



**Medication Assisted Treatment:  
Service Evaluation of People's Experience  
of Accessing MAT in 6 Health Board Areas  
Across Scotland**

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Scottish Drugs Forum

October 2021

*"I hope people don't die, in between times, when we are waiting  
on these MAT standards"*

**(Male, 35-44 years)**

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## **Medication Assisted Treatment:**

# **Service Evaluation of People's Experience of Accessing MAT in 6 Health Board Areas Across Scotland**

### **Prepared by:**

Dave Liddell, Katy MacLeod, Jason Wallace, and Joan Walsh of Scottish Drugs Forum

### **Fieldwork conducted by:**

Barry, James, Joanne, Kevin, Lee, Maureen, Michelle, Rachel, Ryan, Sara, Scott, Steven, and Sylvia.

## Executive Summary

### Background

In July 2021, 1339 drug related deaths (DRDs) were reported as occurring in 2020 - this was the fifth year in a row in which deaths had risen to a record high. To put this in context, National Records of Scotland estimate this figure to be three times that of the UK<sup>1</sup>. To reduce DRDs and other harms associated with drug use, Medication Assisted Treatment (MAT) Standards for Scotland were published in May 2021, with the aim to deliver and measure a no barrier, consistent access to treatment regardless of individual circumstances. The Standards aim to ensure appropriate choice regarding medications prescribed, deliver assertive outreach to those not in services, and ensure people are retained on MAT for as long as they need it.

This project sought to provide a baseline of current MAT provision, prior to implementation, from the perspective of people currently in treatment. It is intended to be a reference point to inform and improve practice in relation to the implementation of MAT.

### Methods

A semi-structured questionnaire was used in which telephone interviews collected both quantitative and qualitative data from participants. Data collection was facilitated by 13 peer researchers, 6 of the core group of interviewers were still in treatment themselves. The study aimed to recruit a sample of 20 participants from each of the targeted areas: Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, and Tayside. The project was approved by NHS clinical governance teams in each of the health board areas. A multi-faceted recruitment process was used to ensure as representative a sample, as possible, under the constraints of Covid 19. Due to the challenges of recruitment, in a pandemic, 95 people in total took part in the study. Qualitative questions provided in-depth insights into the experience of people accessing MAT across Scotland.

A sample of 16 participants from Perth Prison were also included in this study. This data was analysed separately and included as an appendix.

### Quantitative findings

Data was collected from 95 participants, 53 male, 41 female and 1 preferring not to say. Participants were between 24 and 64 years old with 53%\* of participants being in the 35-44 years old age bracket.

Key findings were:

- 59% were living alone
- 6% had children under 18 years of age living with them, all females
- 44% were living in a range of temporary accommodation settings
- 97% were currently in treatment
- Currently prescribed medication for MAT: 61% methadone; 12% buprenorphine wafer; 9% buprenorphine sublingual tablets; 9% long-acting buprenorphine injection; 9%\* other

\*Percentages have been rounded to the nearest whole number which may result in total adding more to 100%

### Standard 1 – Same day prescribing

- 8% had access to same day prescribing
- 86% feel the process of starting MAT could be improved

### Standard 2 – Choice

- 58% stated prescribing options were discussed; of this figure 71% felt they had enough information to make an informed choice
- 62% stated medication dose was discussed; of this figure 56% felt it was a shared decision
- 52% were daily supervised pre-March 2020 lockdown; 27% daily supervised during first lockdown of March – June 2020; 47% currently daily dispensed
- 55% would like a change to their current dispensing arrangements

### Standard 5 – Retention

- 92% had a current length of time in treatment of less than two years
- For 15%, this was their first and only experience of treatment
- 76% had a time when they needed extra support
- 56% had a time when they felt at risk of dropping out of service

### For the 85% who had previous experience of treatment:

- 39% had been retained in service for more than 3 years at *some* point
- For 33% the longest time *ever* retained in treatment is less than two years
- 21% had two previous episodes in treatment
- 64% experienced multiple episodes of three or more periods in treatment

### Additionally:

- 76% felt physically safe to engage with services
- 63% feel supported by their addiction worker
- 47% feel supported by their prescriber
- 64% feel supported by their pharmacist

## Qualitative findings

Thematic analysis was undertaken on all 95 participant interviews. Key findings were:

- For people who had a history of engaging with treatment they feel that access has improved as waiting times have reduced. However, it is felt that this reduction from months to weeks is still too long.
- Limited access to diazepam detox or maintenance prescription.
- Contrasting picture emerged of people who feel it takes too long to get a therapeutic dose with others who feel their dose was too high for them.
- Some participants reported feeling there is more choice of medication available, however it is not felt decisions around choice and dose are always shared decisions between the person and the prescriber.
- Lack of consistency both, in and across, health board areas on choice of medication and dose.
- Staff taking time to explain and encourage discussion around dose and choice of medication promoted engagement, increased wellbeing, and satisfaction with treatment.
- For people who felt they had no choice of prescribing options, they expressed dissatisfaction with services.
- Majority of participants have little engagement with their prescriber or have opportunities to review medication. Significant number of participants do not know who their prescriber is.
- Participants have acknowledged that the pandemic has been a challenging time for services however communication and change of staffing have been identified as areas for improvement.
- Majority of participants feel they need additional support with their mental health.
- Several participants expressed that there are times they feel at risk of dropping out of services but the “safety net” of having access to a prescription keeps them in treatment.
- Feeling physically safe to access addiction services did not equate with people feeling emotionally safe; fear of perceived and actual punitive measure are impacting on the ability of people to engage.
- Access to treatment was viewed as the most important component of harm reduction for some participants, with others acknowledging that their treatment could have gone further to reduce harm.



## Conclusion

This baseline evaluation of people's experiences of accessing MAT in Scotland indicates why the implementation of the MAT standards are crucial to how people access and experience MAT across Scotland. The experiential narrative gives insight into ways in which action can reduce both drug related harms and drug related deaths by increasing satisfaction with services with same day prescribing, choice of treatment and subsequent retention. This snapshot illustrates the issues faced by people who are not retained in services long enough to access the support needed to address presenting issues. It highlights that retention is a major issue and reinforces other studies SDF have undertaken. This work was intended to shed light on the current living experience of people using services and in doing so provide an overall picture to inform quality improvement at local and national levels. The findings outline the challenge is in *how* to move from where we are, to where the MAT Standards require services to be. This report suggests further work on implementation should consider actions in the following areas, as both specific challenges and opportunities for improvement.

### Access

Service models need to reflect the reality of the living situation of the people they are trying to reach. Isolation, social deprivation, and transient populations require services to meet them where they are at. Low threshold services which acknowledge and respond directly to these barriers need to be a first step.

Same day prescribing is essential, delivery models which facilitate this should be replicated and adapted to suit local circumstances. Faster processes for restarting MAT need to be developed to reduce disruption to MAT and deliver same day restarts.

Given the role of illicit benzodiazepine use in participants ability to engage with OST, increasing access to benzodiazepine detox and provision of maintenance prescriptions as a component of MAT should be available where required and clinically appropriate.

### Choice

For people using services, seeing change is crucial. Autonomy and choice in making treatment decisions need to be at the heart of service improvement. Providing adequate information on options of medication and dose is necessary to empower people to have meaningful input in their care. Equitable access to a range of treatment options, in and across health boards, is needed so that the choice of intervention is supported regardless of location. To address treatment holistically and taking account of barriers such as poor mental health, treatment support should include access to a range of psychosocial supports.

### Support

COVID-19 has shown, in some areas, that service can be improved by creatively engaging people. Providing support which recognises the importance of connection within all aspects of care is key to providing emotionally safe environments for people to engage without fear of punitive responses. People need to feel listened to and able to discuss their life without fear; some aspects of current service design precludes engagement for some people. Responding in ways to develop trust is critical for all groups but especially important for females with children. Ways to establish and maintain meaningful therapeutic relationships should underpin all that services do. There is an opportunity for therapeutic relationships to develop across the wider system of care and it

is key that staff in roles with less focus on the therapeutic alliance, such as pharmacy, recognise the importance of their care and support in treatment retention. The gaps in access to additional support, in particular to mental health supports are evident. Services should proactively offer additional support at regular intervals to prevent missed opportunity for engagement and to review treatment goals. Treatment pathways between substance use and mental health services should be further developed to reflect the reality of people who have comorbid substance use and mental health problems and are accessing MAT.

Across the themes of access, choice and support, practice which is identified as disrupting delivery of MAT need to be eliminated if the MAT standards are to mark a watershed moment in reducing drug related harms and drug related deaths in Scotland.

## Considerations for practice

The findings from this evaluation of people's experiences of accessing MAT, suggest a number of considerations for practice, as services progress with implementation of the MAT standards. These are outlined below.

### Access

- **Addressing barriers to access:** Physically taking services to people, by increasing assertive outreach models to the most deprived areas, will allow people the chance to talk and be listened to. This is a crucial first step to getting people into treatment by allowing opportunities to counteract their experience of endemic isolation.
- **Same day prescribing:** It is key that staff across all sectors take responsibility for raising expectations of faster access to treatment. Crucially, access to same day prescribing needs to mean same day. By informing people of the process of starting MAT expectations of receiving treatment upon your first contact with the service will create a cultural shift away from low expectations within this population.
- **Harm reduction:** Services should explore meaningful initiatives and new strategies to engage people receiving MAT in wider harm reduction advice and support in order to increase uptake and provide support to people most likely to benefit from this. The Glasgow City Council WAND initiative (Wound Care, Assessment of Injecting Risk, Naloxone and Dry Bloodspot testing) is one such example of an approach using a contingency management model to reduce harm amongst people who inject drugs<sup>18</sup>.

### Choice

- **Offering choice and involvement in care planning:** Care planning needs to be a collaborative process, with timely regular reviews. The role of the prescriber must be clarified to ensure adequate opportunities to discuss medication choice and dose and allow immediate changes to medication if required. In particular this means that all people using MAT should know who their prescriber is. Conversations should also include exploring and reviewing dispensing arrangements such as opportunities for take home prescriptions.
- **Training, information and communication:** Staff across sectors should have access to up-to-date information and training on MAT treatment options in order to be able to effectively inform service users. Services should consider different mediums of sharing information with service users which support in-person communication, this could include leaflets or digital resources.

## Support

- **Developing support pathways:** Service delivery should ensure that the experience of people using services is taken into consideration to develop support pathways that currently do not exist for them to access the right level of support, at the right time, and by the right people. Particular attention to addressing the pathway into mental health support should be given to avoid people falling through the gaps of being unable to fully engage in MAT due to their mental health, yet unable to access adequate mental health support when in receipt of MAT.
- **Developing therapeutic relationships:** It is crucial to recognise the importance of connection in developing therapeutic relationships between staff and people accessing treatment and equally important staff need to be willing to review this when people in treatment feel, for whatever reason, that a connection is not there. Continuity of support, including changes to named workers should be minimised to allow development of therapeutic alliances with key staff. Staff within the wider system of care such as pharmacy staff, have a key role to play in developing therapeutic relationships and should aim to strengthen these engagements, no matter how brief, ultimately helping to retain people in treatment.
- **Challenging stigma:** To change the experience of stigma for people using services, the workforce training and development needs to lead to a culture change which is more trauma informed in order for people to feel emotionally safe to disclose their needs and barriers which may affect their engagement without fear of sanctions or the removal of services. This is particularly an issue for woman with children who wish to access services and have a strong fear of losing custody of children. Targeted supports which take account of the particular needs of women would be beneficial.

## Acknowledgements

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Thanks to Dr Karen Matthews, School of Health Science, Queen Margaret University, Edinburgh for providing external validation and project support.

Thank you to all services who helped to identify participants and raise awareness of the study across the 6 health board areas.

Finally, thank you to all participants who willingly gave their time and engaged so fully with the work despite a global pandemic. The study team wish you all the very best for the future.

## Background

In July 2021, 1339 drug related deaths (DRDs) were reported as occurring in 2020 - this was the fifth year in a row in which deaths had risen to a record high. To put this in wider context, National Records of Scotland estimate this figure to be 3.5 times that of the UK<sup>1</sup>.

Continuing the emphasis of the Scottish Government Drug and Alcohol Strategy, 'Rights, Respect and Recovery'<sup>3</sup> of evidence-informed interventions to Scotland's drug problems, 'Medication Assisted Treatment (MAT) Standards for Scotland: access, choice and support' was published on 31<sup>st</sup> May 2021<sup>4</sup>. Alongside the Scottish Government 'Health and Social Care Standards: my support, my life'<sup>5</sup>, there is a clear policy directive and framework to deliver evidence-informed interventions which puts people receiving care and support at the centre of decisions made about their care and how it will be delivered.

The MAT Standards aim to deliver and measure a consistent no barrier access to treatment in Scotland regardless of individual circumstances. They are clear on what people should expect from services with the aim to reduce DRD's and other harms associated with drug use. This study sought to provide a baseline of current MAT provision, prior to implementation, from the perspective of people currently in treatment. It is intended to be a reference point to inform and improve practice in relation to MAT.

## Aims

### Overall Aim

The aim of the evaluation was to provide a baseline of current practice in 6 health board areas across Scotland of medication assisted treatment.

### Survey Questions

To establish individual experience of MAT the themes of access, choice and support were explored in a semi structured questionnaire collecting both quantitative and qualitative data from participants. Question and prompts were based on the first five proposed standards for implementation, which were in draft form at the time of data collection and have since been implemented (May 2021):

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

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

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

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

**Standard 5:** All people will receive support to remain in treatment as long as requested.

### The study covered themes of:

- Previous experience of MAT
- Current experience of MAT
- Access to MAT
- Choice of medication, dose, and dispensing arrangements
- Support and retention in services

The questionnaire was designed to facilitate discussion around aspects of access, choice and support which made a key difference to participants rather than attempt to quantify every possible intervention on offer in each of the 6 health board areas.

In line with the standards, the term Medication Assisted Treatment (MAT) is used in this report to refer to, “the use of medication such as opioids, together with any psychological and social support, in the treatment and care of people who experience problems with their drug use”<sup>4</sup> (Scottish Government, 2021: p1)

## Evaluation Design

### Scottish Drugs Forum (SDF) Peer Research Model

SDF has over twenty-years’ experience in successful delivery of peer research projects across Scotland, this method was applied to this study.

Seventeen existing and newly recruited SDF volunteers completed training on the MAT study. Peers were involved in all aspects of planning and delivery of this work. Peer researchers recruited participants through their own peer networks to pilot the questionnaire. From this, one participant who took part in the pilot, was recruited as an SDF peer, and conducted interviews themselves in the study.

A core of eight volunteers carried out most of the interviews. Six of this core group were still receiving MAT themselves throughout the project time frame. Participants were made aware that all peer researchers had experienced treatment services to encourage engagement and elicit a more honest response.

