Justice Social Work (CJSW), and third sector partners such as ADAPT and Pheonix futures.

Underpinning this approach, the meetings are person centred with individual consent obtained by the services supporting liberation. The individual will be offered feedback from their worker and encouraged to play an active, contributing role to support their planned return to the community.

The planning meetings would be held via Microsoft Teams every Wednesday 10am to 11am. The plan is that SPS provide Criminal Justice Social Work and housing with a weekly list of all individuals due to be liberated within 12 weeks and who have been newly admitted to custody. The list would then be shared in advance of the weekly meeting with members of the forum with responsibilities to understand the circumstances of the individual on their systems and bring intelligence and updates to the group.

During the meeting, the person's circumstances will be discussed including accommodation, throughcare engagement, substance use, training, benefits and employment. Recommendations for actions are made in terms of further or ongoing support if required.

Next steps

This intervention is proposed for three months, and evaluation will include the time commitment of staff and the number of individuals liberated. At the time of writing, this proposed intervention still needs services to sign-off on the information-sharing protocol.

MAT 4: Greater Glasgow and Clyde and Forth Valley

Three prisons in Greater Glasgow and Clyde (GGC)

In 2021, Scottish Drug Forum in partnership with NHS Greater Glasgow and Clyde Prison Health Care Team at HMP Barlinnie were awarded Corra funding to undertake a test of change. The aim was to expand the uptake of take-home naloxone using Nyxoid (a nasal spray) and a peer mentoring model, and to include people being liberated from prisons (and their family members).

The project was later expanded to address the gaps in support for people who had been placed on the SPS Management of offender at risk due to any substance (MORS) policy because people on MORS were not routinely referred for harm reduction or health care support, which missed opportunities for early intervention and referral upon liberation. The team aim to meet with people within 72 hours of being removed from SPS MORS observations, which is a key criterion for MAT standard three.

The funding for this project ended in November 2022, however motivated staff members within NHS Greater Glasgow and Clyde Prison Health Improvement team managed to secure further funding until March 2025, to expand the model to all three prisons within Greater Glasgow and Clyde: HMP Barlinnie, Low Moss and Greenock.

Results

The team now offer take home naloxone to all planned liberations using the peer led model. The spread of take-home naloxone has been significant with over 775 Nyxoid being supplied through this team with 613 (80%) being a first supply.

The changes ensured that when someone is placed on the MORS policy this is documented in a GP diary so that the harm reduction team can pick this up as a referral within 72 hours of being removed from observations. At the first engagement, people are informed that they have been referred either because of their recent drug use, or as a self-referral and invited to attend a structured information programme sharing harm reduction messages on poly substance use, myth-busting, identifying signs of overdose, and education on take home naloxone. Information sessions also raise the issues of how to manage risk from BBV and how to maintain positive sexual health. People can be referred to other harm-reduction and recovery-focused services, as well as accessing more tailored psychosocial support from the harm reduction team. As the Harm reduction team is part of the health improvement team in prison, everyone engaging with the service is made aware of the opportunities available through the peer mentor programme and the training opportunities and social connection that this role provides.

During 2023, the harm reduction service received over 2770 referrals either through the MORS policy or self-referred. Only 24% of this population was known to the health care teams, therefore the pathways are now identifying and offering support to all those at risk of all drug harms.

This model of care demonstrates that access to care (MAT 1), notification and response to risk (MAT 3), harm reduction advice (MAT 4) and psychologically informed care (MAT 6) can be offered for people on MORS and to the wider population at risk.

Some of the barriers experienced in service delivery were:

- demand for the service exceeds the capacity for a small team resulting in waiting lists for the group model or 1:1 support
- short term funding makes delivery difficult due to fixed term posts and difficulties in future planning despite the success of the project
- engagement with community teams is essential to ensure the seamless transition for people back to the community settings
- partnership working with SPS and prison healthcare helped with some of the barriers
- funding is only secured on a short-term basis. Further discussions with NHS Greater Glasgow and Clyde are ongoing

Feedback from people in prison

'I had lost everything my world came crushing down on arrival to establishment a decision was made to get help and I sought the help of the Chaplain. If training is delivered through staff, residents are not open to it. However, peers delivering training is more likely to generate interest with training better accepted. I believe Naloxone training saves lives.'

'I am aware of two residents who have used kit in the community that was given here.'

'Best thing that has ever happened, confidence, self-belief in and people skills has improved. Will be able to help others with awareness especially safe use of drugs.'

'I was administered Naloxone in 2021 and went on to be one of the first members of the peer mentoring training group. I now deliver training for trainers.'

'Usually when one resident sees another resident offering Naloxone training, uptake is better.'

'Harm reduction helps, there are conversation about drugs- there have however been temptations to get ‘high’. Harm reduction helps with controlling the temptation.'

'I don’t want to see anyone die through drugs.'

Key learning points

Implementing a standard (MAT 4) in prison settings can be a catalyst for other standards, such as improving access (MAT 1), identifying and offering support (MAT 3), and psychosocial interventions (MAT 6).

Providing residents sessions and training can be an empowering step towards college or moving into work. Giving back was important with one resident administering take home naloxone to his brother. The model could be extended to support prisoners’ general wellbeing.

Continuous feedback can tackle stigma and identify areas for improvement such as engaging people liberated from courts, raising awareness of synthetic opioids, expanding the take home naloxone prison programme to family and friends and extending the model across all prisons.

It is necessary to create the conditions for improvement to happen; there needs to be adequate staffing levels, empowering staff ownership and a shared vision.

Demand exceeds capacity so to further develop the model of care and share this work across the prison estate and communities long-term funding is required.

Police Scotland and Transform Forth Valley Assertive Outreach Service, Forth Valley

Transform Forth Valley (TFV) offers services to support individuals and families to prevent drug harms. Transform also provides support for homelessness, hoarding, early intervention with young people and assertive outreach in partnership with Police Scotland.

