Public Health Scotland

National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2024/25

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Planned developments

Over the course of the MIST programme, we are continuing to develop this report which means that the measurements employed within are subject to annual revision. This is to ensure that we can accurately monitor progress of MAT standards implementation in light of changing trends in drug use and other factors.

Contents

Foreword from Peter J. Cochrane, Development Officer, Falkirk ADP.

Recovery of any kind does not happen in a vacuum. Substance use recovery is no different, the path is built on the tireless efforts of those who made what once seemed impossible, possible. As someone who has walked that same path, I feel privileged to now contribute to the work that will lead the way for those still to come.

The scale of the MAT standards benchmarking report is shaped by those same efforts, and by the deep collaboration needed to bring the standards to life. From their inception to where they stand now, the commitment behind this work goes far beyond what any report, this one included, can fully capture.

The progress reflected in this report tells the story of where the MAT standards sit at a national level, but it's easy to lose sight of the people behind the numbers. Every data point represents a life. Progress in any area should be recognised as real, positive change for someone, no matter how small it may seem.

We know that even the smallest shift, when rooted in care and compassion, can lead to profound and often life-changing consequences. Especially for those who have not always had that support available to them.

But those same data points also reveal where progress has yet to reach. Across the country, there are still areas where care must improve. Importantly, we must remember that services are not responsible for changing people, but they can support that process. No level of access alone can create change. However, when that readiness comes, it is essential that this care is ready and right, regardless of the substance, so that when someone chooses to change, they are offered the same opportunities that have transformed so many other lives.

Experiential data is an important part of the MAT Standards. It reveals detail that numbers cannot and offers personal insights into a person's journey. We should be incredibly grateful for this candour. By recognising where it is helpful to listen to lived

experience, and listening with curiosity and intent, we can better understand where change is still needed, and how to get it right.

The MAT Standards are but one component of care, that should part of a wider person-centred approach to treating substance use in any form. If the efforts to bring the MAT Standards to life were replicated, and embedded across all areas of substance use support, and indeed across health and social care more broadly, our country could truly become the gold standard in how we support people.

What services see, though the public often may not, is the deep impact of trauma, and its role in substance use. It is the self-medicating strategy people adopt to cope with daily life. This is a clear sign that substance use is often a normal response to abnormal living conditions, not the cause of them. It is this understanding that must be normalised, and shape how we respond, how we support, and how we build systems rooted in compassion.

We must also take this same approach toward the people delivering services. Many are supporting others while carrying their own lived experiences. In the drive to improve outcomes for those accessing services, it can be all too easy to overlook their wellbeing. We have a duty to do better. Protecting everyone means caring not just for those who receive support, but for those who provide it too.

This report reflects how far we've come but also serves as a reminder of the work still ahead. Efforts across the country have made meaningful progress in addressing complex challenges, but like recovery itself, change in policy and strategy must be internal, continuous, and applied at every level. We must also take an honest moment to recognise that, despite these efforts, there has been no real decline in substance use-related deaths across Scotland. This stark reality reinforces the urgency for sustained, system-wide commitment to meaningful change.

By continuing to evolve, enabling and strengthening collaboration, and recognising it as the core of our work, while also holding ourselves accountable, we can ensure that progress is not only measured in data, but truly felt in people's lives.

List of abbreviations

AAAQ: available, accessible, acceptable, quality

ADP: Alcohol and Drug Partnership

BBV: blood-borne virus

DAISy: Drug and Alcohol Information System

FAIR: facts, analysis, identification, review

GP: general practitioner

IJB: Integration Joint Board

LAIB: Long-acting injectable buprenorphine

LES: local enhanced services

LEP: lived experience panel

LPASS: lead psychologists for addictions services Scotland

LLE: lived and living experience

MAT: medication assisted treatment

MATSIN: MAT standard implementation network

MIST: MAT implementation support team

NFO: Non-fatal overdose

NRS: National Records of Scotland

OST: opioid substitution therapy

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

PAT: person accessing treatment

PHS: Public Health Scotland

RAGB: red, amber, green, blue

REDCap: Research Electronic Data Capture

SDF: Scottish Drugs Forum

SOP: standard operating procedure

SPS: Scottish Prison Service

StIR: support to implement and report

THN: take-home naloxone

1. Introduction to MAT standards

In 2023, according to the **National Records of Scotland (NRS) annual report**, there were 1,172 drug-related deaths in Scotland which was an increase of 121 deaths (12%) compared with 2022. The 2022 total (1,051) represented a decrease of 279 from the year 2021 and was itself the lowest number of drug-related deaths since 2017. The NRS annual report on 2024 figures will be available in August 2025.

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 drug harms. The latest **Scottish Government quarterly report on suspected drug deaths data** provided by Police Scotland reports a total of 1,065 deaths in 2024, which was 11% (132) fewer than in 2023 (1,197). This represented the lowest annual total from this data series since 2017, the highest for the intervening period being 1,411 in 2020. While encouraging it should be noted that these figures are based on police officers' impressions when attending scenes of death and are not directly comparable to 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 experienced at least one prison sentence.

Based on findings from a recent **rapid evidence review of interventions to reduce drug-related harm** 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 **ten MAT standards**, the focus of this report, are as follows:

1. All people accessing services have the option to start MAT from the same day of presentation.

2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.

3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.

4. All people are offered evidence-based harm reduction at the point of MAT delivery.

5. All people will receive support to remain in treatment for as long as requested.

6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.

7. All people have the option of MAT shared with Primary Care.

8. All people have access to independent advocacy and support for housing, welfare and income needs.

9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.

10. All people receive trauma-informed care.

The taskforce evidence paper, the Scottish Government plan for the **National Mission on Drugs (2022)**, the **National Strategy for Community Justice (2022)** and the new **Scottish Prison Service (SPS) alcohol and drug recovery strategy (2024-2034)** 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 might also experience poor housing, high crime rates, fewer opportunities, trauma in their early years and inequalities in wealth and health.

The Government policy directive: **A caring, compassionate and human rights informed drug policy for Scotland** suggested that in order to achieve and sustain a reduction in drug-related deaths, it will also be necessary to address these social and

systemic issues, to make sure that people know their rights and that their rights are upheld. This is complemented by two further policy initiatives: The '**Charter of rights for people affected by substance use**', published **by the National Collaborative** in December 2024 and the 'National specification for alcohol and drug recovery services', scheduled to be published in 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 support ADP areas to implement the standards in drugs services, 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, published in June 2022 set out the scale of the task around reducing regional variability in specialist services in terms of access and quality responsiveness to population need. Subsequent reports, up to the current publication in 2025, continue to highlight significant year-on-year progress, ongoing fresh challenges and the same services becoming better aligned with human rights-based approaches, substantially informed by lived and living experience.

Drawing upon the National Collaborative's Charter of Rights referred to above, MIST chose to adopt and adapt the FAIR (facts, analysis, identification, review) model to support the systematic assessment of the implementation of human rights-based approaches for the services commissioned by ADPs. **The FAIR model** embeds a lived experience perspective at the heart of service delivery. Given the importance of pro-actively applying rights-based principles to achieving sustained and responsive services for one of Scotland's most at risk population subgroups, an experiential component is now integral to the red, amber, green, blue (RAGB) scoring protocol.

From the launch of MAT standards in 2021 until now, reporting in Scotland's justice settings has been limited to areas of good practice. This report includes links to data gathered in justice services aligned with MAT and further case studies. Incidentally, 2024 also saw the publication of the Scottish Prison Service's Alcohol and Drug Recovery Strategy (**Scottish Prison Service, 2024**), which like MAT standards implementation, is significantly informed and underpinned by a human rights-based approach and the lived experience perspectives of those affected by substance use within the prison estate.

2. Context and focus in 2025

This report provides data to inform an assessment of progress with the implementation of MAT standards 1–10 as of April 2025 across Scotland, based on evidence submitted by the 29 ADPs. This evidence is scored against defined criteria to construct the RAGB assessment, 290 in total. As in previous reports, the RAGB assessment has only been applied to community settings in 2024/25, since MAT implementation in justice settings will not be formally benchmarked and reported on until 2026 (**see section 3**).

- 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 of the time.

- In some instances, the RAGB assessment of implementation may not be in full agreement with the respective 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).

- While for ease of reference, the current report adopts a familiar format and structure to previous annual reports, it should be noted that direct comparisons between years could be potentially misleading, since the evidence requested for scoring of the standards themselves is subject to change in order to capture year-on-year improvement over time.

- This report does not provide a detailed analyses of the processes, policies or numerical data for each MAT standard.

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

The PHS MIST programme will provide the following actions and outputs from 2024-25 evidence following this report:

- Help for local teams to analyse the local nuances and effectiveness of implementation.
- Support for national analysis and discussion through networks, mini conferences and workshops.
- A supplementary report on secondary analysis of the raw data submitted by ADPs as part of their experiential evidence

2.1. Experiential programme

The experiential programme rests on the principle that people have the right to contribute to and influence the decisions that affect their lives and the care that they receive. Furthermore, there is wider **evidence** that involving the people on whom these decisions directly impact results in better care and improved health outcomes. Several key areas of importance were identified within the 2023/24 benchmarking report relevant to the experiential programme and aligned to the stated **Scottish Government priority** to put lived experience at the heart of services. These related to demonstrating the ongoing effectiveness and sustainability of the MAT Standard implementation programme, alignment of the programme with the Charter of Rights for people affected by substance use and a movement toward local ownership and oversight, through structured self-assessment processes that make use of contextual evidence that is itself directly informed by staff and service user experience. Benchmarking of the experiential programme for the 2024/25 reporting period therefore builds upon an already established experiential infrastructure, i.e. the capacities, processes and resources put in place over the past three years. The focus turned to the adoption of a human rights-based approach (HRBA) based on the National Collaborative **Charter of Rights** to underpin improvements determined by local experiential programmes.

The evolving nature of the experiential programme over the past three years has meant that it has not been possible to directly compare the majority of the 2024/25

evidence submission with previous years. The experiential data reported here therefore draws together self-reported evidence of implementation submitted by ADPs over the course of this reporting period with consideration of process data submitted in previous years and making comparisons where possible.

2.2. Current status and challenges ahead

As documented in the preceding 2024 benchmarking report for the year 2023/24, Alcohol and Drug Partnerships across Scotland had continued to make good progress towards the implementation of MAT standards. Specifically for MAT standards 1–5, 90% were assessed as being fully implemented (RAGB blue and green) which represented an increase from 66% in 2022/23 and 17% in 2021/22. Similarly for MAT standards 6–10, 91% were assessed as 'provisional green' (evidence that implementation is beginning), representing an improvement from 2022/23 when 45% were amber (evidence of partial implementation) and 12% had no evidence of implementation (RAGB red).

While the above reported year on year improvements in standards of care from specialist services were certainly encouraging, it has been recognised that this did not always translate into an improved treatment journey for users of the same services. For this reason, the substantial emphasis on learning from user experience to verify improvements which was initiated for 2023/24 has been further developed for the current year and has significantly informed the benchmarking methodology by means of appraising services using a human rights-based approach (see 2.3).

One of the most critical challenges facing front-line drug harm reduction services is the rapidly evolving substance use environment as reflected in the recommendations from the 2024 report to "adapt implementation and monitoring of the programme to poly substance use". Indeed, the escalating complexity of having to respond to multiple substances has occurred alongside substantial increases in the relative contributions of non-opioid drug threats such as cocaine (characterised by increased purity and administration by injection), as well as novel or 'designer' benzodiazepines which can be substantially more potent that those available by prescription, such as diazepam. While MAT standards implementation therefore continues to focus to a

certain extent on achieving positive outcomes with opioid replacement therapy, it is well-recognised that the same degree of commitment to improving the situation for dealing with other substances will be critical to having a meaningful impact on reducing substance-related harms and mortality in Scotland.

2.3. Embedding a human rights approach to substance use treatment

One of the major drivers underpinning the expanded scope of MAT standards to other substance user groups has been the prioritisation within MAT around opioid-related harm reduction which could risk marginalising those affected by other forms of drug use. The launch of **Scotland's Charter of Rights for those affected by substance use**, as noted previously in December 2024, brought added government authorised clarification to the rights-based principle, that those affected by any substance (and their families) should be entitled to expect comparable standards of care. The Charter was developed through extensive consultation with people affected by substance use and with people responsible for design, delivery and monitoring of substance-related support services. While not itself legally binding, the key rights described in the Charter come from national and international human rights law.

At its most fundamental level, the Charter seeks to facilitate a societal wide paradigm-shift away from the criminalisation and stigma which have traditionally been experienced by those affected by substance use, towards services that are fully aligned with broader public health and human rights-based principles. The Charter aims to bring this about by making explicit at the outset the distinction between 'rights holders' (i.e. those affected by substance use who identify and claim their human rights under a legal framework) and 'duty bearers' (i.e. those involved in the provision of care and broader welfare of those affected by substance use which may include local government, health and social care providers, justice sector providers and stakeholders).

Since the seven human rights which make up the Charter of Rights also have notable overlaps with some of the MAT standards, such as the convergence of 'Right to Life'

with pro-active approaches to risk reduction set out on MAT 3, there is a clear alignment already enshrined in human rights-based measures to further the MAT implementation. In consequence, the main compliance framework advocated for the application of a human rights-based approach, namely the FAIR model, can be usefully deployed as a means of assessing the extent to which each MAT standard already embeds these principles and if there is any scope for improvement. Guided therefore by the work of **National Collaborative in Scotland**, the current submission and assessment protocol for the benchmarking report has drawn heavily on a FAIR model template for documenting progress in embedding rights-based principles across all ten MAT Standards.

2.4. Wider harm prevention, advocacy and outreach

Integral to the public health ideal of a whole system approach to reducing drug-related deaths, which formed much of the rationale underpinning the introduction of the MAT standards in 2021 and Scotland's National Drugs Mission around the same objectives, are actions orientated towards what might be considered primary, secondary and tertiary prevention measures. Since tertiary prevention describes intervention at the point of the life threating event itself, the opioid antidote (or potent 'pharmacological antagonist') naloxone-related medications are clearly the most obvious in this area and have been demonstrably effective in averting drug overdose deaths both **in Scotland** and internationally. As with nearly all causes of preventable death however, earlier upstream intervention is always to be preferred and this leaves more scope for sustained recovery. For greatest effect, intervening with those most at risk of overdose (or 'secondary prevention') depends on the reliability of the risk identification indicators.

Based on a recently published analysis of drug-related deaths in Scotland for 2017 and 2018, increased risk of an individual dying from a drug-related death was strongly associated with a prolonged history of substance use (of at least 11 years duration); previous experience of non-fatal overdose (NFO) (50%); multiple substance use (95%) and a psychiatric condition recorded in the six months prior to death (63%). Recent contact with acute health services such as accident and emergency (A&E), custody suite stay, and recent prison release are also featured in

the report and well acknowledged as risk factors. Perhaps most strikingly however, 76% of deaths were among those in contact with a service which could have addressed their drug use behaviour in the six months prior to death. Given this high prevalence of missed occasions to intervene, the importance of pro-active outreach measures, especially around high-risk life events and service interactions such as NFOs or multiple hospital or police custody visits and ensuring such intervention opportunities are not missed should be self-evident. It is reassuring also that MAT standard 3 has enabled an increasingly systematic approach to applying assertive outreach measures that can in turn be better integrated with the wider harm reduction work of MAT standard 4 (now also incorporating vaccination and sexual health from 2025). Innovative models whereby at risk individuals can benefit from specialist advocacy tailored to their life circumstances (now including housing and welfare from 2025, as set out in MAT 8), continue to be used to build a system of care that aspires to be genuinely 'whole system' and responsive.

2.5. Psychological and trauma-informed approaches

The increasing acknowledgement that many of those affected by substance use are effectively 'self-medicating' to deal with past or recent traumatic experiences has been a key rationale for health and social care services to move away from punitive and criminalising responses towards more understanding attitudes that recognise these aspects. Full integration and embedding of psychological and trauma-informed approaches across services are a recognition of the need to address such underlying vulnerabilities for care systems to be fully effective. A service that is genuinely trauma and psychologically informed benefits from feedback from people with lived experience of trauma and/or psychological morbidities. Once established and functioning, a trauma-informed system also supports workforce resilience and is underpinned by appropriate leadership and systems. In practice therefore the implementation and maintenance of such fully informed systems of care, requires considerable specialist skills and training, which the LPASS audit tool (**link to originating publication**) is used to appraise. The LPASS tool was developed by the Lead Psychologists for Addictions Services Scotland (LPASS) and offers a self-reporting route through which to confirm the fitness for purpose of the available

psychological services including the appropriateness of staffing levels, their capacity for internal audit, levels of training and supervision and mechanisms for collating and incorporating lived experience feedback from service users. For the time being the degree of overlap in terms of staff expertise between MAT 6 and MAT 10, enables capacity in these areas to be assessed jointly for the current report.

3. Methods

The 29 ADP areas have been 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 have been scored and triangulated to allocate a RAGB status for implementation of the standards based on the reporting requirements outlined in the 2024/25 guidance.

For any given standard in a particular 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 deliverables in relation to access, availability and uptake,
- the experiential evidence demonstrates whether policies and procedures are in place to enable people to provide feedback and participate and/or be involved in service improvement.

If all three streams are scored as complete, the RAGB status is green for implementation. If any evidence-stream scores incomplete (i.e. partially/ not implemented or data partially/ not submitted) then the RAGB status is not green. The evidence stream criteria are chosen to reflect the key components of a standard so they do not assess all of its aspects, especially for complex interventions such as those encompassed by standards 6 through to 10.

As has been noted in previous reports, Midlothian and East Lothian local authority areas each have separate Integrated 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.

For this report, the definitions and categorisation of the RAGB are as presented in table 1:

Table 1: RAGB definitions and categorisation

RAGB colour	Definition	Categorisation
Red	There is no or limited evidence of implementation of the standard in MAT services	Not implemented
Provisional amber	There is no or limited evidence of implementation of the standard in MAT services	Partially implemented
Amber	There is evidence of partial implementation of the standard in MAT services including meaningful change	Partially implemented
Provisional green	There is evidence of implementation and meaningful changes, however, full implementation is not confirmed by all three evidence streams – usually the experiential stream is lacking	Partially implemented
Green	There is evidence of full implementation and meaningful changes in all unique combinations of setting and service that offer MAT and opioid substitution therapy (OST) across the ADP area	Fully implemented
Blue	There is evidence of sustained implementation and benefit to people plus ongoing monitoring of the standard across all MAT services	Fully implemented

It is important to note that the implementation categorisation framework has been revised since 2023/24 such that “provisional green” is now part of the “partially implemented” categorisation as opposed to “fully implemented”.

After the completion of RAGB scoring there was an opportunity for ADPs to present any concerns that they had over the benchmarking result. If there were any clear omissions or oversights in the data submission or scoring process, these were addressed by correspondence. If there remained any further lack of consensus over the allocated scoring, ADPs were invited to submit to a separate ratification panel who considered the merits of the presented facts and reached a decision on the final scoring independently of the MIST benchmarking team.

3.1. RAGB and FAIR

MAT standards 6 to 10 are complex and difficult to measure using a tightly defined set of national indicators and with limited quantitative data. 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 facilitate 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 to10 in 2023/24.

In the current reporting year 2024/25, **the FAIR approach** (see **Table 2**) was utilised across MAT standards 6 to 10, with the addition of the LPASS audit tool to assess training delivery capacity and staffing appropriateness for MAT standards 6 &10. This enabled incremental advancement towards ‘green’ in standards 6 to 10 and incorporated the supplementary requirement for 2024/25 whereby verification by means of experiential evidence is now an essential component of full implementation.

Table 2: FAIR model

Area of FAIR	Definition
Facts	Gather evidence based on the lived experiences of individuals affected by substance use. From ADP data collection what are the experiences of the individuals involved and the important facts to understand?
Analysis	Assessment of human rights at stake using AAAQ (Available, Accessible, Acceptable, Quality) framework (and considering PANEL principles). What concerns are raised by the facts gathered with respect to rights?
Identification	Identify actions and responsibilities. Establish a shared implementation plan using the PANEL principles (Participation, Accountability, Non-discrimination, Empowerment, and Legality). What needs to be done, how, by whom and by when to ensure that the rights are realised?
Review	Develop a shared understanding of progress indicators and evaluation of these indicators, grounded in the lived experiences of those affected by substance use. How to monitor process and outcomes and evaluate what has happened as a result of actions taken?

Further details on methods points not highlighted in this report are available in the **2022/23 benchmarking report**.

3.2. Process and numerical evidence

Given that the process measures for the 2024-25 report are the same as those for previous years, much of the existing documentation around standard operating procedures (SOPs) and protocols remained current and applicable for this year's report. Where such evidence was previously submitted and allocated the maximum score therefore, there was no requirement to resubmit. A sample audit was conducted to provide assurances around the validity of this process. This involved a random selection of ADPs and reviewing their process documents submitted in previous years to MIST. These were evaluated against the criteria and mapped onto

spreadsheets. This further provided assurance that the amended criteria for the current year have not affected the general validity of the evidence informing the standards.

At this phase in the MAT programme, ADP data submissions reporting on the 10 MAT standards are complete. As a complex and evolving project, some MAT standards data definitions are still under development, particularly for MAT 6 to 10. Criteria continue to evolve therefore for both data capture and benchmarking. Work is ongoing to reduce uncertainty in the interpretation of the guidance and improve consistency of the numerical data across Scotland. Areas that meet the criteria for the classification of remote and rural have extended time frames to reach the benchmarking criteria of MAT 1 and 3.

Since most of the required information had not been routinely collected before the implementation of MAT standards, the collated data in our reports have been derived from different sources using variable extraction protocols. The resulting dataset for analysis therefore represents a combination of extracts from the Drug and Alcohol Information System (DAISy), dedicated MIST submission templates/spreadsheets and the online MIST Research Electronic Data Capture (REDCap) facility. Combining the extracts described above is completed using a process set up in R (programming language for statistical computing and graphics) which extracts, organises and aggregates these data by standard following the layout of the MIST Excel collection spreadsheets. This allows MIST to analyse data from every ADP at the level of each standard.

Details of data definitions are recorded in the MIST numerical measures data manual. Data from the Excel spreadsheets were analysed with Excel and R using a range of measures including upper quartile range, overall totals, and proportions. Data analysis was conducted using R (version 4.4.2), with the PHS methods package (version 1.0.2) for cleaning and running calculations on submitted data as well as all visualisations.

Data for all evidence were anonymised. For standards 1, 3, 5.2, 5.3, 8 and 9, each ADP selected a single three month consecutive period of data to be used for analysis between November 2024 and March 2025. For standards 2, 4, 5.1 and 7 a snapshot

date was selected by each ADP for analysis, recommended as 14th February 2025 with consideration to external factors.

Since the processes, staffing and capacities for the implementation of the current stage of MAT 6 and MAT 10 are essentially identical, they have been appraised and RAGB rated as one combined standard for 2024/25, as in the previous year. For this combined standard check, the two-year period from January 2023 to December 2024 was agreed as the period of analysis to which training completeness and progress referred to, as assessed by LPASS (see below).

Please note that rounding has been applied to present RAGB percentages.

All data were submitted by ADPs to PHS by 14 April 2025.

Lead psychologists for addictions services Scotland (LPASS)

LPASS have developed a self-assessment tool which was used to allocate process and numerical implementation scores for MAT 6 & 10. On review of this document, it also uses a RAGB scoring metric. This is not equivalent to the RAGB score offered by MIST to the full MAT 6 and 10 standards and scored as one: MIST RAGB scores are reflective of self-appraisal readiness and development plans, not the progress on the services offered. The LPASS audit tool therefore allows services to standardise themselves and to develop improvement plans all of which can be utilised when the MIST programme finishes.

3.3. Experiential evidence

ADPs were provided with PHS guidance (internal document, available upon request) in October 2024 regarding delivery of the experiential programme. This outlined the reporting requirements for the 2024/25 period (**see appendix 3**) aligned to the evolving nature of the experiential programme. To reduce the burden of reporting several measures were removed from the reporting requirements for this year including reflections and improvement plans. In addition, case studies were non-mandatory and ADPs were not required to provide evidence regarding the

implementation of MAT standards within justice settings although current plans were discussed and documented during support to implement and report (StIR) meetings.

The emphasis for ADPs for the reporting period 2024/25 was to provide evidence of an ongoing approach to gathering experiential feedback. In addition, there was a focus on HRBA in relation to self-assessment of service improvements. For the purposes of self-assessment and reporting experiential work, ADPs were provided with a standardised template in Excel with formatted spreadsheets. This included FAIR templates for each of the MAT standards and a section for descriptive data reporting the number of participants from each of three groups of people with experience of substance use:

- People accessing treatment (PAT)
- Service providers,
- Family members/nominated people.

