Public Health Scotland

Substance Use Services from a Lived Experience Perspective - Reviewing the Evidence from 2024-25 around MAT Implementation

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1.0	16/04/2026	Document produced.

Contents

Executive Summary

The current report presents a lived and living experience perspective of substance use services with a focus on implementation of the medication assisted treatment (MAT) standards across Scotland centred on the MIST benchmarking reporting cycle for 2024-25. As a qualitative secondary analysis, its draws upon data from interviews, case studies, open-ended survey responses, and conversation cafes. These three primary data sources were collected by local Alcohol and Drug Partnerships and submitted to Public Health Scotland for the purpose of benchmarking (via a RAG rating scale), implementation progress for the Medication Assisted Treatment (MAT) standards.

As part of the Scottish Government's national mission to reduce an unacceptable and persistent toll of drug related deaths, the ten MAT standards set out to save and improve the lives of those people impacted by substance use by:

- Developing pathways to enable individuals to access appropriate care and support,
- Learning about what is working well and what needs to improve,
- Monitoring and appraising service performance as MAT standards are implemented, embedded and sustained.

Central to delivering these three objectives was ensuring that the voices of those with lived and living experience were represented and heard at the heart of service improvement. The source data for the current report came from Scotland's Alcohol and Drug Partnerships (n=20) who submitted qualitative data from ≈458 people currently accessing treatment (35% women, 65% men). In what continues to be characterised as a rapidly evolving substance use environment, many inevitably reported poly-substance use and the majority were between the ages of 35 and 54.

An initial grouping of the results gave rise to four broad themes which was further expanded to accommodate the full breadth of feedback and covered system wide questions around the extent to which services worked for or against people, as well as issues around access and transitions between different components and providers of services. Relationships with specialist support staff were a significant determinant of successful engagement and collaborative care planning, as were perceptions of physical and psychological safety and awareness of respective socio-cultural sensitivities and settings.

The resulting narratives often highlighted stark examples of inequitable treatment experienced by people accessing substance use services, illustrating the gap between current practice and the challenges of delivering a genuinely rights-based approach to healthcare. However, they also highlighted positive experiences and outcomes when the system focused on supporting recovery. While the re-use of qualitative data gathered for different purposes is not without its challenges, the resulting comparisons and contrasts can facilitate novel insights and help reduce the data gathering burden for front line staff. These extra benefits have particular value for more vulnerable groups as well as for community-based services where engagement can be difficult and resources are often constrained.

List of abbreviations

ADHD: attention deficit hyperactivity disorder

ADP: Alcohol and Drug Partnership

DAS: Drug and Alcohol Services

GP: General Practitioner

LLE: lived living experience

MAT: medication assisted treatment

MIST: MAT (medication assisted treatment) Standards Implementation Support Team

OAT: opioid agonist therapy

OST: opioid substitution therapy

PAT: person accessing treatment

PHS: Public Health Scotland

RAGB: red, amber, green, blue

SRC: Scottish Recovery Consortium

1. Introduction

1.1. Background

Despite recent decreases in drug-related deaths, with 1017 drug-related deaths in Scotland in 2024; a reduction of 13% compared to 2023[1], Scotland still has the highest drug related death rates in Europe. The Scottish Government's National Mission[2] set out to reduce drug deaths and harms with the ultimate aim of improving the lives of those impacted by drugs. Following the publication of the charter of rights[3] the MAT programme embraced the human rights tools and as such enabling participation and voice of lived experience to inform service change became a priority for the way that the MAT standards were delivered.

Reflecting the National Mission's aims[4], the core driving principles underpinning the implementation of Scotland's 10 Medication Assisted Treatment (i.e. MAT) standards[5] are to save and improve the lives of those people impacted by substance use by:

- Developing pathways to enable individuals to access appropriate care and support,
- Learning about what is working well and what needs to improve,
- Monitoring and appraising service performance as MAT standards are implemented, embedded and sustained.

Given the well acknowledged possibility that mismatches can arise between the experience of an individual and what the process and numerical data may tell us about a system and a population, it is easy to appreciate the enormous importance of a lived experience perspective. Even where numerical and process data for MAT 2 for example (which covers choice of treatment) indicate that choice is available, this may not be the experience of all individuals. Additionally, what providers regard as trauma-informed care for implementing MAT standard 10[5] may not be experienced as the same by a person accessing the service. This is especially the case for complex interventions such as standards 6–10 where a limited set of process or numerical indicators cannot describe the complexity of delivery and where there is a lot of warranted variation in models of care and methods of evidence collection. It is critical therefore that evidence gathering around the progress of MAT implementation can be corroborated as much as possible by experiential accounts.

The key enquiry process guiding the overall analysis of this report therefore is focused on the extent to which changes / improvements in services arose from identified needs and priorities and were verifiable from first hand experiences.

2. Methods

2.1. Study design

The overall design is that of a qualitative secondary analysis (QSA) of information gathered by Alcohol and Drug Partnerships (ADPs) across Scotland to monitor, evaluate and improve service delivery in accordance with the MAT standards. Undertaking a QSA rather than further primary data collection enables the re-use of data gathered to maximise what can be learned from existing data sets. This can reduce data burden and consultation fatigue in particular for more vulnerable groups such as those affected by substance use, where engagement can be more challenging[6].

Table 1. Overview of framework to assess and review the primary data set

Primary Data Set	Framework	Secondary Data set
Purpose: Determine and monitor improvements and to understand/ submit evidence of MAT implementation. Methods: ADPs recruit people with experience of problematic substance use. Feedback within the locality (interviews, surveys, conversation cafes, case studies). Mixed qualitative and quantitative data sets.	Assessment and review of primary data set. The "Fit" questions, methods and interpretation. Quality, availability and appropriateness of existing data (sufficient depth and detail). Sorting the primary data - Remove quantitative data - Remove missing responses	Purpose: Provide a national picture of people's experiences of substance use in services. Raw data submissions from ADPs as part of experiential evidence stream benchmarking submission. Practical Thematic Analysis (Guided by Saunders[7]) – NVIVO (Non-numerical Unstructured Data Indexing, Searching and Theorising). Wider MIST team. Reading (transcripts, MS forms outputs, case studies). Coding (Codebook). Theming (One Page Analysis).

2.1.1 Data collection

The purpose of the data collected by ADPs as indicated is to determine, prioritise and monitor improvements with the local substance use services.