The TFV assertive outreach service was rolled out in 2020. The Vulnerable People Database allows police to refer people at risk to a dedicated TFV worker who can outreach to people at home or in a healthcare facility. The TFV worker also has a base in the police station and undertakes joint foot patrols around hotspot areas of anti-social behaviour, criminal activity, public drug use, public alcohol use and known areas of rough sleeping.

The key aims are to identify people with complex, unmet needs, provide support to reduce barriers and enable engagement with substance use services and wider support. The harm reduction interventions can include providing take-home naloxone kits, offering BBV testing and support for access to social work services, money advice and housing.

Results

The TFV worker received 301 direct Vulnerable People Database referrals between January 2023 and December 2023. These led to 209 home visits, 92 supportive telephone calls and 160 referrals into other relevant services.

Key learning points

Close working and information sharing between the police and third sector is possible. It can lead to effective joint working to identify people at risk and to offer assertive outreach and harm reduction interventions to a person in flexible locations.

More investment in early intervention and prevention work at all levels (health, social, justice, housing and welfare) can close the gaps and ensure that people get the help they need to improve life chances.

MAT 5 and MAT 6: HMP Shotts and HMP Addiewell

Low-level psychological interventions supported by trained staff within recovery cafes, peer-to-peer support and groups co-facilitated through in-reach by local recovery groups enable residents to build social networks before liberation which can help retain people in care during the transition back to the community.

HMP Shotts has employed two recovery officers, a health and wellbeing frontline manager and identified a dedicated hub for recovery groups and activities. HMP Addiewell has also set up a dedicated recovery space and recently recruited a lived experience addictions and recovery manager. Peer models in both prisons ensure that trained residents can engage and support others in the relevant halls and through the recovery hubs.

An example of success in HMP Shotts is of a former resident who engaged with the recovery café while still on a drug prescription. They accessed peer support, attended Cocaine Anonymous and engaged with Recovery Coaching Scotland and the Scottish Recovery Consortium. As part of their journey they now serve as an influential peer mentor for many people across different prisons.

Key learning points

Recovery and peer support models developing across the prison estate should be consistent and follow a person's journey throughout the justice system and back into the community.

MAT 8: advocacy for prisoners in Perth and Kinross

Independent Advocacy Perth and Kinross (IAKP) has been working in HMP Perth and HMP Castle Huntly for 10 years. IAKP receives funding to support the legal requirement under the Mental Health Care and Treatment Scotland Act (2003)

stating that people with a 'mental disorder' have a right to access independent advocacy.

The organisation advocates enabling people to share their views without being influenced by others. Adopting trauma-responsive practice, advocates contact professionals to clarify or request information on the person's behalf to support discussions. IAKP provides part-time (21 hours) advocacy services to residents in both prisons, and anyone can make a referral. The referrals mostly relate to prisoners who have drug or alcohol issues. HMP Castle Huntly's substance use team have historically been good referrers.

Advocacy case study

Moving away from hometown

Sometimes a resident may wish to move away from their hometown to a new area after liberation. Often people are offered permanent accommodation in their hometown but only temporary accommodation, such as a hostel or bed and breakfast, if moving elsewhere.

Independent advocacy can help residents liaise with community social work and housing so that individuals can make an informed choice, understand the type of temporary accommodation offered and reflect on how they make cope – for example if people around them in temporary accommodation were taking substances.

Key learning points

Collaborating with prison healthcare staff enhanced the role of third sector advocacy services supporting residents' mental health and wellbeing.

The current referral process could be improved at HMP Perth as there are limited referrals compared with HMP Castle Huntly.

Staff and funding capacity is a key issue due to the limited number of hours available to provide support and there is a need to address the lack of independent advocacy services to support residents in Scottish prisons.

5. Discussion

Implementation

The assessment of implementation is based on the evidence submitted by ADP areas and this evidence is scored against defined criteria to construct the RAGB score. Full implementation means that the criteria agreed have been met for the year of assessment. This does not mean that all people who request care receive it to the agreed standard all the time – that needs to be confirmed by experiential feedback and other person-centred measures.

In the 2021/22 report there was considerable unwarranted variation in implementation across the ADP areas but in 2023/24 there is good evidence of consistency. For example, in 2022 MAT standard 1 was assessed as red in 17 ADP areas, amber in 11 and green in one, whereas in 2024 MAT standard 1 is green in 23 ADP areas and provisional green in six. Also, the majority of ADP areas are green for standards 1–5 (88%) and provisional green for standard 6–10 (90%).

This indicates that there is now a high degree of national consistency in terms of clinical processes, attainment of numerical benchmarks and progress with implementation of an experiential programme.

Progress in prisons is at a very early stage but evidence is beginning to demonstrate local innovation and proof of concept and that it is feasible to implement the MAT standards in prisons. However there has been no systematic approach to national coordination, implementation, evidence and benchmarking across justice settings and therefore it will not be possible to demonstrate that MAT 1–10 will be fully implemented in justice settings by the end of phase 3, in April 2025.

Intelligence-led services

People with lived and living experiences of problematic drug use often experience multiple exclusions. Determining and responding to the needs of excluded people can be difficult because membership and experiences of at-risk populations are not

often included in health information systems (**Aldridge et al., 2018**). However, evidence is required to demonstrate where improvement is needed and to demonstrate that improvement has happened. People with lived and living experience of problematic drug use have been clear that they want evidence of change.

The process of gathering, reviewing and reporting evidence is an essential part of the improvement process: It requires partnership working, relationship building and information sharing across multiagency teams; highlights gaps in funding, staffing and training; helps to develop systems; and involves people experiencing problematic drug use. These are key components of what needs to be done for improvement to happen.

In the 2021/22 assessment there was limited evidence available from most ADP areas that could demonstrate what the systems of care were, the experiences of people involved and the things that needed to improve. This is because there were no national systems in place to gather the information required: multiple different databases were used to collect and report on numerical data; systems to include people with lived and living experience were often weak; and sufficient documentation such as policies, guidelines, plans and standard operating procedures were only available for 39/145 (27%) of standards 1–5 across the 29 ADP areas.