Due to ongoing Covid 19 restrictions all interviews were conducted via the telephone between participant and peer researcher with a SDF User Involvement Officer (UIDO) on the line recording a verbatim written transcript of participant responses.

### Sampling and recruitment

Participants were recruited from 6 health board areas recording some of the highest incidences of drug related deaths based on annual averages from 2014 -2018 <sup>1</sup>. Consideration was also given to ensure the study reflected a geographical spread across Scotland with representation from both urban and rural settings. To this end the study aimed to recruit a sample of 20 participants from Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, and Tayside to achieve this balance. The project was approved by NHS Clinical Governance teams in each of the health board areas.

Twenty-one Alcohol and Drug Partnerships (ADPs), NHS addiction services and third sector services within the target health board areas, were informed directly of the study. Wider publicity for the study was shared more extensively through SDF social media platforms and a targeted approach to delegates, who attended MAT implementation workshops hosted by SDF, was applied. Hard copies of recruitment flyers (appendix 1) were circulated where Covid 19 restrictions permitted. Peer researchers disseminated study information through their own networks.

On invitation, Teams and Zoom meetings were arranged with ADPs, frontline services, and key staff members to facilitate support and recruitment for the study by SDF's UIDO.

A sample of 95 participants were interviewed across the 6 health board areas, falling short of anticipated 120 target. All health boards areas were represented in the sample covering 14 local authority area postcodes.

Inclusion criteria was to recruit participants who had engaged for the first time or re-engaged with MAT over the past 18 months and were currently in treatment.

Exclusion criteria was for anyone not currently starting or re-starting MAT over the last 18 months and under 18 years of age in receipt of MAT.

An additional 16 participants were interviewed in Perth Prison. This was analysed separately and included as an appendix (see appendix 2).

### **Data Collection Tool**

A semi structured questionnaire was co-produced by members of the Scottish Government Drug Death Task Force MAT subgroup and peer research volunteers at Scottish Drugs Forum. Semi structured interviews collected both qualitative and quantitative data from participants.

The themes in the questionnaire and prompts were based on the first 5 proposed MAT standards. The questionnaire was piloted in two of the six health board areas and minor revisions were made. The pilot responses are included in the findings. Interviews lasted on average 40-45 minutes. The questionnaire and prompt guide are attached (see appendix 3).

### **Data Collection Process**

A first name and contact phone number were forwarded by service providers or via peer researchers to SDF's UIDO. Some potential participants contacted the SDF directly after being handed a flyer or in response to a social media post. A participant information sheet (see appendix 4) was texted to those wishing to take part. UIDO then made contact to ensure that individuals met the inclusion criteria and were given the opportunity to ask any questions they had and to give verbal consent to take part in the study. A follow up call was arranged. In line with good practice ethical guidance, participants were informed that they could withdraw from the study at any time. No participants chose to do this, although a few participants were given a break as they became upset and teary describing some aspects of their treatment and upon disclosure of traumatic life events. Participants were signposted to services, as necessary. One interview was terminated by SDF's UIDO as participant was under the influence, SDF's '*What to do if*' protocol was followed on this occasion and support was given to the participant (appendix 5).

After each interview, the UIDO and peer researcher had a debrief of the interview and checked transcript for accuracy. Regular peer researcher meetings were held throughout the data collection period, to give support and opportunity to identify emerging themes.

Data collection period was from December 2020 and initially planned to end 31<sup>st</sup> March 2021. The data collection period was extended to include the prison cohort and to maximise opportunities for community participation due to challenges of remote recruitment during the pandemic. Data collection period ended on 7<sup>th</sup> May 2021.

Participants were given the option of a £10 e-voucher or a postal voucher, based on preference and access to a smart device, most participants chose an e-voucher. This was an honorarium for participation.

In addition, participants were encouraged to help recruit further individuals to the study and were given a further £10 supermarket voucher, as an honorarium, for recruiting people from their networks who met the criteria. This additional voucher was only distributed after completion of the interview. Twenty participants were recruited this way.

Individuals who wished to take part but did not meet the criteria were signposted on to other SDF studies as appropriate: Experience of Stigma in East Ayrshire Services<sup>6</sup>; Hepatitis Scotland, HCV completed treatment survey peer research scoping exercise and Injecting Equipment Provision peer research scoping exercise. Additionally, 8%\* participants (n=8) were identified as appropriate for the MAT study from these SDF studies and agreed for the contact details to be passed on.

### **Data Management and Analysis**

Qualitative data was entered into NVivo database for storage and analysis. Additionally, Survey Monkey (Team Advantage Package) and Excel were used to double check individual transcripts as well as to analyse quantitative data. All individual transcripts were sent electronically to Dr Karen Matthews, Queen Margaret University, Edinburgh in PDF, Excel, and SPSS formats to provide external validation and project support. Data was shared with the internal SDF steering group of this project. A thematic analysis approach was used in which themes emerging under each of the underpinning areas of the MAT Standards; access, choice and support were identified and the range of experience under each theme presented using verbatim quotes. Thematic analysis was undertaken on all 95 community and 16 prison interviews.

Topics most relevant to the Standards form this report. Outstanding information gathered will be used to inform future work on the MAT Standards.

Individual health board areas will not be identified in the report.

\*Percentages have been rounded to the nearest whole number which may result in total adding more to 100%



## Strengths and Limitations of the Study

The study sought to recruit 120 individuals across 6 health board areas who had started or re-engaged with treatment services over the past 18 months for MAT.

A limitation is the possibility that the sample could have been more representative of people in treatment. Engagement from services was lower than anticipated or experienced by other SDF studies during the pandemic. Recruitment relied on a few key individuals within each health board area as well as peer networks. As such this was a self-selecting sample as the onus was on individual workers and potential participants to consent to their information to be passed on or to make direct contact with SDF. This was anticipated and every effort was made to promote this study across a range of sites and peer networks to reduce bias in the sample. A further possible limitation was that participants required access to a telephone which had the potential to exclude some people from this study.

A strength of the research was when contact with participants was made, individuals were very engaged in the process. Some participants stated to prefer the anonymity of the telephone interview as they felt more comfortable engaging outside a service setting. Additionally, some participants commented that a telephone interview reduced anxiety of talking about their experience of treatment and stated they may not have taken part in a community setting.

Feedback from participants on the study include:

*“This is the first time that I have felt listened to”.*

*“You can’t learn this from a textbook, I can only be honest with people who know what it is like”.*

Additionally, 9 % (n= 9) of the study participants enquired about volunteer opportunities with SDF. Testament to the strength of the peer research model is that it indirectly promotes volunteering opportunities to people who may benefit from it beyond the scope of the study as well as being a conduit to meaningful engagement.

To gain information around current access to treatment the inclusion criteria of starting treatment within 18 months was decided by the project team to ensure as up to date an insight into current service provision as possible. However, due to the challenges of recruitment in a global pandemic, this criteria were relaxed to include 15 participants who were in service for two years.

A strength of this data is that it can be used as a further resource to assist with the implementation of the MAT standards.

## Demographic Data

### Representation

Telephone interviews were conducted over a 6-month data collection period, 95 people participated. In terms of gender, 53 respondents identified as male, 41 identified as female and 1 participant preferred not to disclose. The most common (mode) age of participants was in the 35-44 years old age bracket 53% (n=50). Table 1 displays the age categories of participants.

**Table 1: Age Categories of participants**

Age Categories	N	%
24-34 years	24	25
35-44 years	50	53
45-54 years	15	16
55-64 years	5	5
Missing	1	1
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Interviews covered 6 health board areas: Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, and Tayside, representing 21 Alcohol and Drug Partnership (ADP) areas. Within this sample, 14 local authority areas were represented covering rural and urban locations.

### Demographic Profile of Participants

All participants were white with 91%\* (n= 86) describing themselves as Scottish, 6% (n=6) British and 3% (n= 3) English. Over half of the sample have their own tenancy via council, housing associations or private let 61% (n=58). Of this group 9% (n=5) preferred to stay somewhere other than their own tenancy. The remaining 44% (n=42) lived in a range of temporary settings. Details of living arrangements displayed in table 2.

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

**Table 2: Accommodation arrangements of participants**

Accommodation Arrangements	N	%
Own Tenancy	50	53
5 have their own tenancy but stay somewhere else- 1 preferring to be street homeless/ 4 staying friends/family	5	5
Supported Accommodation	8	8
Temporary Homeless	15	16
Staying family	5	5
Staying with friends	4	4
Staying with partner	3	3
Between partner and mum	1	1
Street Homeless	1	1
Private Let	3	3
<b>Total</b>	<b>95</b>	<b>99*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Participants were asked if they lived alone or if anyone else lived with them, 59% (n=56) responded that they lived alone as displayed in Table 3 below.

**Table 3: How many people live with you**

How many people live with you?	N	%
Live alone	56	59
1	24	25
2	6	6
3	3	3
Greater than 5	6	6
<b>Total</b>	<b>95</b>	<b>99*</b>

Of the 95 responses, 94% (n=89) had no children under the age of 18 living with them. For the 6% (n=6) who had children living with them, all were female. Additionally, 7% (n=7) respondents have children under 18 years of age currently not living with them, this was slightly higher for female participants, 4% (n=4), than male respondents, 3% (n=3).

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

### Current and previous experience of treatment

Participants were asked which medication they are currently prescribed for MAT. Table 4 displays the current treatment that participants are receiving, 97 % (n=92) of the sample were currently in treatment. Two participants are trying to re-engage with services for the second time in 18 months. One participant just finished treatment in the few days before their interview; they had started treatment within the last two years.

**Table 4: Current treatment**

Medication	N	%
Methadone	58	61
Long-acting buprenorphine injection	9	9
Buprenorphine wafer	11	12
Buprenorphine sublingual tablet	9	9
Buprenorphine/naloxone sublingual tablet	3	3
Naltrexone	1	1
Currently on no medication, waiting to start long-acting buprenorphine injection, hopefully within the next week	1	1
Currently on waiting list (no indication of timeframe given from service). Second time starting MAT in last 18-month period.	1	1
Currently trying to get into treatment, not on waiting list (street homeless). Second time starting MAT in last 18-month period.	1	1
Just finished treatment (Started MAT in last 2 years)	1	1
<b>Total</b>	<b>95</b>	<b>99*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Participants were then asked how long they have currently been in treatment. Responses are displayed in Table 5.

**Table 5: Current length of time in treatment**

Current length of time in treatment	N	%
1 – 10 days	5	5
1 – 6 months	28	29
6-12 months	34	36
1-2 years	6	6
2 years	12	13
On and off for two years	2	2
3 years (both pilot interview)	2	2
More 5 years (pilot interview)	1	1
Five year in total but I had a break in between	1	1
Waiting list	2	2
Trying to access service	1	1
Finished treatment	1	1
<b>Total</b>	<b>95</b>	<b>99*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Participants were asked the longest time that they have ever been in treatment and the number of times that they have started MAT. Table 6 displays these figures respectively as can be seen.

**Table 6: Longest time consistently on MAT**

Length of time consistently on MAT	N	%
1-6 months	8	8
6-12 months	6	6
1-2 years	17	18
2-3 years	25	26
4-5 years	12	13
Over 5 years	12	13
Over 10 years	10	11
Off methadone 3 months ago to start long acting buprenorphine injection	1	1
Not sure	3	3
Missing	1	1
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

**Table 7: Number of times in treatment**

Number of times in treatment	N	%
1	14	15
2	20	21
3	23	24
4	6	6
5	7	7
5-10	18	19
More than 10	7	7
<b>Total</b>	<b>95</b>	<b>99*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

## Findings

### Access

#### Length of time to start treatment

Participants were asked how long it took to start their treatment; the table below provides a breakdown of the length of time to start treatment for the study sample.

**Table 8: Details length of time to start treatment.**

Length of time to start treatment	N	%
Same day	8	8
Days	17	18
Up to 2 weeks	15	16
Up to 1 month	30	32
2-3 months	13	14
4 months plus	6	6
Unsure	4	4
Waiting list	2	2
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

It was unclear whether the length of time to start treatment was from when individuals first contacted the service or from their first appointment. Participants referred to an assessment period, of varying lengths before starting treatment.

#### Same day prescribing

Same day prescribing was reported in four of the 6 health board areas indicating that same day prescribing is taking place. There was some evidence that same day prescribing was prioritised for more at-risk groups and for participants with children. Level of satisfaction was high for this group:

*“put it this way, it’s the quickest. Someone made a call, and I got an appointment an hour later and started medication the next day.” (male, 45-54 years, 28 3/66)*

*“I got put on it the same day because I was fast tracked cause of the kids.” (female, 35 – 44 years, 34 3/65)*

## Improved access

There was a general acknowledgement that waiting times have improved from previous treatment episodes, with a few weeks wait perceived as good:

*"It was quicker this time round, one or two weeks I think". (male, 35-44 years, 27 3/68)*

For people who had a longer wait, it was still described as satisfactory although expectations around time frame for access were low:

*"I thought it would take longer but it only took 4 weeks, and I was surprised by how quick it was especially with Covid." (male, 55-64 years, 38 3/72)*

*"6 weeks wait which isn't too bad as I thought it would take longer." (male, 35-44 years, 63 3/71)*

For people who experienced a longer wait, there was a narrative that this delay was caused by them rather than how the service is designed:

*"I think I could maybe have got it quicker, but my drug use was erratic, and I was missing appointments" (female, 35-44 years, 65 3/69)*

*"I was too chaotic I had to wait 2/3 weeks". (female, 35-44 years, 8 3/74)*

Several noted that their engagement was hindered due to withdrawals hampering their ability to engage at set times:

*"Appointments when you are withdrawing are hard". (female, 35-44 years, 64 3/63)*

*"I am so ill with withdrawals that I can't engage". (female, 35-44 years, 70 3/28)*

## Waiting to start treatment

Frustration for people when waiting to start treatment was in the 'not knowing how long they would have to wait'. The wait was described as a negative experience with continuing risk behaviours and isolation to manage the very issues which were factors in people seeking to access treatment in the first place. This is further confounded by some individuals describing a period of ambivalence before contacting the service:

*"It took me a year to get the courage to go to the service but then things happened quite quickly, I was on a script within a week." (male, 24-34 years, 3 3/10)*

When further probed around, 'what things were like for you while you waited?', there was very limited support offered while people waited to start treatment:

*"I wasn't in my right mind so didn't know where to get help (when I was waiting)". (female, 35-44 years, 8 3/21)*

*"Timing is a big issue; no other support is offered while you wait." (female, 35-44 years, 78 3/49)*



One respondent reduced their drug use when waiting to start treatment. Over half the sample, 51% (n=48) explicitly reported drug use staying the same or increasing:

*“If I had stopped using, I would have went into withdrawals and might not have made it into treatment.” (male, 24-34 years, 42 3/3)*

*“The wait made things worse.... I didn’t want to keep using but I had to maintain my habit until I got into treatment.” (female,24-34 years, 92 3/4)*

Poor mental health was acknowledged, in just under half 40%\* (n=38) of responses, due to drug use, and associated lifestyle contributing to the need for referral to services. No responses indicated an improvement in managing mental health symptoms while waiting to start treatment:

*“Jesus Christ my mental health was bad enough without all that crap of being chaotic and waiting on a script”. (female 24-34, years, 54 3/6)*

*“My mental health was terrible. I think if anything it probably got worse, things certainly didn’t improve when I was waiting. I hope people don’t die in between times when we are waiting on these MAT standards.” (male, 35- 44 years, 62 3/7)*

### Process of MAT

Table 9 displays responses to the question, ‘do you think the process of getting on MAT could be improved?’