Further demographical information was also requested, if collected by ADPs, to demonstrate representativeness of their sample; age group, gender, in treatment/not in treatment, type of MAT (i.e. OST) and resident in prison were requested to describe PAT. Provider group and type (i.e. clinical professional or third sector) were requested to describe participating service providers. ADPs were also asked to provide a brief reflection on the data collected in terms of the representativeness of their sample including participants, setting and services as well as details of other forms of data gathered in addition to interviews.

Data collection

Semi-structured, face-to-face or telephone interviews are considered the primary method of data collection to gather the experiences of people with experience of substance use and MAT implementation. Interviews are regarded as an important part of the experiential programme to enable individuals to provide feedback within their local community where literacy, trust and stigma may offer challenges to

participation. They are also considered important to develop a more in-depth understanding than may be captured through other methods of data collection.

To gather feedback, standardised questions were previously developed by the MIST team and provided to ADPs in order to form the basis of interviews and surveys. These questions could be adapted locally and were accompanied by a bank of additional questions for MAT standards 3,6,9 and 10. Surveys alongside a mix of other methods including public meetings, focus groups, lived and living experience panels, complaints and compliments, patient stories, critical incidents and short conversations can all be utilised alongside interviews to gather information regarding experiences of services and MAT implementation. Using several methods to complement and add to interview data seeks to ensure that differing voices can be heard and information gathered in a way that suits the person and their needs. This can also support gathering real-time experiences to inform ongoing service improvements.

Oversight of the experiential programme

Fundamental to implementation of the MAT standards and the experiential programme is enabling those with lived or living experience of substance use to have a voice. To increase meaningful involvement in service development and enable LLE voices to be heard at all stages of the experiential programme, beyond participation, ADPs were required to have representation from people with experience of substance use on steering groups and/ or create or connect with established LLE panels or groups.

Training

While ADPs can offer their own training, locality interviewers (e.g. statutory employees, commissioned services employees, individuals with lived or living experience) can also access training supported by MIST and provided by Scottish Recovery Consortium (SRC). The SRC training programme provides information on the MAT standards as well as the roles and responsibilities of locality interviewers. Blocks of sessions are offered once a month with refresher sessions available for

those already trained. The format has changed over the years. The addition of a third session enabled a focus on interview skills to facilitate the gathering of qualitative data during interviews with participant groups. It has also changed to provide greater flexibility and respond to the evolving training needs of ADPs including availability and capacity. Initially training was delivered over two half day sessions whereas the current training is structured around three half day sessions. Although mainly delivered online, training can also be provided through in-person sessions or consolidated into one or two-day training sessions dependent ADP requirements.

Analysis

Data gathered by ADPs is analysed locally using thematic analysis. Usually this is completed by the ADPs or by a commissioned service such as Scottish Drugs Forum (SDF). Involvement of people with experience of substance use is considered fundamental to analysis of experiential data, for example in the previous reporting period ADPs had been asked to sense-check their findings with local LLE panels or steering groups. In the 2024/25 reporting period demonstration of the adoption of the human rights-based approach to analysis and subsequent improvement planning was introduced using the FAIR approach (see **table 2**). This was developed in accordance with the **National Collaborative's vision** and latterly published **charter**, **guidance and toolkit**. ADPs were asked to provide evidence using the experiential reporting template (**see appendix 4**) of how they had used their analysed experiential data and involved people affected by substance use, including LLE groups or panels, in their quality improvement process.

The FAIR model (Facts, Assessment of Rights, Identification, and Review) model was included in sections for each of the 10 MAT standards with details of the PANEL principles (Participation, Accountability, Non-Discrimination and Equality, Empowerment, Legality) for reference and AAAQ (Available, Accessible, Acceptable, Quality) questions to consider within improvement planning. The intention was that ADPs would utilise the framework provided in their self-assessment process to reflect upon and report their cycle of experiential data collection, analysis, areas for improvement and review through a human rights-based lens. This enabled illustration of the areas that had been addressed or were in progress. ADPs were provided with

worked examples within the guidance and template and provided with additional support through thematic groups, StIR meetings and the experiential Team.

To determine the RAGB score for the experiential evidence stream ADPs submitted data aligned to process (EX.P1-3), numerical (EX.N1) and intelligence (EX.I1-4) measures indicating that an experiential programme was in place and working. A score of 2 could be achieved on the basis that the evidence submitted met each of the specific experiential reporting requirements (**see appendix 3**) outlined in the PHS guidance (internal document, available on request).

National perspective

As part of the reporting requirements ADPs were asked to submit raw data of feedback from participants. The purpose of this was to provide evidence of ongoing data collection of the experiences of people affected by substance use within ADP localities, that appropriate information governance was in place, as well as providing a measure of change in relation to MAT implementation. A secondary analysis of data is planned which will explore experiences of implementation of MAT standards with consideration of efficacy across Scotland. In the current reporting period, ADPs were not required to submit any further process documentation unless changes or adaptations had been made to existing submissions. To assess whether reporting requirements were met, data were considered from a number of sources including:

- StIR meeting notes (self-reported information on implementation and progress provided by ADPs), with two in-depth assessments of MAT standards, selected from MAT 6 to 10 utilising the FAIR approach).
- Process documentation and data submitted by ADPs in 2023/24 and 2024/25,
- Experiential reporting template submitted in 2024/25 and data collected by SRC.

4. Findings

4.1. Implementation of MAT 1–5

MAT standards 1 to 5 essentially set out the components of what would be expected from high quality, well-functioning, responsive and pro-active specialist substance use services which both respect patients' preferences and autonomy as well as incorporate opportunistic harm reduction interventions. Reassuringly, the very high rates of implementation have been maintained since last year with the added requirement of demonstrating how to apply a human rights-based perspective across the board in order to merit the acknowledgement score for fully implemented status. Specifically, the highest rate of ADPs scoring only partial implementation (at the level of provisional green) is for MAT standard 1 (expanded on in sections 4.3 4.5), a finding likely to reflect ongoing difficulties in engagement with this population group and the real and perceived barriers to making that first appointment after referral. The highest levels of innovation in the current reporting year have been around ensuring that there are appropriate and timely responses to acute high-risk situations by means of assertive outreach teams often linked through to providing advocacy in line with MAT standard 8.

4.2. Implementation of MAT standards 6–10

MAT standards 6 to 10 are concerned with the processes of embedding whole-system improvements in the provision of substance use specialist services by ensuring first and foremost that they are genuinely underpinned by psychological and trauma-informed principles. Having addressed barriers to referral, treatment choices and retention as well as proactive outreach and wider harm reduction using MAT 1 to 5, the wider systems and practicalities of service delivery are a natural progression towards sustainable gains. MAT 6 to 10 also cover indicators for the organisation of shared care, for provision of appropriate advocacy and for recognition of dual diagnosis for those with psychological morbidities. Since improvements in these aspects do not lend themselves easily to straightforward numerical indicators, their review and monitoring necessarily requires more contextual appraisal than for

MAT 1 to 5. For these reasons, the implementation criteria for MAT 6 to 10 are more dependent on a combination of checking that training and service capacities are appropriate for local population needs and examining direct experiential feedback from service users. In general, as with MAT standards 1 to 5, there has been substantial progress achieved across MAT 6 to 10, with standards 6 and 10 combined in the current report, as in 2023/24.

The standards where progress has been more challenging are those dependent on the participation, often on a contractual basis, with other partners or external stakeholders. Most notable here are the requirements for the set up and operation of shared care protocols with general practitioners (GPs) and other primary care providers. Given the widely acknowledged heavy demands on primary care, it is perhaps unsurprising to note that the capacity to provide shared care is often very stretched and changes to local enhanced services contracts have also been cited as a barrier to participation. Several ADPs have however managed to respond very innovatively to local challenges by making use of alternative provision models including pharmacy prescribing. Significant work is ongoing around developing what models might be the most acceptable and most equitable in support of finding workable solutions.

4.3. RAGB assessment of implementation

Across all 29 ADP areas for MAT standards 1 to 5, 91% (132/145) of standards have been assessed as fully implemented (RAGB blue and green), this is an increase from 17% (25/145) in 2021/22.

For MAT standards 6–10, 75% (109/145) were assessed as RAGB fully implemented (green). This is reflective of changes to the evidence requested by the programme for 2024/25. In 2023/24 the evidence requested was insufficient to demonstrate full implementation. Partial implementation (provisional green) accounted for 91% (132/145) of standards assessed. In 2022/23 45% (65/145) of standards were assessed as amber and 12% (18/145) had no evidence of implementation (RAGB red).

4.4. MAT standard specific results

Chart 1: Percentage of ADP areas with RAGB score per MAT standard 1 to 5 – Scotland 2021/22, 2022/23, 2023/24 and 2024/25

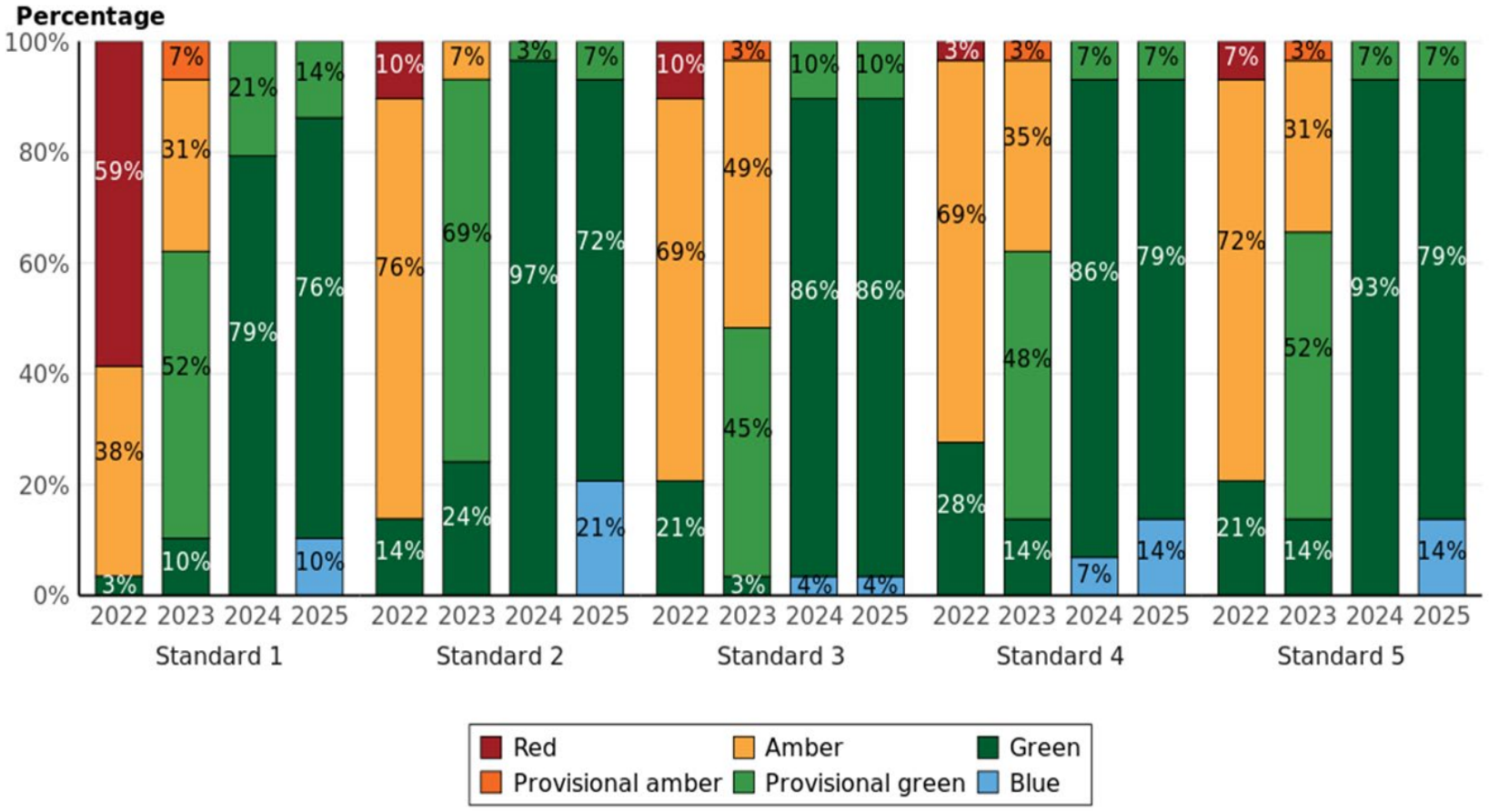


Chart note: Progress with implementation of the MAT standards 1 to 5 at a national level is outlined for experiential, numerical, and process evidence collected in the years 2021/22, 2022/23, 2023/24, 2024/25 noted as 2022, 2023, 2024 and 2025 respectively. It's important to note that evidence required to meet implementation is different for each year of assessment (see **section 3. Methods** for more information).

Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 1: In 2024/25 the standard is fully implemented (green) or sustained (blue) in 25/29 (86%) ADP areas and partially implemented (provisional green) in 4/29 (14%) ADP areas.
- MAT standard 2: In 2024/25 the standard is fully implemented (green) or sustained (blue) in 27/29 (93%) ADP areas and partially implemented (provisional green) in 2/29 (7%) ADP areas.
- MAT standard 3: In 2024/25 the standard is fully implemented (green) or sustained (blue), in 26/29 (90%) ADP areas and partially implemented (provisional green) in 3/29 (10%%) ADP areas.
- MAT standard 4: In 2024/25 the standard is fully implemented (green) or sustained (blue), in 27/29 (93%) ADP areas and partially implemented (provisional green) in 2/29 (7%) ADP areas.
- MAT standard 5: In 2024/25 the standard is fully implemented (green) or sustained (blue) 27/29 (93%) ADP areas and partially implemented (provisional green) in 2/29 (7%) ADP areas.
- In 2024/25 the RAGB score for evidence of sustained implementation for at least two years (blue) was allocated 18 times and to a proportion of all standards from 1 to 5; this was previously only allocated to standards 3 and 4 in 2023/24.

Chart 2: Percentage of ADP areas with RAGB score per MAT standard 6–10 – Scotland 2022/23, 2023/24 and 2024/25

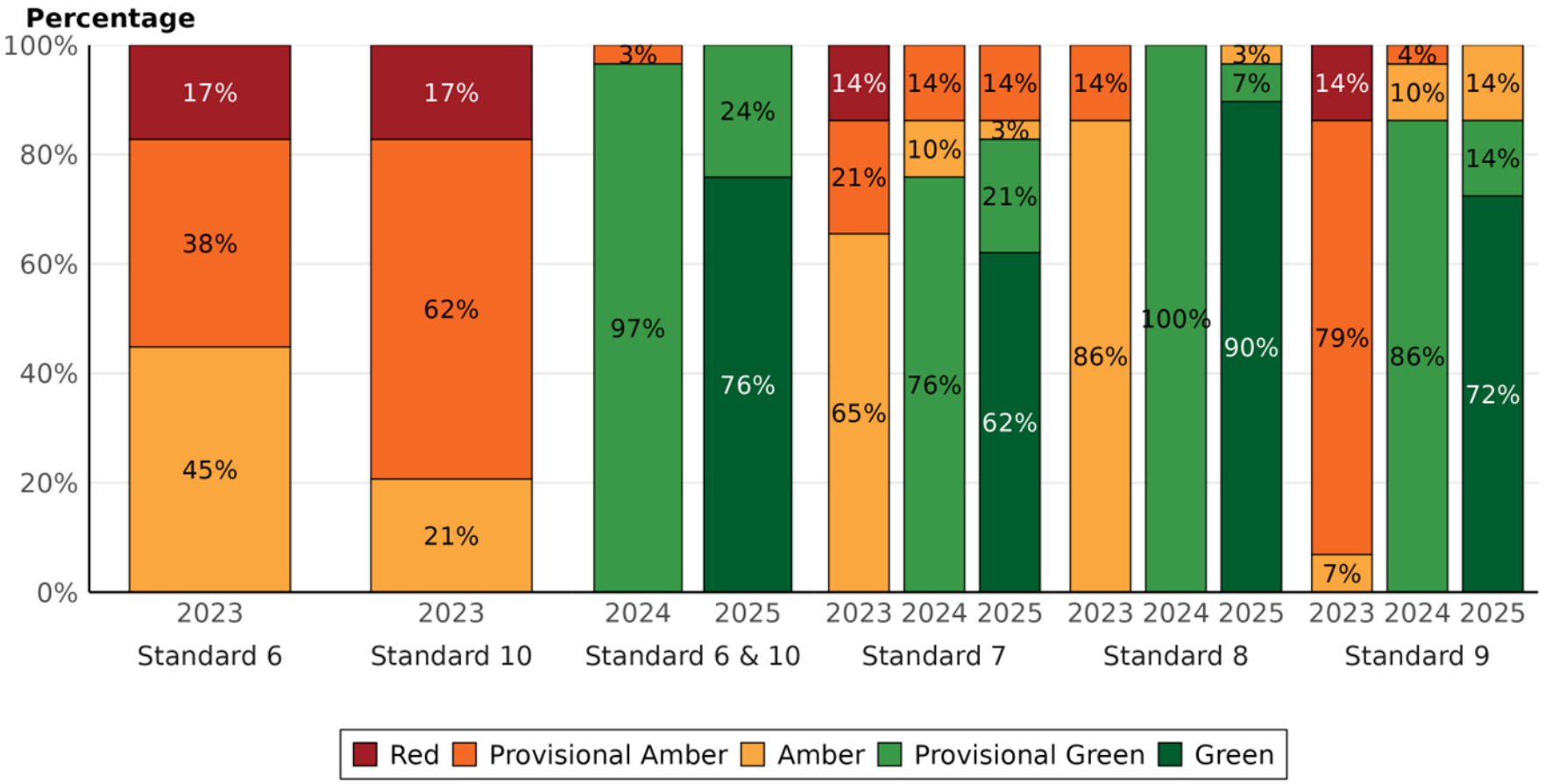


Chart note: In 2022/23 MAT 6 and 10 were assessed separately. In 2023/24 and 2024/25 they were assessed jointly.

Progress with implementation of the MAT standards at a national level is outlined for experiential, numerical, and process evidence collected in the years 2022/23, 2023/24 and 2024/25, noted in the chart as 2023, 2024 and 2025 respectively. Since the processes, staffing and capacities for the implementation of the current stage of MAT 6 and MAT 10 are essentially identical, they have been appraised and RAGB rated as one combined standard for both the 2023/24 and the current report for 2024/25. It should also be noted that provisional green was the highest attainable RAGB standard for MAT standards 6 to 10 in 2023/24 as experiential evidence was not as well-developed as components of these standards until 2024/25. It's important to note that evidence required to meet implementation is different for each year of assessment (see **section 3.** Methods for more information).

Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 6 and 10: In 2024/25 this combined standard was fully implemented (green) in 22/29 (76%) ADP areas and partially implemented (provisional green) in 7/29 (24%) ADP areas.
- MAT standard 7: In 2024/25 the standard is fully implemented (green) in 18/29 (62%) ADP areas and remains partially implemented for the remaining 11/29 (38%) ADP areas (6/29, 21% provisional green; 1/29, 3% amber, 4/29, 14% provisional amber).
- MAT standard 8: In 2024/25 the standard is fully implemented (green) in 26/29 (90%) ADP areas, partially implemented in 3/29 (10%) of ADP areas (2/29,7% provisional green; 1/29, 3% amber)
- MAT standard 9: In 2024/25 the standard is fully implemented (green) in 21/29 (72%) ADP areas, partially implemented in 8/29 (28%) of ADP areas (4/29, 14% provisional green; 4/29, 14% amber).

4.4.1 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 the medication assisted treatment that is appropriate for them from their first day of presentation.

Progress this year in the MAT 1 benchmark of ‘same-day access’ to treatment has been sustained in most ADPs with 3 allocated blue in recognition of sustained implementation. The combination of the 3 strands of evidence supports the conclusion that access to treatment in most ADPs is within 1 day. Areas have set up MAT assessment clinics with variable availability reflecting the needs of their specific communities and the number of referrals coming in. Closely linked with MAT 1 is MAT standard 3 noting that for high-risk events, which may trigger assertive outreach protocols, the turnaround to first contact with services and then access to treatment continues to be an important measure in reducing drug-related harms.

For OST these practices are embedded and represent an established clinical protocol to provide an appropriate opiate substitution prescription. Within the context of a rapidly evolving substance use landscape however, drugs of choice are changing at a time when pharmacological treatments for other drugs are either non-existent or their availability is limited to ongoing evaluation programs, such as two current Scottish feasibility pilots for benzodiazepine prescribing **an intervention model** which was developed in 2022/23.

Five ADP outliers for MAT 1 remain for the 2024/25 period, which largely represent those areas meeting the ‘remote and rural’ criteria where local provision of MAT appointments might be variable or subject to restrictions (e.g. to one MAT referral per day), due to low numbers of patients. For these areas, patients may choose not to travel to alternative offered locations but to wait instead for the local service clinics, thereby extending their wait time for OST assessment. Alternatives to face to face would therefore support better access. It might also be worthy of note that areas with a low OST caseload might encounter challenges when making the case for investing in additional staff capacity. There are also known to be relatively higher proportions of substance use problems linked with alcohol in **Highlands and Islands communities**.

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, 2024/25

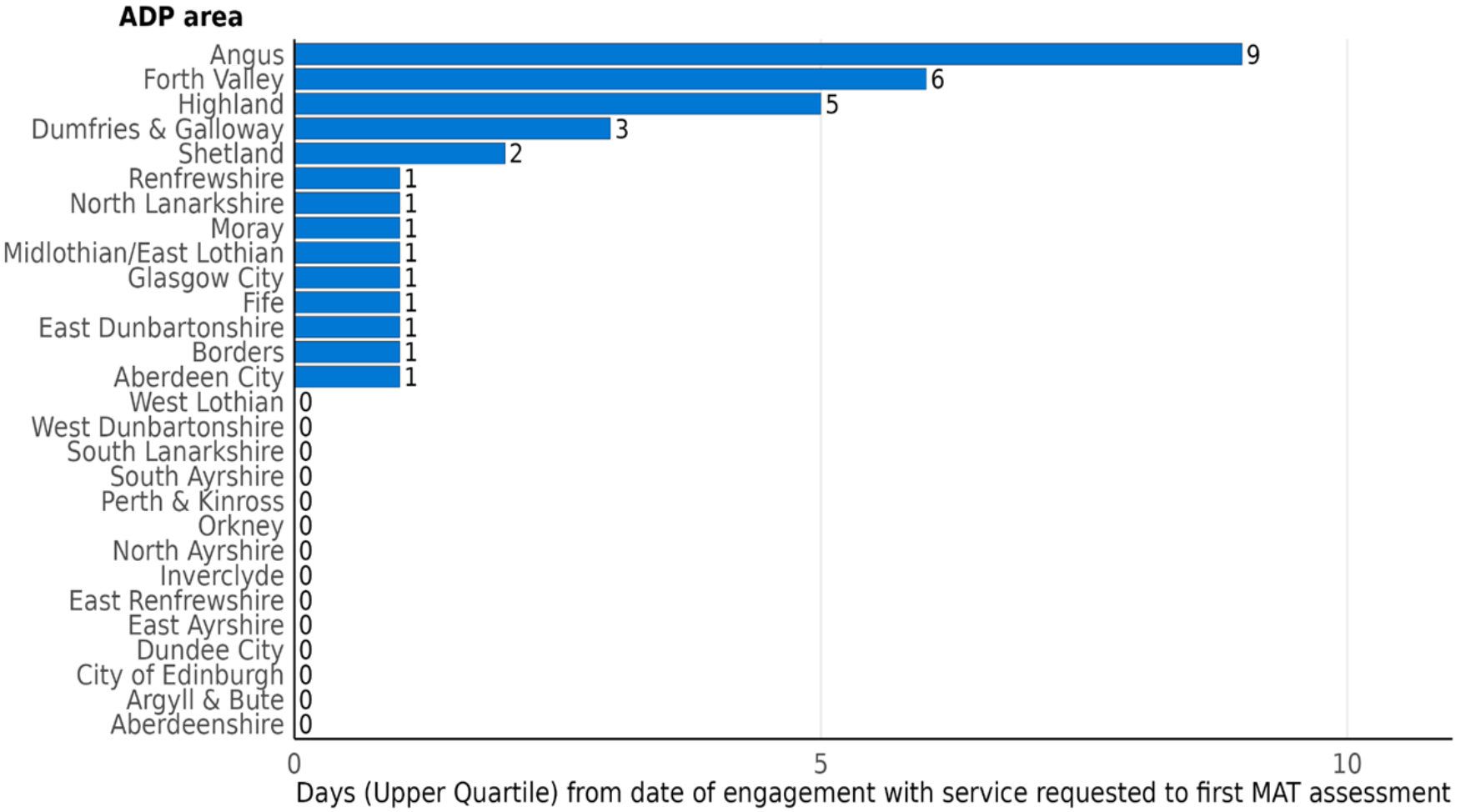


Chart note: ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025 (see **section 3. Methods** for more information).