In the last 3 years the PHS MAT programme has provided clinical support to establish processes, developed automated spreadsheets and Research Electronic Data Capture (REDCap) for numerical data reporting and provided training, tools and advice for experiential data collection.

The 2023/24 assessment shows that all ADP areas now have established systems to collect and use evidence to implement the standards. For MAT standards 1–5, 97% of process scores and 94% of numerical evidence scores submitted was fully compliant with the criteria set out in the MAT standards and for standards 6–10 this was 67% and 94%. Nearly all ADP areas were able to demonstrate key components of an experiential programme. This included analysed data from 1,074 interviews carried out with people seeking treatment, service providers, family members and nominated people; and from a further 474 people who provided feedback through

methods, such as questionnaires, surveys and group work. ADP areas are using the evidence gathered for continuous quality improvement and without this work improvement would not have happened.

Evidence for the effectiveness of implementation requires intelligence on person centred outcomes. This is beginning to happen through the ADP experiential programmes. Analysis of aggregate feedback from the 29 ADP areas indicates that people using services felt there have been fewer delays in accessing treatment, more support to choose different types of OST, good access to harm reduction at the MAT appointment and that they felt cared for and supported by their workers to stay in treatment for as long as they needed. However, there is variation in these experiences and people identified gaps in trauma-informed care or infrastructure, communication, holistic care, mental health care, crisis management and, crucially, staff capacity to resolve these issues. Experiential data also highlights the local nuances that numerical data cannot capture, for example delays between MAT assessment and OST prescription even in areas where 75% of people are assessed within one day of presentation. The experiential programmes in ADP areas need to continue but also tools such as the **Outcome Star tool** could be better used to capture and improve peoples' experiences as could processes for learning when someone dies as a result of drugs.

To ensure sustained improvement, there need to be a balance between resources used for evidence gathering and resource for delivering improvements. **A national survey of frontline staff conducted by PHS** as part of the evaluation of the National Drug Mission identified high levels of awareness and knowledge of the MAT standards (96% aware, 83% knowledgeable) and evidence of positive impacts on practice (just over half agree they can now offer better MAT support, one in five disagrees). But people also note negative impacts on services: data burden, additional pressure and a focus on targets rather than client needs with implementation of MAT standards at times resulting in ways of working that don't make clinical sense to staff, for example overreliance on prescribing. The unintended consequences of implementation and evidence collection need to be addressed for the next cycle of improvement.

Until national integrated systems are in place to support evidence gathering, PHS will continue to support the Excel and REDCap tools used by ADP areas and based on the data definitions and lessons learned to date will make recommendations to colleagues developing the PHS Drug and Alcohol Information System (DAISy) and VISION (a clinical information system used in primary care, including in prison settings) to help services report on the MAT standards. If these systems are not ready to become 'business as usual' by the end of the Drugs Mission there is a risk that due to the burden of manual and 'ad hoc' data systems used for the MAT standards, data for local improvement and national benchmarking will be incomplete, inconsistent and unable to support sustained standards of care.

Justice

The case studies in the report demonstrate that effective partnership work can support the implementation of the standards in justice settings.

There is evidence of systems that increase access to OST (within 72hours in HMP Edinburgh), identify hidden needs (in HMP Barlinnie 24% of people referred to harm reduction from MORS or self referred were known to healthcare teams) and reduce missed opportunities for early intervention and harm reduction (in Inverness MATPACT there was a 12% increase in police referrals to healthcare and increases in BBV testing and take-home naloxone supply, in HMP Barlinnie 80% of take-home naloxone was first supply). In HMP Shotts and HMP Addiewell, staff with lived experience of substance use support dedicated recovery spaces. In HMP Perth and HMP Castle Huntly, systems enabled IAKP to improve access to independent advocacy and in Forth Valley the police and TFV worked together to provide assertive outreach services.

Local approaches are at different stages of development and scale. For example, a multi-agency community justice model to support people liberated into Fife is at the planning stage whereas the improved systems for harm reduction support in NHS Greater Glasgow and Clyde extends across all three prisons in the area.

An important lesson learned from the work so far is that the 'simple' act of establishing communications and referral pathways between professionals and

agencies can dramatically improve access to care and that the involvement of people with experience of substance use can help ensure that this care meets peoples' needs. This process can also help to link together aspects of the MAT standards into holistic care, as demonstrated by the model in HMP Barlinnie where access to care (MAT 1), notification and response to risk (MAT 3), harm reduction (MAT 4) and psychologically informed care (MAT 6) can be provided together for people referred through MORS.

Factors that are common to all the successful improvements are that they are led by dedicated and enthusiastic people, involve multiagency collaboration, make use of diversity and skill mix, have taken a quality improvement and whole systems approach and ensure the participation of people with lived and living experience in the design and implementation.

Challenges common to all are uncertainty of resources, barriers to information sharing, demand exceeding capacity, communication between different parts of the multiple systems and the need for coordination of senior leadership across the justice and community settings.

There is scope to share the valuable learning on how such challenges can be addressed to implement the standards. Building on this learning can support further implementation to ensure that people moving through the community and justice systems will receive consistent, rights-based care and treatment.

Limitations

The RAGB assessment of each standard is based on whether the evidence submitted meets defined criteria in terms of process, numerical and experiential evidence. The assessment has been a helpful way to initiate, structure, measure and communicate improvement across Scotland and will continue to be used for the duration of the Scottish Government Drugs Mission to demonstrate sustained implementation (e.g. RAGB status 'blue').

However, there are limitations.

While RAGB green (fully implemented) means that the criteria agreed have been met for the year of assessment, this does not necessarily give a comprehensive picture of service delivery and does not mean that all people who request care receive it to the agreed standard all the time. It is the start of full implementation not the end point.