**Table 9: Process of MAT**

Do you think the process of getting on MAT could be improved?	N	%
Yes	82	86
No	12	13
No response	1	1
<b>Total</b>	<b>95</b>	<b>100*</b>

When asked, ‘if the process of starting MAT could be improved’, participants 86% (N= 82) felt there was room for improvement. There was a general acknowledgement that waiting times have improved, however for some participants it was stated that, although things had improved for them, this was not necessarily the experience of their peers. Among respondents who had experienced faster access to treatment the perception was around their “luck” rather than access being hastened by clinical need or a general standard in the service.

*“Taking away Covid, things have improved just by the speed that you get on it compared to years ago. I know I was lucky this time, I know plenty of people who had to wait 2/3 weeks to get on it”. This is too slow to prevent overdose and prevent people having a rough few weeks while they wait.” (male, 35 – 44 years, 7 3/40/55)*

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

## Window of opportunity

Participants linked delays in commencing treatment with missed opportunities to reduce risk and drug related deaths. This period was acknowledged as a crucial moment to engage with people seeking treatment and the need for service to seize this as an opportune but limited window to start people on MAT. There was concern that any waiting time reduces the likelihood of people being able to make it to start treatment.

*“Definitely, it takes too long, and the window of opportunity is small so services should be designed to capitalise on this.” (male, 24 – 34 years, 6 3/46)*

*“As you are still doing everything wrong while you wait, and you are wanting help, so it is really difficult. When you want help you need it there and then.” (female, 24-34 years, 11 3/47)*

*“The time you have to wait to start treatment should be cut. It is so long winded that you really have to go through the motions and the window of opportunity is so small.” (male, 35-44 years, 3/48)*

*“I am hearing of guys going to the clinic and being told to come back in 2/3 weeks’ time. By that time, you are dead. Two weeks is a long time to an addict, it’s more like two years”. (male 45 – 54 years, 93 3/52)*

Although there was variation in the period of time taken for people to start MAT from initial contact with a service, this sample did not indicate any differential access across age and gender. In terms of setting and service, homeless settings in urban areas were viewed as providing faster access to treatment. However, there is a perception that regional variation exists:

*“It probably comes down to what area of the country you are in. Different areas act differently. I was lucky, but this is not the general experience of people I know “. (male, 45-54 years. 28 3/59)*

## Accessing treatment

When participants reflected on starting treatment, this was viewed as a positive experience. Access started the process of stabilising drug use and increased their awareness of other support services who could assist them. Crucially, it was viewed as saving lives:

*“As soon as I started treatment, things started to improve massively”. (male 35 -44 years, 82 3/27)*

*“I think the service is great when you get into them and that they save your life, it is just having to wait.” (female 35- 44 years, 15 3/16)*

## Harm reduction

For many participants access to treatment was viewed as the most important harm reduction intervention as they experienced a reduction of adverse outcomes across many aspects of their life, when engaged in MAT. However, some participants acknowledged that their treatment fell short of reducing harm:

*“My meth isn’t enough and I am still using. They gave me harm reduction advice but at the end of the day I am still using”. (male, 35-44 years, 68 8/19)*

The questionnaire did not contain a section on specific harm reduction interventions rather peers promoted participants with, *'what is the best piece of harm reduction advice you have received?'*. A few responses stated that they felt knowledgeable about harm reduction but were reticent to further engagement around this preferring to talk about their experience of accessing medication:

*"I have had loads of harm reduction advice over the years" (male, 45-54 years, 56 8/5)*

*"I know all about that side of things (harm reduction). I am quite knowledgeable about all that kind of stuff" (male, 45-54 years, 28 8/4)*

*"They tried to give me harm reduction advice and I am not being big headed, but I know it all" (male, 35-44 years, 59 8/18)*

One participant acknowledged the impact of Covid 19 on harm reduction services:

*"Before Covid there was like a drop in and you could show your injection site to the harm reduction team." (male, prefer not to say, 66 8/19)*

Of the participants who engaged in conversation around harm reduction, naloxone was mentioned by 43 %\* (N=41). There were degrees of knowledge of naloxone within this group with some having received full training; this was more likely for those who had experienced criminal justice services. Whereas others described feeling less confident around naloxone administration:

*"I have the naloxone spray. I keep it in the house at all times. I have not had any training on it or been told how to do it. At the start of lockdown, I got posted out a nasal spray and got a leaflet." (female, 35-44 years, 64 6/8/9)*

*"I have naloxone, but I wouldn't know how to use it. They just want you out the door. I might ask when I am able to sort myself out again". (female, 35-44 years 70 8/11)*

*"I have had three naloxone (kits), but I have not had much harm reduction advice about how I can keep myself safe". (male, 24 – 34 years, 57 8/7)*

For all participants, who had naloxone, no one had administered it.

For some 19 %\* (n=18) participants, lack of access to a benzodiazepine prescription impeded their ability to fully engage with services even after commencing opiate replacement therapy (ORT):

*"Most of the time I feel I need extra support. A constant problem that I have is that I don't have any help for my benzo use. It's a personal issue but addition services need to deal with all addiction not just opiate use e.g., benzo use." (female, 35-44 years, 60 8/18)*

*"I am trying to get a benzo script. I have been trying for about a month. All that happens with my benzo use is they tell me to cut it down, but I need more help than that". (male, 35-44 years, 44 9/18)*

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

One female participant, with children, acknowledged her reluctance to ask for support for her benzodiazepine use due to fear of the consequences in doing so:

*“Right now, I have nothing to hide but cards on the table. I am using a very minimum amount of benzos. I buy someone else’s prescription, so they are not street benzo’s. If I told them this, then I would be scared that my kids would be removed and put into care.” (female, 35- 44 years, 89 8/16)*

One participant below, commented how much his life has changed after starting a benzodiazepine prescription alongside opioid substitution therapy:

*“You take horrible decisions on Valium that you wouldn’t normally take e.g. I ended up on crack cocaine. Now I am on a Valium script I feel normal. For the first time, I can actually see the future (male, years 35- 44 years, 58 8/8)*

### **Ability to access service**

In terms of accessing services, a range of experiences were acknowledged by participants which suggests a lack of consistency in services provided at the right time, by the right people across the 6 health boards.

Many participants were able to identify themselves, that they needed support, with services missing opportunities for timely engagement as illustrated below:

*“I have been at risk through my own stupidity as I didn’t reach out to anyone and would just stay in and suck it and see. I have just stopped my meth overnight in the past. I know there is people that you can phone but I struggle to reach out and to ask people for help when I need it. I just cut myself off.” (female, 35-44 years, 17 6/242).*

*“When I told them, I wanted to drop out they kinda blamed me for not opening up and I tried to explain to them that seeing lots of different workers doesn’t help you. You are scared to say anything in case it effects your script.” (male, 34-44 years, 50 6/244)*

*“That’s not down to the service that is down to me. Sometimes, I just can’t be arsed. My moods and that. My worker just tells me to take few days. I have a good relationship with my worker. Sometimes, I like to cut myself off from the world. What would help? Probably me just answering the phone to the worker but sometimes that is the hardest thing to do even though I know that would make me feel better. I sometimes just feel at risk of dropping out, but I don’t know what more they could do to help me.” (female, 35-44 years, 55 6/178)*

One participant, who is currently on a waiting list to start treatment for the second time in a year commented:

*“I have (been at risk of dropping out in the past). Right now, it would be good to have a weekly appointment. All you want is to know someone actually thinks about you.” (male, 24-34 years, 88 6/241)*

Two participants acknowledged the impact of having someone close to them dying of a drug related death. One spoke in terms of a DRD facilitating her self-referral to services. For both individuals there was no engagement from assertive outreach services to identify either individual as potentially in need of service; the former participant expressed her disappointment at this:

*“My ex-partner had OD’d and died that is why I made a referral. I had to find the service, no one came looking for me even though my partner had died of a DRD.” (female, 24-34 years, 53 3/2)*

For the other participant, the same circumstances led to a challenging period before contacting services:

*“My sister OD’d and died, and you think that would wise you up, but I went the other way into chaos before I contacted services”. (male, 35-44 years, 2 3/1).*

This theme of needing encouragement to access services was acknowledged by one participant who recognised the barriers that appointment-based systems can have on the ability to access services:

*“I had an initial appointment before lockdown and that was it. There is a perception, amongst people who I know use the service, that if you don’t turn up for an appointment then that is it. When you are still using you need coaxing to cut down, you need encouragement, but you go to the back of the list if you keep using. They will withhold your medication if you miss an appointment, your pharmacist tells you that you need to make an appointment to continue”. (female, 24-34 years, 92 7/111)*

There was a recurring narrative around appointment systems contributing to disruption in the delivery of MAT:

*“When you are caught up in the drug world appointments and drug diaries are impossible.” (female, 35-44 years, 65 3/13)*

*“Previously I have dropped out as I can’t hang about waiting on appointments and I tell them this.” (male, 45-54 years, 12 6/244)*

Majority of participants expressed frustration with trying to contact a worker in service. One participant suggested a protocol in place would help:

*“Don’t get me wrong, sometimes you can get reception staff to send an email, but you can’t just get help when you need it. Be so much easier if they had a protocol in place so you know how you can contact your worker”. (female, 35-44 years, 64 7/84)*

## Missing chemist

Some participants described the impact of disruption to their MAT treatment after missing their medication for three days or more. One respondent, currently on the waiting list, to re start her MAT after missing the chemist, she stated:

*"I wish the service would work more closely with the pharmacy and have better procedures in place for restarting medication after missing it for a few days." (female, 45-54 years, 5 6/233)*

Other participants, below, described their return to risk behaviours after their MAT was discontinued for missing the chemist:

*"Using everything I could get my hands on as I was replacing 80ml of methadone (after missing the chemist for three days). I have been in treatment about 6 times, and I feel I always stumble as I miss the chemist and get struck off and then have to start again." (female, 35-44 years, 41 3/34)*

Again, another participant commented:

*"It was harder the times that my medication was stopped by the service for missing the chemist." (male 35-44 years, 19 3/33)*

The two participants below describe a positive and negative experience of missing the chemist for 3 days in a row and service response:

*"If I don't go to the chemist now my worker is at my door doing a welfare check." (male, 24-34 years, 4 6/223)*

*"My worker never contacts me when I miss the chemist and I get pissed off when no one contacts me as I feel that no one cares, and it is left for me to get back in touch". (female, 35- 44 years, 41 6/234)*

One participant, who had started treatment twice over the last year, acknowledged his rapid re-engagement with services and factors which facilitated it:

*"I was able to get back into service quickly as after the first-time last year my worker kept my case open, he hadn't shut me down, so I was able to get back. My wait, both times, was largely positive. Both times I could get medication pretty quickly but that is not everyone's experience and I know this from recovery networks.... Things have absolutely improved, my experience of being kept open is rare....My experience is that when you make an effort you get support off them." (male, 34-4 years, 76 6 /237)*

## Services during Covid

Participants acknowledged reduced access to support from services since March 2020 with the onset of the global pandemic. Participants recognised that the pandemic has been a challenging time for services however communication and change of staffing have been identified as areas for improvement, with some participants expressing frustration at the reduced contact with services over the last year:

*“Since March 2020 no one has contacted me at all. I get support from my advocacy worker but not from (names addiction service)”. (female, 35-44 years, 23 6/90)*

*“What engagement, I have had two phone calls since the start of lockdown?” (male, 45-54 years 93,6/92)*

*“I can’t engage right now. There is no one to speak to. There is no follow up information”. (male,24-34 years, 88 7/74)*

*“I would like support as I feel my head is a mess, but I have not had a chance to speak to someone”. (male, 24-34 years, 73 6/239)*

*“Cause of Covid, the service didn’t want to see you and I should have been able to get extra help because I was having a baby.” (female, 35-44 years, 25 6/131)*

*“Last year I spoke to my worker once over the space of a year and it wasn’t even for five minutes. I understand the way the world is but still feel it could have been a bit more supportive.” (female, 35-44 years, 65 6/137)*

One participant stated a missed opportunity for observational assessments by services over the pandemic and the impact on retention in MAT:

*“Over the past year, I was on monthly appointments, so I never really got the chance to discuss this (thinking of dropping out of service) and they weren’t seeing me enough to notice changes in my appearance, how I was presenting. There shouldn’t be such a gap in appointments and your worker shouldn’t change so much”. (male, 45-54 years, 22 6/243)*

One participant commented on the importance of having outreach services to facilitate access to services:

*“Not extra medical support but moral support, we all need to know that we are alright. I had a near fatal overdose at the start of last year and I was only using cause I felt rough not cause I wanted to use. The peer team came to me and linked me into service. The whole Covid thing, is no substitute for the face to face.” (male, 35-44 years, 6/238)*



## Choice

Participants were asked about their prescribing options. Table 10 below quantifies the choice offered and subsequent Table 11 expands on the first question, by quantifying the degree to which participants had enough information to make an informed choice.

**Table 10: Prescribing options**

Were prescribing options discussed with you? (e.g., choice of medication)	N	%
Yes	55	58
No	38	40
Not sure	2	2
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

**Table 11: Making an informed decision**

If yes, do you feel you had enough information to make an informed decision?	N	%
Yes	39	71
No	16	29
<b>Total</b>	<b>55</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

### Informed Choice

The outcome of having an informed choice of medication meant that some individuals chose a drug which they knew had worked for them in the past or conversely were opting to try something new based on prior experience. There was some variation about which drugs were available in and across different health board areas, choice was very service dependent. For participants who felt their decision was a joint one, content analysis indicates this to be an overwhelming positive experience and indicative of a cultural shift in services. It was acknowledged that different medications work for different people, and that this may change over time:

*“It was a shared decision. My worker said that it is my care, and it is my choice and I know not everyone had this”. (female, 35-44 years, 8 4/93)*

*“Things are so much better than before, it used to be up to the doctor what you were entitled to.” (male, 35-44 years, 83 4/162)*

A few respondents spoke about having no choice on clinical grounds, yet as this was explained to them by their worker, they felt it was a joint decision:

*“I have mental health issues. They said Subutex wouldn’t work as I am emotionally instable, and they said the better option for me was methadone and I think they were right with that. I don’t think I was ready for that; I think I would have relapsed if I was on Subutex.” (female 24 -34 years, 47 4/145)*



This group accepted that an informed choice, did not necessarily result in receiving your preferred choice of medication, and were satisfied with the joint decision-making process.