Chart description: For 12 ADP areas, the 75th percentile (upper quartile) reported, indicates 75% of cases received a first MAT assessment on the same day of engagement with the service requested, for a further 12 ADP areas, the 75th percentile (upper quartile) reported, indicates 75% of cases received a first MAT assessment within one day. The ADP areas with waiting times longer than one day were Angus, Forth Valley, Highland, Dumfries & Galloway and Shetland with nine, six, five, three, and two days respectively. Western Isles reported no new requests for engagement.

It's important to note that first MAT assessments for the three-month reporting period account for only 3% (n=679) of the full MAT caseload reported in MAT 5 (n=21,212), Full data is shown in **Appendix 5.**

4.4.2 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.

No ADP have highlighted issues in this area other than the cost burden of Long-acting injectable buprenorphine (LAIB).

Chart 4: Percentage of caseload prescribed OST by type – Scotland 2021/22, 2022/23, 2023/24 and 2024/25

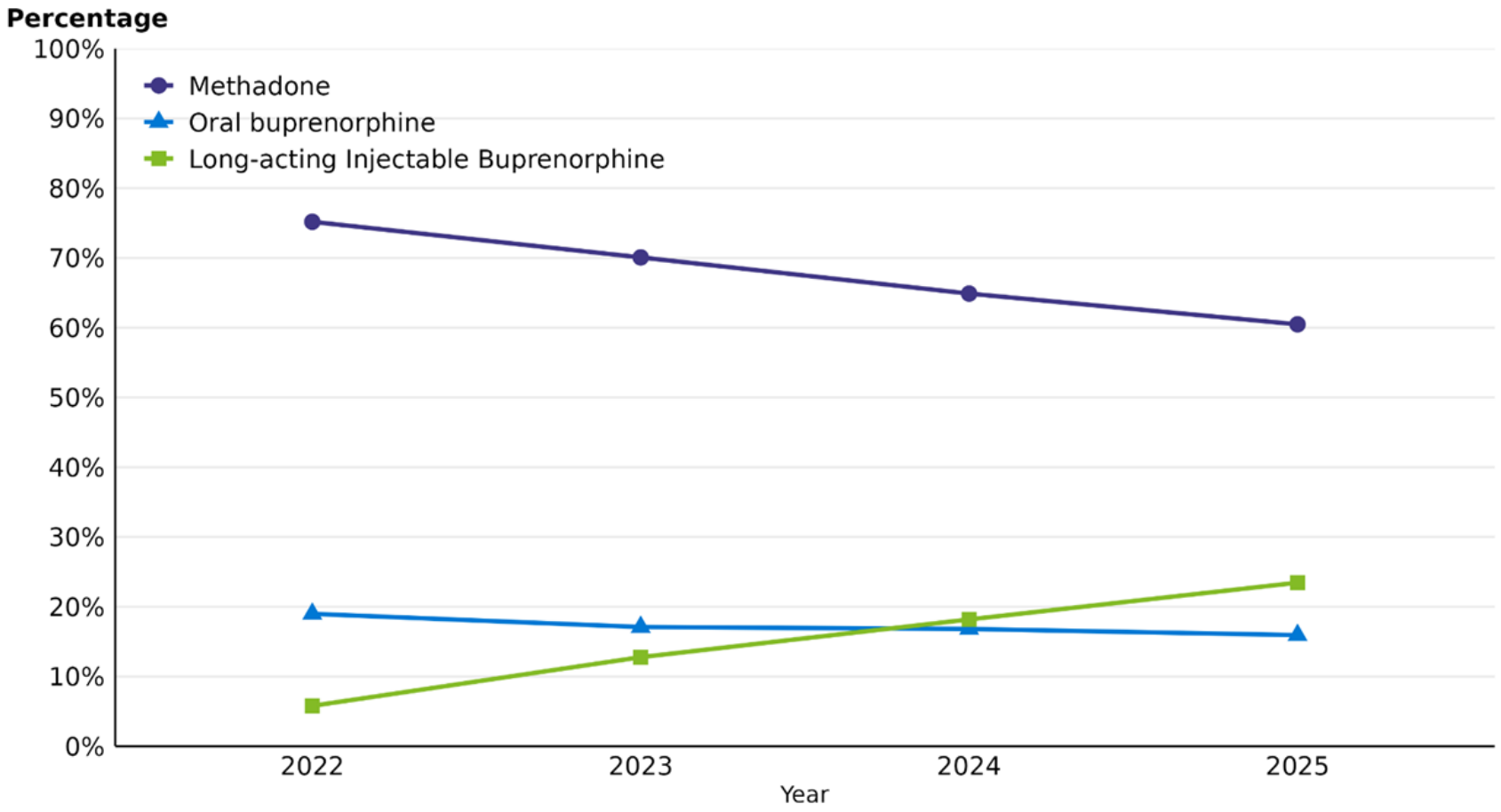


Chart note: These data are presented for a snapshot date in February of each year i.e. a single point in time for 2021/22, 2022/23, 2023/24 and 2024/25 noted as 2022, 2023, 2024 and 2025 respectively (see **section 3. Methods** for more information). Heroin-assisted treatment is included in total caseload but not represented in the chart.

Chart description: Data were submitted by all 29 ADP areas just as in 2023/24. Prescribed opioid substitution therapy across the four-year reporting period (2021/22 to 2024/25) appears to show a stepwise decreasing trend in percentage terms for methadone alongside an increasing trend for LAIB. Despite the downward trend, methadone still clearly accounts for the majority of OST prescriptions at around 60% of the total. More specifically, the proportion of people prescribed methadone on the 2024/25 caseload (n = 20,441), reduced by 5% from 2023/24 to 2024/25, similar to previous year's reporting since 2021/22, (2021/22 n = 19,022; 2022/23 n = 15,560, 2023/24 n = 13,758 and 2024/25 n= 12,363). There was a 1% reduction in the proportion of the caseload prescribed oral buprenorphine (n=3,257) from 2023/24 to 2024/25, this had remained static from 2022/2023 to 2023/2024. There was a small reduction of 2% from 2021/22 to 2022/23 (2021/22 n = 4,859; 2022/23 n = 3,796; 2023/24 n = 3,566). The prescription of LAIB continues to increase, from 6% of the caseload prescribed OST in 2021/22 to 13% in 2022/23,18% in 2023/24 and now 23% in 2024/25 (2021/22 n = 1,474; 2022/23 n = 2,836; 2023/24 n = 3,855; 2024/25 n= 4,794). Full data is shown in **Appendix 5.**

Chart 5: Total OST caseload – Scotland 2021/22, 2022/23, 2023/24 and 2024/25

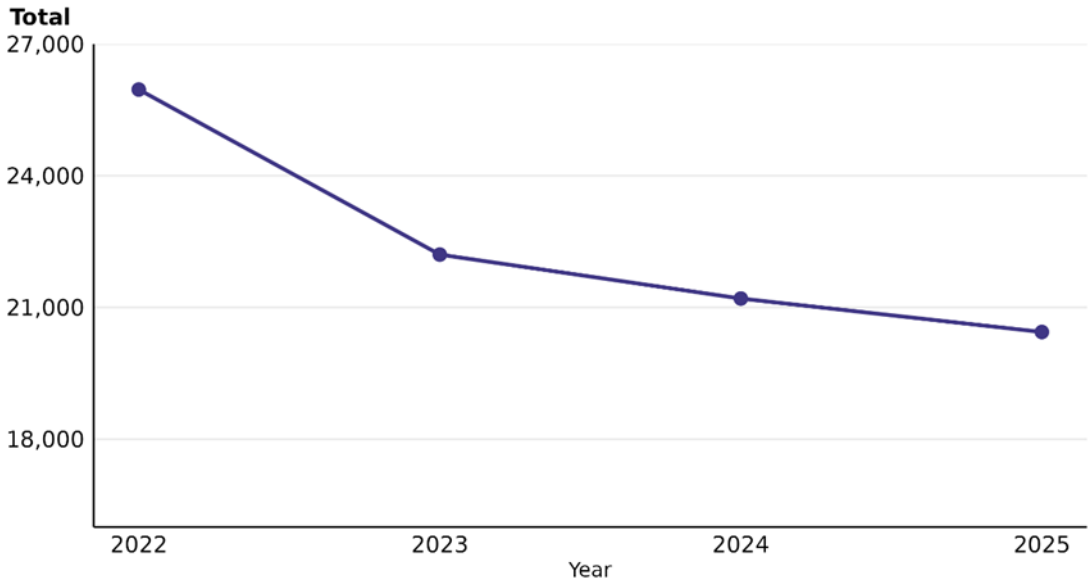


Chart note: These data are presented for a snapshot date in February of each year, a single point in time for 2021/22, 2022/23, 2023/24 and 2024/25 noted as 2022, 2023, 2024 and 2025 respectively.

Chart Description: The data shows a year-on-year decline in overall numbers of prescriptions for OST as a whole (from 25,963 in 2021/22 to 20,441 in 2024/25). The biggest drop occurs in the first of the three years reported. Full data is shown in **Appendix 5.**

Chart 6: Percentage of caseload prescribed OST by type and ADP area – Scotland 2024/25

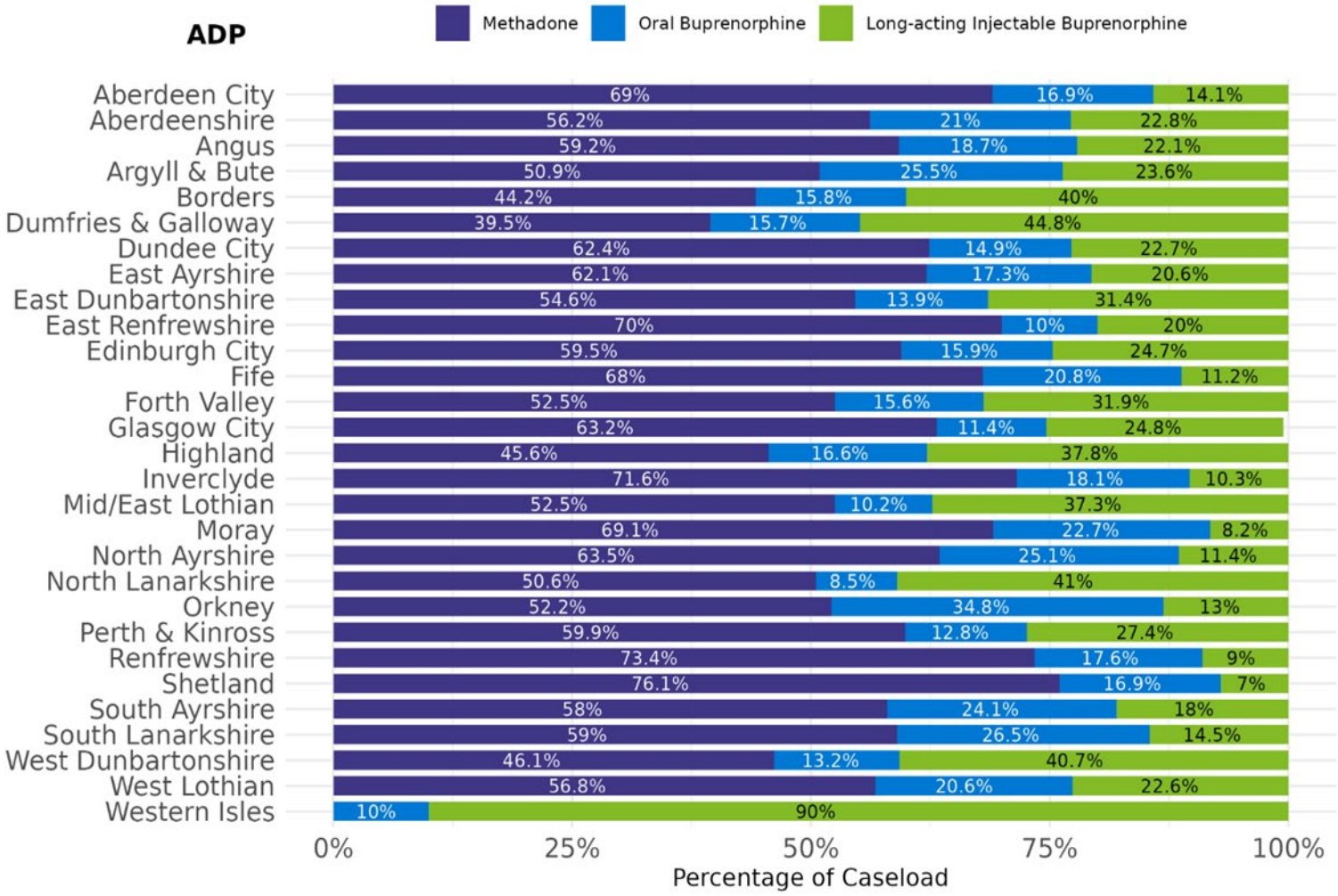


Chart note: These data are presented for a snapshot date in February 2025 (see **section 3. Methods** for more information).

Chart description: All 29 ADP areas reported the breakdown of their caseload by medication type. Please be aware that some of the percentages will not add up to 100% as heroin-assisted treatment is included in the calculation but not shown on the chart since this medication is not used across all ADP areas and accounts for only 0.1% of cases. The proportions of medication split across all ADPs indicates availability of choice as per MAT standard 2. Full data is shown in **Appendix 5**.

4.4.3 MAT standard 3: Assertive outreach and anticipatory care

The intention of MAT standard 3 (covering assertive outreach and anticipatory care), 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 at every reasonable opportunity.

Nearly all locality areas have been able to confirm the implementation of MAT 3.

Chart 7: Number of high-risk events by notification source in 29 ADP areas – Scotland 2024/25

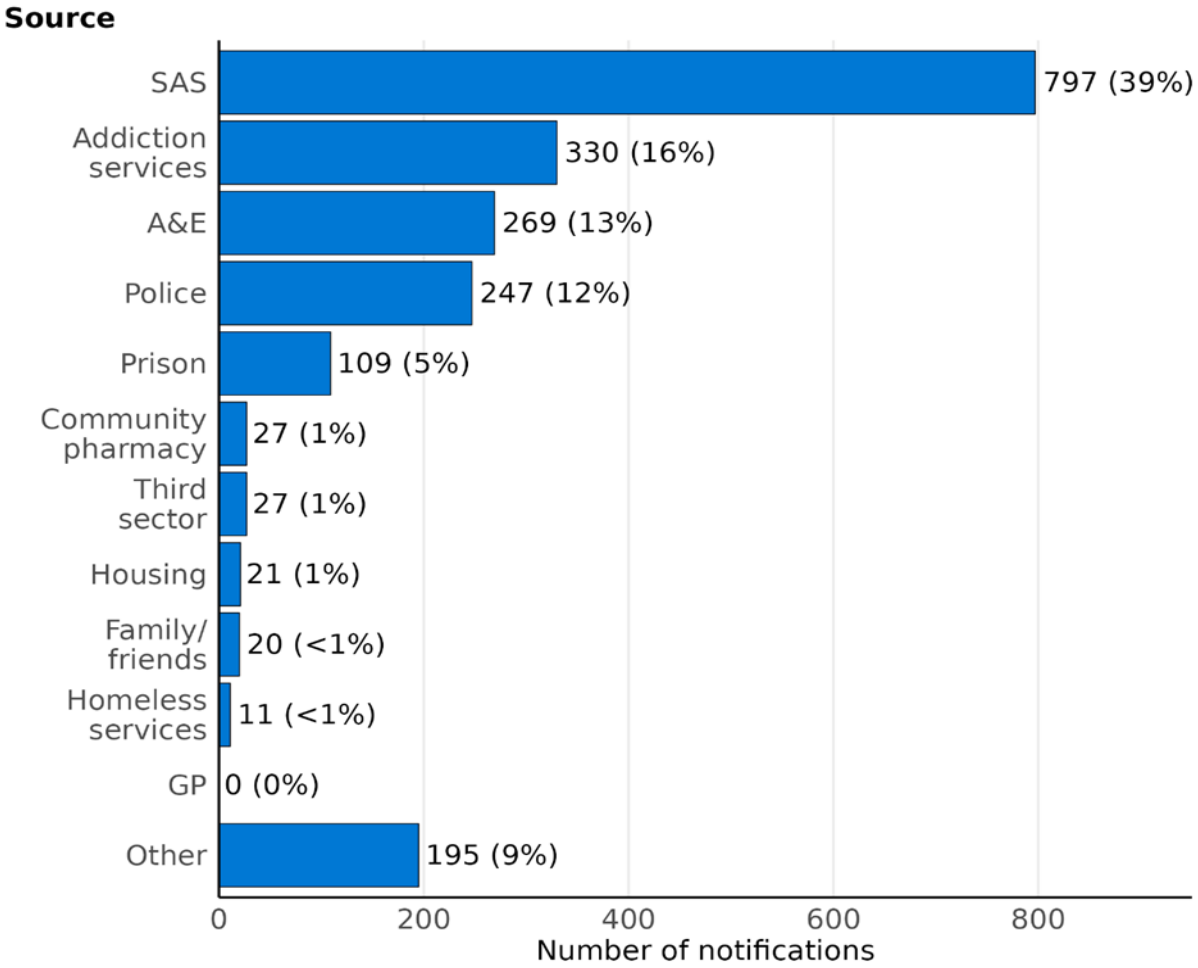


Chart note: ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025.

Chart description: In 2024/25, for the selected three consecutive month period for each ADP area, a total of 2,053 high-risk events were notified. The highest proportion of those were from the Scottish Ambulance Service (SAS), 39% (n = 797) followed by addiction services, 16% (n = 330) and A&E 13% (n = 269). Police make up 12% (n = 247), other 9% (n = 195), prisons 5% (n = 1,095). Community pharmacy, the third sector and housing each account for 1% (n = 27, 27 and n = 21 respectively). Family/friends and the homeless services each make up less than 1% (n = 20, n = 11) and there were no notifications from GP services reported, most likely because they are not generally first responders.

Chart 8: 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 2024/25

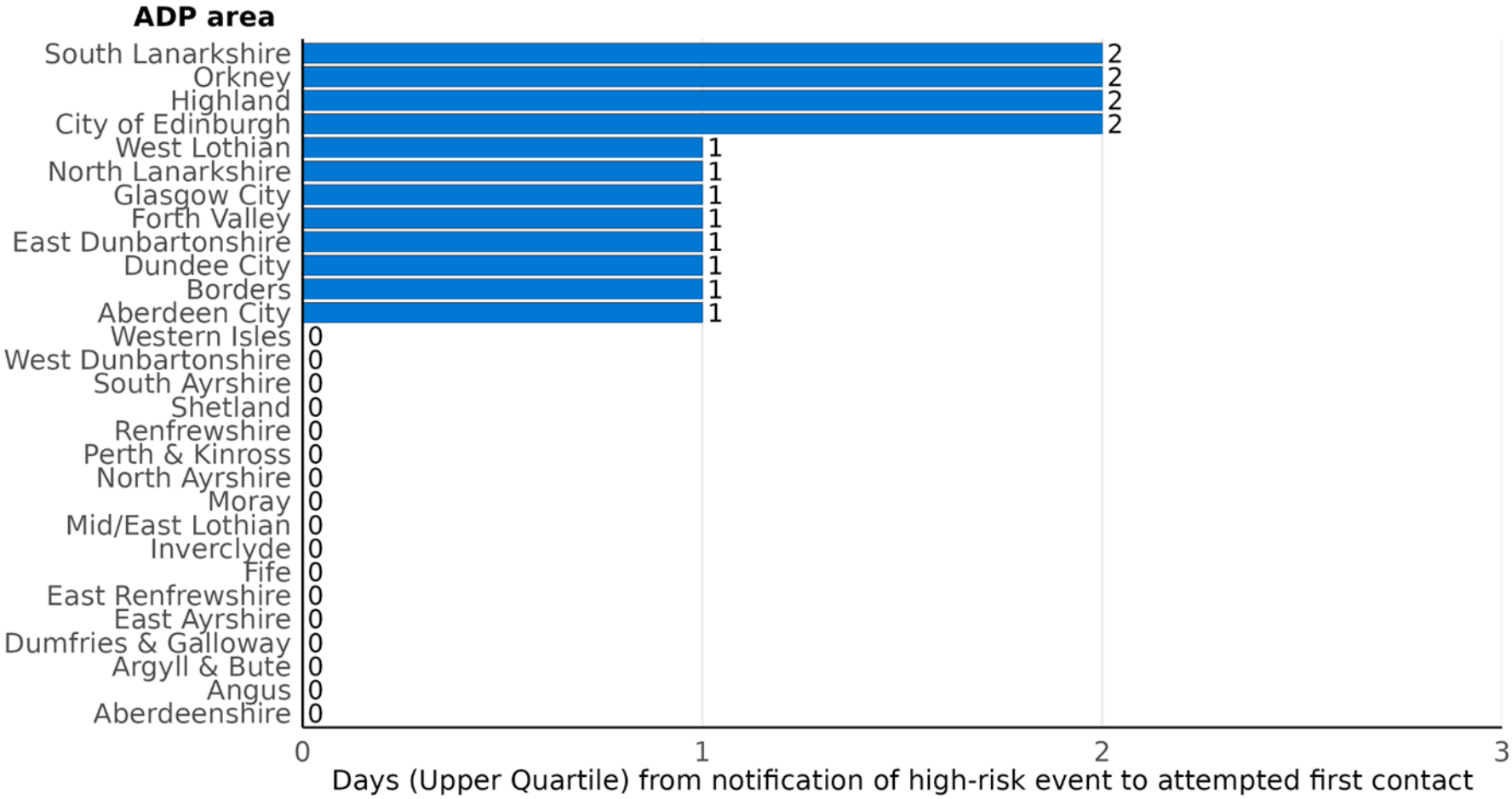


Chart note: ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025 (see **section 3. Methods** for more information).

Chart description: The time taken between notification of a high-risk event sent and the first attempted contact varies from same day for 17 ADP areas, to 1 day for 8 ADPs, to 2 days for 4 ADP areas. All 29 ADP areas provided first attempted contact within the 72 hours stated in MAT standard 3.

It is also worth noting that the number of notifications of high-risk events reported ranges widely between ADP areas with the lowest number reported for a single ADP area being two and the highest 341, though this is highly dependent on the size of the ADP cohort. The median across all of Scotland was 51 notifications of high-risk events over the reporting period.

4.4.4 MAT standard 4: Harm reduction

The aim of MAT standard 4 is to ensure that all people who would be likely to benefit are offered evidence-based harm reduction at the point of MAT delivery, to minimise missed opportunities and to reduce stigma. Harm reduction measures include blood borne virus diagnosis and referral, injecting equipment provision, overdose and naloxone training, wound care and assessment of risks associated with injection and poly-drug use. Few areas (n = 23) had any implementation barriers for MAT 4 and were assessed green. Two ADPs were assessed as provisional green (which reflected a lack of experiential capacity overall and the impact of this on scoring) and four other ADPs showed sustained implementation (RAGB blue). It is important to note that there is no data recorded on how many people have actually been offered or have taken up harm reduction as part of the standard, since it only relates to the availability of these measures on site at time of referral, meaning the information obtained is not sufficiently detailed for a graph or chart. With that caveat in mind however, the process measures were universally in place and numerical indicators confirm that this is a well-implemented standard.

Benchmarking has seen this standard remain well supported and increasingly further embedded as standard practice for many areas. Harm reduction services in

Scotland, delivered in fulfilment of MAT 4 criteria are benchmarked in relation to their accessibility at the point of MAT delivery and have been characterised by significant expansion in 2024/25. This includes the opening of the Thistle safer consumption facility in one ADP area. A report on the service's activity will be available later this year.

4.4.5 MAT standard 5: Retention as long as needed

MAT standard 5 aims to ensure that all people who would be likely to benefit will receive support to remain in treatment for as long as requested.

None of the ADPs reported implementation challenges for MAT 5. Specifically, all scored green for both process and numerical outcomes. MAT 5 is also becoming firmly embedded as routine practice and will ultimately be captured in the current DAISy revision. Numerical returns show that people are being retained in treatment and this is supported by process data. Most areas have SOPs for MAT 1 to 5 and regarding MAT retention, there are documented processes in most areas for both assertive outreach and ensuring continuation of treatment.