There can be a mismatch between the experience of an individual and what the process and numerical data may tell us about a system and a population. For example, even where numerical and process data for MAT 2 indicates that choice is available this may not be the experience of all individuals and experiential data suggests that what service providers regard as trauma-informed care is not always the same as what people say they experience.

Some of the numerical data described in the report do not accurately reflect what is happening in terms of individuals' experiences of care. For example, the intention of MAT 7 is to ensure that people can access holistic multiagency care but what has been measured this year is the number of people prescribed OST by a GP which is only one small part of shared care and may not be needed by some people as part of their care plan. There are also different models of care and different ways to collect data, so the figures are not always comparable.

Similarly, the variation in data presented on the proportion of the workforce trained for MAT 6 and 10 is at least partly because of different local definitions of training and the workforce surveyed. As data on discharges are difficult to collect, MAT 5 is assessed using case retention for six months instead.

These limitations mean that some data serve as a proxy and a prompt for effective implementation rather than confirmation.

All this makes it difficult to combine these data into a summary RAGB score and a judgement needs to be made about the 'facts' and whether these are interpreted as effective implementation. This means that there is only so far to go with national benchmark setting and RAGB allocation especially for complex interventions such as standards 6–10 where a limited set of indicators cannot describe the complexity of delivery and where there is a lot of warranted variation in models of care and methods of evidence collection.

The PHS MAT programme can identify and benchmark against key components of a standard that should be in place for consistency. Thereafter, the nuances of full and effective implementation and the monitoring of this is the role of local systems which are better placed to interpret local evidence and place a value on that.

For these reasons, over the next two years the PHS MAT programme will move towards less evidence gathering. The programme will continue to support the systems that have been set up locally to collect evidence and improve services but there will also be a focus on supporting structured and reflective assessment by local teams against agreed guidance and this can be validated where possible with existing national and local evidence. The programme will also continue to support the collection of representative feedback from people on their experiences of services because this is crucial to assess the extent to which implementation of the standards is effective.

Adaption

Since the start of the programme in 2021, opioids have predominated as contributors to drug-related deaths and this continues with opioids implicated in 82% of all deaths in 2022. However, over recent years there have been increasingly toxic combination of polydrug use, and data shows benzodiazepines implicated in 57% of all deaths, followed by cocaine in 35% and gabapentin or pregabalin in 35%. More recently, new potent synthetic drugs like nitazenes present very high risks of overdose, and others like xylazine can cause serious skin and soft tissue infections when injected.

In a paper by Andrew McAuley, et al. 2023 about survival in drug treatment makes it clear that we need to respond to the polysubstance use challenge with holistic care, harm reduction and a human rights-based approach. In a **national survey of frontline staff, undertaken by PHS** as part of the **evaluation of the National Drug Deaths Mission**, more than seven in 10 respondents asked for better treatment options for those who use drugs other than opioids.

There is an urgent need to adapt models of care to the needs of people at risk. The MAT standards provide a framework but need continued resourcing and evaluation of how to evolve and deliver complex evidence-informed interventions such as

psychological therapies and shared care with mental health, third sector and primary care teams.

To do this effectively it is necessary to resolve information governance and data sharing barriers between partners at national and local level. This will ensure sustained workforce development and that there is a clear national strategy for leadership to make this happen.

To reduce drug-related deaths, an ultimate goal of improving MAT standards, there is a need to address the wider issues of multiple deprivation and exclusion which is experienced by people most at risk of premature death.

6. Sustainability and risks

The core components of the standards are now established in the community in most ADP areas.

However, the main risks identified in the 2021/22 report are still present.

There is a risk that partially implemented strategies to improve access, choice and care will fail because without full implementation, the system will be unable to meet the requirements of people that are identified, and improvement will not be sustained. As a result, the standards will not meet their aim of reducing drug-related harm.

There is a risk that although interim systems to collect numerical and experiential information have been set up by ADP areas and the PHS MAT programme these will not be adapted, sustained or manageable with current workforce capacity. This may mean that data for improvement work are not available and the improvement cannot take place.

As a result of uncertainties about continued funding of the MAT programme (including ADP services) beyond the initial project term of March 2026, there is a risk that the discontinuation of part, or all, of the funding could lead to a decrease in the quality and quantity of care that can be provided. This is particularly an issue for areas that have sought funding to strengthen existing ways of working (as opposed to creating separate service structures for parts of the standard delivery).

There are also new risks.

While full implementation of the MAT standards are necessary to reduce drug-related deaths, this is not sufficient on its own because it is one small part of what needs to be done. For example, there is a need to reduce inequalities in wealth and opportunity; tackle deprivation and trauma in early years, to improve the quality and access to other treatment options, such as residential rehabilitation; and ensure there is a human rights-based approach to the whole system of care for people affected by substance use.

The lack or reduction of public sector funding in the wider systems leads to greater potential unmet needs and more people presenting with multiple complexities, especially with respect to housing, policing, welfare and income. Reduced public sector funding can also result in a return to siloed working approaches and a reduction in effective pathways for providing early intervention or addressing wider support needs.

Barriers to information sharing as and a lack of a clear national strategy for workforce and leadership development put the sustainability of the work in question. This is because multiagency, patient-centred care depends on sufficiently trained workforces being able to share information so that they can respond to people's needs at the right time and with the range of options that people want.

The implementation of MAT standards in justice settings is at a very early stage. There are some early adopters doing very innovative work and overcoming local challenges. However, to scale this up so that all people involved with the justice system have equitable, consistent and sustained care in line with the MAT standards will require a major step change in leadership, resources, workforce, coordination and culture, particularly, but not solely, in justice settings.

The risks set out above: (1) partial implementation that does not adapt to emerging needs and priorities; (2) national data systems that are not set up to sustainably collect and report on improvement, performance and experiential outcomes; (3) lack of public funding to address the wider determinants of health and the complex needs of people at risk; (4) unclear strategies for information governance, workforce and leadership; and (5) uncertainty about sustained investment, especially in the workforce. All of these add up to the clinical and public health risk that if implementation of the MAT standards is incomplete and not sustained they will not be able to help reduce drug-related deaths in Scotland.