The Scottish Government directed ADPs and provided funding to deliver on implementation of the MAT standards to reduce the impact of drug related harm and prevent drug deaths. Part of this directive was to embed the voices of those with lived and living experience of substance use into services and service improvement and development. To carry out this role ADPs recruit people with current experience of problematic substance use to provide feedback within the locality. This project was approved by PHS ethics advisory committee and reviewed by PHS information governance arrangements. Information on confidentiality and ethics were covered in the training for local areas provided by Scottish Recovery Consortium (SRC) colleagues including ethical ground rules and confidentiality provisions around data collection.

2.1.2 Data sources

Table 2. Methods of data collection within ADPs

Method	Mode of Delivery	Description
Interview	Face-to-face, telephone	Semi-structured interviews carried out by statutory or third sector staff, commissioned services or peer interviewers determined by ADP. Mixed data set with closed (requiring yes/no response, rating scales, multiple choice – with one answer or multiple answers) and open-ended questions. While SRC who trained the interviewers provided a template, ADP areas were encouraged to locally adapt their interview questions and prompts.
Survey	Online	Mixed data set of closed (requiring yes/no response, rating scales, multiple choice – with one answer or multiple answers) and open-ended questions
Other sources: Conversation café	Face-to-face	Structured meetings with broad questions regarding services some specific to MAT standards. Participants did not have to remain for all of the meeting or answer all or any questions to participate.

2.1.3 Data sampling

In terms of participant eligibility, ADPs gathered data from three groups of individuals with experience of substance use: people (currently) accessing treatment (PAT), service providers and family members or nominated people. The sampling strategy generally reflected local ADP circumstances and characteristics so there were no set number of individuals from each service and/or ADP. For the purposes of this analysis there was an exclusive focus on PAT, but they were contacted by several means (e.g. third sector and not just through ADPs). The current analysis does not include evidence from service providers and family members.

Data gathered by ADPs is primarily through (see table 2):

- Interview transcripts or Microsoft forms outputs in Excel,
- Data capture (sticky notes, flipcharts or scribed notes) from focus groups or conversation cafés,
- Survey responses through Microsoft forms report in Excel.

Final Data Formats included:

- Semi-structured interviews
- Open-ended survey responses
- Case studies
- Notes from conversation cafés and focus groups

In total, approximately 472 responses from people accessing treatment were included over the reporting period prior to publication of the 2024-2025 MAT Standards Benchmarking report.

2.2. Data analysis

Analysis of data was guided by the steps for thematic analysis outlined by Saunders et al.[7] For practical purposes the thematic analysis process consisted of reading texts, text segmentation (i.e. For practical purposes the thematic analysis process consisted of reading texts, text segmentation (i.e. identifying meaningful segments of text), creation of a codebook (i.e. categories and definitions), content coding and developing themes.

All available and appropriate data from interviews, surveys, case studies etc was uploaded for analysis into QSR NVIVO (v15.0 or later) software. Only documents which could be converted into a machine-readable format were uploaded into NVIVO, otherwise they were excluded from the analysis in NVIVO. Where these data were accessible however (i.e. legible and therefore readable), they were checked for confirmatory and dis-confirmatory information.

2.2.1 Reading

The lead researcher read all transcripts, and other formats, when assessing and reviewing the data sets. Two colleagues and the lead researcher each read a diverse sample of transcripts, recording brief notes of thoughts and ideas regarding the data set and potential codes. These were then discussed during a Microsoft (MS) Teams meeting.

2.2.2 Data coding

From the team discussions a code book was developed with a non-hierarchical list of codes transferred into NVIVO. Codes were derived from the data but with broad consideration of the MAT standards. Coding was therefore primarily inductive to answer the research questions posed and understand and interpret the information provided exploring descriptions, explanations, differences and similarities. Codes were initially applied to a selection of interview transcripts, these were then reviewed and discussed with the team (the main author and two colleagues familiar with the programme).

A further version of the codebook was agreed and then applied to all transcripts by the lead researcher. Coding followed an iterative process and was revised accordingly developing further codes and redefining or expanding upon codes where necessary. This allowed for divergent views and experiences to be added to the initial codebook and an in-depth knowledge of the data to evolve.

2.2.3 Developing themes

Following data collection and collation, PHS MIST developed themes in a workshop where participants were provided with a code book, descriptions and examples from the transcripts. The lead researcher then merged and renamed codes based on the discussions, recoding where necessary. Analysis was iterative, codes grouped into categories and then reduced and consolidated under themes. Analytic memos also enabled themes to be developed and potential patterns to be explored. One sheet of paper was also utilised to help develop and describe themes[8] by means of a summary diagram. Table 3 was created to illustrate the inter-connections between themes and sub-themes.

Table 3. Interconnections between themes and sub-themes

Main theme	Description	Associated sub-themes
Theme 1: A system that works for or against me	How people experience the wider substance use treatment system and its structures	Getting access to substance use services Transitions and communication between services A system that supports recovery. The physical and economic setting
Theme 2: Physical and psychological safety of people accessing substance use treatment	Factors affecting safety, wellbeing, and protection while engaging with services	Getting access to substance use services. Transitions and communication between services A system that supports recovery The physical and economic setting
Theme 3: Engaging with substance use treatment	Practical and relational factors influencing ongoing engagement with treatment	Ongoing attendance and engagement with services. Active involvement in treatment Getting my script Treatment support from family and friends

Main theme	Description	Associated sub-themes
Theme 4: A network to support recovery	Personal and social factors that support recovery	Wellbeing and welfare Friends, family, nominated people
Theme 5: Engaging with substance use treatment	How people engage with and experience treatment	Attending / ongoing engagement Active involvement in treatment Getting my script
Theme 6: The substance use service system	Structural and organisational aspects of services	Getting access to services Transitions and communication between services Differences between / changes in services The policy, economic, socio-cultural setting
Theme 7: Physical and psychological safety	Factors affecting safety, health, and protection	Mental health Harm reduction Physical health / other health-related needs Stigma and discrimination
Cross-cutting factors across all themes	Factors influencing experiences across themes	Relationships with workers Individual characteristics

3. Results

Four overarching themes and thirteen sub-themes were identified: (3.1) A System That Works for or Against Me; (3.2) Access to Substance Use Services; (3.3) Transitions and Communication Between Services and (3.4) Relationships with Workers. For the purposes of the current report, the material allocated to the sub-themes was grouped into the four additional broad explanatory categories or supplementary overarching themes of: (3.5) Physical and Economic Setting; (3.6) Psychological Safety; (3.7) Engagement with Substance Use Treatment and (3.8) Care Planning and Review. These are each explored in more detail below.