Chart 9: Percentage of caseload retained in treatment for six months or more by ADP area – Scotland 2024/25

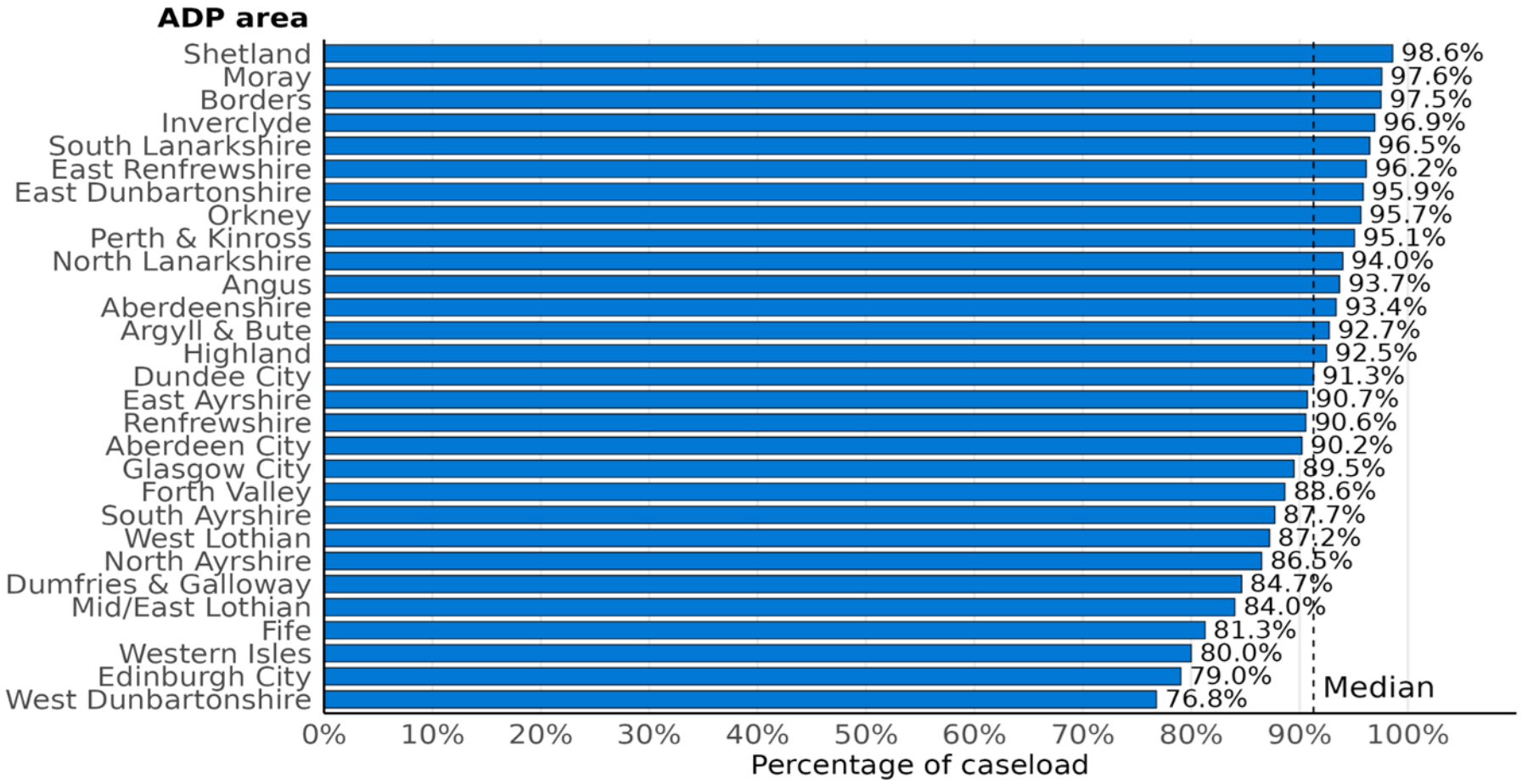


Chart note: These data are presented for a snapshot date in February 2025 (see **section 3. Methods** for more information).

Chart description: The total reported MAT standard 5 caseload was 21,212 with 90% (n = 18,995) retained in treatment for at least six months at the point of the reporting snapshot date.

All 29 ADP areas reported that 77% or more of their current caseload were retained in treatment for at least six months with the highest retention reported by Shetland (99%; n = 70). The median across Scotland was 91% of the current caseload retained in treatment for at least six months. Nineteen ADP areas reported 90% (13,618/14,789) or more of their individual caseloads retained in treatment for at least six months.

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

MAT standard 6 aims to ensure that the system providing MAT is psychologically informed, can provide psychosocial interventions and is also able to support individuals to develop their own social networks. MAT standard 10 aims to ensure trauma-informed principles underpin all care and support provided by specialist services. MAT standards 6 and 10 were assessed separately in 2022/23 but assessed jointly in 2023/24 and 2024/25 due to the overlap within process documentation, staff skills and training as well as delivery protocols.

Chart 10: 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 2024/25

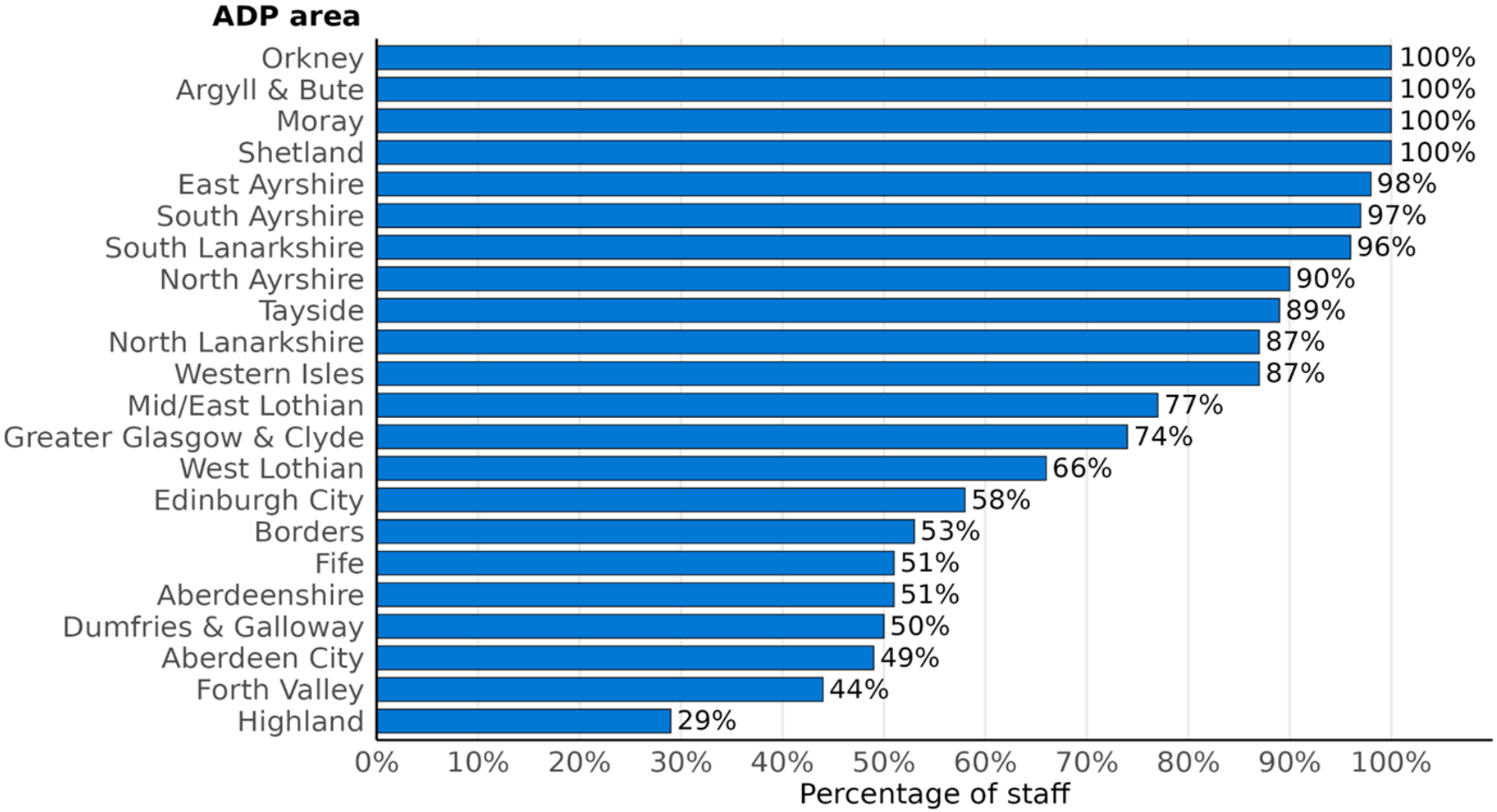


Chart note: The reporting period for Tier 1 staff training covers data from January 2023 to December 2024. Data were submitted at health board level for Tayside (Angus, Dundee, Perth & Kinross) and Greater Glasgow and Clyde (Glasgow City, East Dunbartonshire, East Renfrewshire, Inverclyde, Renfrewshire, West Dunbartonshire (see **section 3. Methods** for more information).

Chart description: Percentage of staff who have completed appropriate Tier 1 training in the last two years as defined in local training and implementation plans. Therefore, there is likely to be a variation in submitted data. 90% (26/29) ADP areas have achieved over 50% staff receiving Tier 1 training over that period.

4.4.7 MAT standard 7: Primary care

The aim of MAT standard 7 is to ensure that all people have the option of substance use intervention and support including MAT shared with primary care and this would help support receipt of care for general health issues.

MAT 7 has seen many encouraging developments this year with most areas scoring well but also adopting some alternative models of shared care. The criteria set for benchmarking aims to allow all people to be able to access MAT from Primary Care namely GPs and community Pharmacy. For confirmation of process, we requested details of local enhanced service (LES) agreements with GP practices. A number of ADPs find themselves struggling to have any impact on the interface between substance use services and shared care for individuals. One ADP area has no buy-in from GP practices around participation in a shared care steering group and there is at present no shared care in that area. Another ADP does have shared care but they have no documentation to support this therefore were allocated reduced scores on the process documents. This was the same for a further four ADPs all of which without exception did host some form of alternative shared provision that offered substance use patients tailored access to selected services in primary care.

Chart 11: Number of people prescribed OST by primary care by ADP area – Scotland 2024/25

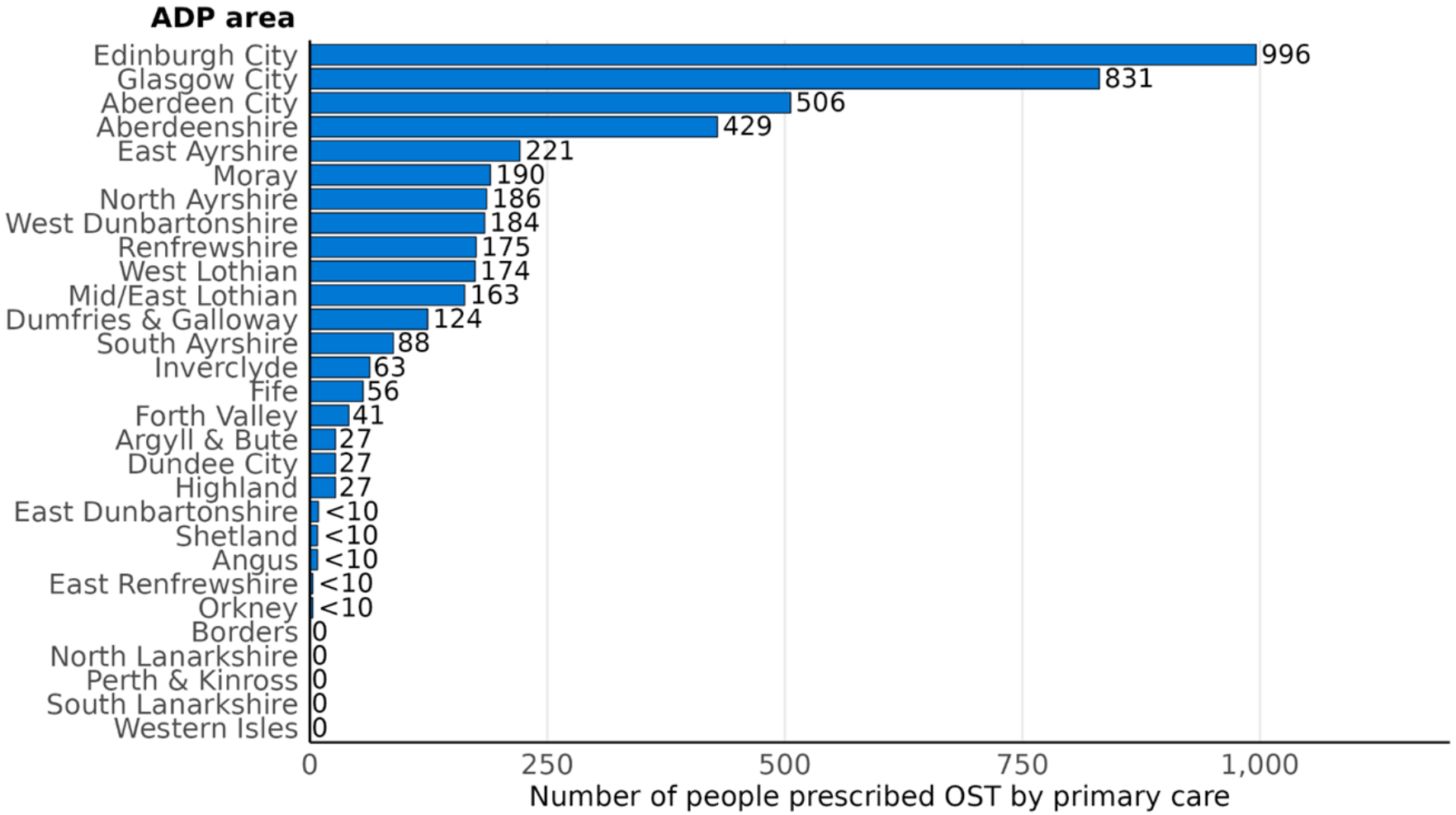


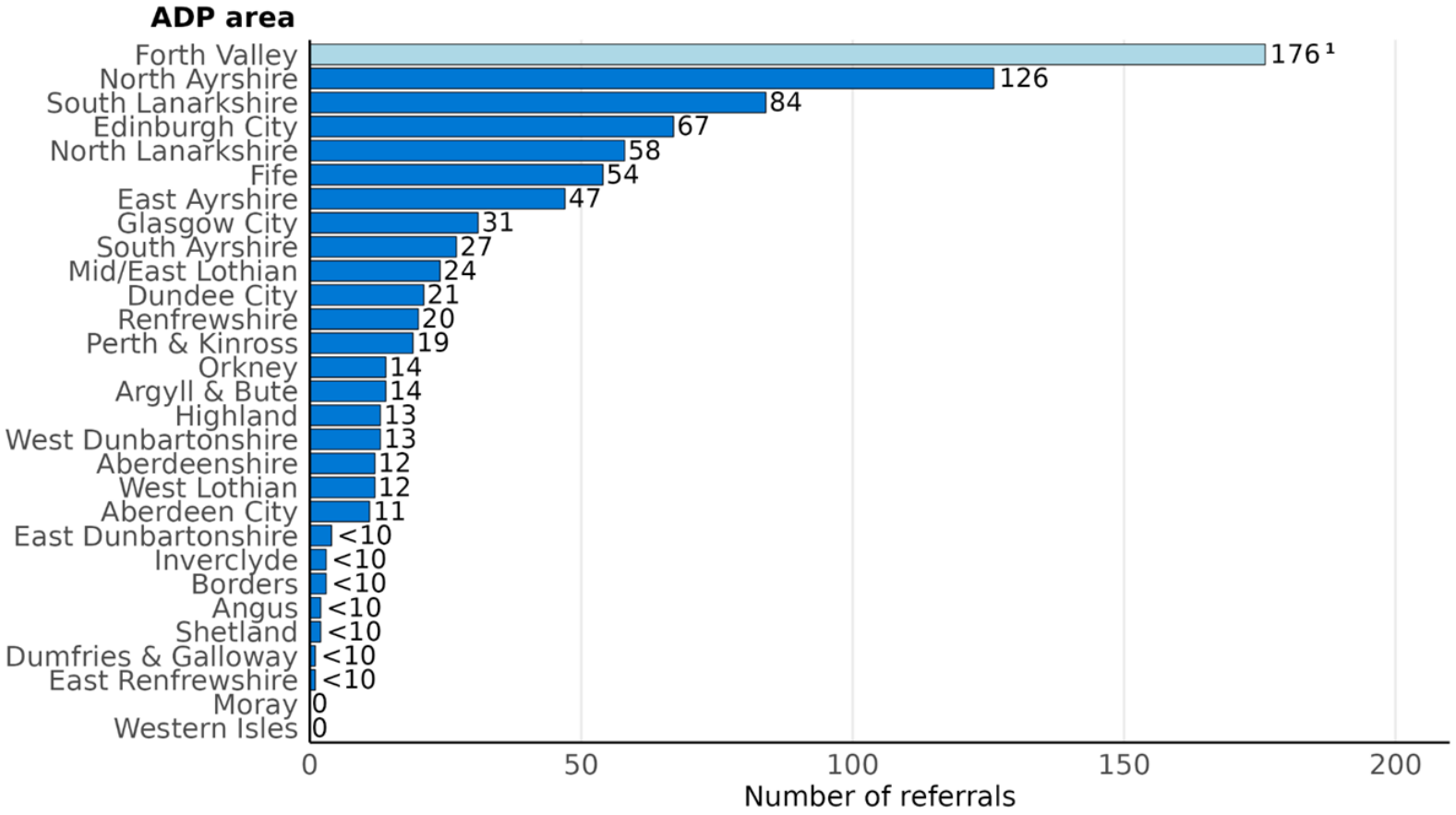
Chart note: These data are presented for a snapshot date in February 2025 (see **section 3. Methods** for more information).

Chart description: The reporting period for 2025 data covers any three consecutive months between November 2024 and March 2025. This shows that 4,539 people were prescribed OST through primary care, a reduction from 5,712 people reported in 2023/24. The City of Edinburgh had the most people prescribed through primary care with 996 people, which is also less than 2023/24 where 1,453 people were reported. Glasgow City followed with 831 people, both reflecting their larger populations and agreed models of care. Western Isles, South Lanarkshire, Perth & Kinross, North Lanarkshire and Borders had no patients prescribed OST through primary care, this remains the same as 2023/24.

4.4.8 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.

Chart 12: The referral numbers from substance use services to independent advocacy services by ADP area – Scotland 2024/25



1* Please see chart note

Chart note: Forth Valley may have included referrals that are not specifically from substance use, due to available data, confirmation was unavailable.

ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025 (see **section 3. Methods** for more information).

Chart description: For the selected three-month period, 792 people were referred from substance use services to advocacy for support. This represents a decrease of 5% from 835 referrals reported in 2023/2, larger than the percentage change decrease of 2% in overall reported MAT caseload. While Forth Valley referred the most people overall with 176 referrals these were not specifically referrals from substance use, so it is misleading to compare this total with other areas. North Ayrshire was therefore highest for known substance use referrals with 126 in total. Moray and Western Isles reported no referrals.

4.4.9 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 receive mental health care at the point of MAT delivery in an integrated way. MAT 9 is often a more complex standard to achieve as this is dependent on many services prioritising and working together. Some of the omissions for ADPs where the standard is reported as not being fully implemented may include interface documents or SOPs detailing the co-ordination between mental health (MH) and substance use (SU) services, with a number in draft stage or not actively being worked on.

Reflections from StIR meetings have nevertheless shown encouraging process developments in many areas with work continuing where the full standards have not yet been achieved. Process measures related to MAT 9 benchmarks have also become established in areas with work actively continuing in the areas not fully green to date. Encouragingly, there are no ADP areas which are completely lacking in any MAT 9 related development work that is ongoing or sustained for 2024/25. Some localities report having utilised **the quadrant model** to ensure referrals for those identified as eligible are supported by the correct services at the right time where

people can transition into other teams for support dependant on their needs. Reflections from the LLE community continue to cite perceived stigma in relation to services for which appropriate support structures are not always available.

Chart 13: Substance use service new referral screening for mental health difficulties across 29 ADPs – Scotland 2024/25

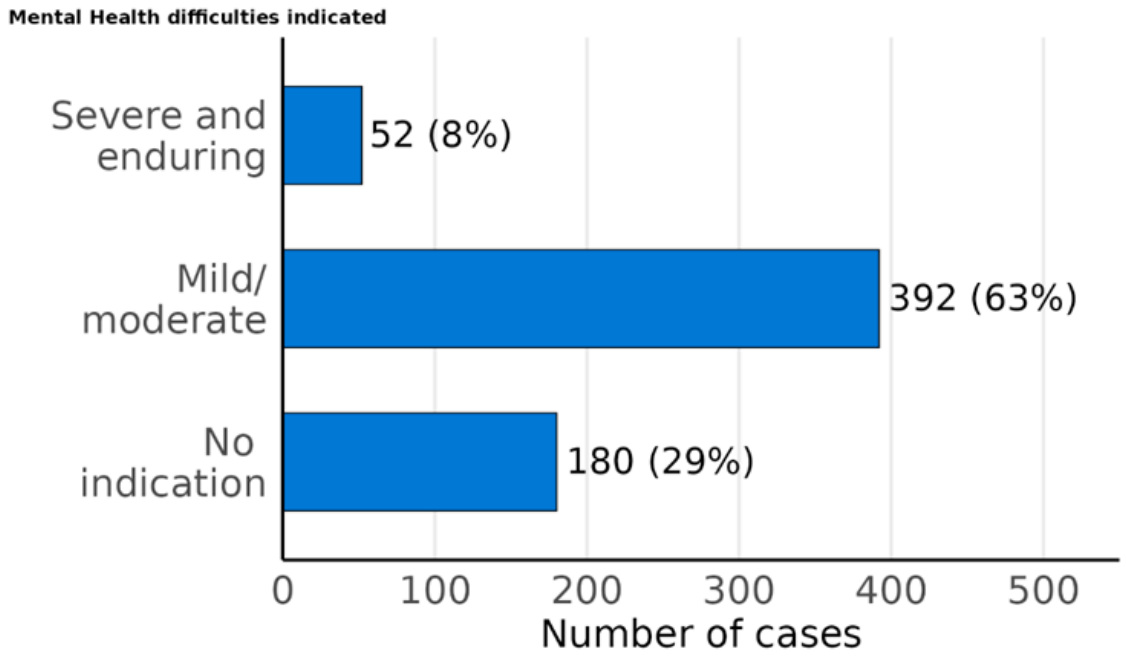


Chart note: ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025 (see **section 3. Methods** for more information).

Chart description: Data reported for MAT 9 show that during this reporting period, for 679 new referrals for MAT assessment, 92% (n = 624 cases) were reported with both screening took place and the result was documented, similar to the 629 cases reported in 2023/24.

The highest proportion of 63% (n = 392) of cases indicated mild/moderate mental health disorders, 29% (n = 180) of cases indicated no mental health difficulties and 8% (n = 52) of cases indicated severe and enduring mental health disorders. The

proportions reported are very similar to those in 2023/24 (62%, 32% and 8% respectively).

Chart 14: Substance use service new referral screening for existing mental health treatment, across 29 ADPs – Scotland 2024/25

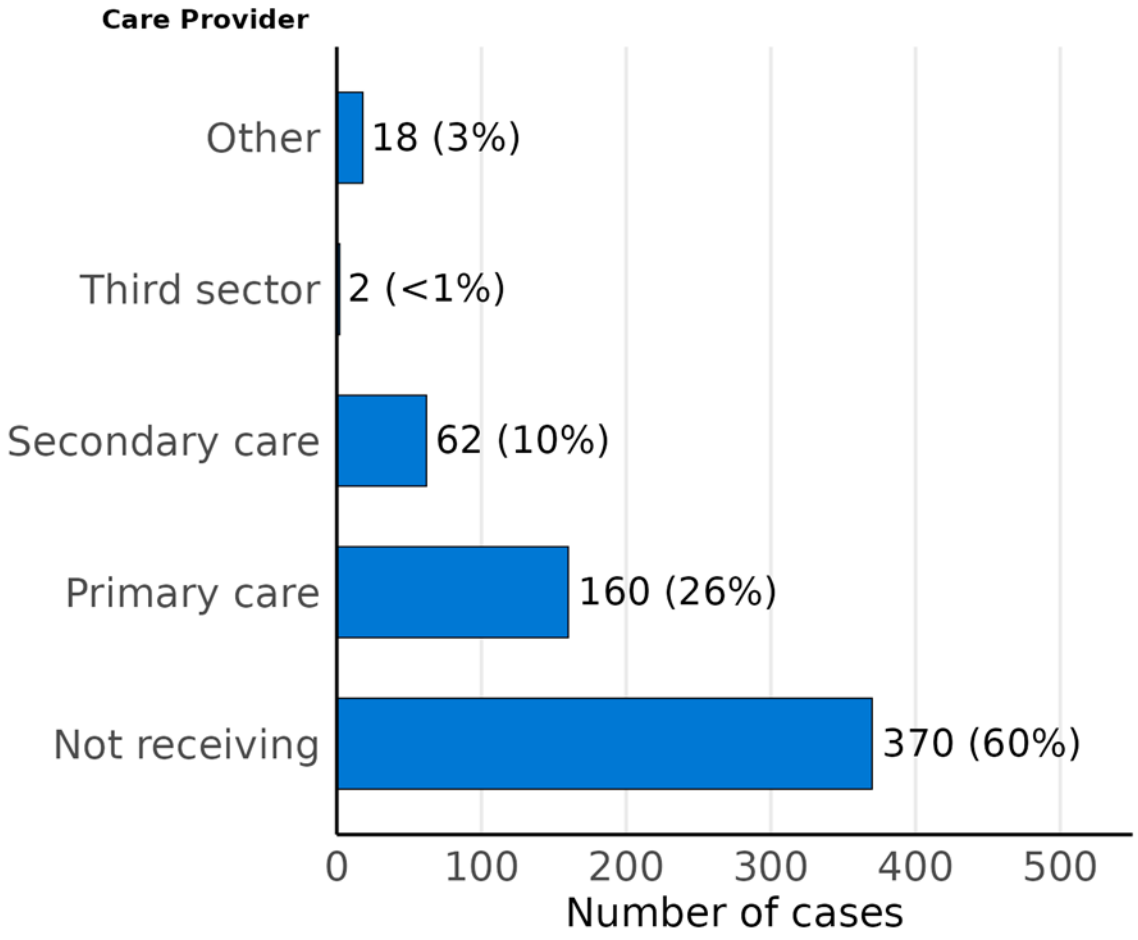


Chart note: ADP areas each chose a three-month period to report data from any three consecutive months between November 2024 and March 2025 (see **section 3. Methods** for more information).