7. Conclusions

To support the rapid implementation of the MAT standards in the community, the PHS MAT programme has combined local clinical support and structured evidence collection with national benchmarking. So far this has led to a prioritisation of drug care and treatment by IJBs and this means that ADP areas have demonstrated a year-on-year improvement in substance use work in the community. But now the main components of the standards are in place the emphasis needs to shift away from national comparisons towards local improvement journeys.

Progress in prisons is at a very early stage because there has been no systematic approach to national coordination, implementation, evidence and benchmarking across justice settings and therefore MAT standards 1–10 will not be fully implemented in justice settings by the end of phase 3, April 2025.

The extent to which an experiential programme is in place has been used to contribute to the RAGB assessment of implementation of the standards. However, experiential feedback from people using services is needed to assess the outcome of implementation (whether implementation is effective and provides benefits) and this is something that should be developed by local teams with support from PHS.

Experiential evidence is beginning to indicate that there are improvements in access, choice and care but gaps include-trauma-informed care and infrastructure, communication between multiagency teams and between service users and providers, holistic care, mental health care, crises management and, crucially, staff capacity to resolve these issues.

The approach to implementation has sometimes resulted in an emphasis on delivering a medical model of care for a subgroup of people affected by substance use – those using opioids and requesting OST. This is contrary to the intention of the MAT standards. Although OST was a priority at the time the standards were written, and an essential part of the improvement needed, medicalisation is an unintended consequence of the local resources and priorities allocated to certain standards and of the evidence requested to demonstrate progress, which has focused on OST for MAT standards 1 and 2.

To remain relevant to the needs of people affected by substance use, the approach to the MAT standards needs to ensure holistic care, meet the needs of people using multiple substances, be implemented in justice settings and align with key policy developments. These include the Charter of rights for people affected by substance use (due to be published in December 2024), the National specification for alcohol and drug recovery services (early 2025) and the Right to addiction recovery (Scotland) bill (due to be published in May 2025).

The next two annual reports will need to describe how the MAT standards have been adapted to support wider substance use needs and whether the implementation of the standards is scalable to justice settings, sustainable in the community and making a difference to people.

To make these things happen, policy makers, senior clinical and senior management leaders need to ensure that there is a clear strategy for sustained funding, information governance, workforce and leadership across community and justice settings. If this is not done, the standards of care achieved to date may not be sustained and therefore unable to help reduce drug-related deaths.

8. Recommendations for 2024 to 2026

8.1. Questions

The wider partners involved in the implementation of the MAT standards, in community and justice settings, need to address the following questions over the remaining two years of the Drugs Mission:

- Given that drug-related deaths are still too high or increasing, what else needs to be done in addition to implementation and adaption of the MAT standards?
- How to develop more effective responses?
    - How to adapt to ensure holistic care and support polysubstance use?
    - How to discover, understand and respond to outcomes for women?
    - How to develop and sustain data systems to monitor service delivery for poly substance use in community and justice settings?
- What changes across leadership, workforce and systems are required to sustain and scale up implementation in community and justice settings?
    - How to resolve information governance and data sharing challenges?
    - How to ensure that chief officers demonstrate sustained commitment, for example, through allocation of long-term resource?
    - How to ensure that workforce development ensures there are appropriately skilled people to deliver services?
    - How to ensure that services are offered in trauma-informed environments and infrastructure?
    - How to help ensure other policy developments and existing national systems linked to poly substances use and drug harms are effective?

- how to align with the Charter of rights for people affected by substance use and the National specification for alcohol and drug recovery services?
- How to support the intended impact of initiatives like **the new Housing bill** introduced in April 2024?
- How to work with the national harm reduction, immunisation, health protection and BBV programmes?

- How to ensure great involvement and recognition of the third sector in the whole systems approach to care and treatment?
- How to sustain effective sharing of innovation and good practice?
- How to tell whether the implementation of the standards is making a difference to people?

8.2. Priorities for the PHS MAT programme

1. Align the programme with the Charter of rights for people affected by substance use.
    a. Review the toolkit for Charter of rights for people affected by substance use and the FAIR (facts, analysis, identification, review) model to apply the PANEL (participation, accountability, non-discrimination, empowerment, legality) principles to the implementation and monitoring of the MAT standards.
2. Adapt implementation and monitoring of the programme to poly substance use, holistic care and new policies.
    a. Produce guidance on the adaptions required for poly substance use, the need for holistic care and implementation of services in a way that mitigates the unintended consequences of the approach to date.

b. Guidance will also be aligned with the Charter of rights for people affected by substance use which is scheduled for publication in December 2024 and with the accompanying National specification for alcohol and drug recovery services scheduled to be published in early 2025.

c. Develop and support a structured self-assessment against the guidance for programme adaptations. This, with guidance on refined numerical indicators and benchmarks will enable ADP areas to score against agreed criteria and move to 'sustained implementation', RAGB status blue.

d. Agree a communication strategy so that the way the MAT standards are being implemented and adapted are understood by all partners, including frontline clinicians and other providers.

3. Share the learning from local implementation and innovation.

    a. The PHS MAT programme will work with MAT Standard Implementation Network (MATSIN) and MATSIN Justice networks, Healthcare Improvement Scotland and other partners to deliver a series of mini-conferences, workshops, webinars and network events to share innovation. This will be a combination of face-to-face and virtual events and will include statutory and third sector partners, as well as people with experience of problematic substance use.

    b. The programme will complete and disseminate the MAT 3 guidance and the justice MAT toolkit.