3.1. A System that works for or against me

The narratives for the first theme indicated a complex, sometimes convoluted system of services which was hard to navigate without support. Given that there were also mixed views on the capabilities of the system to adequately support people, there were contrasting impressions from peoples' perceptions of whether the recovery system was working on their behalf or not.

3.1.1 A System that supports recovery

People sought recovery, stability, and meaningful lives with recovery itself often cited as the primary motivator for engaging with treatment services. Many also described wanting a whole system that was optimistic about (…the prospects for) recovery. Experiences varied widely however and contrasting attitudes between different organisations emerged as a distinguishing feature in the responses:

- Third sector organisations were often seen as more recovery-focused than statutory services.
- Gaps existed in housing, welfare support and social connection.
- Recovery support groups were valued where involved but availability and access were inconsistent.

In addition to recovery as an overriding aim, participants also desired better social connections to help rebuild and improve relationships, and rediscover fulfilling and purposeful lives:

> "I have got my wee boy to think about. Because of my drug use he stays with my parents, but I would like to have him back home with me to rebuild a relationship so that he can be proud of his mum. I now have more regular access and I am focussing on him returning home in 3 years' time" (PAT, area 16).

There was evidence of some signposting to social welfare organisations through drug and alcohol services (and support through third sector workers) which enabled people to get help with benefits and get help with housing. However, this aspect of care was not often discussed and people reported feeling dissatisfied by services or expressed gaps in support:

> "Lack of help with housing as I needed a lower flat/house due to medical conditions. I am still not supported" (PAT, area 19).

Specifically in relation to recovery, there was a perception that people were stuck in a ‘medical-oriented system’ and unable to move forward because drug and alcohol services were not designed to move a person toward or promote recovery:

> "… as a whole the service isn’t interested in me getting better. I am stigmatised and folk see me coming and immediately palm me off - this leaves me in chronic pain and unable to reduce methadone and make the progression I want" (PAT, area 5).

3.2. Access to substance use services

Access routes included general practitioners (GP), third sector organisations, pharmacies, self-referral, and crisis points (e.g., overdose, police contact). Experiences ranged from rapid access to long delays, with some feeling dismissed or not taken seriously.

3.2.1 Substance use patterns

There was clear concern around specific substance types, such as alcohol or cannabis, being allocated the same level of concern or understanding as opioid drugs. In a few cases there was a belief that their problems had been downplayed or disregarded which had delayed accessing treatment:

> "I felt dismissed by my GP because I didn’t present as a typical alcoholic. GP…openly judged me as being a normal female drinking wife - like mummies’ wine hour.... " (PAT, area 5).

3.2.2 Prescription availability

Experiences regarding obtaining a drug prescription for substance use varied considerably for both those starting treatment for the first time as well as for those who were restarting treatment. A number of people commented about the relative ease of getting a prescription or starting their medication quickly on the same day they attended an appointment, the next day or soon after.

> "I was ecstatic. I didn't have to come back and that I got started on medication there and then" (PAT, area 6).

There were also some instances of long delays in obtaining prescriptions, which were attributed for the most part to medical reasons, such as still having opiates in their system, the need for medication review or discussion between doctors due to complexity or previous relapses:

> "On the first day I left only with advice as I had to have 24 hours clean of all substances before I could be started on Buvidal" (PAT, area 15).

3.2.3 Residential rehabilitation

Residential rehabilitation was described as challenging to access, with long waits, unclear criteria, and inconsistent support. Where it was appropriate and available however, it had been described as leading to transformational ‘life saving’ differences. The picture was also often complicated by less-than-optimal information provision about options available and what they entailed:

> "A [third sector] worker assessed me and supported me to secure a place in rehab, it took about 12 weeks then they came with me on the train to take me to the rehab but I didn't stay. I wasn't ready this time and I feel the rehab didn't explain to me about what the detox actually was" (PAT, area 17).

3.2.4 Information provision

Overall, in relation to access, there was a general sense that there was often insufficient information and advice offered in relation to substance use treatment services and the wider system of treatment and recovery. Fundamentally, people wanted to know what was available and what they could access in their local area. More specific to remote and rural areas the lack of anonymity sometimes presented a challenge for people wanting to access substance use services:

> "In [name of town] there's only a small population of people who are using drugs and to be honest with you they're all on the fence about accessing help because of the lack of an anonymity in such a small place" (PAT, area 5).

3.2.5 Facilitators and barriers

A number of factors facilitated access into substance use services. Previous contact with services seemed to ease access with people having been in treatment in the past or having people close to them accessing services.

> "It was easy to find out about services as I was surrounded by people who used the services. I went down to a service with my partner for the first time" (PAT, East Scotland locality).

People appeared to be supported into services if they had experienced a life event or crisis such as an overdose, hospitalisation or a mental health crisis. Third sector providers, specialised outreach teams or emergency services were reported to have proactively connected people with substance use services:

> " [Third sector provider] approached me, my partner passed away and she was involved with the service, so when she died the service knew of me and they approached me" (PAT, North Scotland locality).

A number of barriers were also reported. Not having specific services including drop-ins, for people who are struggling, or services for young people under 16 prevented people from accessing help. In some cases, people reported that it was difficult to speak to someone within substance use services in particular if they had to go through a generic contact number, even if they had been in services before.

> "Just phoned them up and kept phoning because nobody would speak to me, basically harassing them to get put up the list, I know it wasn't fair on anyone else, but I needed help and wasn't getting it" (PAT, area 4).

3.3. Transitions between services

Transitions between prison, hospital, primary care, and community services were often described as fragmented. Some individuals described seamless support, but many experienced gaps, especially after detox or release from prison. As with accessing substance use services there was very little clarity regarding the pathways between services and how they communicated or worked together

3.3.1 Primary care

For primary care, a preference for GP involvement was generally related to the value placed in that connection such as when a person with complex medical needs required additional medical support. It was also connected to the relationship between GP and the person accessing services, their knowledge and their needs and therefore trust in medical management.

> "My GP is aware of what goes on and prescribed me various medications. Addictions have tried to get involved in prescription take over with Diazepam, but I do not want this as I want my GP to control this, I worry addictions team would take the benzos off me and I need them" (PAT, area 3).

Other people did not have GP involvement but thought it would be helpful to understand the benefit or believed it could be useful within their substance use treatment. An alternative view was offered of limited benefit or for some a preference to have little primary care involvement.

> "My GP doesn't show interest in my OST (i.e. opioid substitution therapy) only day to day stuff. It suits me this way" (PAT, area 5).