Chart description: MAT 9 existing mental health treatments: In the three-month period selected, new referrals at MAT consultations, where mental health difficulties were identified at screening, 60% (n = 370) of 612 cases reported on were not currently receiving mental health treatment, 26% (n = 160) were receiving mental

health treatment through primary care, 10% (n = 62) through secondary care, <1% (n = 2) through third sector services and 3% (n = 18) were reported as other providers. In comparison to 2023/24 the proportions of those not currently receiving mental health treatment and those receiving mental health treatment through secondary care have increased from 56% to 60% and 7% to 10% of cases respectively. The proportion of cases reported as receiving mental health treatment through primary care and other providers are both lower than reported in 2023/24 (31% to 26% and 6% to 3% of cases respectively).

Chart 15: Mental health treatment agreed in care plan with the service user across 29 ADP areas, for new referrals – Scotland 2024/25

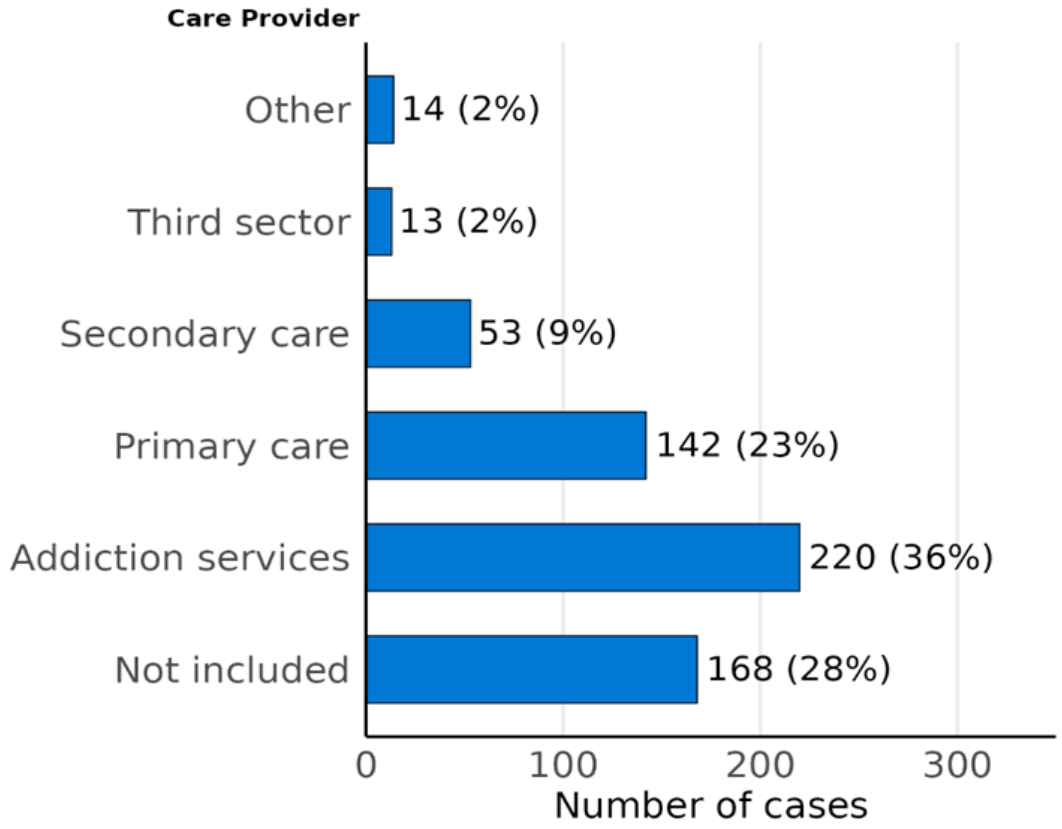


Chart note: ADP areas each chose a three-month period to report data from any three consecutive month period between November 2024 and March 2025 (see **section 3. Methods** for more information)

Chart description: MAT 9 Mental Health Treatment: for new presentations at MAT consultations, 168 of the 612 cases reported on for the three-month selected period, as those identified with mental health issues, had no mental health treatment in their initial care plan. With 23% (n = 142) of cases referred or continuing mental health treatment through primary care, 9% (n = 53) were referred or had continuing treatment through secondary care, 36% (n = 220) were referred or had continuing treatment through addiction services, 2% (n = 13) were referred or had continuing treatment through third sector care, and 2% (n = 14) were reported as other care provider.

In comparison to 2023/24, these data reported for 2024/25 show a decrease of 53 cases with no mental health treatment in their initial care plan. Proportions of those referred or had continuing mental health treatment remained around the same for both primary care and third sector care providers. Reported proportions for the care providers in secondary care and in addiction services increased from 2023/24 by 5% and 26% respectively. The proportion of cases reported as other care provider has decreased from 8% (n = 49) in 2023/24.

4.5. Experiential process findings

To evidence that the experiential reporting requirements aligned to RAGB (**see appendix 3**) have been met, ADPs were required to submit evidence of:

1. having the resources and capacity to carry out experiential work
2. a summary of activity including reflection on numbers of participants
3. raw experiential data (i.e. in its original, unanalysed form)
4. a self-assessment of service improvements using the FAIR approach.

The findings based on each of these requirements are reported below. ADPs were not required to provide results from their local analysis of experiential data therefore experiential findings are not reported here.

ADPs did however provide information regarding the facts gathered (see **table 2**) and analysis of experiential data (alongside numerical and process data) within the reporting templates. Data submitted within the two FAIR reporting templates provided supporting evidence to derive to overall RAGB score for MAT standards 6 to 10. These data were mapped and synthesised using FAIR as a framework to provide a brief insight of how the data gathered from people with experience of substance use underpinned the improvement work undertaken. This is presented below in the narrative for self-assessment of improvements and tables **3** and **4**.

4.5.1 Resource and capacity to deliver

The majority of ADPs indicated that they had not changed their processes for the experiential programme from the previous year. Most ADPs had provided documentation such as a standard operating procedure (SOP) or corresponding working document outlining their process for data collection and analysis. This often included how the experiential programme aligned with service improvement, oversight of the experiential programme and links with LLE groups.

17 ADPs had an identified experiential lead. Generally, the role of experiential lead was carried out alongside another role in the ADP (e.g. ADP Lead Officer) or the NHS. Other ADPs identified an individual or individuals as a key contact with responsibility for the overall experiential programme within the ADP. 20 ADPs had individuals in supportive roles, such as development or support officers, within the ADP or from third sector organisations. For example, 31% of ADPs commissioned a third sector or other public sector body primarily to complete data collection and analysis, whereas others completed this in-house. Six ADPs had analyst support for their experiential work. Many ADPs indicated that they had adapted the questions used within interviews and surveys, primarily reducing the number of questions and making changes to how questions were worded, in order to enhance participation.

4.5.2 Training

Twenty one ADPs incorporated the requirement to attend SRC locality interviewer training into their SOP or experiential plan for data collection. Other ADP areas did

not specify training for interviewers or indicate that their commissioned service undertook responsibility for recruitment and training. Locally, ADPs often indicated interviewers were required to complete additional training, such as adult protection and understanding trauma.

Chart 16: Number of people trained by SRC across ADPs between 2021/22 and 2024/25.

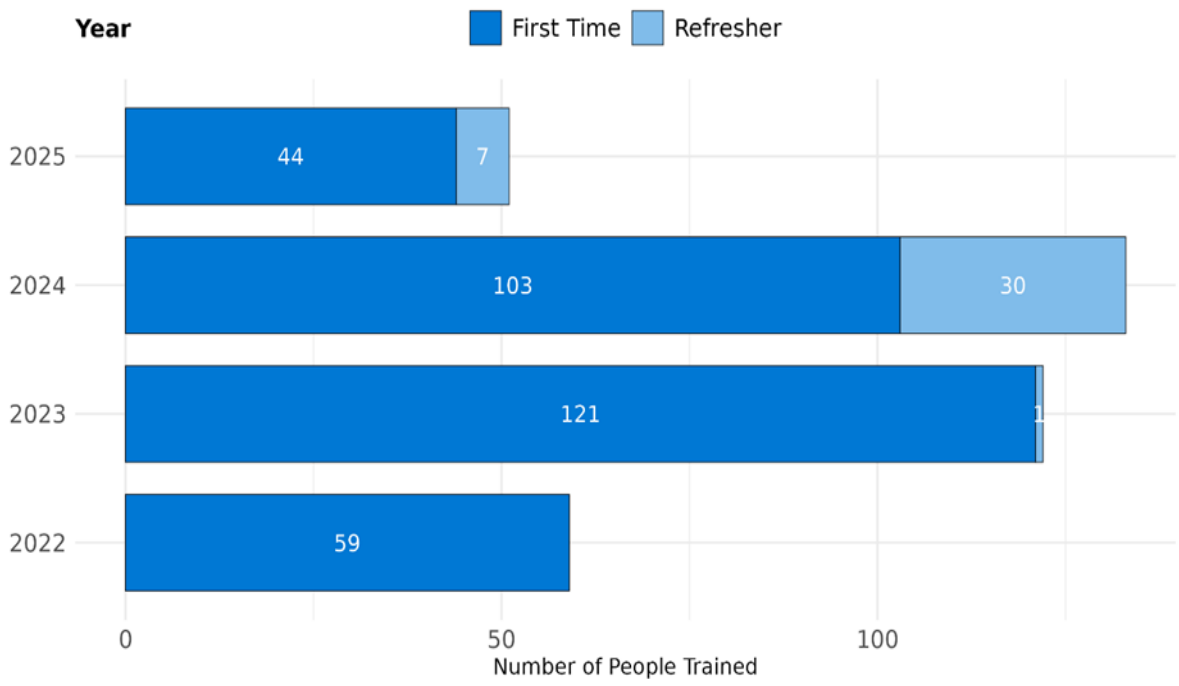


Chart note: These data are taken from information provided by SRC. Figures include those who refreshed or repeated a session or sessions including when the third skills-based module was added. These figures do not include those who refreshed their training more than once.

Chart description: The Scottish Recovery Consortium trained 365 individuals to conduct interviews across all ADP areas between 2021 and 2025. Of these, 38 completed further refresher training. In the first year (2021/22), 59 individuals were trained. During 2023/24 the largest number of individuals were trained (133) for 30 of whom these were refresher sessions. 2022-23 had the second largest number of individuals trained (122) with one refresher session completed. In 2024/25 (to report submission date) 51 individuals completed training with 7 refresher sessions.

A total of 449 people initially registered for SRC training with 84 people unable to complete the required sessions or not attending on the arranged dates. In the first two years of the MAT implementation programme the number of new individuals trained to conduct interviews by SRC increased from 59 in 2021-2022) to 121 people in 2022-2023. The number of new individuals completing training has subsequently declined from 103 in 2023-2024 to 51 in 2024-2024 across ADP areas. The number of locality interviewers currently active across ADP areas is not known.

4.5.3 Oversight and LLE groups or panels

Documentation was provided in 2024 of the existence of a multidisciplinary oversight group, including representation from people with lived or living experience of substance use. Further documentation and/or confirmation this was in place was provided in 2025 for 25 ADPs. Four ADPs did not explicitly report having an oversight or steering group. These groups take various forms and include advisory boards, steering, strategy or management groups with representation from NHS, ADP, Health and Social Care Partnership (HSCP) and people with lived or living experience including those from third sector organisations. Some groups were at health-board level, and some were sub-groups within the ADP.

Twenty-six ADPs reported engaging with LLE, beyond participation in collection of feedback, within the experiential programme. The form of engagement varied across ADPs. In some cases, there was greater emphasis on involvement from LLE groups or forums as drivers of the experiential programme. These had been set-up by ADPs or ADPs were utilising LLE groups already established within the local area. Some approaches were more passive. For example, some ADPs indicated that peer researchers were part of the ADP data collection team or they had engaged in informal consultation with individuals with experience of substance use. Two ADPs reported specific difficulties with establishment of LLE group, which had not progressed as expected, and therefore had limited involvement in improvement process within the ADP. The extent to which these groups functioned overall and were involved at each stage of the improvement and review process (in accordance with FAIR) was not always clear across ADPs.

4.5.4 Summary of activity and reflection on numbers

ADPs gathered feedback from the different types of participants (i.e. PAT, service providers and family/ nominated people) by a number of different methods. They used MAT-specific questions (i.e. utilising the questions provided by MIST or an updated version of these to gain insight into experiences of MAT) in interview (telephone, face-to-face and MS Teams) and survey form (online). They also collected MAT-related feedback through other sources such as conversation cafes, service questionnaires, other surveys, team meetings and local events. If reported by ADPs, feedback gained from MAT-specific interviews and surveys was distinguished from feedback from other sources. ADPs did not always report the specific method used (e.g. interview, survey or focus group) or if questions asked to obtain feedback were MAT-specific or MAT-related. The difficulties separating information reported by ADPs mean numbers should be interpreted with caution.

Table 3a: Experiential data gathered by ADPs in 2023/24 and 2024/25 – Interview or survey

Type of Participant	2023-2024	2024-2025
People accessing treatment	584	653
Service providers	342	274
Family or nominated person	148	130
Total	**1074**	**1057**

Table 3b: Experiential data gathered by ADPs in 2023/24 and 2024/25 – Other sources

Type of Participant	2023-2024	2024-2025
People accessing treatment	295	192
Service providers	133	295
Family or nominated people	46	71
Total	**474**	**>558***

Note: Other sources included focus groups, conversation cafes, feedback from commissioned services, local events and meetings. *Exact numbers of PAT, service providers and family/ nominated people are not known.

The total number of interviews or surveys carried out in an ADP area ranged from 0 to 129; one ADP area reported carrying out focus groups only. Despite an increase in the number of interviews or surveys carried out with people accessing treatment, over half (55%) of ADPs reported a decrease in data gathered from people with experience of substance use. Less feedback was gathered in 2024/25 from both service providers and family or nominated people than from the previous year.

Sixty nine percent of ADPs reported some level of demographical or service data (i.e. gender, age group, in treatment, type of treatment, residing in prison) for people accessing treatment who were interviewed or completed a survey. Most people accessing treatment who participated in interviews or surveys were male (54%), aged 45-55 (36%), were in treatment (92%) and currently receiving ORT (86%). No MAT-specific interviews or surveys were recorded for people residing in prison. However, one ADP indicated that two MAT-related surveys regarding LAIB treatment had been conducted with people living in prison (n=50). Only one ADP reflected on the numbers of participants and therefore representativeness of their sample.

Twenty ADPs provided additional case studies to complement the evidence submitted. These provided reflections from service-users in addition to detailing examples of service developments such as joint-working. During StIR meetings 20 ADPs indicated there was a level of ongoing work within the justice setting. This included direct work with prisons, for those located within an ADP area, as well as working with the early release programme and with individuals returning to their local community. Seven ADPs provided evidence of work being carried out with prisons and in justice settings, for example provision of advertising for local community justice events and one ADP provided a case study of a survey conducted in the prison setting (for further information see **Section 7 Justice – Local alcohol and drug partnerships**).

4.5.5 Submission of raw data on participant experiences

Twenty ADPs submitted raw experiential data, i.e. unprocessed or unanalysed feedback from participants. The remaining ADPs either provided no evidence for this measure or provided analysed or reformatted data such as summarised notes or bullet points from meetings and conversation cafes or representative themes from their analysis (reporting themes had been a reporting requirement for 2023-2024). During StIR meetings a number of ADPs highlighted concerns and difficulties around information governance, with specific reference to data protection issues. Limited details were provided making it difficult to determine with certainty the current challenges.

4.5.6 Self-assessment using FAIR approach

All ADPs provided a range of examples, using the experiential reporting template, of service improvements made across MAT standards 1-10 using the FAIR approach.

Twenty two ADPs each provided two in-depth examples of service improvements using the FAIR approach (see **table 2**), considering the AAAQ and PANEL principles. The FAIR examples provided assessed ADP priorities in terms of how these standards had been achieved and/ or actioned to date. The remaining seven ADPs either did not provide this information or provided limited details regarding progression of priority areas aligned to the FAIR approach and according to MAT standards 6 to 10.

The majority of ADPs detailed service improvements for MAT standards 7 (n=15), 8 (n=17) and 9 (n=12). Eight ADPs provided detailed FAIR assessments for more than two MAT standards.

FAIR: Facts

Evidence gathered to underpin the facts within the FAIR approach was mainly derived from experiential evidence collected during the previous (2023-2024) reporting period (select experiential feedback had been reported from this source in the 2023/24 publication). A combination of numerical data and local and/or national

process data, such as policies, was also commonly provided to complement this information.

For example, one area assessing improvements for MAT 7 (shared care with primary care) indicated that 92% of GP practices engaged with the local LES for drug treatment (numerical data). However, feedback from service users indicated that they wanted or there was a need for continuity of care, better access to GPs as well as a greater availability of face-to-face appointments (experiential data).

Where and when these data were derived from was not always explicitly documented and in some cases experiential data was not the basis of the facts gathered.

Table 4a: Summarised facts by MAT standards 7– 9 reported within FAIR templates – MAT standard 7

Evidence stream	Summary of facts
Numerical	Numbers supported by collaborative approach or by primary care delivery e.g. number of GPs prescribing opiate substitution therapy.
Process	Policy, strategies under development or in place to support shared care with primary care e.g. Local Enhanced Service for drug treatment, National Enhanced Service Level Agreement. If policies in place, often not in all GP practices. Some areas had no formalised pathway. Recruitment and resources barriers e.g. not having a Lead GP for substance use.
Experiential	Some indications that GPs (and other health professionals such as pharmacists) were involved in MAT-related care as MAT prescribers, for harm reduction and for other medical reasons. Involvement of GP often inconsistent and down to individual GPs rather than a specific policy or strategy. Mixed views from people accessing treatment on whether they wanted GPs involved in their substance use care or not. Some people accessing treatment thought that access to MAT through primary care could reduce stigma, offer anonymity, improve understanding of living with problems with substance use, could encourage engagement. Where people accessing treatment did not wish GPs to be involved this was often related to having previous

Evidence stream	Summary of facts
	negative, often stigmatising experiences or not having a relationship with their GP. Those with GP involvement indicated a level of satisfaction with their care. Involvement of GPs was often inconsistent and down to individual GPs rather than a specific policy or strategy. Service providers expressed uncertainty about involvement of primary care in terms of prescribing or role of pharmacy. They also indicated a breakdown of shared care in some areas with a reluctance among GPs to take on the role or withdrawing from prescribing MAT.

Table 4b: Summarised facts by MAT standards 7– 9 reported within FAIR templates – MAT standard 8

Evidence stream	Summary of facts
Numerical	Numbers referred to independent advocacy services provided, number of individuals accepting referrals to advocacy services.
Process	Independent advocacy implemented across ADPs. Some have adopted alternative models such as peer advocates from recovery community within remote and rural context. service level agreements, SOPs and referral pathways in place, although pathways not always well established.
Experiential	Information about or referral to independent advocacy was not always routinely offered to people accessing treatment or not offered at the point of need (such as after initial engagement). People accessing treatment would generally be in favour of access to advocacy. A lack of clarity was evident among people accessing treatment about rights to advocacy / service availability or the potential benefit of such a service. Other barriers identified included travel costs; not all referrals being accepted by independent advocacy providers or inconsistencies in information offered by service providers. Service providers indicated that they referred individuals to advocacy services. Service providers themselves, including social workers and clinical staff also often adopted the role of advocate. Although not

Evidence stream	Summary of facts
	necessarily appropriate for all, there was nevertheless positive feedback when they did provide advocacy support for people accessing treatment.

Table 4c: Summarised facts by MAT standards 7– 9 reported within FAIR templates – MAT standard 9

Evidence stream	Summary of facts
Numerical	Numbers of new presentations receiving mental health screening, numbers offered mental health screening at initial assessment, numbers receiving mental health treatment at time of assessment, service/ setting in which individuals receiving mental health treatment (e.g. third sector, secondary care, primary care), severity of mental health difficulties at initial screening (e.g. mild to moderate, severe).
Process	Many ADPs reported joint-working between Drug and Alcohol Recovery Services and Mental Health Teams/ Community Mental Health Teams. This took different forms or combined a number of formats: some areas had joint assessments or Single Shared Assessments including the use of **ASSIST-Lite** (short screening tool for alcohol, drug use and smoking). Other examples of joint working between the teams included development days, care planning and regular multi-disciplinary team meetings but this was not consistent across or within localities. Some ADPs reported having no current joint working arrangements between Community Mental Health Teams and Alcohol and Drug Recovery Services/ Drug and Alcohol Recovery Services. While some ADPs indicated that interface documents and referral pathways had been developed or were under development, others did not have these in place. Several teams were co-located or shared a single service manager. A few areas had a steering group or planning group which focused on MAT 9. Criteria for access to Community Mental Health Team was another potential barrier: in some areas mild-to-moderate presentations were reportedly not seen by Community Mental Health Team and access to mental health teams often required stability or abstinence.

Evidence stream	Summary of facts
Experiential	Mixed experiences reported by people accessing treatment of mental health support. Many individuals received support as part of their assessment. Some were satisfied with the support received, others had less positive experiences reporting long delays and waiting times. Both people accessing treatment and family (or nominated people) indicated that there was a lack of information regarding available services. Family or nominated people suggested that MH was often not appropriately addressed or support available for family members and they weren't aware of support for themselves. Service providers indicated they were able to provide a level of support for mental health as well as making referrals to mental health services. They noted some issues with resource constraints such as not having referral access to clinical psychology or limited support available from third sector services introducing a risk of disjointed care.

FAIR: Analysis – Human rights at stake (AAAQ)

Most ADPs had identified priority areas for progression based on the previous year's data submission and relayed these during StIR meetings. The AAAQ was clearly utilised in many of the submissions. Some ADPs had not applied the AAAQ or any tool to assess the concerns identified through evidence gathered to better understand the potential rights at stake.

Table 5: Analysis of data by MAT standards 7– 9 reported within FAIR templates

MAT standard	Main concern(s):
MAT 7	Inconsistency and variability of involvement of primary care in substance use care in all settings (i.e. rural, remote and urban areas). Service providers uncertainty about how primary care are involved in MAT-related patient care.

MAT standard	Main concern(s):
	Availability not driven by patient choice or preference. Accessibility sometimes based on location, e.g. rural settings may be more usual to have GP involvement in shared care. **Main rights at stake:** Limitations in availability and accessibility. Lack of clarity regarding acceptability and quality – not enough data.
MAT 8	Limited awareness of the right to independent advocacy services among service users. Independent Advocacy not consistently offered to all service users at point of need. Limitations in accessibility of service for specific vulnerable groups and more generally due to opening hours, mode of delivery (e.g. telephone and online not suitable for all due to issues with digital literacy) capacity of service, location, criteria for referrals. **Main rights at stake:** accessibility (lack of clarity regarding acceptability and quality of service offered – requires further monitoring and exploration through feedback gathered)
MAT 9	Lack of clear, cohesive pathways between Alcohol and Drug Recovery Service/ Drug and Alcohol Recovery Service and mental health services for those experiencing problems with substance use and mental health. Barriers due to criteria in place for mental health services, i.e. substance use was a contraindication to referral to or acceptance by mental health services. Limitations in support for those experiencing less severe mental health problems, and for specific groups such as women. Capacity and resource issues across mental health services: psychiatry, nursing, general mental health. **Main rights at stake:** Availability, accessibility (limited experiential (and numerical) data with regard to acceptability and quality of service offered)

4.5.7 FAIR: Identification – Actions and responsibilities for Improvement (PANEL)

All ADPs provided information regarding improvements and related actions. The improvements detailed were often complex, multi-faceted approaches to address

identified gaps related to MAT standards within services. There was some indication of individuals, groups or organisations with responsibility to take forward actions but this was rarely reported. Generally, the priorities or concerns identified were based on the evidence provided in the facts and related to subsequent improvements but there was sometimes a disconnect between each of these parts of the FAIR approach.