The other strong emerging theme was that discussion of prescribing options did not always lead to treatment decisions feeling informed:

*“I am not sure how much of an informed decision it was. I was given some options, but I wouldn’t say it was explained in detail.” (female, 35-44 years 78 4/123)*

*“I think things were discussed with me, but I don’t know how much my opinion was taken into account.” (male, 35- 44 years ,13 4/139)*

Additionally, a few respondents commented on poor physical and mental health as well as withdrawals impacting on informed consent:

*“I wasn’t in a state to understand options.” (female, 55-64 years ,72 4/22)*

Many participants were unable to describe when prompted, options to review choice of medication.

### No choice of prescribing options

For participants who stated they had no choice of prescribing options, the sentiment of their responses was viewed as negative in relation to their experience of treatment; they viewed themselves as passive recipients of their treatment:

*“they told me what I was to go on, I don’t feel I was given a choice.” (male, 35-44 years, 48 4/111)*

*“it wasn’t a shared decision; it was their decision.” (male 45-54 years, 45 4/131)*

*“I wasn’t consulted about what the right medication would be for me. I was just told this was the substitute for heroin and everything would help”. (male, 24-34 years, 73 4/136)*

Few respondents commented that choice was not an informed one due to not having received adequate information on all choices available:

*“I wasn’t sure what would work best for me and that wasn’t discussed, it was more like what do you want?” (male, 35-44 years, 50 4/135)*

### Dose

**Table 12: Dose discussed**

Was dose discussed with you?	N	%
Yes	59	62
No	31	33
Not sure	5	5
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

**Table 13: Dose shared decision**

If yes, do you feel that the dose you started on was a shared decision?	N	%
Yes	33	56
No	19	32
Not sure	7	12
<b>Total</b>	<b>59</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

### Shared decision

Shared decision making over medication dose, was presented as a positive aspect of treatment for 56 % (N=33) of participants. Staff taking time to explain and encourage discussion around dose promoted engagement and increased wellbeing:

*“I don’t have a bad thing to say about the service as they have been really great with me. They explained the dose, they have been good for me”. (male, 55-64 years, 38 5/5)*

*“I was told it was my body and it was up to me”. (female, 45-54 years, 81 8/50)*

*“I got a leaflet re dose and was kept informed of how I would be titrated and the reasons why decisions were made.” (male, 45-54 years, 36 5/9)*

*“The nurse said if I needed more, I was to come back, but I felt brand new. I felt that the dose was carried out in a safe way, everything was explained, and my blood pressure was checked. It was getting on it in the first place that was the problem.” (female, 45-54 years, 86 5/15)*

### Not shared decision

A contrasting picture emerged for remaining participants 65 % (N=62) who asserted that it takes too long to establish a therapeutic dose and others who felt their dose was too high for them. There seemed to be a lack of consistency in communication to participants around their titration dose, leading to a lack of agency over medication and dissatisfaction with their treatment. Few respondents articulated the tension between a perception of service protecting themselves from a drug related death, over person centered care.

*“I know every drug workers nightmare is giving out medication and then someone dying, but I really feel that I could have been up more”. (male, 35 – 44 years, 63 5/25)*

*“I feel I am rattling at night and have asked for an increase but have been told that it is too risky to put me up in case I OD. I am still using heroin every couple of days.” (male, 35-44 years, 48 5/38)*

*“Dose wasn’t discussed I was told. It was basically, no you can’t get an increase and it took months to get the dose I am on now. They are frightened to increase you when they can’t see you and I was still using IV.” (female, 24- 34 years, 54 5/40)*

*“No, I was put on 35ml to begin with, but it didn’t even touch the side.” (female, 35- 44 years, 23 5/54)*

*“Dose was discussed, they started me on 20ml and then I was put up. I have been on 115ml before. 20ml doesn’t tickle my tonsils. I was still using on top but they would only put me up by 5 mls. Dose was explained and apparently you have to start on a small dose and work your way up.” (female, 35 -44 years, 65 5/19)*

Few spoke around the need to have a fuller explanation around decision making to feel confident with accepting clinical advice:

*“I had to build up to the dose I am on now. They wanted me to start on a higher dose but I didn’t want to as I felt what I had was holding me. They explained why they wanted to do this and only when they explained was I certain about what was the right dose for me.” (male, 35 – 44 years 82 5/13)*

*“I think it was the right dose now but not at the start I didn’t.” (female, 45-54, 20 5/53)*

A few participants acknowledged holding back medication or disengaging with services when they felt that their dose was increased without their consent, even if it may have been in their best interest:

*“They shouldn’t be able to control you life so much. I can’t remember about dose. I was just itching to get on it. They might have explained it, I wasn’t in a state to take it in.” (female, 24 -34 years, 26 5/16)*

*“My dose was increased and increased, it was never a shared decision.” (male, 35-44 years, 19 5/35)*

*“They want to put you up as high as possible to keep them safe, it isn’t about what you want.” (male, 35-44 years, 14 5/50)*

*“They should listen to how medication is affecting your body before making decisions about putting it up or down.” (female, 35-44 years, 46 5/37)*

It was suggested by a couple of participants that an increased dose could put people at more risk if they are still using street drugs:

*“Because you give dirty urines, I don’t believe that the answer is for your dose to go up and up. There should come a point when someone should be saying, ‘hang on meth is not stopping the using’ (male, 35-44 years, 7 5/32)*

*“When I was on methadone, my dose was discussed with me although it wasn’t right as I was still using on top” (male, 24-34 years, 85 5/44)*

## **Information**

Participants acknowledged that feeling more informed whether from previous treatment episodes or from researching options themselves, was an important aspect in their recovery and increased satisfaction with their treatment. This was a theme which respondents were particularly passionate about; being active recipient of care:

*“I felt informed as I had knowledge in my head from previous times in treatment.” (male, 45-54 years, 31 4/183)*

*“You feel better when you can manage yourself, you need to be able to make your own choices.” (female, 35-44 years, 75 4/175)*

*“I need to know how things are going to work. I am not sure everyone asks but I like to understand. I am not going to go blindly into something.” (female, 35-44 years, 8 4/180)*

*“I knew a lot about things from my own education. I don’t think they tell you enough about the neuroscience behind how your medication affects your brain. This is something that I would like to know more about.” (male, 24- 34 years, 6 4/178/179)*

## Dispensing

Table 14 displays dispensing arrangements before and during Covid 19 and current dispensing arrangements.

**Table 14: Dispensing arrangements**

Dispensing arrangements	Frequency	N	%
Before lockdown March 2020	Daily supervised	49	52
	Daily pick up	5	5
	Other	41	43
<b>Total</b>		<b>95</b>	<b>100*</b>
During lockdown March 2020	Daily supervised	26	27
	Daily pick up	8	8
	Other	61	64
<b>Total</b>		<b>95</b>	<b>99*</b>
Current	Daily supervised	45	47
	Daily pick up	4	4
	Other	46	48
<b>Total</b>		<b>95</b>	<b>99*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Participants were asked to state their dispensing arrangements before and during Covid 19 lockdown compared to their current arrangements. There is a caveat to these figures, not all the study sample were in treatment before March 2020, some individuals started and stopped treatment during lockdown only to subsequently re-engage. Additionally, the research design assumed that the lockdown of March 2020 was a one-off event whereas people were in and out of various restrictive measures depending on where they lived over the last year. What can be inferred from this data, is a period at the onset of the pandemic in which dispensing arrangements changed; the need to control viral transmission of Covid 19 superseded normal dispensing arrangements. The following qualitative data explore some of the implications of this.

The majority of responses acknowledged they had choice over which chemist they went to but no say in how frequently they went. There was some anger from participants that change to the frequency of dispensing arrangements was only made possible due to Covid 19:

*"I was told to just go every day until they trust you, but it only happened (reduced frequency) because of Covid." (female, 34 – 44 years, 23 3/206)*

*"I have been daily for years and it has taken some virus to come along and change that". (male, 45-54 years, 93, 2/27)*

*"Since lockdown cause I get a weekly script (now) I feel x100 better not having to go to town and be surrounded by the wrong people when you are weekly, you are not reminded of your drug history all the time. It gives you a positive mindset." (female, 35-44 years, 64 2/21)*

Few respondents stated that daily engagement with the pharmacy added routine and structure to their life:

*"Going everyday means I get washed every day and have a purpose". (male, 35 – 44 years, 27 2/2)*

Additionally, a further few responses illustrated a protective factor in having daily contact:

*"I am happy with the way things are just now as I am not 100% stable". (female, 24- 34 years 47 2/3)*

*"Being on a daily supervised dose is their way of checking to see if I am out my nut and that actually makes me feel safe." (female, 24-34 years, 54 3/227)*

For many participants daily supervised dispensing or pick up was viewed as punitive treatment which reinforces stigma:

*"I have spoken to my worker 2 or 3 times in the last year, there is no support, you have to do it yourself and then they punish you by having to go daily. It is a daily embarrassment." (male, 35-44 years, 19 7/77)*

Comments from some of the participants illustrate physical challenges of engaging with daily prescribing:

*"I lost my leg in 2012 from heroin injection. It is really hard to go to the chemist every day." (female, 35-44 years, 65 2/11)*

For one person, the physical challenge that he faced seemed particularly unnecessary as his wife had her medication delivered from the same pharmacy due to her poor health:

*"I have to go to the chemist every day and I have emphysema and the mile there and back is absolutely killing me and I have to stop and get a breath. If I don't go, they will stop my medication" (male, 55-64 years, 38 2/10)*

Travel time and expense of public transport to access the pharmacy was also acknowledged by a few participants:

*“I have to go a fair distance as my chemist more locally only takes on one at a time. It costs £3.80 on the bus and I don’t always have that so I have to walk miles.” (male, 35-44 years, 82 3/342)*

*“It wasn’t made clear that not all pharmacies dispensed buprenorphine. So, I had a bit of any issue trying to find my own pharmacy. I was not told that it would need to be daily dispensed. A six-mile round trip, £4.80 on a bus. I was only able to afford to go as I can travel as a companion on my mum’s bus pass. Without this, I would have to walk, which I would have, but there is no help available to pay for travel” (female, 45- 54 years, 86 3/354)*

Reflecting on changes to dispensing arrangements over the pandemic, 55 % (N=52) would like a change to their current dispensing arrangements.

Two participants would like an option of splitting their dose:

*“I would like to take some (medication) away with me so I can split my dose.” (female. 35-44 years, 60 2/13)*

Few participants acknowledged that addiction staff had explained conditions to reducing frequency of dispensing arrangements, with one individual feeling fully informed of the process:

*“It was supervised daily and they saw I was going every day so I got the option to go less” (male, 24-34 years, 6 3/199)*

*“Fully informed on what it would take to go twice a week and then weekly. It is mandatory daily until you can go on to once a week.” (male, 35- 44 years, 31 3/212)*

## Support

### Retention

For 15% (n=14) of participants, this was their first and only experience of treatment. The vast majority, 85% (N=81) had previous experience of treatment, with 64 % (N=61) having experienced multiple episodes of three or more periods in treatment.

### Extra Support

Participants were asked, if for their current time in treatment, had they ever felt in need of extra support. Table 15 shows that the majority of responses 76% (n=72) felt that this was the case at some point.

**Table 15: Extra support**

Have you had times on your MAT that you felt in need of extra support?	N	%
Yes	72	76
No	20	21
Not sure	3	3
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For this group, having someone to talk to would have helped:

*“A few times I have just been fed up with it. I told the service but there was a six-week waiting list to get to speak to anyone. My dose has never been reviewed. I wanted more support but not an increase in my medication. I needed someone to talk to.” (male 35-44 years, 14 6/7)*

*“When I split up with my partner, I could have done with help, but my worker wasn’t in contact with me at all.” (female 24-34 years, 52 6/15)*

*“All the way through I have felt the need for extra support, and it shouldn’t be like this. I don’t feel able to talk to a worker, there is a lack of trust on both sides. They are not interested.” (male, 35-44 years, 91 6/21)*

When asked to give examples of, ‘what type of support helped’, increased frequency of contact with a service alongside having a therapeutic relationship, which supported participants to self-determine their recovery helped to keep people engaged with services:

*“Now I am going twice a weekly it used to be weekly, but it has recently changed (name of 3<sup>rd</sup> sector service) have been pretty good with extra support.” (male, 24-34 years, 6 6/24)*

*“I have had low periods when I struggled. I often miss my meth and the service heard about that and they try to see me earlier than my scheduled appointment. It was very much my choice if I felt I had to increase my dose and I have a good worker, so I felt I was listened to and I was happy to discuss things.” (female, 45-54 years 20 6/29)*

Additionally, access to community psychiatric nurses for mental health support was cited as an important factor of support. Community based third sector services were also rated as important points of support and as gateway to access other services. However, access to all aspects of support were variable in and between different health board areas:

*“Where I am at this time round, I feel I have all the help that I need. Previously, especially over lockdown, you were just left to get on with things yourself which is why I ended back out of treatment and using again.” (male, 24-34 years, 4 6/240)*

### Dropping out of service

Table 16 quantifies the number of participants who feel they have had times when they felt at risk of dropping out the service.

**Table 16: Risk of dropping out**

Have you had times when you have been at risk of dropping out of service?	N	%
Yes	53	56
No	42	44
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

The majority of participants identified needing support for their mental health. Participants found it difficult to articulate the constituent parts of what mental health support would need to look like, but currently felt their mental health needs were not being adequately assessed and addressed.

*“It is really hard just now but it is down to my mental health, trying to keep appointments when you are paranoid and anxious makes things really difficult. You don’t want to go out the house. I am getting extra support this time round because I am pregnant. I feel I have more support.” (female, 35-44 years, 10 6/166)*

Participants acknowledged that the pandemic has been a challenging time for services however recurring themes of poor communication and changing staff have been identified as areas for improvement.

This is exemplified for one participant who had started treatment twice in the past year:

*“I couldn’t phone them as I had three workers in the past year and didn’t have that kind of relationship with them to phone and say, ‘I am struggling a bit today.’” (male, 45-54 years 22 6/145)*



## Safety Net

For the 44% (N=42) who answered 'no' to having times they may have been at risk of dropping out of service, for a few participants this was around fear of withdrawals, having to start treatment again and needing their medication too much to drop out of service rather than with a general overall satisfaction with treatment services.