3.3.2 Justice interface

Supportive transitions connecting individuals on release from prison with community-based services, through referrals and signposting were often reported. These were generally enabled by a particular worker or team, including outreach, probation and health teams in prison with for example the ability to continue prescriptions after liberation. Specific treatment orders also helped with continuity of care and treatment:

> "With regards to justice, I received daily support as workers checked in with me to see if I was having any issues. They also supported me to receive 1-1 trauma counselling through justice services, and I'm still currently accessing this support despite my DTTO (i.e. drug treatment testing order) ending" (PAT, area 20).

However, people also spoke about the lack of continuity when transitioning between services, such as moving from inpatient to community-based or outpatient services and from prison to the community as well as from one geographical area to another.

> "On discharge from hospital there was no aftercare offered or any information on recovery services available, I was just given a bag of pills and basically left to my own devices" (PAT, area 19).

3.3.3 Information sharing

There was a presumption among some people that their substance use worker communicated with other health care providers they were involved with. However, there was also some uncertainty whether information was passed between them or the degree to which information was shared. When information was shared and teams communicated, this generally worked well:

> "They [GP] prescribe me gabapentin, and they are good at being in touch with addictions (services) about that, so I think it works well, I think they send them a 3-month progress report to keep in touch with what is being prescribed, so it doesn't feel too separated" (PAT, area 3).

People also thought that communication could be better with information shared more consistently, frequently and easily between teams. This would, for many, alleviate some of the frustration and distress of having to repeat their story over and over again.

> "All disconnection between services causes me to have to explain myself over and over to many different services and it feels like symptoms of PTSD i.e. post-traumatic stress disorder) over and over again" (PAT, area 17).

3.4. Relationships with workers

Workers were described as pivotal: "If you get a decent worker, that changes everything. " Positive relationships enabled trust, engagement, and hope. However, inconsistency, staff turnover, and perceived stigma undermined engagement.

3.4.1 Worker / staff roles

Workers or providers of substance use services were most often described in relation to their role within the substance use system relating to access and engagement.

They were also central to a person’s experience of substance use services. People accessing services discussed a wide range of workers and providers who they interacted with as part of their treatment and support within the substance use system including CPNs, (community psychiatric nurses), third sector workers, social workers, peer support workers, housing support workers, GPs, pharmacists, reception staff, CMHN (community mental health nurses), assertive outreach workers.

3.4.2 Relationship centrality

Workers within the substance use system whether statutory or third sector were described as central to individuals engaging with and moving through the system as well as their understanding of the system itself (connecting to other sub-themes). Importantly in this context they were viewed as a connecting force and the cornerstone of change for that person:

> "If you get a decent worker, that changes everything - mine at the moment is decent and checks in and seems to care. I do feel I can trust him and be honest if I am struggling and I know he will try and help" (PAT, area 10).

Conversely, when relationships were absent or had been poor, which was inter-related with experiences of stigma and discrimination, on occasion with particular groups or professionals, there was a sense that these perceptions were long-lasting and impacted help-seeking and engagement.

> "To an extent, workers do care and treat me well, not social workers though…." (PAT, area 18).

Some of the best experiences of peer-type relationship support came from a range of mutual aid groups (e.g. Narcotics Anonymous, Alcoholics Anonymous, peer support groups, SMART groups and recovery meetings), community-based activities and alternative therapies (e.g. acupuncture) that people had access to. These groups were viewed as giving people a purpose, structure, offering them a place to go where they could meet people they could relate to, build positive relationships as well as providing motivation and accountability.

> "I first accessed the recovery hub when a friend took me along with her...For the first time in my life, someone met me where I was at, and I feel that I got more support from [recovery café] than what I ever did from services. This experience gave me hope and it showed me that there was something better out there and that I could be better…" (Narcotics Anonymous-Case Study).

There was also a perception that while people accessing treatment were “encouraged” to attend recovery groups or join in activities within their communities, this was more of a ‘tick-box exercise’, where there was no impetus to join and they were not actively supported for example through offering help to people to attend. Support was important as many people talked about not being ready to attend or anxious about joining groups this prevented them from taking up groups and activities without support, creating a gap between treatment and recovery.

> "…need a bridge to support people" (PAT, area 17).

3.4.3 Physical and economic setting

The location or physical setting of substance use services was closely related to people’s views and sense of wellbeing within the system. People accessing treatment indicated that they either felt safe and secure in the service or services they accessed or they did not. Views and experiences of specific settings such as community-based third sector services, pharmacies (further explored in 3.5.2 and 3.6.3 respectively) and remote and rural areas were reflected here. Much of the discussion centred around barriers and facilitators related to the physical location of substance use services in the context of limited resources.

3.4.4 Determining factors

Barriers to effective service access from a physical and economic standpoint cited included:

- Travel distance and cost
- Unsafe or triggering service locations
- Lack of privacy in pharmacies
- Limited anonymity in rural areas

People discussed problems with local transport, service locations not being accessible via public transport or due to mobility issues such as using a mobility scooter, having to walk long distances, and relying on family or the NHS to get them to and from appointments or to pick up prescriptions:

> "I have to go to 3 different services and my GP. They are all in different places. It costs a fortune to get to all these appointments" (PAT, area 19).

Other barriers were also described regarding the location of substance use services. People talked about locations being risky or triggering for several reasons. In some cases, the service they attended was close to shops or pubs, or they could encounter people that they would prefer to avoid such as drug dealers, previous associates or people who were still using substances. They were concerned about their vulnerability when dealing with difficult situations leading to lapses or relapses:

> "I feel safe and welcomed in the [third sector service] but sometimes it can be a bit triggering because it’s beside a pub and opposite the court, so folk you maybe don't want to see are there" (PAT, area 17).

3.4.5 Setting specific feedback

Pharmacies were a setting within the substance use system which posed challenges for people. There was often a perception that the needs of people with substance use problems did not appear to be considered about opening times or the scheduling dispensing. The availability of pharmacists and adequacy of the space to dispense and take medication were also aspects that could benefit from improvements:

> "…the one everyone is having to use is meant to be open 9-5 but open 10-12 then closed till 2, so it's terrible trying access at decent times. They don't want to treat you respectfully either and make people take methadone in front of the whole chemist, if there are no rooms available" (PAT, area 5).

In remote and rural areas, the small size of towns, for example, meant that everything was nearby and therefore accessible. However, this and the small population meant there was less anonymity. People spoke about having grown up with people that were now working in the services they could access which made it more difficult.