Some ADPs aligned their actions clearly to the PANEL principles. Mostly the actions related to participation, accountability and empowerment. Under participation and empowerment, ADPs provided a sense of how they had engaged with services users and providers as well as others in decision-making and involved them developing policy and practice. An example of this in practice, included the engagement of people with lived experience through the local lived experience panel (LEP) and communication sub-group to support shaping advocacy service delivery.

Although process information had previously been submitted to suggest LLE panels or groups had been established, the information provided did not always explicitly indicate how those with lived experience were involved in the process of improvement. It was therefore difficult to determine the degree of involvement of people with lived and living experience within the ADP going beyond participatory activities such as taking part in interviews or surveys or engaging with people in the community to share improvements. Some ADPs did highlight that further work was required to improve involvement, to have better representation from those with LLE, including PAT and families, to strengthen these processes and to empower people to shape services.

4.5.8 FAIR: Review – Process indicators, evaluation and monitoring

The review section within the FAIR templates were less complete than other parts of the FAIR approach reported by ADPs. In response to reviewing improvement and implementation plans, ADPs generally provided broad, longer-term outcomes such as: ‘people can continue recovery in a service that best suits their needs’ (MAT 7), ‘people will have a better understanding of the policy and procedures relating to housing and homelessness services’ (MAT 8), or ‘an agreed operational interface

document between mental health services and substance use services is in place and evidenced by experiential data of staff and people (their families) accessing treatment and support' (MAT 9). Some ADPs provided details of measures and monitoring, including use of experiential data to understand impact, as well as future work but this was quite limited.

Reviews generally did not incorporate the current (2024/25) experiential data, thereby reviewing the evidence regarding the impact of changes made. Sometimes 2024/25 data was relayed, alongside experiential data from 2023/24, within facts but not within the review process.

5. Discussion

5.1. Implementation

The assessment of MAT standards implementation is based on the evidence submitted by ADP areas which is then scored against defined criteria to construct the RAGB score. Full implementation means that the criteria agreed have been met for the year of assessment. It is an important aspect of the annual RAGB criteria that they are intended to capture ongoing year on year improvements and for that reason are themselves subject to potentially being modified / enhanced with each reporting cycle. This means that even retaining the same RAGB rating as the previous year will require an appraisal based on the current year's requirements and any changes to the criteria. For 2024/25 for instance, there is significant emphasis on improvement measures being subject to protocols that can adequately capture service user perspectives and that these in turn are able to inform an ADP's self-managed continuous improvement plans. This was measured in FAIR model and experiential templates with process measures remaining the some throughout the criteria.

For the 2024/25 report, even with the additional complexities around reporting requirements to corroborate and demonstrate progress, ADPs have made very substantial progress in moving towards full and sustained implementation across the 10 MAT Standards. As the results show, 83% of the 290 RAGB reference scores across 29 ADPs, were graded as either fully implemented or sustained, the latter proportion being 7% of the total. Areas which experienced the most significant challenges were generally those in relatively remote areas with low OST populations and no prospects of economies of scale against already stretched teams and resources. In spite of these challenges, these same areas were often able to achieve exemplary practice by virtue of their high levels of innovation and unquestionable commitments to service improvements.

5.2. Key challenges

5.2.1 Data sharing and governance

A key challenge for other areas regarding the experiential programme related to information governance and data sharing; specifically, the sharing of anonymised raw data between ADPs and PHS as well as sharing challenges described between ADPs and commissioned services. One proposed solution to resolve the issue is to ensure participants are appropriately informed regarding data sharing to improve health outcomes (which could not be done within the reporting timeframe), this should be viable for future reporting. Data sharing barriers were also highlighted in the previous benchmarking report and a lack of clarity persists around the challenges within ADP areas including aspects of data protection legislation within health boards. Limited progress in addressing these issues has a bearing on developing a national overall perspective of MAT implementation and its impact for individuals using substance use services. In addition, this may negatively impact the prospects for optimising the use of LLE data and the subsequent sustainability of the experiential programme.

There may be a compelling justification to adjust benchmarking indicators for areas in the future, where the overall scoring in these areas does not align well with expectations, given otherwise impressive progress. In each of the areas where this applied, the most significant shortfall was around the experiential evidence component and the capacity to meaningfully reflect on the human rights aspects of delivery within accepted international frameworks, such as the FAIR template adopted by the National Collaborative in Scotland. Of course, there are already some extended time-windows for MAT 1 and MAT 3 in relation to ADP localities which are categorised as being ‘remote & rural’ in view of the well acknowledged additional access challenges faced in such areas.

5.2.2 Changing drug landscape and treatment challenges

It is probably a testament to the ambition of the MAT standards programme in Scotland that there are few international examples of efforts at a national level to coordinate treatment standards for those affected by substance use. While the relevant UK clinical guidelines or the so-called **'Orange Guidelines'** were last updated in 2017, much of the rationale which has underpinned the components of MAT standards are set out in that guidance including the importance of trauma-informed care, the value of psychosocial interventions, screening for mental health co-morbidity and addressing retention and wider harm reduction. Aspects of substance use treatment which remain characterised by an unclear evidence base such as treating benzodiazepine addiction or where there are no clear pharmacological interventions such as for cocaine or ketamine, present an increasing challenge to specialist services for the UK as a whole, especially given that proven treatment options for all three of these drug types depend largely on psychosocial treatment programmes, often with the probability of a residential component.

5.3. MAT specific reflections

5.3.1 MAT 1 to 3: Referral, choice and engagement

Notable among the current benchmarking submissions for 2024/25 have been several examples of integrating MAT 1 and 3 using an MDT approach with multiple agencies involved at the point of Non-Fatal Overdose reviews alongside virtually immediate referral into services such as the Aberdeenshire Responsive Intervention Engagement Service or **ARIES** (Overdose Response Team). This issue has been supported using digital systems such as Near Me and Teams or providing practical personalised support to access assessment such as lifts from partner agencies, promoting close working relationships in supporting patient choice and access to treatment.

By definition, 'opiate substitution therapy' or OST represents the only currently available 'medication' within assisted treatment programs for substance use for the

purposes of MAT appraisal. From a benchmarking perspective, this inevitably creates challenges for those areas who find that they do not have significant numbers of new patients requesting OST prescribing. There are a few reasons for this which are discussed in more detail elsewhere including a changed drug scene and people being retained in treatment for longer. Services also continue to see increasing numbers of patients attending with alcohol issues, which in some areas now accounts for the highest percentage of patients accessing treatment. The challenges presented by other drugs has prompted innovation and service developments in most areas. Care pathways for those using cocaine for example where there are no medically assisted treatments makes it challenging to link these into MAT.

Treatment for other substances are also generally enhanced by psychological therapies and can include residential rehabilitation placements. These are supported from ADP resources, but not solely and we have seen a growth of recovery community supports, often unfunded. The clear benefits of such community provision include ease of access with less perceived stigma than traditional services and streamlined care pathways, though their sustainability outside of mainstream funding routes remains a concern. High risks of harm due to cocaine use can include psychosis, injury and accidents as well as significant cardiovascular risk, which present specific challenges for therapeutic journeys.

Regarding treatment choice, ADPs look forward to seeing a cost benefit analysis as the price of medication is not thought to be the sole contributing factor around the economics of buprenorphine medications. Other cost savings/ potential benefits are harder to quantify though include the reduction in daily dispensing, better social integration and a reduced likelihood of trigger encounters in daily attendance. There is a widely acknowledged cognitive cloud effect associated with opioid agonists therefore alternatives may make some daily activities more feasible, including accessing tier 3 and 4 psychological therapies. One area described staff working in prescribing services where the benefits of LAIB have been realised, being hesitant to fully promote it as an option due to cost scrutiny in the current financial climate, so methadone remains the primary treatment. Overall, across Scotland treatment choice is becoming more firmly established with improved access to all treatment choices and relevant information provided as routine. There is ongoing work from HIS in

realising the residential rehabilitation as an option of choice and therefore within MAT 2.

For MAT 3 progress this year, there have been some changes to assertive outreach teams due to funding coming to an end and some of those services becoming NHS or statutory rather than contracted third sector services. This has resulted in some areas reducing their cover from seven days a week to five days a week which has inevitable implications for outreach capacity and responding to events out of hours.

Through the MAT 3 thematic group, clarification on the definition of a high-risk event has been sought in order to use a generic term that can then be assessed across all services in Scotland. An emergent consensus around the most relevant high-risk harms that should prompt an assertive outreach response include NFO, serious skin and soft tissue infections and high-risk transitions including unscheduled discharge from hospital, community treatment or prison. Specialist substance-use teams based within acute and emergency healthcare settings can also play a significant role in the early identification and investigation of high-risk presentations which have substance use as a candidate cause. Being located onsite, these teams can respond to immediate referrals with this effectiveness being supported by **international evidence**, although they are often subject to precarious funding arrangements both of which can impact their capacity to respond.

5.3.2 MAT 4 and 5: Retention and wider harm reduction

In view of the changing drug landscape noted above in 5.2.2., there is an aspiration for MAT 4 harm reduction efforts to be more generally applied for those affected by non-opioid drug types and the particular health risks they encounter such as cardiovascular complications related to cocaine use. Although these are not currently measured in MAT standards, this would clearly be a priority to address in future and was already implicit in our previous benchmarking report's recommendations. This would help services to be genuinely responsive to changing patterns of drugs used and their respective methods of consumption, including a rise in injecting cocaine as found in the RADAR reports.

MAT 4 thematic group members have assisted in the development of three surveys to support PHS work. These are around wound care, take-home naloxone in prisons and sexual health and blood-borne virus (BBV) testing pathways including the assessment of hepatitis B immunisation in prisons and in substance use services. The thematic group have also developed a survey to fill a gap identified as part of the FAIR process in MAT 4 information. The survey will review data of the actual take up of harm prevention and the associated outcomes rather than being restricted to offers of harm reduction made. This modification seeks to assess the real impact of interventions and map how they correspond with staff training needs. The thematic group has also been key in compiling a training needs paper using the returns from ADPs to develop harm reduction for MAT 4 national training. A good example of this is the **Greater Glasgow and Clyde (GGC) training videos for harm reduction workers**. Since staff training is clearly highly variable across services and ADPs, a degree of training standardisation will be critical to ensuring that services which are delivered are comparable across different regions and treatment providers.

Areas where vaccinations have been challenging to deliver due to a lack of facilities have responded with creative solutions such as re-configured pathways back into mainstream services and onward referrals where appropriate. These developments include links into primary care in remote and rural environments. Much of this harm reduction work remains within the remit of third sector services but has continued to grow in parallel with MAT standards progression and to be more closely aligned with mainstream services who work with substance users, leading effectively to a genuine expansion in the overall capacity of harm reduction services.

The thematic group for MAT 4 will continue into next year with an identified priority around using the earlier noted survey returns to better inform further refinements to practice where indicated. The group will also assist in the planned incorporation of MAT 4 information into DAISy. Such an integration with DAISy across a number of MAT standards should hugely facilitate the future of data capture for benchmarking exercises, as well as being of enormous value to all stakeholders with an interest in the improvement of harm reduction measures for both opiate and non-opiate drugs.

Some ADPs have shown a multiple shared service approach to maximising the retention component of MAT 5, between treatment providers, community pharmacy and third sector or families providing a positive impact to retention. This brings multi-agency communication and anticipatory care planning together to form a more fully rounded person-centred model of support. Previously, individuals were not highlighted until after leaving treatment which can prompt the requirement for lengthy reassessments. A key component for successful retention in treatment has been the existence of ongoing support pathways and good relationships cultivated by staff. It has also been highlighted in discussions with ADPs however that the treatment options for non-opiate drug types in particular may not require the same retention time periods. Given that MAT 5 does show low numbers of unsupported discharge, it is also important to note the change since 2022 of the total number of people on OST in Scotland. This reduction by almost 6000 people is worthy of further consideration, shown in Chart 5.

5.3.3 MAT 6 and 10: Psychologically and trauma-informed care

The investment and upskilling of staff capacities in Scotland reflected by the rapid progress in MAT standards 6 and 10 across all ADP localities has been encouraging and the development and embedding of the LPASS tool will be a major asset in continuing to monitor progress in this area. However, according to a **SDF publication in 2024** perceptions of trauma-informed care differ between staff, persons accessing treatment, family members and peer interviewers. For example, some staff thought their services were for the most part fully trauma-informed but many patients and family members thought there was perceptible stigma in relationships and environments of the care accessible to them. The SDF publication highlights training in this area as requiring further development. The further development of psychologically and trauma-informed practices in relation to substance use services is also likely to necessitate a more closely calibrated means of improvement monitoring beyond what can be gauged within an effectively combined ‘standard’, meaning that MAT 6 and 10 should be appraised separately in future.

5.3.4 MAT 7,8 and 9: Shared care, advocacy and mental health

As has been highlighted in the 2017 **Orange guidelines** and in a recently published **review by PHS**, the provision of integrated or shared care with primary care, set out under MAT Standard 7 is another aspect of substance use treatment characterised by unclear definitions and a dearth of information around outcomes. The MAT 7 aspiration that: “All people have the option of MAT shared with primary care” is further qualified by the stipulation that “Care provided would depend on the GP or community pharmacist as well as the specialist treatment service”. In practice from the current year submissions to MAT benchmarking, this suggested plurality of provision has enabled localities to reduce reliance on formal local enhanced service arrangements which have been beset with contractual complexities and broaden the provider base to community pharmacies and specialist-orientated practices.

Given the above widely recognised complexities therefore, it has been reassuring to see that the MAT standard requirement seems to have prompted innovation and locally tailored solutions. While these do not fit within the benchmarked criteria of MAT standards, they do appear to be supporting individuals with their healthcare needs, as evidenced through process measures but not numerical outcomes. Engaging GPs directly with shared care has also been described as being outside the capacity of ADPs to directly influence and perhaps as a consequence, MAT 7 remains among the most challenging of the standards to implement in full accordance with the parameters set out in the benchmarking specification (which focus on GP prescribing). However, there are indications from clinicians and service providers that the source of a prescription is relatively unimportant to patients as revealed in StIR meetings. Indeed, in some instances patients might prefer not to have their OST prescribed by their family GP. These aspects will be important to capture as innovation continues to evolve in shared care provision.

Since arrangements with other MAT standards such as the wider harm reduction measures of MAT 4 are also readily available in community pharmacies in which ‘Pharmacy First’ supports primary care activity, it is logical that this extends to MAT 7. By no means a full ‘shared care’ model in most instances, the use of community pharmacies to dispense LAIB, utilise premises as hubs or have key workers based in

pharmacies are not uncommon. Examples of shared care with pharmacies include those where the prescription is provided by statutory substance use services, but medication reviews are undertaken by staff within the community pharmacy, therefore providing substance use services within the primary care structure. Another model uses trauma-skilled and specialist substance use Advanced Nurse Practitioners working with primary care professionals to ensure the holistic care needs of people on MAT are met.

Where areas have improved their scores for MAT 7 this has invariably been because of the criteria being met due to the scoring methodology and not the alternative models described above. As highlighted above, this standard can take the longest to implement due to the complexities of enhanced care agreements; protracted negotiations with individual GP practices (dependant on the local population make-up), or from a starting position of zero provision in some areas. Enhanced care agreements have also been made with community pharmacies, particularly in areas with no alternative option from GP practices but also as there may be no pre-existing pathways in place for people on MAT to attend community pharmacy for medications as mentioned above. The standard itself was also set out prior to the COVID-19 pandemic and therefore does not reflect the massive changes in primary care which have happened since then.

A significant aspect of the less-than-optimal scoring for access to advocacy services in MAT 8 has been related to changes to contracts for independent advocacy services and/or the lack of formalised training for staff in what advocacy entails. For example, if ‘substance use’ was not mentioned in the independent advocacy contract, this has been described by ADPs as resulting in low pickup following referral from a substance use service to independent advocacy. Of course, if those accessing substance use services are entirely satisfied that their needs are being adequately met, there is likely to be no perceived need for any advocacy support, thereby reducing requests and referrals. These aspects are being addressed as contracts come up for renewal with additions to substance use services contracts going forward in some areas. Additionally, refining benchmarking criteria to accommodate instances where there may be a reduced need for advocacy needs also to be considered.

Scotland's ADPs are also responding to MAT 8 challenges using new and adaptive approaches to advocacy provision, which for the most part make use of third sector specialist expertise to either provide training for in-house staff (such as REACH) or are themselves contracted to provide advocacy for ADP service users. Given the full MAT 8 standard is now aligned with housing, welfare and social support, it is vital to broaden the information capture criteria to reflect these changes. Widening the scope will also address some of the concerns around the standards being overly medication focused and thereby having effectively reduced efforts and attention to fostering the growth of recovery communities to the disappointment of many who work in the sector.

The primary objective of MAT standard 9 to facilitate closer integration of substance use and mental health services has not been without its own challenges, probably reflective of the mutual access barriers that can characterise their interface and the fact that like MAT 7, such specialist onward referral is not within the gift of front-line services. Another possible reason relates to the post COVID-19 landscape where this type of service integration has not been an active priority for Mental Health services and not part of their strategic development. Until this is prioritised by both mental health and substance use services it will remain a challenge to address the gaps. Alternatively, this aspect of joint working might also have stalled locally due to staffing and leadership issues. While this perceived and frequently encountered separation in service domains has been long recognised, there have been recent significant strategic policy efforts at the national level to facilitate solutions. Most notable among these has been the publication of a **National Mental Health and Substance Use Protocol** by Health Improvement Scotland. The protocol sets out a five-component system of care for mental health and substance use in Scotland with a focus on greater alignment with whole system planning, with strengthened joint decision-making, leadership and accountability.

In view of the above national policy drivers for more integrated provision, the continuing high proportion of individuals in substance use treatment who are not receiving mental health support (63%) might initially be seen as discouraging. It is important to consider however that this information is being gathered at first referral, at a stage when psychological morbidity may not be an overriding concern. In areas

where MAT 9 initiatives have developed well, we see an already functional joint leadership with MH and SU services. The development of specialist hubs for instance, where MH, SU, as well as statutory and third sector services work together, can effectively strengthen the philosophy outlined in **No Wrong Door** that most areas adopt. These hubs and services are supported by MDT meetings and pathways to ensure there is governance around a person's journey.

The MAT 9 thematic group within MIST are currently supporting the development of a guidance document covering the skill needs of staff for embedding a human rights-based approach within their day-to-day practice for mental health services. The group are also looking to provide scoping for a derived secondary data set with the capacity to track health outcomes that have crossover relevance to both SU and MH. The new tool would utilise existing data sources such as the Scottish Suicide Database as well as DAISy. Future meetings will continue to develop these actions from last year but also look at other areas of poverty and deprivation as highlighted in the **Hard Edges Report** that affect health (including neurodiversity and complex needs), mental health and substance use. These recommendations will be considered within the thematic group's workplan going forward.

5.4. Limitations

While the introduction of the FAIR template to support a human rights-based approach has been broadly welcomed as a means of capturing experiential evidence for implementation and reviewing progress, its relative weighting in the collective scoring process has meant that the overall RAGB standard score for the current reporting year in some instances has been reduced from that seen for previous years. For these ADP areas there is clearly potential scope for providing greater assistance or scoring adaptions where they might very legitimately struggle with the experiential component. From experiential evidence in this report, numerous training sessions have been run throughout the programme, but it is not clear how many current interviewers are active throughout Scotland. The interviewers provide the essential experiential interviews required to align LLE evidence with meaningful service improvement. With the establishment of pre-set criteria for each MAT standard, there is a risk that these might overlook some of the adaptive innovations

and stifle alternative models of provision. An example includes the use of community pharmacy for shared care not being captured in scoring by MAT 7 target for GP prescribing such that those ADPs do not then receive due recognition for their efforts; this fits a numerical evidence stream but not the process evidence as defined in the benchmarking criteria.

For RAGB scoring as a whole, it is important to keep in mind that an improvement in the implementation score for any particular MAT standard does not necessarily imply that there has been a corresponding increase in the effectiveness of the services themselves in delivering any associated health gain. The score may simply be a reflection of greater accessibility or choice for example, both of which are very worthwhile in their own right and may also contribute to the effectiveness of a programme by (for example) enabling it to reach the highest risk individuals.

The effect of basing certain MAT standards on the data for new patients can effectively give the latter undue weighting thereby distorting the picture in terms of the efforts involved to meet the criteria for what can be a small number of relatively high need patients. Smaller caseloads can also mean less staff resources which can impact on the number of people coming forward to share experiential evidence, with implications for RAGB scoring as noted above; this can apply particularly to remote and rural settings.

The development of MAT standards based on OST prescribing means that retention time targets for other types of drugs such as cocaine or ketamine might be unrealistically long. As MAT fully adapts to all substance use therefore, it will be important to consider how other drugs and alcohol affect target outcomes.

The scoring system as a whole is not fully suited to areas of substantial variability between ADPs. Relative size has been alluded to above but there are clearly profound differences between ADP areas in terms of wider resources, local provider networks and respective populations that do not lend themselves to a ‘one-size-fits-all' appraisal system. We would therefore urge ADPs to focus on their own improvement journeys and not to be overly concerned with relative RAGB status in relation to other areas.

6. Adaptation, sustainability and risks

For standards not meeting full implementation scores, these were discussed through the Support to Implement and Report (StIR) meetings between November 2024 and March 2025, then reviewed by MIST clinical staff. MIST have reviewed safety measures, risks and proposed amendments to the current benchmarking criteria. These modifications will come into effect for the 2025-26 reporting cycle and will seek to accommodate work already underway by ADPs around developing alternative models of care provision, particularly for MAT 7(shared care), and MAT 9 (co-provision of mental health diagnosis and treatment). ADPs' perspectives have also been considered for how engaged other services have been regarding the implementation of MAT standards, particularly for those standards mentioned above, adding context to evidence in this year submissions.

The core components of the standards are now established in the community in most ADP areas and other areas are moving into these being sustained.

There have been substantial measures taken to make reporting more sustainable with the moves into utilising DAISy for numerical scoring in MAT 1,2,3,4,5,8,9 and the use of the LPASS created self-assessment to report on MAT 6 and 10. These will be tested in the forthcoming year and have some restrictions already noted such as the assessments being conducted by the services themselves, DAISy data being limited to the health services inputting and this increased data request adding to the existing challenged workforce. Much of the process measures required for meeting the MAT criteria are established and being sustained. However, these documents of process are mostly due for review throughout most ADP areas.

Some of the risks and challenges remain or have emerged as the programme has evolved; funding has changed or other improvements have highlighted the risks to other areas of substance use care and treatment. As a result of uncertainties about continued funding of the MAT programme 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 in the run-up to this. This issue was also highlighted within **the Audit Scotland report from 2024 of**

the Alcohol and Drug Services. This is particularly an issue for areas that have utilised funding to strengthen existing ways of working, leading to these services reducing in sustainability. We are seeing a risk that interim systems to collect numerical and experiential information have been set up by ADP areas and MIST, which may not be sustained or manageable with current workforce capacity. This may mean that data for improvement work is not available, potentially affecting prospects for continued improvement. The developments in the area of quality improvement and linking this into the FAIR model have not been realised in all ADP areas therefore this is also a risk around workforce and continuation of the FAIR model as a quality improvement tool.

During networking and meetings over 2024-25 a risk and sustainability issue of costs was raised in relation to LAIB. This was compounded by the use of this medication across the Scottish prisons and the early release programme referred to during StIR meeting with ADPs. The concerns were in relation to scrutiny of budgets already ongoing but the need to maintain current MAT for people upon release from prisons. This represents an ongoing sustainability issue in regards to the costs of medication in MAT.

As part of a **recent report by PHS** the drugs mission was reviewed from the perspective of the ADP co-ordinators. The outcomes were clear that this population feel the burden of delivering the mission outcomes while not always fully supported by the systems around them including those set up to support implementation of the standards, such as MIST. There was a clear perspective that the streams of national work set up to support are not always interconnected and by functioning independently may lead to duplication or add to data burden. This is a risk to gathering data, if not co-ordinated and clear, on roles and responsibilities of national services which can lead to enhanced burden on these ADPs and reputational risks. Another risk identified in this report is the impact on the wellbeing and health of ADP coordinators themselves, with over half of respondents finding work ‘extremely’ or ‘very’ stressful and a quarter reporting that work ‘makes existing health conditions worse’.

While sustainability of MAT implementation lies heavily with ADP coordinators and supporting roles, it appears this can have a physical and mental health cost. The roles within MIST have fluctuated to reflect the changes required for implementation which has in turn reduced the interface with ADPs to StIRs and to networks including those of the thematic groups. The ADP and MIST collaborative structures would be expected to continue to evolve as the mission moves on and the ADPs become more self-sustainable in their reporting and experiential programmes.