*"I have never felt the need to drop out as I need my medication too much so that keeps me going." (female, 24-34 years, 94 6/247)*

*"My script is my safety net. I need that too much to risk dropping out." (male, 35-44 years, 58 6/239)*

## Experience of service

### Safety

Table 17 shows that the majority of people feel safe when engaging with different aspect of treatment services.

**Table 17: Feeling safe to engage with the addiction service**

Do you feel safe to engage with the addiction service?	N	%
Yes	72	76
No	19	20
Not sure	4	4
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Responses were focused on feeling physically safe to access service premises. It was acknowledged that social distancing requirements of Covid 19 had increased feelings of physical safety due to reducing gatherings inside and outside the services of other people in treatment.

Few participants acknowledged that although they felt physically safe to access services this did not equate to feeling emotional safety:

*"I feel physically safe, I just don't feel supported." (male, 45-54 years, 37 7/42)*

Two of the six female participants with children, illustrated the challenge for mothers to feel emotionally safe in services:

*"I know a lot of mothers who go in there and don't tell the truth for fear of losing their kids." (female, 35-44 years, 89 7/118)*

*"When you have weans you can never trust them. You can never tell the truth. My worker is a nice person, but it is her job to feed back if I fucked up so the consequences of telling the truth are too great" (female, 35-44 years, 34 7/120)*

A further few participants continued this theme around concerns of confidentiality across services:

*“You are scared to talk to them in case they pass it on to like social worker, DWP, they would stick you in it.” (female, no children, 35-44 years, 23 7/116)*

One noting that some services are not adequately private:

*“I feel safe but worry that everyone can hear what you say as when you are outside you hear everything that is going on inside.” (prefer not to say, 24-34 years, 40 7/119)*

For this group physical safety was only one aspect of measuring, ‘feeling safe’ to engage with services.

### Addiction staff

Table 18 participants were asked to state if they feel supported by their support worker in addiction services.

**Table 18: Support in addiction service**

Do you feel supported by your support worker in addiction service if you have one?	N	%
Yes	60	63
No	23	24
Not sure	11	12
Missing	1	1
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

There was a wide variation in types of workers supporting participants within addiction services. The majority of participants responded to this question by focusing on the key member of staff who they have most contact with. For some individuals this was a support worker or CPN and others named addiction or social worker staff.

In terms of worker competencies which were viewed as having the biggest impact, support and accessibility of worker was a recurring theme:

*“I have my workers mobile, and I can phone out with working hours, and they will get back to me in work hours. This is good as I suffer anxiety.” (male, 45-54 years, 45 7/2)*

Additionally, a worker recognising difficulties with engagement and working creatively to overcome obstacles to accessing support increased satisfaction with services:

*“My worker lets me wait outside for appointments when my anxiety is bad.” (female, 35-44 years, 55 7/34)*

The majority of participants stated the importance of having a connection with a worker, regardless of their professional qualification:

*“I feel my worker is really caring and I feel I have a connection and that she always looks out for me. This hasn’t always been the case with previous workers.” (female, 35 - 44 years, 15 7/12)*

For a few respondents’ workers having their own experience of treatment was valued:

*“It helps to have some of the services that I use employ people who have been there. Life experience is your best asset when dealing with people who use drugs”. (female, 35-44 years 8 7/7)*

A majority of respondents reflected that ‘luck’ played a hand in how you are paired with a worker and this ‘luck’ can facilitate retention or drop out in treatment. One person suggested that having a say in your worker should be part of a review process to increase retention in service:

*“I feel alright with services, but it took a while to get a worker that I feel I get on with..... You should be asked after 6-8 weeks, ‘Do you get on with your worker?’. Having a good rapport with your worker has a lot to do with your recovery.” (male, 35-44 years, 7 7/6)*

## Prescriber

Table 19 below displays participants response to the question of, *do you feel supported by your prescriber?*

**Table 19: Prescriber and support**

Do you feel supported by your prescriber?	N	%
Yes	45	47
No	41	43
Not sure	9	10
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

This question proved difficult for respondents to answer without significant explanation and probing from peer researchers.

Further analysis of the qualitative responses to this question reveals a more complex picture, amongst the 47% (N=45) yes responses; it was clear that many people did not know who their prescriber was. Respondents described a culture of prescribing as remote, with missed opportunities to explain issues pertinent to their recovery such as negotiating a therapeutic dose. The narrative was around limited opportunities to review dose and choice of medication.

*“I have no idea who my prescriber is and currently feel I have no say in treatment.” (female, 45-45 years, 5 7/150)*

*“I don’t get to see the doctor who writes my script. The script is already written, and I don’t get to discuss anything with them at all. I have to speak to my worker to pass on a message”. (female, 35-44 years, 15 7/127)*

*“I have never met my prescriber, never had a phone call, no opportunity to review things. I only know it (who prescriber is) from my prescription. My worker passes on information to the doctor.” (female, 24-34 years, 37 7/136)*

For participants who felt supported by their prescriber a feeling of being in control of their recovery was a key measure of support:

*“I have a really good relationship, he lets me control my own recovery, he never imposes his will. Always dead fair but won’t take any snash”. (male ,35-44 years, 76 7/206)*

*“If you have a problem with your dose you can talk to them. I had to talk to them about getting an increase after I used kit once. They understood the circumstances”. (male, 35-44 years, 82 7/205)*

## Pharmacy

Table 20 displays responses to the question of, *do you feel supported by your pharmacist?*

**Table: Pharmacy and support**

Do you feel supported by your pharmacist?	N	%
Yes	61	64
No	18	19
Not sure	13	14
Missing	3	3
<b>Total</b>	<b>95</b>	<b>100*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Notwithstanding the previous themes discussed in dispensing section (see page 36), pharmacists and pharmacy staff were valued as having a key role in support. Many participants acknowledged being referred to by name, short waiting times and having access to a private consultation room as all facilitating a supportive environment. Additionally, pharmacists were seen as having a key mediating role with addiction services and accessing medical care:

*“They don’t look down on you and you never have to wait too long. They always reassure you. If they were bad that would be a big turn off. My worker works with them, and they will pass on messages via her to me”. (male, 35-44 years, 27 7/272)*

*“More so than the service (addiction), they see you every day and are able to build up a relationship. I had phoned my service when I had to self-isolate, and the service didn’t get back to me, so I missed a dose. The pharmacy sorted it out and are now dropping off my medication. The pharmacy phone the service for me and left a message that I was self-isolating. The pharmacy are really great at communicating.” (female, 24-34 years, 92 7/294)*

*“When my partner died of a drug overdose, they were really supportive and gave me numbers and tried to link in with services”. (female, 35-44 years, 11 7/264)*

A few responses stated the importance of pharmacy staff demonstrating care and concern for the individual's general presentation:

*"They ask me how I am. I don't feel they report back if I am under the influence. They just don't give you your script that day and there is no issue the next time you go in, they just ask after you and check you are okay" (female, 35-44 years, 21 7/270)*

*"Staff in the pharmacy are great, they are always asking after my son. They treat you like you are normal. It makes you happy that people actually care". (female, 24-34 years, 35 7/275)*

*"All the staff are brilliant. They care, they ask how you are and ask if there is anything they can do to help if I am looking rough". (male, 35 – 44, 21 7/271)*

For participants who responded, 'no' and 'not sure' to the question of feeling supported, the sentiment was feeling they were treated differently from other customers adding to the stigma of accessing services. Five responses mentioned examples of being treated as a "second class citizen" regarding waiting times and non-MAT customers receiving preferential treatment. This was compounded in pharmacies who relied more on locum pharmacists which was viewed as inhibiting opportunities for forming positive relationships.

*"It is a big step going to the chemist and being told to stand left, it's just you are treated differently". (male, 35-44 years, 79,7/308)*

*"I am sometimes in for 30 mins and people that come in after me get served first. My worker (at supported accommodation) was horrified at how I was treated in there. You are treated like a second-class citizen, there is no conversation or concern that your script has been reduced they only do it cause they are paid too." (female, 24- 34 years, 37 7/302)*

## Discussion

### Demographic Characteristics of sample cohort

For this sample of 95 people accessing MAT, 59%\* (n=56) lived alone. When considering the 6% (n=6) of single parent households, the number of participants as the only adult in a household increases to 65% (n=62). This increases to 77% (n=43) when considering participants aged 35 and above. This reflects the age range of participants in, 'Older People with Drug Problems in Scotland Report' (SDF, 2017)<sup>7</sup> which found that 78.9% of their study sample lived alone; this is comparatively higher than the general population of 36% (NRS, 2018)<sup>8</sup> who live alone. These demographics are consistent with the findings from 'Older People with Drug Problems in Scotland' report which highlighted themes of isolation and loneliness for this demographic.

A considerable proportion of respondents, 44%\* (n=42) lived in temporary accommodation indicative of a transient population. This reflects other literature on the huge cross over between problem substance use and homelessness<sup>9</sup>. Participant post codes mirror some of the most deprived areas of Scotland<sup>10</sup>. This is not a moot point; drug related deaths are *18 times* more likely to occur in the most deprived areas of Scotland<sup>2</sup>. A total of 85% (n=81) have had two or more treatment episodes. Of this 85%, 64% (n=61) have had three or more treatment episodes. When asked about the longest period that they had ever consistently spent in services 39%\* (n=37) have experienced retention in treatment for more than three years, at some point, and for 33% (n=31) their longest period of treatment is less than two years. As people are subsequently seeking to re-access treatment, often within a very quick timeframe of exiting service; this figure implies that people are not getting the level of support required for retention in treatment long enough for services to provide care for physical, emotional, and social needs for people to subsequently exit services and successfully move on. Additionally, there was evidence of punitive treatment impacting on retention with people describing changes to MAT for missing appointments. The evidence base on rewards and contingency management is clear; positive feedback, encouragement and acknowledgement of incremental progress is linked to stabilisation on medication (DoH, 2017: p.57-58).<sup>11</sup>

### Access

For the 8% (n=8) of participants who had received same day prescribing, their satisfaction with the service was high. Amongst the remaining 92% (n=87) of participants it was broadly acknowledged that waiting times have improved across all 6 health board areas and increased satisfaction with services in this regard. For those participants who described increased risk while they waited for MAT to commence, it is important to stress that for some people the wait and risk-taking period is greater as there was evidence of ambivalence before contacting a service. Participants in this group internalised blame for failing to meet access criteria on themselves rather than on the system of services designed to support them. It was acknowledged that as withdrawal from society is often a coping mechanism rather than non-engagement, it is key to understand 'non-engagement' through this lens and for services to target such groups by displaying encouragement and demonstrating that they care; to empower access to the right support, at the right time thus ensuring equitable access. Over supervised and appointment-based systems were viewed as barriers to access. The engagement phase within treatment is crucial for positive engagement with services, retention in treatment and ultimately positive outcomes for people's recovery. It is also a crucial intervention point in which to reduce drug related deaths. (NHS Health Scotland, 2017)<sup>12</sup>. The Drug Misuse and Dependence; UK guidelines on clinical management, outline MAT as one of the "key drivers of early engagement" (DoH, 2017: p.65)<sup>11</sup>, this point is echoed by participants here and outlines the crucial role of same day prescribing.

Considerable discussion focused on access and adequate medication dose was the most important harm reduction intervention for this group. These findings echo good practice indicators for OST in 'Staying Alive in Scotland' (SDF, 2019)<sup>13</sup>. For some participants, ability to engage fully in MAT was impaired by their need for a benzodiazepine prescription to stabilise their illicit use. There was evidence of a lack of access to benzodiazepine prescription to either detox or stabilise thus increasing risk by causing disruption and discontinuity of care received for opioid use.

This sample displayed hesitancy when prompted around other types of harm reduction intervention and this is an area requiring further research. Whilst not explicitly asked about naloxone, 43% (n=41) of participants had naloxone. This number may be higher, future work would need to ask this explicitly. Of the 43% who had naloxone, further research is needed in terms of how people at risk plan to use it and this is particularly relevant given the high percentage of people who live alone.

Data collection took place at the height of Covid 19 restrictions in 2021 and this had a detrimental impact on support received during this time. Most participants acknowledged the difficult circumstances that services were working under and were understanding of constraints placed on individual workers. For some people new ways of delivering service such as telephone support and fewer people in clinics increased satisfaction with services. As such these new ways of working may increase retention in services post pandemic.

## Choice

For participants who stated they had adequate support and information to make an informed choice in relation to medication and dose received, they expressed an overall positive experience of MAT. The degree of involvement with decision making, feeling listened to and having opportunity for meaningful input into clinical decisions improved individual experience of services. This must be balanced against participants who felt that although information was provided, they did not feel included in decisions made in relation to medication choice or dose and acknowledged feeling less satisfied with services as a result, in particular increased dose without informed consent heightened dissatisfaction with services.

Participants described a range of needs that required to be addressed on presentation to services. Receiving the right medication was seen as imperative to moving beyond drug use and achieving wider social connections to addressing these other presenting issues. As illustrated by participants, when they were asked to describe, '*what things were like for you when you waited to start treatment*', consideration needs to be given to the physical and mental health status of people presenting to services.

Opportunities for choice often take place in the context of people seeking treatment experiencing physical withdrawal. Textual analysis highlighted the importance of reducing the titration period for people to hasten stabilisation, reduce harm and to improve retention in service. Evidence connects the first four weeks of starting treatment and the first four weeks after leaving treatment with an increased mortality risk (SG, 2021: p.6). Trujols et al. (2019) cited in MAT standards p.48<sup>4</sup>, identified that a person's dose adequacy is influenced by care they receive and not just pharmacological effects of MAT. This sample supports this finding, ultimately that meaningful inclusion over treatment decisions will result with increased satisfaction with services. It is crucial in order to improve retention in treatment that all decisions feel informed and consented to. Seen in this context, choice is more than simply empowering people seeking treatment; it is ensuring staff have the resource, time and adequate training to facilitate conversations about treatment choices. Offering such choice, fundamentally increases retention in services and ultimately saves lives which is at the very core of the MAT standards.



These interviews revealed a group of people desiring to be more involved in their treatment and a group who wish to be more involved in all aspects of their care. Arguably a more engaged group, is to be expected from any self-selecting sample however it does challenge some of the negative stereotypes of drug users both in services and depicted by wider society, as highlighted by UK Drug Policy Commission (2011)<sup>15</sup>, around assumptions concerning people's ability to change.