3.5. Physical and psychological safety

3.5.1 Harm reduction

For the purposes of this report, the concept of physical safety has been interpreted broadly to include standard harm reduction measures for substance use services and psychological safety is closely aligned with mental health and trauma informed practice (see 3.6.2). Based on participant feedback, discussions in relation to harm reduction focused upon advice and information provision, equipment provision and testing for sexual health and blood borne viruses (BBV). Wound care in contrast was rarely discussed across ADPs other than in a receiving hospital or having a home visit for wound care. Conversations about harm reduction, provision of information and equipment and testing were described as occurring across a number of different providers and settings including local pharmacies, DAS (Drug and Alcohol Services), prison, mobile units (e.g. van), third sector providers in addition to specific services such as mental health teams and needle exchanges.

Accounts of participants included: perceived missed opportunities in relation to early intervention (retrospectively recognised); irregular access to advice and equipment; inconsistency around blood borne virus testing access as well as Naloxone training with cocaine and cannabis users also reported little by way of tailored harm-reduction support. Discussions regarding psychological support for instance often indicated that it would have been more helpful if they had been given support sooner:

> " … Feels a lot of people self-medicate as not supported around mental health quick enough. Mental health will not support due to self-medicating substances" (PAT, area 12).

There was also a suggestion that earlier psychological support would also be beneficial prior to reducing or ending OST medication, thus helping to maintain progress and alleviate fears.

In terms of equipment provision, the availability of both naloxone kits and sterile injecting equipment were referred to often when discussing harm reduction. While people had received naloxone kits from DAS, from pharmacies and from third sector providers, kits were not always offered or provided. When not provided through DAS some individuals indicated that they were aware of where they could get them, whereas others were unaware that it was possible to get naloxone and had not been given that information through services:

> "No one has ever spoken to me about naloxone; didn't even know you could get it from them. I know some pharmacies give you clean needles and that, but I heard that through my pal not from the pharmacy" (PAT, area 13).

BBV and other testing was not spoken about as commonly as other forms of harm reduction interventions. There was again a mixed response to information provision and therefore awareness about accessing BBV testing as well as other tests and referrals. People did report being able to get BBV testing through third sector providers, mobile units and needle and syringe exchanges:

> "[Third Sector Provider] van that drives around, they offered me BBV testing and results came back fine" (PAT, area 11).

For other tests, there was a suggestion that there were long waits (e.g. for sexual health screening), in a rural area and they should be available much sooner. Although harm reduction interventions and the type of substance use were discussed several times throughout the narratives, there was a sense that for certain substances, such as cannabis or cocaine, there was no information, advice or help offered regarding harm reduction:

> "I feel like with cannabis there is no help, there is no information about how to come down or how to stop, so I am not even sure what they could do" (PAT, area 6).

The widely acknowledged recent increases in the use of cocaine (either by injection or smoking) were also noted as being misaligned with the practical supports from specialist services with the implications noted for missed engagement opportunities that could in principle be easily addressed:

> "There needs to be equipment for cocaine users, so many people are using cocaine and sharing equipment. Pipes and straws need to be available... If they were able to get equipment through the exchange services, it would bring them in and they could get help" (PAT, area 5).

More generally, there were calls from a number of respondents for there to be more consistent access to drug testing facilities, given the increasing risks from contaminant substances which they learned about sporadically and from anecdotal reports.

3.5.2 Mental health and trauma

It was quite common for people accessing substance use services to report a mental health diagnosis and a current prescription for medication with some access to psychiatry, a CPN or often a GP was the main provider involved in their mental health care. People described a wide range of diagnoses from mild to moderate psychological problems to more severe mental health problems, including psychosis and personality disorders. Trauma was common but often unaddressed.

In part, people accessing treatment reported limited access as a resource issue with low numbers of specialist healthcare providers or issues with long-term (staff) sickness also creating problems for access. In some cases, people had resorted to seeking help for themselves, because they were unable to get it through substance use services, or had to push hard to get the support they needed. There was a sense that they had been left on their own to deal with their mental health problems:

> "I'm only now being seen by them. That's taken 6 years of asking [for mental health support through DAS (service)]. Imagine someone gave up and killed themselves as a result or something. I'm lucky I don't take no for an answer, but other folk aren't like that and shouldn't have to be" (PAT, area 3).

There were clear inconsistencies across the system with some individuals reporting they were unable to access mental health services because they received an OST prescription, while others were unable to access psychological support without a prescription for OST:

> "GP won’t treat anxiety without going on methadone" (PAT, area 9).

Individuals had also often been told that they could not access mental health treatment without abstinence, including OST, and a period of stability which was often undefined:

> "I also went back to CATS [Community Addiction Team] team, but they always told me that my drug issues need to be sorted first before my mental health" (PAT, area 9).
>
> And/…

> "Psychological therapy is only available when totally drug free, I realise now I need this and things to help me cope and stay off drugs" (PAT, area 20).

Attendance at appointments as well as remaining in treatment for mental health problems was also reportedly difficult and missed appointments with DAS could mean disruption or loss of their prescription while in mental health services this could result in discharge.

> "… discharged from [NHS MH Service] for missing two appointments. Then they would not take me back on their books, as I was discharged" (PAT, area 16).

Participants highlighted experiences of trauma throughout their lives with childhood trauma, rape, domestic abuse, violence all described. Some people indicated that they had been offered help for past traumas. In other cases, they were certain that this had never been part of a discussion or were uncertain that this had been offered. When they did start treatment, people talked about readiness as well as some of the negative experiences including lapses. The timing of trauma interventions also appeared to be critical:

> "Tried and failed, this was a while ago and I just wasn't ready. Hopefully once I am on my meds, I will be ready OR I don't want to right now, feel like it's a can of worms" (PAT, area 16).

3.5.3 Stigma and discrimination

Stigma was pervasive across healthcare settings, especially in pharmacies and primary care. People described being judged, dismissed, or treated as 'drug-seeking'. This discouraged help-seeking and exacerbated health risks. Specifically, people described experiencing stigma in numerous different ways which included: not being listened to; not being believed and being openly judged because of their problems with substance use. There were in addition more subtle indications through the language used when speaking to them that tended to convey that they were not considered a priority or there were others more worthy of treatment.

> "I went to my GP for help first and was told that I wouldn't die from opiate withdrawals so they couldn't help me" (PAT, area 17).

Discrimination was often implicit in the manner of being treated differently to others, as well as noticeable inconsistency in treatment and responses. People accessing treatment were very aware of being judged when attending appointments, accessing services and more generally asking for help. Common experiences were being categorised or told they were ‘drug-seeking’ or ‘chasing pills’ when they asked for help.