While full implementation of the MAT standards is necessary to reduce drug-related deaths, this is not sufficient on its own. For example, there is a need to reduce health inequalities related to poverty and opportunities at population level; tackle deprivation and trauma, to improve the quality and access to other treatment options, such as residential rehabilitation and to invest in the growth of recovery communities and also to ensure the human rights-based approach is applied to the whole system of care for people affected by substance use.

There is a risk that strategies to improve access, choice and care could not be sustained without full implementation of the full range of MAT standards. The system will be unable to meet the requirements of people, and improvement will not be sustained. As a result, the standards will not meet their aim of reducing drug-related harm in the longer term.

The implementation of MAT standards in justice settings is developing across the country. In police custody there are some early adopters doing very innovative work and overcoming local challenges, working collaboratively with partners. Prisons have shown progress in engaging towards MAT standard implementation and some of this has been shared with MIST. However, to scale this up so that all people subject to the justice system have equitable, consistent and sustained care in line with the MAT standards will require major developments in resource, workforce, coordination and data systems. Going into this year with the major reporting period for prisons in MAT standards, the reporting structure is still to be confirmed. Most ADPs have limited resources into prisons to assist with data and there are elements of the MAT standards applicable to different partners. The risk will be realised in the returns of the survey and then the benchmarking for report in 2026. As yet, benchmarks which

will be used to assess prisons have yet to be agreed, while the MAT standards will remain as those in the community.

As with other areas, remote ADPs have challenges around the changing drug scene with increasing benzodiazepines and cocaine use as well as continued higher volume of patients using alcohol in these areas to harmful or dependant levels. This is evidenced in the low caseloads and low referrals for MAT, noting the definition has been restricted to OST. The risks of this are that while not meeting the restricted criteria of MAT, the lower scores have a potential impact on services and funding provision. This also impacts on patients, families and workforce, to be part of services graded as lower performing due to what can be perceived as arbitrary criteria, not necessarily reflecting the impact each service and staff member are making to people and the community of people with LLE.

7. MAT standards in prison and justice settings

7.1. Introduction and background

Ensuring MAT standards parity across community and justice settings remains a key priority within the PHS MIST programme. In 2024/25 the programme focus was on developing systems, mapping services, identifying reporting structures and sharing good practices across justice settings. The forthcoming benchmarking of the ten MAT standards in prisons will be described in the 2025/26 annual report. This year's report does not provide benchmarking or reporting on the standards across any justice settings, namely the prison estate, police custody suites, social work or drug testing and treatment orders.

The data presented in this section includes case studies from local teams illustrating relevant MAT work across justice settings and information sharing from thematic and knowledge exchange events. Numerical and process data were not systematically collected for review and verification by MIST. MIST have been supported this year with access to unpublished justice setting data from across the NHS and SPS.

The new **SPS alcohol and drug recovery strategy (2024-2034)** contains four key priorities to tackle stigma, develop recovery pathways, engage people with lived/living experience and implement the MAT standards. Taking forward the MAT standards will involve working collaboratively with key partners and engaging all key sub-groups of Scotland's prison population, including sentenced and remand populations, to ensure consistent and full implementation across all prisons.

Implementation will take place within a changing context. For example, new **legislative changes** this year to reduce the prison population led to the introduction of an early release programme of some short-term prisoners. Three early release phases took place between February and March 2025 and were expected to reduce the sentenced population by approximately 5% compared to what it otherwise would have been, yet the current overall population remains at or near capacity. Alongside these population challenges, longstanding **changes in the illicit substances used** in prisons could be characterised by the emergence of synthetic cannabinoids, newer

benzodiazepines and synthetic opioids, along with new ways of introducing drugs into prisons using drones, as mentioned in the SPS strategy above. Many of the newer substances have an increased potency when compared to their predecessors.

Police Custody suites also continue to play a role in contributing to the MAT standards across justice systems. As of November 2024, there were 60 custody suites across Scotland and **Scottish Government data** for 2022/23 recorded 96,821 custody episodes across all suites. Police Scotland's response to reducing drug harms includes referring people to custody healthcare teams. A significant minority referred to the teams will have current or past access to MAT. Within this wider context, collaborative work continues to be progressed in justice settings with plans to undertake RAGB benchmarking of the ten MAT standards across all prisons throughout 2025–26. Therefore, the remainder of this section will provide an overview of the national Naloxone Programme and national Drug Early Warning System work in prisons, summary of the MATSIN justice network activity over the last year, learning from a recent knowledge exchange event, case studies from prison and police custody and reported developments in local ADPs will be described.

7.2. National naloxone programme

Scottish prisons continue to play an important role in supporting the **National Naloxone Programme**. Accidental overdose is a well-recognised cause of death among users of opioids and prison liberation is a known high risk to prisoners. Naloxone is a drug which temporarily reverses the effects of a potentially fatal overdose with these drugs and providing easy access to this, saves lives. This latest data is available from the **PHS quarterly reporting**.

Chart 17: Number of take-home naloxone kits issued by prisons, by financial year and quarter – Scotland 2012/13 to 2024/25

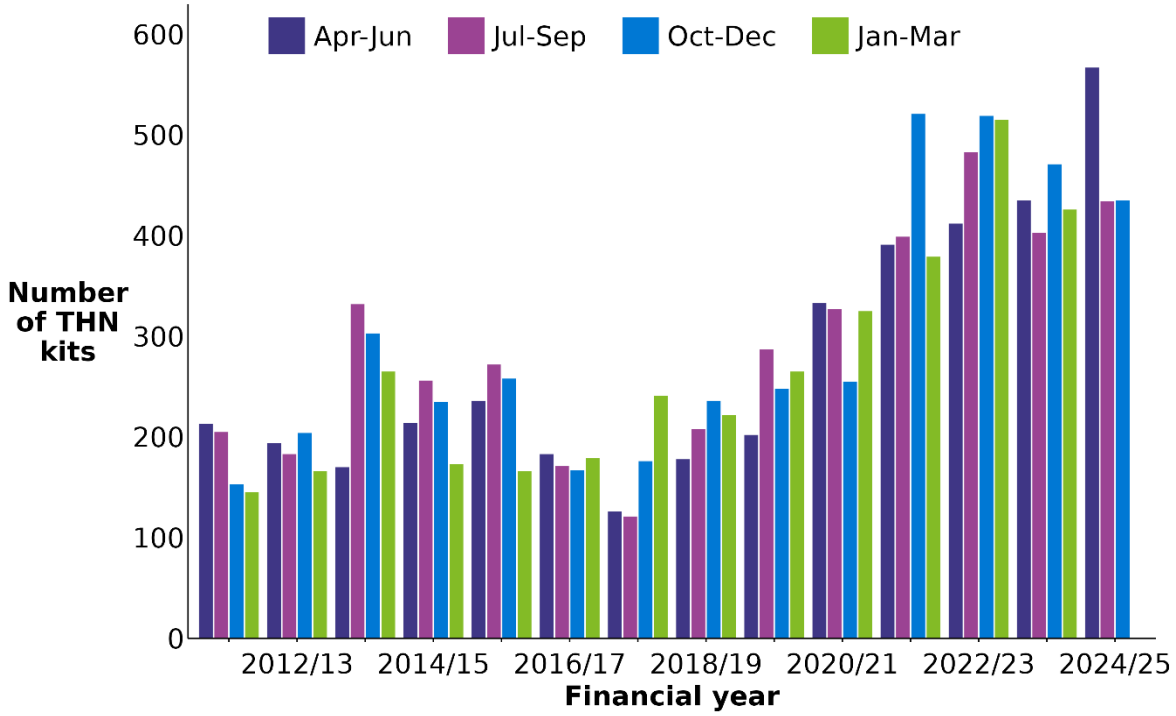


Chart note: The data presented is for the three-month ending time periods available, presented for the financial years 2012/13, 2014/15, 2016/17, 2018/19, 2020/21, 2022/23 and 2024/25.

Chart description: The chart reflects the changes over time in the number of take-home naloxone (THN) kits issued over 2012/13 to 2024/25. Methods to increase the number of kits issued have had positive impacts as can be seen with the increase in supply of kits, most notably from 2020/21.

The latest available PHS quarterly data showed that 435 THN kits were distributed on release from prison in Scotland between 1 October and 31 December 2024. This was similar to the previous quarter (434 kits) and an 8% decrease compared to the same quarter in the previous financial year (471).

Of the 435, THN kits issued during this latest quarter, 309 (71%) were reported to be a ‘first’ supply and 112 (26%) a ‘repeat’ supply, and one (<1%) a ‘spare’ supply. A further 13 (3%) kits were of ‘unknown’ supply type. Of the 112 ‘repeat’ supplies, 14

(13%) cases were because the previous kit was used on a person at risk (13 cases were ‘used on other’ and one case ‘used on self’).

The peer supply of naloxone commenced in November 2020 and remains an important harm reduction component in many prisons. The Scottish Drugs Forum plays a lead role in training peer mentors to offer naloxone administration training at the point of liberation to all, irrespective of drug use, and if training is accepted a THN kit is provided for use after liberation, if required.

Peer supply accounted for 72% of THN kits issued by prisons in this latest quarter with kits provided to people at risk, families and friends. Peer led approaches currently operate within 11 of the prison establishments across the SPS.

7.3. National drugs early warning system

Public Health Scotland coordinates the **RADAR** (Rapid Action Drug Alerts and Response) which is Scotland’s drugs early warning system. The RADAR aims to support partners, including those working in justice settings, by analysing and sharing data on substance use and attending prison incident management teams to respond to harms. The **quarterly RADAR reports** provide detailed insights into the drugs detected in local communities and prison settings to improve understanding of the different types and forms of drugs used. The latest data shows that synthetic cannabinoids, often called ‘spice’, continue to be the most prevalent drug type detected in prisons. The information helps to equip prison authorities, healthcare teams and policymakers to take informed action and implement effective support. PHS has also designed a booklet for prisoners to provide essential information on recognising and responding to a drug overdose. Produced by SPS and NHS Scotland, the **‘How to save a life’ resource** includes step-by-step instructions on how to respond to an overdose.

7.4. MATSIN Justice Network

The MATSIN Justice Network continues to meet monthly and serves as an important forum supporting a membership that includes partners working in prisons, police

custody, community, third sector, PHS and ADPs. Over the last year, the network looked at the MIST programme future priorities in justice settings, followed by an update on the work of the Scottish Health Custody Network, and a session on BBV testing and vaccination in prisons, which served as a catalyst for a subsequent Knowledge Exchange Event.

7.5. Knowledge exchange events

The first of a planned series of PHS online knowledge exchange events was held on March 2025. The event looked at BBV prevention, testing modalities and pathways in prisons. The target audience was frontline practitioners in prisons, NHS Board BBV Coordinators, ADP coordinators, third sector partners and people with lived and living experience of substance use and BBVs. The aim was to share good practice for learning and improvement and to provide recommendations for further implementation.

The key reflections to emerge from the event included the need for clear and consistent communication between Healthcare and Prison Staff for effective BBV testing and vaccination programs, tackling stigma around testing, more use of peer educators, and ensuring timely offering of testing and vaccination. Some key priorities identified included strengthening the workforce to ensure confidence in delivering testing and vaccination and closer working with partners like the Hepatitis C Trust and Waverly Care to support and expand reach and effectiveness. Other areas of concern were the need for funding to maintain and expand the hepatitis B vaccination program, ensure equity of access across all prisons, rolling out the HITT (Hepatitis C Testing and Treatment) trials, if successful, and improving data collection systems.

Future events will consider looking at how the managing risk in overdose can support MAT standards in prisons, how engagement with healthcare teams and residents can improve implementation of the MAT standards, sexual health and BBV prevention care and treatment in prisons, and how continuity of care could be strengthened across community and justice settings.

7.6. Prison case studies

In previous years of reporting case studies have been gathered and this was continued in 2024-25 for knowledge exchange and network presentation.

Between August 2024 and March 2025, offering Near Me video appointments in one prison led to 30 prisoners engaging with a local community addiction team before liberation. Video appointments were offered seven to 10 days prior to liberation. On the day before liberation, prison healthcare staff visited the person in the halls to provide typed details of the community addiction team appointment, naloxone kit, reminder of the community pharmacy from which to collect OST and the latest RADAR drug alerts. Building relationships and meeting with key community addiction team colleagues can support testing this type of continuity of care across justice and community settings.

Staff in another prison worked with services in a local authority area to develop a multi-agency approach to prevent prisoners being evicted from their homes and to provide support to those with a history of homelessness. This multi-agency approach was supported by four-weekly meetings with local authority partners and weekly meetings nearer liberation to ensure plans were in place. In 2023/24, five prisoners from the local authority area were offered Housing First support, rising to ten in 2024-25. Housing First supports people with multiple and complex needs with a history of rough sleeping and repeat homelessness. Support was also offered to remand and short-term prisoners by accessing established welfare benefits or other funding sources to maintain existing housing tenancies. This type of approach led to a set of positive housing and wider outcomes through services working together and sharing timely information.

As part of a series of tests of change, a similar multi-agency approach in another prison included a Complex Needs Co-ordinator accessing the prison halls to improve engagement with hard-to-reach individuals and ensure resources were targeted effectively. Other work included identifying if someone was of no fixed abode, sharing homeless applications with the local housing matching team, allocating property and a support worker. Community Care Grant applications to furnish tenancies could be fast tracked to decision makers and, if appropriate, families were engaged to help set

up the property. In 2024-25, across these tests of change 32 people signed up for support with 9 leading to sustainable tenancies. Despite housing availability pressures, there were plans to extend the criteria to include those accepting throughcare support and those with an offer of employment on release from prison.

7.7. Police custody case studies

As previously noted, based on a **Scottish Government report**, in Scotland there were 60 police custody suites and 96,821 custody episodes in 2022/23. Referrals to custody healthcare teams will include a portion of people with current or past access to MAT. Therefore, staff working in custody suites will continue to play a role in contributing to the MAT standards across justice settings as demonstrated by the following case studies.

A case study of two custody suites in one of Scotland's largest health board areas provided anonymised data gathered between September 2023 and September 2024. This showed that police made 1,702 referrals to custody healthcare staff, including repeat attenders in custody suites. Of the 1,702 referrals, 555 (33%) were accessing some type of OST. The majority (463) were known to local community prescribing services, of which 70 had stopped engaging with services. Almost one in seven (79) of the OST group received treatment in police custody for opiate withdrawals. Urine drug testing showed that the most common illicit use drugs were cocaine and benzodiazepines. The majority on OST (479 out of 555) were offered harm reduction interventions, such as foils, sterile injecting equipment, take home naloxone, BBV testing and condoms. Ten accepted some type of intervention and six agreed to onward referral to a local community addiction service.

A further case study provided an example of strengthening continuity of care in a semi-rural area. This involved a drug and alcohol service extending the pathway for people requiring OST in police custody to include those attending a local court. The aim was to maintain OST compliance and prevent drug withdrawal symptoms from occurring. Over 12 months, the service undertook 22 court visits to support clients on OST with each visit taking between 30-60 minutes, excluding time to document the visit on return to base. Building relationships with police and court staff enabled

effective communication and timely delivery of this intervention. Although the current level of demand was manageable, this type of unscheduled care was not part of a commissioned service.

An urban case study showed that nurses working in a city police custody suite noted a marked rise in the numbers of detainees under the influence of cocaine or crack cocaine. Among 606 custody referrals to nursing staff between January and May 2025, 81 tested positive for either traces of cannabis and/or cocaine, after taking a roadside saliva drug test. These changes are part of wider trends. Between July 2021 and February 2025, testing in outpatient drug services in this region revealed a gradual rise in positive testing for cocaine metabolites. Stabilising at around 40-50%, cocaine remains the most detected drug in those local outpatient drug services, reflecting the growing prevalence of use in the region. Responding to these changes, in June 2025 the custody nurses will participate in a wider pilot to deliver workforce training on cocaine brief interventions. Applying this type of intervention with cocaine users in custody could enhance their motivation to seek help. The training will also provide opportunity to audit the impacts of this new way of working in custody settings. This could include capturing referrals, if plans to develop a specialist service for cocaine users in an NHS primary care setting are realised.

7.8. Local alcohol and drug partnerships

Local ADPs provided an update on justice work as part of routine StIR meetings with MIST, though non-mandatory for collection as part of their benchmarking evidence. Among the ADPs providing updates, 12 indicated having some links with prisons and 7 reported having no prisons in their area, an important point of overlap across ADP areas. The 12 ADP areas described various types of engagement that included having clear pathways following liberations, including unplanned liberations, established links with recovery groups in prison, same day follow up response from prison to community and through care pathway. Two ADPs reported having strong links with social work in relation to liberations. Although 7 ADPs reported having no prisons in their local area, there were reports of some having processes and pathways in place for liberations. The complexities and practicalities around providing substance use services for prison populations especially around drug / medication

supplies and information / governance issues makes for a far less straightforward implementation process than for community settings and ADPs are not resourced with supports into prisons to co-ordinate reporting.

8. Conclusions

As detailed in the current report, the 2024/25 reporting cycle has seen substantial progress in the implementation of MAT standards 1 through to 10 from all ADP areas. The extent to which the standards have stimulated local innovation and the tailoring of services has been particularly noteworthy. Aspects of MAT which have proved challenging in previous years, such as establishing pro-active outreach services that are well-integrated with wider harm prevention measures have improved markedly. In addition, an increased provision of advocacy services and joined up models of care provision, by both health and social care staff as well as independent providers has further enhanced a genuinely whole system approach to MAT implementation. These developments have increasingly encouraged all involved to see the standards as a complete road map for those affected by substance use, as opposed to a separate distinct set of isolated objectives.

The embedding of a human rights-based approach from what has effectively been a standing start in the current year while making use of complex frameworks such as the FAIR model has clearly enabled ADPs to progress and transition towards a situation where they can systematically interrogate their own systems and processes. The wealth of LLE data on which much of this validation work has been carried out will be the subject of a follow up report and will also help refine and modify the data collection systems for the next submission.

The greatest challenges around this year's submission have been for those standards which to some extent sit slightly outside the ADP sphere of influence, thinking of shared care (MAT 7) and dual diagnosis (MAT 9) in particular. In response however, these standards have also seen the greatest levels of innovation and locally developed initiatives, such as the use of community pharmacy and dedicated specialist providers. That having been said, the variability between areas does potentially make for a very unequal playing field and further targeted modifications such as expanding verifiable benchmarking criteria to accommodate such innovations will be explored for the next report.

Even setting this report's cited examples of innovative practice aside, by far the greatest achievement of ADP areas overall in 2024/25, has been their demonstrated capacity to embrace a steep learning curve and embed a human rights-based lens at the heart of their review and learning processes. While human rights-based principles might be an obvious foundation for substance use treatment provision, to have taken such great strides in a single year to formalise this foundation is a great credit to the resourcefulness and commitment of the ADP community.

For the forthcoming year, the MIST team look forward to continuing to support ADPs on their improvement trajectories and extending the same aspirations that embody the MAT standards to the justice sector and other non-community settings such as acute care.

Additionally, of course, the predominant focus to date on opiate substitution prescribing is becoming increasingly difficult to justify and the standards, to ensure continued relevance need to seek to address this.

Finally, implementation of the MAT standards in justice settings remains a key priority in tackling drug-related deaths and the wider risks to health of individuals moving through custody settings. Despite fluctuations year to year, the number of drug use deaths in prison custody has increased and is similar to the trend observed in the general population, according to a report on **deaths in prison custody**. Therefore, looking forward, the important MAT related activities being undertaken across justice settings will serve as building blocks throughout 2025-26 to enable systematic reporting and benchmarking of the MAT standards across Scotland's prisons.

9. Recommendations

Based on findings in 2024/25, recommendations for the forthcoming year of MAT standard implementation are as follows:

1. Re-appraisal of the prospects for the formal inclusion of other substances (particularly non-opiates) and including benzodiazepines within the scope of MAT standards and how the programme might need to evolve to accommodate these in future in collaboration with other PHS, government and external colleagues.

2. For all MAT standards, review the reporting requirements and measures for evidence streams and develop resubmission guidance for 2025-2026 to support ADPs, and the substance use services that they commission, to remain standards compliant. Preparation for full year data submission should be considered for future years.

3. Continue to monitor and collate data on variability in models of service delivery, such as shared care and wider advocacy provision, with consideration as to how these might be benchmarked in consultation with relevant thematic groups.

4. Improve the alignment of MAT Standards with the National Mental Health and Substance Use Protocol and its whole system planning ethos, especially around the services' interface of mental health and substance use treatment.

5. Develop and support sustainable networks to monitor and instigate (where appropriate) service improvements within ADP areas. A significant part of this recommendation would be maintaining the case for substance use treatment and care that is adequately staffed and resourced, as well as clearly underpinned by human rights-based principles and corroborated by experiential evidence.

6. Renewed and enhanced development of numerical, process and experiential evidence streams, in consultation with relevant thematic groups, to optimise

data collection, improve data sharing and reduce data burden at a national level.

7. A critical review of LPASS guidance and implementation, with a view towards developing greater clarity and assurances by defining training requirements and measurement thresholds for categories of training completion and separation of MAT standards 6 and 10 for benchmarking.

9.1. Priority actions for 2025/26

1. Support the implementation of MAT standards in justice settings including the development of compatible data systems for the timely sharing of health data in line with governance safeguards. This would entail the development of measures for benchmarking across the three evidence streams for 2025-2026, collaboration on a prison experiential programme and a StIR model for prisons.

2. Finalise and agree a communication strategy so that MAT standards implementation and adaption are understood by all partners, including frontline clinicians, LLE community and other providers.

3. 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. This programme is under development and will be rolled out by the SRC experiential team in 2025-26 allowing sustainability into the future.

4. Contribute to the formulation of a clear transition plan, aligned with the PHS evaluation of the national mission on drug deaths, alongside PHS, NHS, the Scottish Government and third sector colleagues, for the continuation of MAT standards progress past the end of the Scottish Government Drugs Mission timetable in March 2026.

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Further information

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Appendices

Appendix 1 – Update on: Proposed actions for 2024-25– from 2023-24 benchmarking report

Given that last year's report outlined a total of 30 proposed actions, we have highlighted progress below on a selection of these. Many of the proposals have already been previously documented in this report. Due to a focus during 2024/25 on community implementation, prison and justice settings have not had the same degree of emphasis meaning that aspects of that work are yet to be fully developed, such as data collection systems and experiential components. For the sake of brevity commentary here is restricted to real progress updates.

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 exercises.

   From 2024-25: Within PHS, MIST numerical have been engaging with the DAISy team from PHS to develop an upgrade to their system featuring MAT standards, as a national database. Further developments of self-assessment tools for process measures are ongoing as DAISy begins to incorporate data collection for specific MAT Standards and work towards a more user-friendly dashboard model.

   Thematic groups are running for several of the MAT standards where there are developing workstreams, such as for the MAT 3 thematic group where high risk situations are defined to inform the addition of this MAT to DAISy. These groups will be able to continue post-MIST if needed and are not reliant on MIST for chairing or sustainability.

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.

   From 2024-25: The Charter was published in December 2024 and MIST supported ADPs to be early adopters of the FAIR model. This model has enabled a human rights-based approach to be imbedded at the heart of continuous service improvements. The FAIR model was used to support additional evidence in MAT 6 to 10 by showing service improvements linked to experiential evidence.

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.

   From 2024-25: Work is progressing with HIS involvement to review guidance for benzodiazepine treatments and two pilot studies are underway in separate ADP areas. For other substances, increasingly, areas are developing their own services such as for cocaine and ketamine. Education and harm reduction around changing drug threats is being supported by a number of third sector organisations.

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.

   From 2024-25: ongoing work into 2025-26, see **adaptations section**

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.

From 2024-25: A communications SOP is currently being developed which considers the numerous ways MIST engages with stakeholders including sharing best practice at MATSIN meetings, providing guidance and advice at StIR meetings and keeping stakeholders updated through regular forums. Ultimately, the greatest value of the information collated as part of the MIST implementation process is as a means of communicating with front-line services about the real and perceived impacts of their efforts to continue to improve services and maintain vigilance over service standards. The importance also of the lived experience perspective which is now central to mapping progress needs also to be clearly communicated and continuously informed, as well as challenged where necessary. Our communication strategy therefore needs also to live up to these aspirations and effectively facilitate a dialogue with our lived experience communities.

Numerical

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

   From 2024-25:

   - Mandatory fields for recording MAT standard 1 and MAT 3 were reduced. Immunisation and sexual health onward referral routes data were included in MAT 4 and GP LES take-up was added to MAT 7

   - Guidance was issued for the completion of MAT submission templates at the end of October 2024 with additional addendums being provided as required when the need for clarifications arose.

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.

From 2024-25: DAISy capture for MAT standards 1,2,4,5,8 and 9 on course for early summer 2025 for both community and prison settings. Development work with VISION (in prison settings) has stalled for contractual reasons.