Throughout discussions on choice, it was evident that there is infrequent opportunity to review medication and dose. This lack of opportunity to review treatment was also evident in discussions around frequency of attendance at pharmacies. Over half the sample 55% (n=52) would like a change to their current dispensing arrangements. Experience of attending pharmacies less over the course of the pandemic has perhaps fuelled this as more people have experienced managing their medication in a different way; the pandemic, initially, reduced daily dispensing. Daily attendance at the pharmacy had a protective factor for some, for others daily attendance was viewed as punitive treatment and reinforcing stigma of drug users by the wider population. Options for alterations to prescribing regimes including take home prescriptions are outlined as important incentives for recovery in the 'Drug Misuse and Dependence; UK guidelines on clinical management' (DoH, 2017)<sup>11</sup>. The important role of pharmacy-based prescribers in people's treatment was evident in this sample, where opportunistic care by pharmacy staff was broadly welcomed by participants but having the choice to engage less was more highly valued.

## Support

As discussed above, participants in this study have experienced multiple episodes of MAT. For this sample 76% were able to identify specific times when they required extra support. Qualitative findings outlined that the majority of people required additional support around mental health in particular. There are significant challenges in accessing mental health support especially in regard to psychological services, where stability within substance use prior to commencing psychological treatment is recommended (SG, 2018)<sup>15</sup>. This further highlights the crucial role of MAT within addressing people's mental health issues; it is also important to note that psychological therapy enhances the outcomes of OST (SG, 2018). The balance of optimal dosing recommendations (DoH, 2017)<sup>11</sup> and issues pertaining to possibilities of impaired cognition for psychological therapies for those in receipt of common optimal dose ranges of MAT (SG, 2018) can serve as a barrier to accessing mental health supports and needs further consideration within treatment to avoid people falling through the gaps.

The experience of participants is suggestive of variable support availability, in and across, different health board areas of what to expect and of support received. It was acknowledged that changes of named worker and ability to communicate easily with services had been made more difficult during the pandemic. People know when they required support; the challenge to practice, is in how to succeed in giving care and support in a timely fashion, to ensure retention when people may not feel secure enough to disclose these feelings to services. This is especially pertinent as 56% of participants have considered themselves at risk of dropping out of services at some point. Participants spoke about the difficulty of contacting a worker when there had been little time to build up a therapeutic relationship due to repeated staff changes.

A total of 76% felt physically safe to engage with services however the barrier was in feeling sufficiently *emotionally* safe to ask for help and concerns that asking for support could result in punitive treatment; this was a particularly strong theme for female participants with children. This finding regarding females and treatment and care was also highlighted in SDF and Dumfries and Galloway, Alcohol and Drug Partnership report into treatment and care needs of pregnant women who use substances<sup>15</sup>. Given the high rates of trauma within this population (SG, 2018), it is key to address issues around emotional safety which is outlined as a key principle in providing trauma



informed care (SG, 2021)<sup>17</sup>. The findings suggest there is work in services to be done to enhance feelings of emotional safety by reducing instances of or concerns about punitive practice which act as a barrier to engagement.

For the 44% who felt that they were not at risk of dropping out of service this was around their need for medication rather than overall feeling satisfied with the service. Worker attributes that increased engagement with service focused on: accessibility; easily contactable; recognising obstacles and removing barriers to access. Overall, having a connection was more highly valued than professional background of worker. Frustration for some participants was on the element of luck with regards to allocation of worker. As connection is so important to promoting emotional safety within services then this should be an area where more consideration is given to improve care and support received. This finding is supported in the 'Drug misuse and dependence; UK guidelines on clinical management' (DoH, 2017: p.53)<sup>11</sup>, which provides the evidence base for the importance of a good therapeutic alliance in delivering any treatment intervention.

Pharmacy staff were viewed as having a key role in providing care, support and in mediating with addiction services and medical care. The support area that participants expressed most dissatisfaction was around their relationship with their prescriber. Of the 95 participants, 47% felt supported by their prescriber however on further probing around, '*which aspects of their support people valued*', it was clear that people were confused as to who their prescriber was. This impacted on ability to access and review appropriate treatment. This contrasted with individuals who had a good relationships with their prescriber who felt in control of their recovery and decisions made in relation to MAT.

## Conclusion

This baseline evaluation of people's experiences of accessing MAT in Scotland indicates why the implementation of the MAT standards are crucial to how people access and experience MAT across Scotland. The experiential narrative gives insight into ways in which action can reduce both drug related harms and drug related deaths by increasing satisfaction with services with same day prescribing, choice of treatment and subsequent retention. This snapshot illustrates the issues faced by people who are not retained in services long enough to access support needed to address presenting issues. It highlights that retention is a major issue and reinforces other studies SDF have undertaken. This work was intended to shed light on the current living experience of people using services and in doing so provide an overall picture to inform quality improvement at local and national levels. The findings outline that the challenge is in the *how* to move from where we are, to where the MAT standards require services to be. This report suggests further work on implementation should consider actions in the following areas as both specific challenges and opportunities for improvement.

## Access

Service models need to reflect the reality of the living situation of the people they are trying to reach. Isolation, social deprivation, and transient populations require services to meet them where they are at. Low threshold services which acknowledge and respond directly to these barriers need to be a first step.

Same day prescribing is essential, delivery models which facilitate this should be replicated and adapted to suit local circumstances. Faster processes for restarting MAT need to be developed to reduce disruption to MAT and deliver same day restarts.

Given the role of illicit benzodiazepine use in participants ability to engage with OST, increasing access to benzodiazepine detox and provision of maintenance prescriptions as a component of MAT should be available where required and clinically appropriate.

## Choice

For people using services, seeing change is crucial. Autonomy and choice in making treatment decisions need to be at the heart of service improvement. Providing adequate information on options of medication and dose is necessary to empower people to have meaningful input in their care. Equitable access to a range of treatment options, in and across health boards is needed, in order that choice of intervention is supported regardless of location. To address treatment holistically and taking account of barriers such as poor mental health, treatment support should include access to a range of psychosocial supports.

## Support

Covid 19 has shown, in some areas, that service can be improved by creatively engaging people. Providing support which recognises the importance of connection within all aspects of care is key to providing emotionally safe environments for people to engage without fear of punitive responses. People need to feel listened to and able to discuss their life without fear; some aspects of current service design precludes engagement for some people. Responding in ways to develop trust is critical for all groups but especially important for females with children. Ways to establish and maintain meaningful therapeutic relationships should underpin all that services do. There is an opportunity for therapeutic relationships to develop across the wider system of care and it is key that staff in roles with less focus on the therapeutic alliance such as pharmacy, recognise

the importance of their care and support in treatment retention. The gaps in access to additional support, in particular to mental health supports are evident. Services should proactively offer additional support at regular intervals to prevent missed opportunity for engagement and to review treatment goals. Treatment pathways between substance use and mental health services should be further developed to reflect the reality of people who have comorbid substance use and mental health problems and are accessing MAT.

Across the themes of access, choice and support, practice which is identified as disrupting delivery of MAT needs to be eliminated if the MAT standards are to mark a watershed moment in reducing drug related harms and drug related deaths in Scotland.

## Considerations for practice

The findings from this evaluation of people's experiences of accessing MAT, suggest a number of considerations for practice, as services progress with implementation of the MAT standards. These are outlined below.

### Access

- **Addressing barriers to access:** Physically taking services, by increasing assertive outreach models, to the most deprived areas will allow people the chance to talk and be listened to. This is a crucial first step to getting people into treatment by allowing opportunities to counteract their experience of endemic isolation.
- **Same day prescribing:** It is key that staff across all sectors take responsibility for raising expectations of faster access to treatment. Crucially, access to same day prescribing needs to mean same day. By informing people of the process of starting MAT, expectations of receiving treatment upon your first contact with the service will create a cultural shift away from low expectations within this population.
- **Harm reduction:** Services should explore meaningful initiatives and new strategies to engage people receiving MAT in wider harm reduction advice and support in order to increase uptake and provide support to people most likely to benefit from this. The Glasgow City Council WAND initiative (Wound Care, Assessment of Injecting Risk, Naloxone and Dry Bloodspot testing) is one such example of an approach using a contingency management model to reduce harm amongst people who inject drugs<sup>18</sup>

### Choice

- **Offering choice and involvement in care planning:** Care planning needs to be a collaborative process, with timely, regular reviews. The role of the prescriber must be clarified to ensure adequate opportunities to discuss medication choice and dose, and allow immediate changes to medication if required. In particular this means that all people using MAT should know who their prescriber is. Conversations should also include exploring and reviewing dispensing arrangements such as opportunities for take home prescriptions.
- **Training, information and communication:** Staff across sectors should have access to up-to-date information and training on MAT treatment options in order to be able to effectively inform their service users. Services should consider different mediums of sharing information with service users which support in person communication, this could include leaflets or digital resources.

## Support

- **Developing support pathways:** Service delivery should ensure that the experience of people using services is taken into consideration to develop support pathways that currently do not exist for them to access the right level of support, at the right time, and by the right people. Particular attention to addressing the pathway into mental health support should be given to avoid people falling through the gaps of being unable to fully engage in MAT due to their mental health, yet unable to access adequate mental health support when in receipt of MAT.
- **Developing therapeutic relationships:** It is crucial to recognise the importance of connection in developing therapeutic relationships between staff and people accessing treatment. Equally important, staff need to be willing to review this when people in treatment feel, for whatever reason, that a connection is not there. Continuity of support, including changes to named workers should be minimised to allow the development of therapeutic alliances with key staff. Staff within the wider system of care such as pharmacy staff, have a key role to play in developing therapeutic relationships and should aim to strengthen these engagements, no matter how brief, ultimately helping to retain people in treatment.
- **Challenging stigma:** To change the experience of stigma for people using services, the workforce training and development needs to lead to a culture change which is more trauma informed. This would be in order for people to feel emotionally safe to disclose their needs and barriers which may affect their engagement, without fear of sanctions or removal of services. This is particularly an issue for woman with children who wish to access services and have a strong fear of losing custody of their children. Targeted supports which take account of the particular needs of women would be beneficial.

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## Appendices

### Appendix 1: Participants flyer

## VOICES OF PEOPLE WHO RECEIVE MEDICATION FOR THEIR DRUG PROBLEM NEEDED

We're looking for people to share their recent experiences of accessing and receiving Medication Assisted Treatment (MAT). MAT is otherwise known as Opiate Substitution/ Replacement Treatment, and includes medicines like methadone and buprenorphine.

We want to talk to people who:

- ✓ Have started or re-engaged with a service in the last 18 months and are receiving medication for a drug problem
- ✓ Live in Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian or Tayside
- ✓ Are 18 years or older

Interviews will be carried out over the phone with a trained peer researcher and information shared will be kept confidential.

People who take part will receive a £10 shopping voucher to thank them for their time.

To take part or for more information, please contact Joan Walsh at [joanw@sdf.org.uk](mailto:joanw@sdf.org.uk) or call/text [07570683063](tel:07570683063)

Part of the MAT Study of  
Current Practice in Six Health  
Board Areas Across Scotland  
December 2020 - April 2021



**SCOTTISH  
DRUG DEATHS  
TASKFORCE**



## Appendix 2: HMP Perth Cohort

### Executive Summary

#### Background

In July 2021, 1339 drug related deaths (DRDs) were reported as occurring in 2020 - this was the fifth year in a row in which deaths had risen to a record high. To put this in context, National Records of Scotland estimate this figure to be three times that of the UK<sup>1</sup>. To reduce DRDs and other harms associated with drug use, Medication Assisted Treatment (MAT) Standards for Scotland were published in May 2021, with the aim to deliver and measure a no barrier, consistent access to treatment regardless of individual circumstances. This project sought to provide a baseline of current MAT provision, prior to implementation, from the perspective of people currently in treatment in six health board areas. It is intended to be a reference point to inform and improve practice in relation to implementation of MAT.

After seeing a recruitment flyer for the Medication Assisted Treatment (MAT) project, HMP Perth Offender Outcomes Unit Manager (acting) approached Scottish Drugs Forum (SDF) with an offer of support to include a prison cohort in the work. Discussions took place between SDF, prison and NHS healthcare staff to plan and manage the work. To ensure consistency with the community-based work already under way, the questionnaire already in use, was refined for a prison setting (see appendix 6).

#### Methods

Prison and NHS staff promoted the work to people who met the criteria of starting treatment within the last 18 months either in prison or in a community setting. SDF researchers received further training for this phase of the project. All peer researchers involved in the prison fieldwork were currently in treatment and two peer researchers had previous experience of serving a custodial sentence. Telephone interviews were arranged by prison staff in 30-minute time slots. Participants received a £10 payment into their prison account as an honorarium for taking part. A three-way telephone interview took place between the participant, peer researcher with an SDF User Involvement Development Officer (UIDO) on the line to scribe a verbatim note.

A total of 16 participants completed an interview.

#### Demographic Data

Telephone interviews were conducted over a two-week period, 16 people participated. All respondents identified as male. The most common (mode) age range of participants was in the 35 – 44 years old age bracket. Participants were resident in Tayside and Fife health board areas before entering prison. Currently prescribed medication for MAT: 44% buprenorphine;44% methadone; 6% detox to start methadone;6% reduction to start long-acting buprenorphine. All participants currently in receipt of medication assisted treatment; 12 in treatment immediately before entering prison and 4 participants not in treatment prior to sentencing. Fourteen participants were currently on remand awaiting a court hearing, 2 participants nearing the end of a custodial sentence.



## Findings

Thematic analysis was undertaken on all 16 participant interviews. Key findings were:

- There was a limited understanding of the process of accessing MAT in prison.
- Missed chemist doses and time in police custody prior to being remanded in prison severely disrupted MAT.
- Frustration with time delay in recommencing MAT to appropriate level for those who were in receipt of MAT in the community prior to entering prison.
- For participants not in MAT when remanded, at least two week wait from referral to starting MAT.
- Main area suggested for improvement was faster access to MAT, although acknowledgement that waiting times have reduced from previous prison experience.
- Having options and process of MAT explained increased satisfaction with treatment.
- Discussion around dose did not always translate into a shared decision.
- Low literacy levels made understanding options difficult for some participants.
- Stability and safety net of MAT given as reasons for continuing treatment in prison.
- More access to staff support especially during titration and when starting treatment would increase satisfaction with service.
- 75% of participants have felt the need for extra support at some point.
- More support for mental health required.
- Staff time and encouragement to engage with services viewed as key attributes of worker.
- Some participants stated they were less likely to drop out of MAT in prison compared with community setting.
- Acknowledgment that the pandemic has limited the range of support options available with an increase in isolation in cells.
- Most participants felt safe to engage with services although the process of referral and delay in response were areas identified for improvement.
- Prison officers and other prisoners valued as having a key intermediary role in signposting to services.
- Largely, based on previous experience, participants were confident that their MAT would continue in the community however there was some concern about what would happen to treatment on being released straight from court.
- Overdose training and information highly rated although some participants expressed concern about the time it could take to get Naloxone if they witnessed an overdose.