4. Sustain and improve the work done so far.

    a. Overall, the emphasis will shift to supporting local ownership and oversight.

        i. There is a need to ensure there is a clear transition plan for relevant programme components to local and national partners by the end of the Scottish Government Drugs Mission

ii. There is a question over what improvement support and performance management will be in place after 2026 and the need to consider options such as a national clinical audit.

b. The programme will continue to provide clinical improvement support for local implementation and reporting.

c. Work with partners to address recommendations from the **PHS evaluation of the national mission on drug deaths**

d. The numerical team will support the Excel and REDCap tools used by ADP areas for as long as needed and will work with the PHS DAISy team and with colleagues developing VISION in prison to help establish national systems for MAT standards in the community and prisons.

e. The experiential team will establish a programme of training for trainers so that ADP areas can maintain capacity to gather the experiences of people affected by substance use. The programme will align with the Charter of Rights.

Next steps for the PHS MAT programme

In April and May 2024 an informal scoping exercise was conducted with MATSIN, PHS colleagues, some members of the national thematic groups for individual MAT standards and national partners such as Healthcare Improvement Scotland. A summary of issues and ideas to consider for the main components of the PHS MAT programme is provided in Appendix 1.

An update on recommendations for PHS MAT programme from the 2022/23 report is provided in Appendix 2.

Full and sustained implementation also requires the next steps for wider partners as set out in the **2022/23 benchmark report** to be completed.

9. Implementation

Table 1: Phases of implementation of the MAT standards

Note: Shaded areas correspond to work completed and work due for completion between April 2022 and 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. • Annual benchmarking report.					

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 resources for remand, institutional culture and cross-sectoral collaboration.

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Further information

Further information and data for this publication are available from the **publication page** on our website.

The next release of this publication will be June 2025.

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Appendix 1: Proposed actions for 2024/25

Benchmarking

1. Work with partners to consider ways to maintain long-term oversight of standards of care for substance use, such as a national clinical audit.

Process and clinical

2. Review the Charter of Rights and apply the FAIR approach to ensure the programme aligns with the PANEL principles (in partnership with the Charter Change Team). This to be done for all the MAT programmes approach and includes the clinical process and experiential components.

3. Identify ways that processes can adapt to meet the needs of poly substance use, holistic care and mitigate unintended consequences of implementation to date.

4. Develop guidance on process 'adaptions' together with a structured self-assessment tool to enable ADP areas to score against agreed criteria to maintain 'full implementation' RAGB status and develop guidance on any additional numerical indicators agreed with partners.

5. Agree a communication strategy so that the way the MAT standards are being implemented and adapted are understood by all partners, including frontline clinicians and other providers.

Numerical

6. Develop guidance on any refinements of existing and additional numerical indicators agreed with partners.

7. Work with the DAISy and VISION (in prison) development teams to make recommendations about MAT data that could be included in or extracted from these systems for future monitoring and improvement work.

8. Conduct further analysis of data for improvement work and for dissemination in peer reviewed journals as appropriate.

Experiential

9. Review the Charter of Rights and apply the FAIR approach to ensure the programme aligns with the PANEL principles (in partnership with the Charter Change Team). This is to be done for all the MAT programmes approach and includes the clinical process and experiential components.

10. Set up training of trainers for experiential data gathering locally.

11. Develop a structured reflective self-assessment with guidance.

12. Summarise the themes from the evidence gathered in 2023/24 and use this to inform programme improvements.

13. Analyse the raw data from 2023 (submitted with the 2023 Benchmarking Report) at national level when capacity to do so is available.

14. Extend the experiential programme to justice settings.

Justice

15. Complete the toolkit for implementation of the MAT standards in justice settings.

16. Provide support on a case-by-case basis to early adopters to implement individual standards in justice settings with the aim to sustain, extend and disseminate good practice.

17. Emphasise the essential link with between justice and community services.

18. Support the establishment of experiential programmes – extending the community programmes into justice.

19. Work with national partners and networks, plus the MATSIN justice network to support and develop a strategy for the MAT programme and wider work.

20. Work with VISION and DAISy developments to ensure numerical data is available to enable improvement work in justice settings.

Benzodiazepines and stimulants

21. Consider a two-year programme to develop systems to implement national guidance on Benzodiazepine care in line with the MAT standards:

    - Year 1: Define data needs and develop data systems, engage and train partners, support the development of care pathways, identify resources and clarify definitions of the treatment. Definition of denominator sources and endpoints to be discussed with clinical and analyst colleagues.

    - Year 2: Support implementation and evidence collection.

22. Consider how to include stimulants in the above, since there is emerging evidence that a similar approach in terms of psychosocial and harm reduction interventions can be supportive.

23. Consider the above in terms of monitoring the offer of interventions under MAT 6 and 10 as well as MAT 1, 2, 3, 4 and 5. Improvement work in this area can include numerical and process measurements but given the lack of resources, for example to offer psychosocial interventions within one day, this should not be criteria for scoring RAGB, and progress can be assessed through reflective practice against agreed guidance as discussed above.

MAT 1, 2 and 5

24. Liaise with clinicians to advise on:

- current data needs and recommendations to the PHS DAISy group
- changes with respect to benzodiazepines and stimulants as above
- understanding the variation in prescribing of long-acting injectable buprenorphine across ADP areas and between population groups, such as by gender, age and length of time on treatment
- understanding the reasons for the relatively high proportion of unsupported and early discharges from services and to find ways to move towards the majority of people discharged from services being supported after greater than six months in care.
- including psychosocial interventions, for example, for benzodiazepine in options for 'choice'

MAT 3

25. MAT 3 thematic group to advise on:

    - current data needs and recommendations to the PHS DAISy group
    - gaps in the definition of high risk
    - completion of MAT 3 guidance.