> "No help at all, they all just looked at me like he doesn't want any help, he is just pill seeking, I wasn't there for pills I was asking for a detox, for help of anything to get me off and they didn't want to hear it, they need to care and want to help people" (PAT, area 16).

A lack of knowledge and training in relation to substance use was referred to as a possible reason for stigmatising attitudes and behaviours.

> "I think my experience with the NHS didn't help my addiction, I don't think they are fully educated (informed). There is so much red tape, they're not bad people but there is a little stigma. My first worker was awful, felt so much stigma off him, the following workers were compassionate and nice, but just not fully educated on addiction" (PAT, area 20).

Feelings of worthlessness, embarrassment, shame, discomfort were described regarding substance use. People were afraid to ask for help or believed if they did that, they would be treated unfairly or wouldn’t get the help or healthcare they needed. These feelings and beliefs had consequences in terms of attendance and help-seeking:

> "…but sometimes I just don't report if I have seizures/ bumps/ falls as I don't want to feel embarrassed or humiliated" (PAT, area 3).

In terms of wider connection, these feelings and beliefs also had an impact on whether people accessing treatment had their family involved to support them and could even influence their treatment choices:

> "Went on Subutex because I thought better than methadone, there is so much stigma with methadone and how people treat you on it, so for me it was easier" (PAT, area 4).

These inconsistencies experienced in what was expected of them and in how they were treated meant services were often difficult to reliably manage and navigate.

The ongoing mental health impact of experiencing stigma and discrimination was clear in many participant narratives and contributed to a sense of exclusion from mainstream ‘deserving’ health care:

> "Mental health support with addictions services is really lacking, it feels like you are part of society that is not allowed to get help for poor mental health or a medical emergency because you are an addict" (PAT, area 9).

The sense of being “dehumanised” or “second-classed” was often also related to the setting. There was inevitably a high level of contact for instance with pharmacies for those having medication dispensed daily. This was a setting where stigmatising attitudes and behaviours were commonly experienced. Going to the pharmacy was a difficult part of many peoples’ daily lives.

> "Pharmacies could do with more care and compassion - the treatment from workers there is so poor and they treat me like scum. I have found this with a lot of chemists to be honest. Pain in the arse, sometimes you can go and they are nice to you and next they talk and look at you like

> crap, then it annoys me because they tell me I need to put my script in early. Inconsistency providing prescriptions on time and what they expect when I am handing them in" (PAT, area 3).

People also reported being made to wait in queues or outside, other customers being served ahead of them or having restrictions placed on when they could collect their prescriptions.

> "I hate it, I feel judged going into the booth for methadone. Pharmacists prioritise other customers first, feels it’s a neon sign over my head saying I’m a drug addict. I don't like the booth…" (PAT, area 10).

In addition, there was often very little privacy or discretion when having their medication dispensed or picking up their prescription.

Experiences in secondary settings were also flagged as examples with providers who were stigmatising but also in some cases traumatising in their own right:

> "…was in hospital, , my son died when he was born and they treated me like I had killed him, I honestly can't explain how bad they were and it all came down to how I was using drugs and they thought that I wasn't good enough, but it has traumatised me for life" (PAT, area 3).

3.5.4 Engagement with substance use treatment

Perhaps unsurprisingly there was significant variability in the extent to which respondents were pro-actively engaged with their substance use treatment. Some were currently only engaging with harm reduction services and were not actively engaged with treatment services, while others were nearing or at the end of treatment and therefore no longer regularly engaged with specialist services. Four sub-themes reflected the discussions under this theme: active involvement in treatment, involvement in care planning and review, obtaining prescriptions, treatment support from family and friends. Given the multi-layered and often complex association between engagement and individual health needs, the complexity of underlying health needs has been subsumed as an additional subtheme category within engagement.

3.5.5 Active involvement in treatment

There was a degree of inconsistency in the perceived completeness of information provided about medication options and in the degree to which individuals felt that they were genuinely involved in decision-making about their treatment options. Advocacy around individually tailored medication advice was rarely offered despite a clear need with some seeking peer level advocacy around treatments:

> "More discussion and time to think about and make decisions. Actually, I think having a conversation with others who had been through this would have been useful and who knows the score, who could answer my worries" (PAT, area 4).
>
> "I [need] advocacy support to articulate myself so I can express myself properly as I can't get words out easily" (PAT, area 10).

Many people accessing treatment talked about being given very limited or vague information about the different medications. These were rarely clearly explained and there was little information about what treatment might look like, in terms of dose or titration, and what their treatment or care plan and objectives (see 5.2 below) would be:

> "I never got anyone to talk to me about treatment and what that would be like, that would probably be helpful" (PAT, area 13).

The lack of information meant that people were often worried or uncertain about the medications, how they worked and the impact they would have on them and their lives.

> "I was worried about Buvidal as Espranol made (me) feel straight…" (PAT, area 18).

In contrast, other respondents indicated that they didn't require that much information as they had a level of knowledge and understanding about the different medications. In these cases, they generally knew or were very clear about what they wanted, such as wanting methadone or 'the injection' (i.e. long-acting injectable buprenorphine) or to be put on anti-craving medication:

> "It was what I was on before and never wanted methadone. I think most of what I know about all the meds is from my own experience more than what they have told me, so I know what's there but not from them [DAS]" (PAT, area 13).

There were also instances where information provision was closer to optimal in helping people make genuine informed choices:

> "We discussed multiple options which I found were clearly laid out and I got to choose what was best for me by making an informed decision" (PAT, area 9).

3.6. Care Planning and Review

Care planning was noted to be inconsistent and variable. Some had clear plans; others reported never having one. Many felt "stuck" on long-term prescriptions without progression. Where there were discussions around treatments, it was not uncommon for respondents to cite instances of pressure being applied for a 'favoured option':

> "They make me feel I shouldn't go down, like they ask are you sure are you want to, are you sure you won't mess up or overdose. Patronising ways of making me feel like I shouldn't try to do better for myself.

> Sometimes feels like you are stuck on methadone for rest of your life" (PAT, area 3).

Even when personal decision-making was seen to be compromised in this way, there was a general acceptance that ‘advice’ had been based on clinical guidelines (for both OST and alcohol-related medication), enabling a measure of reassurance and trust in the process and/or the provider. An overall impression remained however that there was clearly considerable scope for more comprehensive tailored treatment advice, especially as the scope of available options expands in response to changing drug consumption practices.

An important component of satisfaction around care planning that is known to be predictive of positive outcomes is the inclusion of family and friends in the decision-making processes. Awareness of this being an option however seemed to be relatively low among respondents. More concerning perhaps was reports of some that the DAS they attended were very clear that this was not an option, and that they were not allowed to bring someone with them to treatment appointments (or if they did, they needed to wait outside).