## Conclusion

This baseline study indicates why the implementation of the MAT standards are crucial to how people access and experience MAT within a prison setting. The experiential narrative gives insight into ways in which action can reduce both drug related harms and drug related deaths by increasing satisfaction with services with same day prescribing, choice of treatment and subsequent support. This snapshot illustrates some of the challenges of implementation within a prison environment. This prison baseline study aimed to be consistent with interviews already under way in the community. It demonstrated that the peer research model is transferable to a prison setting and should be an approach built into the planning stages of any future work into service user experience of the MAT standards. It highlights that fast access to treatment and ongoing support are issues for this cohort. In line with the community survey, this work was intended to shed light on the current living experience of people using services and in doing so provide a starting point to quality improvement in Perth prison. The challenge is in the *how* to move from where we are, to where the MAT standards require all services to be. This report suggests further work on implementation in prison should consider actions in the following areas as both specific challenges and opportunities for improvement. A caveat in the following is that 14 participants were on remand and more investigation is needed with individuals not currently on MAT as well as people serving a sentence.

## Access

The process of accessing MAT for the first time in prison and continuation of MAT from community addiction services need to be made clearer to those requiring treatment.

For people who are already in withdrawals in police custody, there needs to be an urgency to get people stabilised on treatment as quickly as possible. Participants acknowledged a frustration with time delay in recommencing treatment in prison at the appropriate level. There was a strong motivation to remain in treatment for this cohort.

For those not in treatment in the community when remanded there requires to be faster access to MAT. Of the four people not in treatment in community addiction services, they all waited more than two weeks from referral to starting treatment. In this time potential for drug harms increased as reported drug use increased. The wait to start MAT also impacted on motivation to change and was viewed by some participants to be a missed window of opportunity. The prison and NHS healthcare service need to consider how they proactively identify and engage with people who use substances to start treatment.

Prison officers and other prisoners were identified as a good source of information on services available in prison and consideration should be given to approaches that capitalise on this.

For people who had previous prison experience, it was acknowledged that waiting times to access appropriate MAT has improved but there was still improvements to be made.

## Choice

Participants felt informed about prescribing options in terms of medication available. There was less agreement with this sample around involvement in decision making around dosing. The importance of being able to access information in an accessible format was highlighted. For participants who continued their treatment from the community there was missed opportunities to review dose and engage in the process of MAT in a prison setting.

For individuals not on treatment in the community better access and information on what is available to them is required.

Having adequate support is imperative to make informed choices and increase satisfaction with treatment services in prison. This sample suggests a varying degree of knowledge on what is available to make an informed choice.

## Support

Extra support is required for people when waiting to start treatment and during the titration phase.

Access to support for mental health concerns need addressed as participants expressed limited opportunities to speak to someone. Service development should also be clear on proactive engagement of individuals who may be reluctant to ask for help. Time and encouragement from staff to engage with treatment services were valued attributes.

This study provides evidence that drop out from treatment in a prison environment is less likely than a community setting. There is a unique opportunity in prison to engage people and provide a quality of care which provides stability beyond prison.

The global pandemic has limited options of interventions available and increased time spent confined to cells.

The intermediary role of prison officers was viewed as key to linking with other services, this should be acknowledged and developed. People felt safe to engage with services on offer although the process of referral and delay in response results in appropriate help by the right people at the right time being missed. There was limited understanding of the roles of addiction worker and prescriber.

Continuation of support on release from prison requires to be strengthened.

Potential time delay in administering Naloxone was also highlighted as an area for improvement.

In line with the community survey, across the themes of access, choice and support, practice which is identified as disrupting delivery of MAT need to be eliminated if the MAT standards are to mark a watershed moment in reducing drug related harms and drug related deaths in Scotland.

## **Background**

In July 2021 1339 drug related deaths (DRDs) were recorded in Scotland, the highest number on record. To put this in context, National Records of Scotland estimate this figure to be three times that of the UK<sup>1</sup>. To reduce DRDs and other harms associated with drug use, Medication Assisted Treatment (MAT) Standards for Scotland were published in May 2021, with the aim to deliver and measure a no barrier, consistent access to treatment regardless of individual circumstances. This project sought to provide a baseline of current MAT provision, prior to implementation, from the perspective of people currently in treatment in six health board areas. It is intended to be a reference point to inform and improve practice in relation to implementation of MAT.

After seeing a recruitment flyer for the Medication Assisted Treatment (MAT) project, HMP Perth Offender Outcomes Unit Manager (acting) approached SDF with an offer of support to include a prison cohort in the work. Discussions took place between SDF, prison and NHS healthcare staff to plan and manage the work. To ensure consistency with work already under way, the questionnaire already in use, was refined for a prison setting (see appendix,6).

## **Methodology**

Prison and NHS staff promoted the work to people who met the criteria of starting treatment within the last 18 months either in prison or in a community setting. SDF researchers received further training for this phase of the project. All peer researchers involved in the prison fieldwork were currently in treatment and two peer researchers had previous experience of serving a custodial sentence. Telephone interviews were arranged by prison staff in 30-minute time slots. Participants received a £10 payment into their prison account as an honorarium for taking part. A three-way telephone interview took place between the participant, peer researcher with an SDF User Involvement Development Officer (UIDO) on the line to scribe a verbatim note.

A total of 16 participants completed an interview.

## **Strengths and Limitations**

A possible limitation of this work was that the cohort was not part of the original project planning and, as such, a limited period was available to plan this phase with no scope for pilot interviews prior to fieldwork period.

The strength of this work was that it demonstrated the adaptability of the peer research model to a prison cohort. Considering the elevated risk of the prison population to drug harms, this work demonstrated that this group can be successfully engaged, and their voices heard and should be part of planning for any future consultation of MAT implementation.

## Demographic Data

Telephone interviews were conducted over a two-week period, 16 people participated. All respondents identified as male. The most common (mode) age range of participants was in the 35 – 44 years old age bracket. Table 1 displays the age categories of participants.

**Table 1: Age categories of participants**

Age categories	N	%
18-24	2	13
25-34	4	25
35-44	5	31
45-54	4	25
55-64	1	6
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Within this sample, participants came from two health board areas before entering prison, displayed in table 2: below.

**Table 2: Heath board area of participants**

Health Board	N	%
Fife	5	31
Tayside	11	69
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Fourteen participants are planning to return to the area they came from with one participant unsure whether to return to Fife or Tayside. One participant stated they will return to Tayside reluctantly as it is, *“not where I would like to be”* (N/P).

Participants were asked which medication they are currently prescribed for MAT. Table 3 displays participants current treatment that they are receiving.

**Table 3: Current medication in MAT**

Current treatment	N	%
Buprenorphine	7	44
Methadone	7	44
Detox about to start methadone	1	6
Methadone reduction about to start Long-acting buprenorphine	1	6
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For this sample, Table 4 displays the current length of time in treatment.

**Table 4: Current length of time in treatment**

Current length of time in treatment	N	%
Waiting to start	1	6
Up to 6 months	2	13
1 year	1	6
1 year – 2 years	6	38
2- 3 years	1	6
5 years – 10 years	5	31
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Table 5 shows the longest consecutive time that participants have *ever* spent in treatment.

**Table 5: Longest time consistently spent in MAT**

Longest time consistently spent on methadone	N	%
Up to 2 years	6	38
2 years to 5 years	3	19
More than 5 years	7	44
<b>Total</b>	<b>16</b>	<b>101*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Table 6 presents how many times participants have started treatment.

**Table 6: Number of times starting treatment**

Number of times starting treatment	N	%
1	6	38
2	1	6
3	3	19
4	1	6
5-10	3	19
Greater than 10	2	13
<b>Total</b>	<b>16</b>	<b>101*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For this sample 12 participants were in receipt of MAT immediately before entering prison. Of the 4 who were not in treatment, one had tried to unsuccessfully access a Drug Treatment and Testing Order (DTTO).

Fourteen of the participants were currently on remand awaiting a court hearing. Two participants were nearing the end of a custodial sentence.

## Findings

### Access

From the participant responses, there was limited understanding of the process of accessing treatment in prison. Some individuals described a medical on admittance in which they were screened for drug use:

*“When I came in, I was seen by a nurse and they ask you about your drug use, and I was drug tested”. (C/AK)*

*“If you are on a script, you give a urine sample and then you have to wait for confirmation from the addiction service outside”. (E/AK)*

Other individuals struggled to convey the process of accessing MAT. This was particularly the case for people who experienced an extended period in police custody before incarceration. Access to either continue a community prescription or access treatment for the first time was severely disrupted the longer someone was in police custody. The impact was further exasperated if there was a missed dose prior to entering police custody:

*“About a week (to access treatment) in total as I had missed the chemist and was also in police custody”. (D/AN)*

*“I waited for about 36 hours to get my script, but it was quite good given all the things they have to check. I was in police custody prior to coming in so I had missed a good couple of days of my meds”. (H/AO)*

*“I was in a bad way and had been in police custody and had missed meds then. I was remanded on the Monday and think it was Tuesday evening, Wednesday morning, I think before I got anything. I was given 50mls and they built it up slowly. It took a few weeks to build it up. I was 110ml in the community. I was just left to rattle in a cell with someone else who was rattling as well. There was no support, the nurses didn’t come to see me, I was just left”. (C/AO)*

*“Prior to being in prison I had been in a cell (police) rattling for days”. (Q/AO)*

Frustration with the time delay in recommencing their community MAT on entering prison was a recurring theme of participants:

*“I don’t see why you can’t start there and then as it would save a lot of hassle if you could just start.” (J/AO)*

*“It was pretty rough, but it takes time to check these things out, so I suppose it wasn’t too bad. I couldn’t sleep and was constantly checking the time, I felt sick. I have done this in jail before, so I knew what to expect.” (H/AP)*

Additionally, one participant described the anxiety caused by not knowing the outcome of the assessment:

*“There is a heavy fear of the unknown. You don’t know if you are going to get the script.” (6/AO)*

For participants in treatment, prior to entering prison, motivation to continue MAT in prison was around not wanting to have to start treatment again:

*“Because I was on it outside and I didn’t want to come in here and start gubbing drugs.” (D/AQ)*

*“When I came into jail I was already on a script, and I don’t want to start again.” (H/AQ)*

One participant, who had accessed MAT thirteen months previously, compared the experience of accessing MAT in prison favourably to his experience of accessing treatment in the community:

*“It took 6 weeks to get started in the community, but I was able to get my script started the next day (in prison)”. (I/AO)*

For the four participants who were not on MAT when remanded Table 7 below details the length of time from self-referring to NHS healthcare to starting treatment.

**Table 7: Length of time to start treatment in prison**

Length of time to start treatment in prison	N
Two weeks	1
3- 4 weeks	1
1 month	2
<b>Total</b>	<b>4</b>

For all four participants who were not in receipt of MAT in the community when remanded, drug use increased as participants described withdrawals while waiting to access help in prison:

*“Drug use really bad, I was using all the time and not caring what it was doing to me. I am trained to use Naloxone. The wait played on my mind, just waiting to get put on it. Now I am on it, my mental health is feeling a lot better”. (R/AO)*

*“Really hard, chasing the drugs”. (K/AO)*

*“Up and down. Still taking drugs that I could buy, that were available. My mood was low, I had got to the point that I needed help”. (M/AO)*

*“Terrible, using everything.” (Q/AO)*

All four self-referred to services. One participant self-referred after being encouraged to during admission medical. Three participants received no support or encouragement to self-refer. As well as continued risk behaviours while waiting, one participant expressed concern that the wait impacted on motivation to change:

*“You should get treatment immediately as you can change your mind while you wait.” (N/AS)*

*“The wait is too long; I was rattling for weeks.” (Q/AS)*

*“From what I heard from other prisoners it is good (once you get into treatment). The wait is a bit long, doctor said it will be about 4 weeks”. (K/AS)*



*“If you are on remand, it is really difficult to get help especially if you are not on a script when you come in.” (E/AS)*

*“You need to know who to ask and if you aren’t on a script, it can be hard to find out how to get help. You can ask a prison officer or other boys as they let you know how to get things sorted.” (H/AT)*

When asked, “do you think the process of accessing treatment could be improved in any way” 14 participants stated ‘yes’ and two participants felt satisfied with the access to treatment that they had received.

The main area suggested for improvement was faster access to MAT:

*“It needs to be quicker. They should contact addiction service in the community quicker.” (L/AS)*

*“The wait is too long; I was rattling for weeks.” (Q/AS)*

*“They need to get the waiting time down.” (R/AS)*

*“What would help would be when you come in especially on remand you should get access to treatment quicker to stop using in the prison and to get people to be stable before they come out. It is a missed opportunity to keep people alive.” (E/BQ)*

One participant acknowledged that access to MAT has improved:

*“I think things have got better. I only had to wait three weeks to get into service here.” (O/AS)*

## Choice

Table 8 and 9 below detail the responses to the question, ‘were prescribing options discussed with you’ and if so, was there, ‘enough information to make an informed choice?’

**Table 8: Were prescribing options discussed with you?**

Were prescribing options discussed with you?	N	%
Yes	10	63
No	6	38
<b>Total</b>	<b>16</b>	<b>101*</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

**Table 9: If yes, do you feel you had enough information to make an informed decision?**

IF yes, do you feel you had enough information to make an informed decision?	N	%
Yes	9	90
No	1	10
<b>Total</b>	<b>10</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For participants who felt the decisions around MAT were informed, having options and the process explained increased satisfaction with treatment:

*“Yes, they have explained all about the (medication) and what will happen with dispensing my meth.” (H/BA)*

*“I was given the choice of meth or buprenorphine. They tell you your name is on the list, and they told me the amount and if I want to up my dose, I can speak to my worker.” (R/BA)*

When prompted more specifically about decision making in relation to dose with the 8 participants who stated that dose was discussed; 6 responses stated that this discussion did not translate into a shared decision:

*“I didn’t get an option I was told it was buprenorphine and I was told that this would be the strongest thing for me they never said about how rough I would feel.” (G/BA)*

*“Obviously meth and buprenorphine aren’t for everyone, but we need more options discussed with us. I only found out about Buvidal from another Con but as soon as I asked my addiction worker, I was given a leaflet and waiting to start.” (I/AS)*

Two participants stated that no discussion took place. For one participant, his low level of literacy caused difficulty with understanding the written information meaning that his input was limited. Another participant said that he had no information provided to him which led him to taking his medication incorrectly:

*“Nothing at all was discussed with me, on dose, dispensing or choice. The only thing you get is a letter to sign that you won’t hold the medication back. You have to sign that even if you can’t read.” (E/BA)*

*“The first time I swallowed it, it wasn’t explained to me that I had to let it dissolve.” (Q/BA)*

Participants identified missed opportunities for agency over the dose received:

*“They just handed me the cup and there was only 50ml in it as they wanted to build it up slowly, but there is slow and then there is slow. I was put up 10 ml ever 4/5 days it wasn’t enough.” (C/DB)*

*“I didn’t know what I was starting on or what the plan was. My starting dose didn’t hold me. I was started on 20ml in prison but in Dundee they start you on 40ml. Why the difference in prison?” (E/BD)*

*“There was no discussion, I was told I would go on the same as I was outside. I didn’t want to go up or down.” (H/BD)*

*“I was just told that was the dose I will start on.” (I/BD)*

*“Everyone gets the same amount.” (O/BD)*

*“I wanted a lower dose, but medical staff wanted me to be higher. I didn’t want a higher dose. It wouldn’t have mattered what staff said or what I was offered, I knew I wanted meth as I know this helps me manage the pain of other strong health conditions.” (F/BD)*

Eight participants commented that the timings of dispensing arrangements changed regularly. There was a narrative from participants around more consistency with timings although there was a general understanding around the difficulty for the prison to provide an alternative arrangement:

*“The current way is the only way they can do it, but I would prefer my meds in the afternoon if I had the choice”. (P/AJ)*

*“I think it should be the same time every day. One day it could be 8am another day it could be at 10am. It should be the same time every day”. (L/AJ)*

Table 10 below details the responses to, “Did you have an idea of what you wanted when you first accessed services in prison?”