MAT 4

26. MAT 4 thematic group to advise on:

    - the response to the changing drug use patterns, such as the emergence of xylazine and associated soft tissue infections
    - liaison with the national BBV prevention network, Immunisation coordinators and Needle Exchange Surveillance Initiative to use available evidence to validate the self-reported data from MAT 4

- alignment with the BBV elimination work
- review of harm reduction governance as required with the mission oversight group

MAT 6 and 10

27. MAT 6 and 10 thematic group to advise on:

    - clarifications of existing definitions and guidance especially around training requirements
    - Lead Psychologists in Addiction Services Scotland (L PASS) contribution to an improved structured self-assessment tool and guidance to cover all elements of MAT 6 and 10 including the parts left out last year – for example collection of evidence on the development of social networks (MAT 6)
    - what fields may be useful to include in DAISy to demonstrate access and effective care for MAT 6 and 10
    - how to deliver and monitor psychosocial interventions for people using benzodiazepines and stimulants as above (will need to include third sector partners)

MAT 7

28. MAT 7 thematic group to advise on:

    - the definition of shared care through review of peer reviewed and grey literature (e.g. processes submitted to the PHS MAT programme by ADP areas)
    - guidance on how to implement MAT 7
    - collection of numerical data on the proportion of GPs contracted to provide care for substance use and proportion of people in shared care

- improved access to training and workforce development on MAT 7 through learning events

MAT 8

29. MAT 8 thematic group to advise on:

    - updated guidance on implementation and evidence to sustain the advocacy component and introduce housing, welfare and income, for example, it may be based on a structured self-assessment against guidance as above and may include numerical requirements
    - the feasibility of complementing programme data with the Scottish Government data on housing advice and assessment
    - what fields may be useful to include in DAISy to demonstrate access and effective delivery for MAT 8

MAT 9

30. MAT 9 thematic group to advise on:

    - current evidence collection and consider updated guidance and evidence requirements
    - how to combine and make consistent the data from the substance use perspective collected by PHS with the mental health perspective collected by the Scottish Government
    - the development of the national guidance on mental health and substance use with Healthcare Improvement Scotland

Appendix 2: Recommendations for the PHS MAT programme – update from 2022–2023 benchmarking report

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

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

Action taken in 2023–24:

- Done in collaboration with ADP areas.

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.

Action taken in 2023–24:

- Ayrshire, Tayside, Highland, and Greater Glasgow and Clyde health boards submitted board-wide documentation for multiple standards.

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.

Action taken in 2023–24:

- Done in collaboration with ADP areas.

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.

Action taken in 2023–24:

- This is underway with support of the PHS drugs programme.

e) Strengthen the MAT standards implementation network (MATSIN Justice), the MAT remote and rural group and the Healthcare Improvement Scotland learning system to share learning and good practice.

Action taken in 2023–24:

- A justice conference was held by the PHS MAT programme in January 2024. The MATSIN justice meets regularly.
- The MAT remote and rural group advised on implementation during the year and is now on hold pending further work.
- Healthcare Improvement Scotland held seven webinars in collaboration with the PHS MAT programme.

f) Continue the programme of 'support to implement and report (StIR)' with ADP areas to offer clinical advice, provide online and face-to-face training and workshops, field visits and continuous support for ADP areas to collect, report and use data throughout the year.

Action taken in 2023–24:

- Throughout the year regular face-to-face or TEAMS StIR meetings were held with all ADP areas, there were national workshops held for MAT 3 and for justice and 51 experiential training sessions for 309 people.
- The MATSIN network and numerical consultation group met weekly and the national thematic groups, justice network and experiential networks met multiple times to advise on guidance and evidence collection.
- Over this period the PHS MAT programme made over 150 field visits to support ADP colleagues.

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

Action taken in 2023–24:

- Many third sector organisations have participated in the MAT programme activities outlined above. For example, organisations like REACH Advocacy have had a leading role in the development of MAT 8, the Scottish Drugs Forum has been commissioned to gather and analyse experiential evidence and **Turning Point Scotland**, **We are With You**, **Change Grow Live** and many others are crucial to the implementation of MAT 3.

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 benefiting people as a result of the changes implemented.

Action taken in 2023–24:

- The collaborative work above informed multiple modifications to guidance on implementation and evidence gathering. The benchmarking methodology has remained essentially the same but adapted to changes in assessment, for example, of the experiential programme (in response to constructive feedback from multiple partners) and MAT 6 and 10 which were joined to better reflect mental health improvement work.

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.

Action taken in 2023–24:

- It was decided in response to further advice from the Scottish Government and other partners that the MAT standards document does not need to be refreshed. However, the experiential programme was changed in response to feedback and adaption of the approach to the standards to reflect polydrug use and the Charter of Rights is a major recommendation for 2024–26.

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.

Action taken in 2023–24:

- This was done.

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.

Action taken in 2023–24:

- Guidelines on MAT 3 have been developed with the national thematic group. These will be picked up again in the summer 2024 for further development and wider consultation beyond the thematic group.

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.

Action taken in 2023–24:

- A national specification and theory of change has been developed by the Public Health Special Interest Group and reviewed by the National Drugs Related Death Incident Management Team. Letters of support have been provided to researchers who have developed evaluation funding proposals.

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.

Action taken in 2023–24:

- Procedures for offering hepatitis, tetanus, flu and coronavirus disease (COVID–19) vaccines were considered but further work is needed to support delivery and assessment of this aspect and of sexual health care.

This will be re visited in 2024-26.

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.

Action taken in 2023–24:

- This work was done in some ADP areas, but the PHS MAT programme did not coordinate this nationally.

This will be re visited in 2024–26.

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.

Action taken in 2023–24:

- A phased approach was taken for MAT 6–10.

This will be re visited in 2024–26.

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

Action taken in 2023–24:

- A review of MAT 9 evidence is underway by Healthcare Improvement Scotland to develop national guidance for MAT 9.

g) Justice – Develop a toolkit on the 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.

Action taken in 2023–24:

- A draft toolkit for MAT implementation and experiential evidence gathering in justice settings has been developed with the national MATSIN justice network.
- The toolkit has been informed by successful implementation of some MAT standards in some prisons which has been a proof of concept that MAT standards can be implemented in prison settings.
- This will be picked up again in 2024 for further development and wider consultation.

h) Justice – Conduct improvement work on MAT standard 3 across ADP areas 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.

Action taken in 2023–24:

- This has been covered as above under the MAT 3 guidance and justice toolkit.

i) Justice – Expand the national system established in ADP areas 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.