3.6.1 Support from family and friends

When people talked about having a family member or a nominated person to support them in treatment, some indicated that this had never been discussed with them or that they were not aware of this being an option. Others were aware of the provision but were not themselves clear why this could be important or believed that it was not necessary. Of most concern was reports that the DAS they attended had sought to discourage this option or they were not permitted to bring someone with them to treatment or while they could bring them, they had to wait outside:

> "In waiting room, it says nobody (to accompany you) into appointments, that includes children. They also make you sign a form when you start that also says about nobody coming into appointments with you. It's made very clear they don't want that" (PAT, area 3).

There were clearly also notable examples where family members had been the driving force behind getting them to appointments and into treatment or had a role in advocating for them, especially where there were literacy issues, problems completing forms due to dyslexia or cognitive impairments.

> "My best mate comes along to appointments with me which is great - and it helps me to remember what the meetings have been about" (PAT, area 3).

Respondents also commonly highlighted a degree of reluctance to include friends or family explaining that they preferred their substance use problem to remain private or they would rather have the support from workers, such as third sector providers. Weighing up the very broad mix of responses in this area, there are clearly implications for service providers to consider ensuring that family input is positively encouraged and excluding this type of input could leave a lasting legacy of regret (potentially exacerbating past sense of trauma):

> "I know when my mum was alive then she would have really benefitted coming along to appointments with me, but I was always told she was not allowed" (PAT, area 4).

A number of people accessing treatment had family with caring responsibilities for children or parents, which of itself, often pushed people to make changes and begin treatment, but there were substantial concerns about asking for help, in particular where children were involved:

> "Felt very worried about approaching support the first time due to fears around social works and children" (PAT, area 12).

3.6.2 Multiple health needs

Many people accessing treatment described having complex needs either due to physical health problems or other health-related needs requiring additional support.

Physical health issues included long-term conditions such as diabetes, cardiovascular problems, COPD (chronic obstructive pulmonary disease) and chronic pain. People also described sleep problems and having sustained physical injuries, as well as substantial mobility issues. Additional health and support needs adding to complexity, such as neurodivergence with attention deficit hyperactivity disorder (ADHD) and autism were often raised as significant concerns.

The complexity of having multiple conditions meant that people struggled with attending appointments and they had worries and concerns about their health. Much of this related to medical management of other conditions alongside treatment for substance use, such as taking large amounts of medication or the impact of plans to reduce medication:

> "Ideally, GP would listen to you and help plan for chronic pain management around meth (Methadone) reduction. This really worries me as I don’t see a way to reduce and no-one is helping with the pain" (PAT, area 5).
>
> "I feel that I should've been treated for the menopause as well as OST. My methadone was 25ml when I moved to [local area] and slowly went up to 90 ml but I had nothing for my moods/hormones" (PAT, area 10).

Many people talked about their GP being their main contact for physical health problems and where they attended for diagnoses and ongoing health care but not necessarily for their substance use problems. Some people thought that GPs did not have the knowledge and expertise to support them with substance use, or that they could not support them, and would struggle to get regular appointments or would be reluctant to support them for their health needs due to substance use problems.

> "It would be helpful to have support from the GPs for medical issues but the GPs won’t accept (that) potential (unmet) medical needs can run alongside addiction" (PAT, area 4).

However, getting primary care support for physical health problems was somewhat dependent on the relationship they had with their GP. Where poor relationships existed, people avoided or were reluctant to attend their GP. Some had not seen their GP for years or they would not go unless it was a last resort, when their health problems had reached a level of severity. There was a suggestion that they would rather phone an ambulance or go to hospital than attend their GP.

> "Only if I can't sleep and it's really bad, I'll go speak to them. Nearly two weeks broken wrist and still didn't go. Had enough of trying and chaos in life, so I couldn't focus and they didn't help, so feels a waste of time" (PAT, area 3).

Some respondents spoke about their desire to have greater input from their GP into their healthcare and a broader hope that their GPs in turn might work more closely with other health and social care providers. Although this did not happen regularly the experiences people had with service providers communicating and collectively looking after their care was generally positive.

> "I have complex health needs, such as diabetes, so it helps to have primary care involved. They do work together and I feel supported. This especially applies with the prescribing side of things and contra-indications" (PAT, area 5).

4. Discussion

4.1. Findings and context

A major overriding impression from the findings of the current report would support the observation that individuals almost invariably come into treatment services with a genuine expectation and desire for recovery. While this ambition itself is very understandable, the precise pathway and component steps through anyone’s preferred recovery journey are nevertheless often highly unique and ‘person specific’ to the individual concerned. Successful recovery progress is therefore unlikely to be linear, meaning that optimal success rates will require a whole system ‘adaptive approach’ rather than individual services working in isolation according to a pre-set sequence. While there is now better information on pathways for residential rehabilitation services, this needs to expand to cover all treatment routes and substance types, including recognising the important role that recovery communities and mutual aid can play in helping to promote and sustain recovery.[2]

It is useful to highlight at this stage that the ten MAT standards on which the currently reported programme of service improvement is based started out with a relatively restricted focus around opiate agonist therapy. While that perspective dominated the early years of the programme, it was always anticipated that the rapidly changing substance use landscape and the normalisation of ‘poly-drug’ use, would require that MAT standards adapt to these changes (as also alluded to in the above extract from the new 2026 strategy). The MAT standards annual benchmarking reports themselves have in turn documented year on year progress towards full and sustained implementation since the initial launch of the 10 MAT standards in 2021. The increasingly critical contribution from lived and living experience sources has also underpinned and corroborated MAT aligned improvements (as well as slippages and omissions), over the course of the whole programme and has helped enhance our understanding of changing trends over time as well as the ongoing perspectives of those accessing treatment.

From the evidence gathered in 2024-25, LLE (lived living experience) has been reviewed across the range of MAT standards, allowing people in treatment, their families and workers to contribute experiences and to build up this evidence stream. People continue to experience problems with access to treatment (MAT 1), choice of treatment (MAT2) and perceived stigma within health and social care collaborative partners e.g.: primary care, pharmacy or acute hospital care. The legacy of a primary focus from the outset on opioid agonist therapy (OAT) regimens, has also continued to impact on the levels of support, care and harm reduction advice (MAT 4) for other substances, even for those currently in receipt of OAT.