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

   From 2024-25: Management Information reports were created and disseminated with ADP level analysis within each Health Board to support improvement work.

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 standards and includes the clinical process and experiential components.

   From 2024-25: The Charter was published in December 2024 and MIST supported ADPs to be early adopters of the FAIR model. This model has enabled a human rights-based approach to be embedded at the heart of continuous service improvements. Application of the FAIR model to two standards from MAT 6 to 10 was an evidence requirement to progress to fully implemented status in 2024/25.

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

    From 2024-25: See **priorities**

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

    From 2024-25: See **methods section**

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

From 2024-25: Generic findings from last year used as the basis of discussions with ADPs concerning their improvement plans

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

    From 2024-25: As was the intention for the current years report, there was a request for the submission of experiential data obtained from both interviews and focus groups. Since analysis of this type of data is time and resource intensive, it was not possible to complete this within the window for report completion. While a proportion of 2023/24 data has enhanced the FAIR template processes, the bulk of the experiential information submitted in 2024/25 is still to be analysed and will form the basis for a follow up report in due course.

14. Extend the experiential programme to justice settings.

    From 2024-25: Paused due to community support with FAIR implementation.

Justice

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

    From 2024-25: The work to be showcased in the Toolkit is under development with partners in ADP areas, National Prison Care Network and individuals in NHS Prison Healthcare with whom working relationships are now established.

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.

    From 2024-25: Support has taken place in the form of MIST engagement visits to all prisons this year with highlighted good practice at networks,

forums and events. Please also see **justice section** of this report for further case studies and practice.

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

    From 2024-25: Case Studies this year to reflect these areas of good practice.

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

    From 2024-25: Paused due to community support with FAIR implementation.

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.

    From 2024-25: Strategy and options to support the implementation underway through regular MATSIN Justice meetings.

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

    From 2024-25: VISION developments are currently stalled. DAISy updates are expected to be live from July 2025 onwards, this is with an accompanying wrap around support package including training in the new developments.

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.

From 2024-25: Ongoing programme of work with DAISy to refine data definitions and outcome measures for other substances including benzodiazepines for limited inclusion of MAT standards 4,8,9. Further national guidance on MAT for benzodiazepines will rely on outcomes of pilots and features in work of HIS. Certain MAT targets may need to be adapted for some treatment options (e.g. to offer psychosocial interventions within one day), so would likely to be included as RAGB indicators.

- Year 2: Support implementation and evidence collection.

  From 2024-25: Included in 2025-26 work.

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.

    From 2024-25: As with benzodiazepines, stimulant use is available to be captured via DAISy training and StIR meetings with ADPs will highlight this and the need for ongoing data collection.

23. Consider the above in terms of monitoring the offer of interventions under MAT 6 and 10 as well as MAT 1, 2, 4 and 5. Improvement work in this area could 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 instead be assessed through reflective practice against agreed guidance as discussed above.

    From 2024-25: Additions to DAISy for MAT standards 1,2,4,5,8,9 are available where there is a Medication (currently only OST). MAT 6 and 10 are available on the LPASS tool which will be maintained as the self-assessment for those standards in future, with alternative RAG scoring built into the self-assessment. MAT 3 for addition to DAISy at a later stage of development.

Priorities related to specific MAT standards

Please refer to **discussion section** where progress on MAT standard specific aspects of implementation is covered in context for 2024/25.

Stated priorities from 2023-24 report: Reply from 2024-25

1. Align the programme with the Charter of rights for people affected by substance use.

   Completed 2024-25: Use of the toolkit around the FAIR model has been demonstrated in all areas with support at StIR meetings and returns for the benchmarking report.

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.

      Under development 2024-25: Following Benzodiazepine SWLG in PHS cross organisation, passed over to HIS, for development of guidance as this reflects a clinical guidance improvement. As yet, there is no guidance under development for other substances.

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

      Publication awaited 2024-25: to date National Specification not yet published by the Scottish Government. MIST continue to support Charter of Rights approach following launch in 2024 and see **methods section**.

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.

   Improvements ongoing 2024-25: Most ADP areas have seen improvements or sustaining of the improvement already made. MIST have reduced StIR meetings to ADP areas with a view to moving to self-assessment and ongoing sustained improvements. MAT standards will be developed into the DAISy system following upgrades in 2025. For reporting in the 2025-26 period a duplication for DAISy and benchmarking over a short period will ensure there is equitable data entry and results are obtained.

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.

   Update 2024-25: A communications SOP is currently being developed. To date there has been no guidance developed by thematic groups.

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.

      Progress 2024-25: Face to face benzodiazepine event held, online knowledge exchange on BBV in prison held, MATSIN meetings, thematic groups and network events supported by MIST in total: 58 in 2024-25

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

Update 2024-25: MAT 3 thematic group reached the conclusion that full guidance on the implementation of the MAT 3 standard was not required: as shown in this benchmarking report MAT 3 is being met and is moving into sustained implementation for many ADPs.

A definitive consensus on what is constituted by the term “high risk event” remains somewhat elusive depending on the context, but as a minimum needs to include that set out in **MAT 3 guidance** namely: those who may have left residential, justice and inpatient settings, as well as those who have stopped attending treatment services and people who have just experienced a near-fatal overdose.

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

      Ongoing 2024-25: MIST continues to work with partners currently with an emphasis for the 2025-26 period on enabling ADP self-assessment to be self-sustaining and guided and informed by the Scottish Government's ‘post drugs National mission’ landscape. Ongoing 2024-25. This has continued in 2024-25 but to a much lesser extent, into the next reporting period when clinical improvement support will be available if required for ADP areas. However the main focus of this will move to implementation in prisons and supporting the clinical development in those establishments.

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

Ongoing 2024-25: this continues to be a question actively worked on.

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

Ongoing 2024-25: This has continued in 2024-25 but to a much lesser extent, into the next reporting period clinical improvement support will be available if required for ADP areas however the main focus of this will move to implementation in prisons and supporting the clinical development in those establishments.

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

Ongoing in 2024-25: as a main priority of the MAT standards this will always be a focus for MIST.

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.

Focussed work ongoing and delivered 2024-25: Workstreams for the upgrade and subsequent training in DAISy have been supported by MIST numerical team, this will continue until full upgrade of system. In 2024-25 support has been ongoing as required for Excel or REDCap to allow data submissions, this has also seen support in StIR meetings as well as individually and at network forums. VISION upgrade for prison healthcare clinical record is currently on hold for contractual reasons.

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.

Developed and implemented 2024-25: Training for trainers programme is under development and will be rolled out by SRC experiential team. This will be into 2025-26 allowing sustainability into the future.

Appendix 2 – 2024/25 RAGB table by ADP area

Health board	ADP	MAT 1 2025	MAT 2 2025	MAT 3 2025	MAT 4 2025	MAT 5 2025	MAT 6 and 10 2025	MAT 7 2025	MAT 8 2025	MAT 9 2025
Ayrshire & Arran	East Ayrshire	Green	Green	Green	Green	Green	Green	Provisional Green	Green	Green
Ayrshire & Arran	North Ayrshire	Green	Green	Green	Green	Green	Green	Green	Green	Green
Ayrshire & Arran	South Ayrshire	Green	Green	Green	Green	Green	Green	Provisional Green	Green	Green
Borders	Borders	Green	Green	Green	Green	Green	Provisional Green	Provisional Amber	Green	Provisional Green
Dumfries & Galloway	Dumfries & Galloway	Green	Blue	Blue	Blue	Blue	Green	Green	Green	Green
Fife	Fife	Green	Green	Green	Green	Green	Green	Green	Green	Green
Forth Valley	Clackmannanshire, Stirling, Falkirk	Provisional Green	Green	Provisional Green	Green	Green	Provisional Green	Green	Provisional Green	Green
Grampian	Aberdeen	Green	Green	Green	Green	Green	Provisional Green	Green	Green	Green
Grampian	Aberdeenshire	Green	Green	Green	Green	Green	Green	Green	Green	Green
Grampian	Moray	Green	Blue	Green	Green	Green	Green	Green	Green	Green
Greater Glasgow & Clyde	Glasgow	Blue	Blue	Green	Green	Green	Green	Green	Green	Green
Greater Glasgow & Clyde	East Dunbartonshire	Green	Green	Green	Green	Green	Green	Green	Green	Green

Health board	ADP	MAT 1 2025	MAT 2 2025	MAT 3 2025	MAT 4 2025	MAT 5 2025	MAT 6 and 10 2025	MAT 7 2025	MAT 8 2025	MAT 9 2025
Greater Glasgow & Clyde	East Renfrewshire	Blue	Blue	Green	Green	Blue	Green	Green	Green	Green
Greater Glasgow & Clyde	Inverclyde	Green	Blue	Green	Green	Blue	Green	Green	Green	Green
Greater Glasgow & Clyde	Renfrewshire	Blue	Blue	Green	Blue	Blue	Green	Green	Green	Green
Greater Glasgow & Clyde	West Dunbartonshire	Green	Green	Green	Blue	Green	Green	Green	Green	Green
Highland	Argyll & Bute	Green	Green	Green	Green	Green	Green	Provisional Green	Green	Provisional Green
Highland	Highland	Green	Green	Green	Green	Green	Provisional Green	Green	Green	Green
Lanarkshire	North Lanarkshire	Green	Green	Green	Green	Green	Green	Provisional Amber	Green	Provisional Green
Lanarkshire	South Lanarkshire	Green	Green	Green	Green	Green	Green	Provisional Amber	Green	Amber
Lothian	Edinburgh	Green	Green	Green	Green	Green	Green	Green	Green	Amber
Lothian	Mid/East Lothian	Green	Green	Green	Green	Green	Green	Green	Green	Green
Lothian	West Lothian	Green	Green	Green	Green	Green	Green	Green	Green	Green
Orkney	Orkney	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Amber	Amber

Health board	ADP	MAT 1 2025	MAT 2 2025	MAT 3 2025	MAT 4 2025	MAT 5 2025	MAT 6 and 10 2025	MAT 7 2025	MAT 8 2025	MAT 9 2025
Shetland	Shetland	Green	Green	Green	Green	Green	Provisional Green	Provisional Green	Green	Provisional Green
Tayside	Angus	Provisional Green	Green	Green	Blue	Green	Green	Provisional Green	Green	Green
Tayside	Dundee	Green	Green	Green	Green	Green	Green	Green	Green	Green
Tayside	Perth & Kinross	Green	Green	Green	Green	Green	Green	Amber	Green	Green
Western Isles	Western Isles	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Green	Provisional Amber	Provisional Green	Amber

Appendix 3 – Measurement checklist (2024-25)

Process measurements

Code	Process measurements	Tick
M1P1	Is there a documented care pathway that meets the MATs criteria?	
M1P2	Is there an SOP that meets the MATs criteria?	
M1P3	Are there prescribing guidelines that meet the MATs criteria?	
M2P1	Are there prescribing guidelines that offer all choices of medication?	
M2P2	Does the service have in place a Home Office license/s or an SOP for named patient prescribing?	
M3P1	Is there a documented care pathway that meets the MATs criteria?	
M3P2	Is there an SOP that meets the MATs criteria?	
M3P3	Are the above guidelines applied to all those at risk of drug-related harm?	
M4P1	Is there a local protocol or improvement plan in place to enable core harm reduction services at the same time & place as MAT & OST delivery?	
M4P2	Is there a training plan in place to ensure all staff offering MAT & OST can provide the core harm reduction services at the same time & place as MAT & OST delivery?	
M4P3	Is there a system to record the delivery of core harm reduction services at the same time & place as MAT & OST delivery?	
M4P4	Are there appropriate quantities, ranges & sizes of needles, syringes & equipment available to ensure that the correct equipment is used for each injection according to drug, injecting site & individual preference?	
M4P5	Is the necessary equipment (needles, syringes, filters, foils, naloxone etc.) & documentation available in order to provide core	

Code	Process measurements	Tick
	harm reduction services readily available in all rooms where MAT is offered?	
M4P6	Are appropriate harm reduction interventions offered to people engaged in polysubstance use?	
M5P1	Are there documented care pathways or models of support that meet the MAT standards criteria?	
M5P2	Is there an SOP that meets the MAT standards criteria?	
M610P1	Are documented MAT 6 & 10 service/delivery plans in place?	
M610P2	Service Audit LPASS MAT Standards 6 & 10 Implementation Self-Assessment Tool	
M7P1	Are there documented protocol(s) in place to share care between specialist services, GP & community pharmacies for people who are on MAT?	
M7P2	Are there documented pathways in place that enable the transfer of appropriate elements of care between specialist, mental health, GP & community pharmacy services?	
M7P3	Is there a steering group established to oversee the development & implementation of drug treatment in primary care?	
M8P1	Are independent advocacy services commissioned or engaged with locally?	
M8P2	Do staff have access to training to understand the role of independent rights-based advocacy & health inequalities training?	
M9P1	Is there a documented service implementation plan that includes the MAT criteria in MH services?	
M9P2	Is there a documented service implementation plan that includes the MAT criteria in SU services?	
M9P3	Are there agreed care pathways in place to support any identified mental health care needs across the ROSC & clear governance structures to establish effective joint working arrangements to care for people with co-occurring mental health & substance use?	

Numerical measurements

Code	Numerical measurements	Tick
M1N1	Does the data show that 75% of people are offered first MAT assessment (MAT1DI37) within 1 day from date of engagement with service (MAT1DI11)? (5 days for Remote and Rural areas)	
M1N2	Does the data show that 75% of people receive a prescription (MAT1DI29) for MAT(OST) are within 1 day from date of engagement with service (MAT1DI11)? This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M2N1	Does the data show availability of all 3 (4 where HAT applicable) OST options?	
M3N1	Does the data show that 75% of notified high risks events to multi-agency assessment team for assertive outreach have attempted first contact (MAT3DI20) within 3 days of notification (MAT3DI9)? (5 days for Remote and Rural areas)	
M3N2	Does the data show that 75% of notified to multi-agency assessment team for assertive outreach and Date of initial assessment (MAT3DI25) within 3 days of notification (MAT3DI9)? This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M4N1	Does the data show 75% of ADP MAT(OST) caseload have access to the four core harm reduction measures immediately? (As in Data Manual MAT 4(As in Data Manual MAT 4)	

Code	Numerical measurements	Tick
M4N2	Does the data show 75% of ADP MAT(OST) caseload have access to immunisation and sexual health? This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M5N1	Does the data show that 75% of MAT(OST) caseload are retained in treatment for 6 months or more?	
M5N2	Proportion of overall supported discharges vs unsupported discharges. This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M5N3	Does the data show that 75% of supported discharges are retained in treatment for 6 months or more? This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M5N4	Does the data show that 75% of unsupported discharges are retained in treatment for 6 months or more? This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M6&10N1	Have at least 50% of staff completed appropriate Tier 1 training in the last 2 years?	
M6&10N2	Number/percentage of staff delivering Tier 1 interventions who have access to appropriate reflective practice/coaching/supervision (governed by psychology) to support Tier 1 working (in line with local training and implementation plans). This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M6&10N3	Number/percentage of staff delivering Tier 1 interventions who have attended appropriate reflective practice/coaching/supervision (governed by psychology) to support Tier 1 working (in line with local training and implementation plans). This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M7N1	Provide number of people prescribed OST by Primary care and Pharmacy	

Code	Numerical measurements	Tick
	(Include service users in Primary care (GP and Pharmacy) currently prescribed OST (Exclude community services- NHS Addictions services/ Substance use services).	
M7N2	Provide number of GP practices on Enhanced Contract agreement (For OST prescribing) This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M8N1	Provide the number of referrals submitted to advocacy from SU services.	
M8N2	Provide the number for uptake of referrals submitted to advocacy from SU services. This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M9N1	Initial screening - provide numerical evidence for routinely checking MH and providing support (including referrals to appropriate service).	
M9N2	Provide numerical evidence for Mental Health difficulties indicated in the initial screening (self-reported, diagnosed or based on the impression of the assessing practitioner). This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M9N3	Provide numerical evidence for Existing mental health treatment in place at time of screening. This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	
M9N4	Provide numerical evidence for Mental health treatment agreed as care plan in conjunction with service user (at point of initial screening). This measurement will not be scored for the RAGB assessment but may be incorporated into wider discussions.	

Experiential measurements

Code	Experiential measurements	Tick
EX.P1	Resourced capacity to deliver your experiential programme. How well is this working\operating? Has there been changes actioned following consultation and learning in 2023\24?	
EX.P2	Documented procedures that set out how to identify local priorities, people to interview, (includes PAT, Fam\NP and Staff), and how to gather, analyse and use data to inform Continued Quality Improvement (CQI) work. This should include reflection and resultant improvement plans and evidence use of the FAIR model in this process. Has there been adaptions made to processes previously followed in 2023\24 to reflect these?	
EX.P3	Multidisciplinary working\steering group which includes representation of people with lived experience. Does this group link and provide feedback on improvements to existing engagement and recovery groups? Is there an existing and functioning LEP or LERN group, or plans to action one, that is included in the review process? How has this progressed in current year?	
EX.N1	To submit the number of interviews and other demographic detail using the adapted template from 2023\24.	
EX.I1	ADPs are requested to submit copy of their raw data for further analysis by MIST and reporting on a national basis	
EX.I2	Has ADP identified priority areas to progress and action. These to be discussed and detailed during regular StIR meetings\sessions and recorded in Comments and Continued Narrative cells provided in this spreadsheet. This should include comment and or detail to how the FAIR Model and the AAAQ process has been adopted in these deliberations.	
EX.I3	ADPs will complete tabs 1-10 in adapted Experiential Reporting Template from 2023\24 and provide examples as described in guidance tab in said template	
EX.I4	Is ADP giving consideration into how MAT Standards Implementation is to be integrated in Prison and Justice Settings ahead of reporting requirements being mandatory in year 2025\26? This measurement will not be scored for the	

Code	Experiential measurements	Tick
	RAGB assessment but may be incorporated into wider discussions.	
EX.I5	Ideally ADPs should also submit case studies. (Non-Mandatory and will not affect scoring)	

Appendix 4 – Experiential reporting template

ADP area:

Please read Guidance (TAB) and review the Example (TAB) provided for this Experiential Reporting Template before completing this spreadsheet

Provide example of processes followed which takes into account considerations to the PANEL principles when collecting experiential data, (with a focus on qualitative). This to include how and where the FAIR model and AAAQ has been utilised to identify areas for improvement as well as how processes can be developed to ensure delivery of a Human Rights Base Approach.

Considered PANEL Principle	Questions to consider	Standard 5. Criteria considered	FACTS gathered from experiential\qualitative data	ANALYSIS	IDENTIFICATION	REVIEW
PARTICIPATION: Ensures meaningful participation of everyone affected by substance use which can influence outcomes in healthcare decisions.	AVAILABLE. Are there recognised ways for individuals-as well as families and communities-to participate in and influence decisions made about healthcare treatment and support services? ACCESSIBLE. Are these forms of participation inclusive? Are people excluded for any reason? ACCEPTABLE. Is the approach taken responsive to peoples different needs? I.E. Women, Families, People with disabilities \ People of different ethnicities and language barriers, People with other health issues such as mental health. QUALITY. Is the approach to participation done in a non-stigmatising, trauma informed way? Are people able to influence the outcomes of decisions					
ACCOUNTABILITY: Improves health outcomes through enabling decisions to be challenged when rights are denied.	AVAILABLE. Are there different ways for people to address things that they are not happy with? Consider complaints procedures but also other less formal ways lessons can be learned. ACCESSIBLE. Are these ways of addressing issues inclusive? ACCEPTABLE. Are people with different experiences able to address issues? Consider the different needs of women, families, people of different ethnicities, people with disabilities and LGBTI people, people experiencing language barriers and people with other health issues such as mental health. QUALITY. Are the accountability mechanisms effective for individuals and communities? Are people able to get things resolved? Does poor practice change? Are there ways to follow up if nothing changes?					

NON-DISCRIMINATORY and EQUALITY: Helps identify the relevant rights-holders, particularly those at most risk, and ensure that there is equal access to all rights for everyone affected by substance use.	What is being done to identify stigma and discrimination against people who use drugs in different settings, including health and social care? Are people at most risk prioritised? Consider, for example: Women who may also be mothers who are afraid of having their children removed. Family members or carers concerned about any consequences for the family. People from ethnic communities who might experience racial discrimination. People who use differing types of drugs or who are not abstinent.					
EMPOWERMENT and CAPACITY-DEVELOPMENT: Enables people affected by substance use to know and claim their rights and improves the ability of duty bearers to implement these rights.	AVAILABLE Is information about services and support available to people? ACCESSIBLE Is information provided in a way that people understand and use? Is it accessible to everyone including those people who may not be engaged in services? ACCEPTABLE Is information provided in a way that is relevant for different groups? Consider the different needs of women, families, people of different ethnicities, people with disabilities and LGBTI people, people experiencing language barriers and people with other health issues such as mental health. QUALITY Is information adequate and useful for people? Are service providers adequately trained in relation to taking a trauma-informed, rights based approach?					
LEGALITY: Ensures that the checklist is grounded in the legal rights that are set out in the national and international frameworks	AVAILABLE Do services provide sufficient choice and person-centred support? ACCESSIBLE Are services inclusive? Are people excluded due to geographical or financial barriers? ACCEPTABLE Can services respond and adapt to people's different needs? Consider the different needs of families, women, different ethnicities, LGBTI people and people with disabilities, people experiencing language barriers, people with other health issues such as mental health. QUALITY Are services of sufficient standard? Are they de-stigmatised, evidence-based and trauma informed? Do they meaningfully involve individuals and families in decision-making?					

Appendix 5 – Numerical data for MAT 1, MAT 2 and MAT 5 by ADP: Scotland 2024/25

ADP	MAT 1 New Assessments	% of MAT5 caseload	Total	Methadone	% Methadone	Oral Buprenorphine	% Oral Buprenorphine	LAIB	% LAIB	MAT 5 Caseload
Aberdeen City	42	4%	991	684	69%	167	17%	140	14%	991
Aberdeenshire	31	5%	694	390	56%	146	21%	158	23%	694
Angus	<10	2%	380	225	59%	71	19%	84	22%	380
Argyll & Bute	<10	9%	55	28	51%	14	26%	13	24%	55
Borders	<10	3%	285	126	44%	45	16%	114	40%	281
City of Edinburgh	65	7%	940	559	60%	149	16%	232	25%	940
Dumfries & Galloway	11	2%	484	191	40%	76	16%	217	45%	541
Dundee City	21	2%	1,056	659	62%	157	15%	240	23%	1,056
East Ayrshire	36	4%	636	395	62%	110	17%	131	21%	905
East Dunbartonshire	<10	3%	194	106	55%	27	14%	61	31%	194
East Renfrewshire	<10	4%	130	91	70%	13	10%	26	20%	130
Fife	31	2%	1,549	1,054	68%	322	21%	173	11%	1,549
Forth Valley	36	4%	796	418	53%	124	16%	254	32%	810
Glasgow City	94	2%	5,276	3,335	63%	604	11%	1,310	25%	5,276
Highland	22	5%	439	200	46%	73	17%	166	38%	439
Inverclyde	<10	1%	619	443	72%	112	18%	64	10%	619
Mid East Lothian	24	6%	413	217	53%	42	10%	154	37%	413
Moray	<10	2%	207	143	69%	47	23%	17	8%	207
North Ayrshire	77	9%	586	372	64%	147	25%	67	11%	859
North Lanarkshire	26	2%	1,252	633	51%	106	9%	513	41%	1,264
Orkney	<10	*	23	*	*	*	*	*	*	23
Perth & Kinross	14	3%	446	267	60%	57	13%	122	27%	446
Renfrewshire	12	2%	711	522	73%	125	18%	64	9%	711

ADP	MAT 1 New Assessments	% of MAT5 caseload	Total	Methadone	% Methadone	Oral Buprenorphine	% Oral Buprenorphine	LAIB	% LAIB	MAT 5 Caseload
Shetland	<10	*	71	*	*	*	*	*	*	71
South Ayrshire	53	10%	395	229	58%	95	24%	71	18%	545
South Lanarkshire	18	2%	1,047	618	59%	277	27%	152	15%	1,047
West Dunbartonshire	19	5%	349	161	46%	46	13%	142	41%	349
West Lothian	23	6%	407	231	57%	84	21%	92	23%	407
Western Isles	0	-	*	*	*	*	*	*	*	*

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain confidentiality.

Appendix 6– Publication metadata

Publication title

National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2024/25

Topic

Substance Use

Data source(s)

Data submitted by Alcohol and Drug Partnership areas in Scotland

Date that data are acquired

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Release date

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Frequency

Annual

Accessibility

It is the policy of Public Health Scotland to make its websites and products accessible according to published guidelines. More information on accessibility can be found on the **PHS website**.

Disclosure

None

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Help email

Phs.mist@phs.scot

Date form completed

27 May 2025

Appendix 7 – 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’, i.e. 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 8 – PHS and official statistics

About Public Health Scotland (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.