Action taken in 2023–24:

- This has been covered as above under the justice toolkit

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

Action taken in 2023–24:

- This will be re visited in 2024–26.

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.

Action taken in 2023–24:

- A national thematic review of this year's experiential evidence submissions has been undertaken and some aspects included in the 2024 report
- Further analysis will be conducted in 2024–26 once analytic capacity is available.

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

Action taken in 2023–24:

- Specific requirements were included in the guidance and process evidence for 2023.
- Further work for adaption and evidence gathering is proposed for 2024–26.

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.

Action taken in 2023–24:

- This was done. For MAT 6–10 a phased approach was taken as it was not possible to identify numerical indicators that can truly reflect the complexity of these interventions.
- This will be further developed in 2024–26.

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.

Action taken in 2023–24:

- The numerical team worked closely with ADP areas to ensure systems were in place and data were being collected. When required ADP areas were supported to review and use their data for local improvement.

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.

Action taken in 2023–24:

- REDCap data handling was implemented and used by eight ADP areas to collect data for MATs 1, 3 and 9.

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; and support to use evidence to update improvement plans.

Action taken in 2023–24:

- Following feedback received from ADP colleagues and training attendance during 2022/23 a full review of the questionnaires as well as the content and delivery process of the locality interviewer training programme was undertaken. After a consultative process this was completed and along with the revised questionnaires was relaunched in the June of 2023. An accompanying interviewer handbook was also created to assist interviewer trainees in their continued learning and competence.

- The experiential reporting requirement was also revised and there were adjustments made to the requested measures to demonstrate that the chosen experiential programme initiated was embedded and sustainable into coming years. New reporting guidance to reflect this was also issued in the autumn of 2023.

- Following an introduction period, where the experiential team provided additional advice and support to ADP's to accompany this variation to the reporting ask, feedback received reflected that these modifications have been generally well received and seen as simplifying the process, especially around the thematic analysis aspect, as well as beneficial in looking at identifying improvement planning to take into 2024/25 reporting period.

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

Action taken in 2023–24:

- The PHS MAT programme worked with prisons and police to develop methods of gathering experiential evidence and learning is included in the draft justice toolkit

Appendix 3: 2023/24 RAGB table by ADP area

Health board	ADP	MAT 1 2024	MAT 2 2024	MAT 3 2024	MAT 4 2024	MAT 5 2024	MAT 6 and 10 2024	MAT 7 2024	MAT 8 2024	MAT 9 2024
Ayrshire & Arran	East Ayrshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Ayrshire & Arran	North Ayrshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Ayrshire & Arran	South Ayrshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Borders	Borders	Green	Green	Green	Green	Green	Provisional Green	Provisional Amber	Provisional Green	Provisional Green
Dumfries & Galloway	Dumfries & Galloway	Provisional Green	Green	Blue	Blue	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Fife	Fife	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Forth Valley	Clackmannanshire, Stirling, Falkirk	Provisional Green	Green	Provisional Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Grampian	Aberdeen	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Grampian	Aberdeenshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Grampian	Moray	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Greater Glasgow & Clyde	Glasgow	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Greater Glasgow & Clyde	East Dunbartonshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Greater Glasgow & Clyde	East Renfrewshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Greater Glasgow & Clyde	Inverclyde	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green

Health board	ADP	MAT 1 2024	MAT 2 2024	MAT 3 2024	MAT 4 2024	MAT 5 2024	MAT 6 and 10 2024	MAT 7 2024	MAT 8 2024	MAT 9 2024
Greater Glasgow & Clyde	Renfrewshire	Green	Green	Green	Blue	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Greater Glasgow & Clyde	West Dunbartonshire	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Highland	Argyll & Bute	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Highland	Highland	Provisional Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Lanarkshire	North Lanark	Green	Green	Green	Green	Green	Provisional Green	Provisional Amber	Provisional Green	Amber
Lanarkshire	South Lanark	Green	Green	Green	Green	Green	Provisional Green	Provisional Amber	Provisional Green	Amber
Lothian	Edinburgh	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Amber
Lothian	Mid/East Lothian	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Lothian	West Lothian	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Orkney	Orkney	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Shetland	Shetland	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Amber	Provisional Amber	Provisional Green	Provisional Amber
Tayside	Angus	Provisional Green	Green	Green	Green	Green	Provisional Green	Amber	Provisional Green	Provisional Green
Tayside	Dundee	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green
Tayside	Perth & Kinross	Green	Green	Green	Green	Green	Provisional Green	Amber	Provisional Green	Provisional Green
Western Isles	Western Isles	Provisional Green	Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Amber	Provisional Green	Provisional Green

Appendix 4 – Publication metadata

Publication title

National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2023/24

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Help email

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Appendix 5 – Early access details

Pre-release access

Under terms of the 'Pre-release Access to Official Statistics (Scotland) Order 2008', PHS is obliged to publish information on those receiving pre-release access ('pre-release access' refers to statistics in their final form prior to publication). The standard maximum pre-release access is five working days. Shown below are details of those receiving standard pre-release access.

Standard pre-release access

Scottish Government Department of Health and Social Care (DHSC)

NHS board chief executives

NHS board communication leads

Early access for management information

These statistics will also have been made available to those who needed access to ‘management information’, that is as part of the delivery of health and care:

Early access for quality assurance

These statistics will also have been made available to those who needed access to help quality assure the publication:

Appendix 6 – PHS and official statistics

About PHS

PHS is a knowledge-based and intelligence driven organisation with a critical reliance on data and information to enable it to be an independent voice for the public's health, leading collaboratively and effectively across the Scottish public health system, accountable at local and national levels, and providing leadership and focus for achieving better health and wellbeing outcomes for the population. Our statistics comply with the **Code of Practice for Statistics** in terms of trustworthiness, high quality and public value. This also means that we keep data secure at all stages, through collection, processing, analysis and output production, and adhere to the Office for National Statistics '**Five Safes**' of data privacy.