The proactive seeking of views has also clearly empowered people accessing treatment through MAT arrangements to provide frank and honest feedback about their experiences. Of course, given that MAT 6 and MAT 10 encourage all services to embrace psychological and trauma informed services delivery, the ongoing stigma being felt by people in services suggest that there could still be some way to go for this ambition to be fully realised despite the positive benchmarking reporting from MIST. Support and provision for advocacy (the focus of MAT 8), on behalf of those affected by substance use is characterised by significant variability across the country, so the capacity to provide closely tailored individual support will also be variable, as is borne out in the findings of this report.

As with so many other aspects of health and social care interaction, the quality of relationships also emerges as strongly predictive of positive outcomes, as do structural factors and the sense of recovery optimism just highlighted. It should also be self-evident that more firmly grounded and diversified supportive social networks such as peer groups, enhance greater resilience in the face of the important challenges highlighted in this report. While the practicalities and investments in time and energy that underpin the development and maintenance of such relationships are easy to underestimate, their provision (in terms of resources and structures), need to be considered ideally at the planning and commissioning stages. If overlooked, there is likely to be an emergent lack of the necessary organisational and system resilience that all parties can depend on in the event of challenges, to the detriment of the most vulnerable for whom the consequences might be severe and long-lasting.

First hand evidence from lived experience perspectives within the report around the need for further improvements in both psychological and physical safety seem to be related to several underlying and overlapping concerns that themselves at least do come across as potentially resolvable. Where there are inconsistencies in what can be expected from services and where there appear to be perceived shortfalls in staff training, knowledge and experience, it is easy to appreciate why service users might begin to lose their assurances of safety that had helped initiate their engagement. This might extend to a triggering or reinforced stigma response to ongoing treatment that is completely at odds with the aspirations of MAT 6 and 10. The overriding focus of course from the outset of MAT on OAT has created both real and perceived barriers for those affected by other substances and probably also reflects on the consistency and appropriateness of staff expertise levels (which itself will affect perceptions of safety). This highlights the importance for specialist staff of keeping abreast of substance user preferences and current trends.

Psychological and mental health co-morbidities of course continue to present some of the most intractable challenges around the delivery of substance use specialist services, so it is not unexpected that these aspects, alongside unresolved trauma responses feature across a number of the themes. From respondent comments, the persistence and pervasiveness of a medical model for treatment and approaching addictions continues to frustrate efforts to better understand and address psychological aspects, although there has clearly been much progress in recent years from community level projects and novel human rights based interventions, the latter in turn being stimulated and directed by approaches such as the FAIR (Facts, Analysis, Identification, Review) template and PANEL (Participation, Accountability, Non-discrimination and Equity, Empowerment and Legality) principles. Continued application of human rights-based principles therefore together with ADPs being encouraged to engage across the widest range of stakeholders and draw upon local lived experience will clearly be the best guarantor of recent progress towards genuine whole systems of care.

4.2. Strengths and limitations

There is clearly no question (based on 2024-2025 data), that the drug consumption landscape is subject to continuous evolution such that improvements made at any one time may not fully capture the current context in which people are accessing substance use services. Based on the current report however, there did appear to be a consistency in experiences over a lengthy period, both positive and negative, and the issues reflected were reportedly ongoing. People also referred to both negative and positive changes in services which provide an insight into the current setting and how it is working or not working. Since in most instances the positive changes have been trackable to the systematic identification of opportunities to improve service user experiences, it will clearly be important to continue with that direction of travel in future years whatever the format of the MIST set-up.

As this is a secondary analysis, there are of course some notable considerations in terms of methodological constraints. While guidance was issued regarding gathering experiential evidence and training provided through PHS MIST, there was limited control over primary data collection in terms of recruitment, sampling, question set/ topic guides or the training or the skill-level of interviewers. Additionally with interviews being scribed and not transcribed verbatim there are legitimate concerns over verifiability and a great deal of reliance on the reporters themselves. This in turn introduces potential inconsistencies into the thoroughness and compatibility of different information sources.

Qualitative data from interviews and surveys was commonly derived from a mixed data set. As surveys were used by certain areas and tended to have less information due to the type of responses as well as containing substantially more quantitative questions (frequency, counts with multiple responses). This meant that LLE from these areas may be under-represented due to the lack of qualitative data gathered and therefore skewing the narrative toward those that gathered data through interviews. Not all ADP areas provided usable primary data again this excludes particular LLE voices from this analysis – there are sections of the population missing. Due to time and data constraints, it was not possible to analyse according to remote and rural populations or type of substance use. However, we were able to develop some understanding of the experiences of treatment for problematic alcohol use. In future having better demographic information would support understanding the different populations that access substance use services.

5. Conclusion

Specialist substance services in Scotland exist in a complex and often challenging landscape which can make it problematic to navigate for people accessing treatment and support. The services have invested a great deal of time, energy and support into building what for the most part are strong trusting relationships with service users. These solid foundations have enabled services to implement and embed their own protocols for service review and improvements in line with MAT standards that are underpinned by strong LLE inputs. Nevertheless, it is evident that certain inconsistencies and gaps persist across various areas and specific services. The degree of variability indicates that work is still required to fully embed and integrate MAT standard principles and processes including progressing services toward becoming fully trauma-informed and non-stigmatising.

Service caseworkers are of course the key link into specialist treatment and recovery programmes in that they have both the relationships and skill-mix to enhance engagement and support people to understand and move through the system. Specialist staff also play a critical role in enabling positive outcomes from their support for the belief that change and recovery are possible for all. When such levels of commitment to those affected by substance use become genuinely system wide, there is real hope that the changes and early wins of MAT standards can be extended to all substances in a sustainable manner.

Overall while there are clearly limitations in the extent to which the above findings might be generalisable elsewhere, the programme itself represents a uniquely innovative approach to appraising the extent to which systematic approaches to service improvement and delivery are reflected in the real-world experiences of people accessing treatment. The integration of monitoring and improvement efforts with human rights-based approaches was also facilitated by the recent introduction of the Charter of Rights for Substance use[3] in 2024 and aligns well with the centrality of lived and living experience perspectives set out in Scotland's new Alcohol and Drug Strategy[9]. On the basis of this report, we would further emphasise that is only by means of the type of real-world evidence contained herein that we can best guard against any reversal in improvements already made and ensure that the ongoing efforts of ADPs and partner organisations are equipped for the challenges to come and continue to be aligned and embedded within rights-based principles. The documented progress achieved to date provides clear evidence of ADPs and partner organisations exercising effective local ownership and accountability in responding to the evolving drug landscape, while advancing the ambitions set out in Scotland's partnership delivery framework.[10]

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