**Table 10: Did you have an idea of what you wanted when you first accessed services in prison?**

Did you have an idea if what you wanted when you first accessed services in prison?	N	%
Yes	11	69
No	5	31
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

The yes responses all stated seeking stability as the motivation to access services in prison:

*“I knew I wanted to be stable, and I knew meth could do this for me because of my experience with it. I wasn’t thinking about the future or anything, I just wanted to be stable.” (F/AW)*

*“I wanted to feel better, I wanted back onto my meth.” (L/AW)*

For participants who stated not knowing what they wanted when they first accessed services in prison, reasons for this were around a lack of information on what options were available as well as feeling that there could be more direct engagement from staff on admittance to prison:

*“Yeah, I do now as I work well with my worker but not at the start. My worker really wants me to help me turn my life around. Some nursing staff are just in it for the job. You need the right person.” (C/AT)*

*“If you are on remand, it is really difficult to get help especially if you are not on a script when you come in.” (E/AS)*

*“More advertised regarding help in prison, not everyone knows what is on offer in prison or in the community..... there is leaflets everywhere but I think they should talk about it more.”*

*(P/AS/AU)*

Two participants commented that having more information and more access to staff would help them to make better choices and increase their satisfaction with treatment service in prison:

*“I don’t want this yo-yo of being in and out of treatment to continue. I understand they are doing other stuff because of Covid. It would be good to get a wee chat and for people to check more how you are getting on and give you some positive feedback”. (D/AS)*

*“A lot of people are harming themselves there is not enough information available or visible. Staff need to be getting in touch with us more and getting officers to talk to us about our mental health as that impacts on your drug use. The priest welcoming you into the jail feels like a reality check and is the best thing that happens. People listening to you.” (J/AU)*

## Support

### Extra Support

Participants were asked, if, for their current time in treatment, they had, ‘ever felt in need of extra support’. Table 11 shows that 75% (n=12) of participants felt that this was the case at some point.

**Table 11: Have you had times on your medication that you felt in need of extra support?**

Have you had times on your medication that you felt in need of extra support?	N	%
Yes	12	75
No	3	19
Not sure	1	6
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For participants who felt they had times when they needed extra support, waiting to commence treatment and during the titration period were identified as key points when having contact with someone to speak to would have helped:

*“I really struggled when I first came in and just felt like no one was listening to me.” (C/BH)*

*“At the beginning when I was on 16mg (felt in need of extra support), but it was okay once I levelled out. I would have liked more access to my addiction worker”. (G/BH)*

There was a recurring theme from participants stating the importance of having someone to speak to specifically around mental health concerns that participants had:

*“You just want to speak to someone (about mental health).” (N/BH)*

*“My mental health, I need extra support with this.” (E/BH)*

*“I have mental health issues and I don’t really feel I am getting the chance to speak to anyone about it.” (Q/BH)*

*“Mental health and things like that. In the jail it is hard, if you need to increase, they will but you don’t get the impression that they like doing it. They should be more understanding; they make you feel like you are drug seeking.” (L/BH)*

Two participants reflected that they would like to have someone to speak to, but they did not feel able to ask for additional support:

*“If I feel the dose isn’t working or feel the need for extra drugs it would be handy to have someone there, but I don’t speak to anyone about it.” (M/BH)*

*“I get a lot of depression, but I haven’t asked for any help with this.” (O/BH)*

## Retention in service

Table 12 details the number of participants who acknowledged they have had times when they felt at risk of dropping out the service.

**Table 12: Have you had times when you have been at risk of dropping out of the service?**

Have you had times when you have been at risk of dropping out of the service?	N	%
yes	9	56
no	7	44
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

For participants who stated there have been times when they were at risk of dropping out of service, one said that his mental health prevented him from speaking to staff:

*"I have felt that I wanted to but then I give myself a kick in the arse and that. It is when I am depressed and feeling low, but I never talk to anyone in prison about this." (P/BJ)*

Another respondent felt frustrated at not being supported to make decisions in relation to his recovery:

*"Loads of times especially when I wasn't getting help to detox. I tell them every time I go to the hatch. All they want is for me to go on this jag. They keep telling me I am at risk of overdose when I come out, but this is my recovery and I have worked really hard to come off this." (E/BJ)*

*When prompted with, "how did the service respond?", two participants spoke about speaking to staff at the addiction service and were given time and encouraged to keep engaging with staff:*

*"There have been one or two times (at risk of dropping out). The service was just curious as to why I felt like this." (J/BJ)*

*"I have in the past (felt like dropping out) and I have felt like doing it this time because they think you are just a drug user. I have spoken to staff about this, they told me this is all in my head and that I just need to speak to them." (M/BJ)*

Some participants felt that they were less likely to drop out of treatment in prison than the community:

*"The temptations aren't the same as they are on the outside. I feel better able to control my drug use on the inside." (8/BH)*

*"Not really in here but in the community definitely." (G/B7)*

*"Not in here, but on the outside yeah." (J/BJ)*

For another participant, medication was described as a "safety net" and both participants, below, identified MAT reducing harm from illicit drug use.

*"It is a safety net and keeps me off the illegal drugs." (D/BJ)*

*"No, there is nothing to lose for me. It either me asking for help or using." (K/BJ)*

## Help available

When asked about what help was available to them, there was an acknowledgment that the pandemic has changed support options available:

*“I am aware of the support that is there. I think there is some recovery places, but I don’t think they are on just now. I think things are different with Covid.” (M/13)*

*“With Covid going on there is not much happening. There is a number in the hall that you can phone.” (J/BM)*

*“I know there is support there but I don’t know much about it. I am not sure how much I need right now to be honest. I have heard rumours there is a recovery cafe, but I don’t know if that is an option because of Covid.” (J/BK)*

Some participants spoke about the pandemic increasing time spent in cells as a missed opportunity to address issues while in prison:

*“There should be places in the hall to support your drug use to give you a second chance especially if you are younger as you need to get people at a younger age before they are past this. You are not meant to lock animals up, but you are left for 22 hours in a cell. There is no rehabilitation at all, and they wonder why you end up back in a few weeks later. Life in jail sets you up for life of drugs.” (Q/BQ)*

*“Because of this lockdown thing you don’t even get to see the doctor, it is only a phone call. You are lucky to get out of your cell.” (Q/AT)*

Table 13 presents data on how safe participants feel to engage with addiction services. The majority, 88% (N=14) felt safe to engage with addiction services in prison.

**Table 13: Do you feel safe to engage with the addiction service in prison?**

Do you feel safe to engage with the addiction service in prison?	N	%
Yes	14	88
No	1	6
Not sure	1	6
<b>Total</b>	<b>16</b>	<b>100</b>

\*Percentages have been rounded to the nearest whole number which may result in total adding to more than 100%

Privacy and confidentiality was rated highly by participants. Having a relationship with staff was viewed as contributing to a positive environment by one participant:

*“I know some of the staff now, so it is easier to get a bit of support.” (D/BH)*

A recurring theme throughout the interviews was that participants felt they knew there was help available however there was a lack of clarity around the process of requesting help and an issue with the time delay for addiction staff to respond:

*“It is just hard to get access as you need to fill in a form and that can take a couple of weeks and by the time, they get back to you, you can’t always be bothered.” (L/BM)*

*“No, you have to run to them and put a referral in and that can take weeks and by that point you can be past the stage that you referred for. You are locked up for 21 hours a day because of Covid so things aren’t easy.” (M/BP)*

*“You get quite a lot of info, on poster boards although the wait to see someone can be lengthy.” (N/AT)*

*“I don’t feel supported (now) that I am stable but there is no aftercare. I wouldn’t know how to contact my drug worker or prescriber. I would need to put in a form, and it would probably be picked up about 3 weeks later.” (J/BO)*

*“I am on remand and have been on remand for 7 months. I only tried to access additional support here the last few weeks as I felt too low when I came in to do so. I am still waiting.” (O/BR)*

One participant suggested that having staff from the addiction team regularly ‘checking in’ would increase their satisfaction with service:

*“No, it’s like you are on your plan, you are on your meth. You only get to speak to them when you ask, I think they should come to you.” (L/BP)*

This was particularly an issue for participants knowing the process for accessing their prescriber with some participants unsure of who their prescriber is:

*“I don’t know who writes my prescription”. (G/BO)*

*“I never see my prescriber. I see my addiction nurse who I work with on my treatment plan.” (H/BO)*

*“It needs to be made easier to get access to your prescriber and your key worker, so you know what is happening with you script and to get help.” (G/BQ)*

One participant shared their frustration at not having opportunities to discuss changes of medication dose with either their prescriber or worker:

*“You need more than medication. You are allocated a worker, but you never see them unless you self-refer and sometimes you don’t get to see them. Your dose just goes up or down they don’t contact you. If I hadn’t referred, I would just have kept using.” (M/AS)*

One participant’s experience of accessing support is that it is only available if requested both in the community and prison setting:

*“If you chase help you get it both in the community and in prison. I only saw my keyworker in the community once over 12 months”. (G/AT)*

Some participants valued the intermediary role that prison officers play in linking in people with addiction services as increasing satisfaction with their prison experience:

*“Staff in the halls give you info and try and help you out by pointing you in the right direction and that.” (M/AT)*

*“They speak to you (prison officers), if you feel your mental health is going down you can refer*



*yourself or get (prison) staff to speak to mental health support for you.” (R/AT)*

Having time to build a relationship with your worker and feeling listened to were some of the key attributes of a good worker described by the following participants:

*“Yeah, I do now as I work well with my worker but not at the start. My worker really wants me to help me turn my life around. Some nursing staff are just in it for the job. You need the right person”. (C/AT)*

*“Only because I have a good worker, but my worker is about to leave. I didn’t really feel supported by my first worker. My worker genuinely listens and can see you are struggling. She doesn’t treat you like a stereotypical drug user”. (B/BP)*

One participant suggested being able to access the drug service for support when you need it via the telephone in your cell would give access to support when you most need it:

*“There is a new thing that you get a telephone in your cell and you can phone the Samaritans but you can’t access the drug service through this. It would be good if you could speak to someone about drugs.” (N/AU)*

## **Leaving Prison**

Participants were asked if they know what will happen to their MAT on release from prison. Largely based on prior prison experience, participants did not seem duly concerned about their prescription being continued in the community:

*“It hasn’t been discussed but because I am on remand, I know it will continue in the community.”*

*“It hasn’t been discussed yet. I have 4 months left so it will probably be discussed closer to my liberation date.” (R/BF)*

*“Not yet but I imagine it will be the same as any other time. You just go to the addiction service, and they will get you a chemist.” (J/BF)*

One participant was concerned about continuing his MAT in the community if he were to be released straight from court:

*“I have discussed it with my worker as I asked what will happen. I wanted to check what will happen if I get released from the court. They said I would have to access the drug service myself.” (C/BF)*

Another participant expressed not knowing what will happen to his MAT on release and having no opportunity to speak to anyone about this:

*“I have never spoken to a drug worker here, so I have no idea. I was actually sitting wondering this the other day. I think people are maybe given an appointment, but I am not sure.” (M/BF)*



## Naloxone

Overdose training and information was highly valued by participants although some expressed concern about the time it could take to get help:

*“Going through overdose prevention. You go to a prison officer if you witness an overdose, and they get someone from the health centre. When you get released, they will put a Naloxone in my property. Some people are too scared to tell the prison officer regarding witnessing an over dose.” (C/AU)*

*“You can’t get naloxone in the hall. You have to get an officer to get a nurse and that all takes time.” (E/AU)*

*You are trained in Naloxone but don’t have personal access to it so you have to ring a bell and it could take 20 mins for someone to come and speak to you and a further 30 mins to get to whoever needs help. (There is) no access to nasal naloxone. (N/BQ)*

One participant, who has been in prison multiple times, felt that the emphasis of naloxone in prison increase the likelihood of you taking it on release. Although he still felt there was a stigma in the community to carrying naloxone with you:

*“They push Naloxone on you, which is a good thing as a lot of guys don’t bother with the health service. You stand a better chance of taking this with you when you leave because of this. Maybe a bit more pushing would save a few lives. There is a stigma in the community to carrying about naloxone” (F/AU)*

## Conclusion

This baseline study indicates why the implementation of the MAT standards are crucial to how people access and experience MAT within a prison setting. The experiential narrative gives insight into ways in which action can reduce both drug-related harms and drug-related deaths by increasing satisfaction with services with same day prescribing, choice of treatment and subsequent support. This snapshot illustrates some of the challenges of implementation within a prison environment. This prison baseline study aimed to be consistent with interviews already under way in the community. It demonstrated that the peer research model is transferable to a prison setting and should be an approach built into the planning stages of any future work into service user experience of the MAT standards. It highlights that fast access to treatment and ongoing support are issues for this cohort. In line with the community survey, this work was intended to shed light on the current living experience of people using services and in doing so provide a starting point to quality improvement in Perth prison. The challenge is in the *how* to move from where we are, to where the MAT standards require all services to be. This report suggests further work on implementation in prison should consider actions in the following areas as both specific challenges and opportunities for improvement. A caveat in the following is that 14 participants were on remand and more investigation is needed with individuals not currently on MAT as well as people serving a sentence.

## Access

The process of accessing MAT for the first time in prison and continuation of MAT from community addiction services need to be made clearer to those requiring treatment.

For people who are already in withdrawals in police custody, there needs to be an urgency to get people stabilised on treatment as quickly as possible. Participants acknowledged a frustration with time delay in recommencing treatment in prison at the appropriate level. There was a strong motivation to remain in treatment for this cohort.

For those not in treatment in the community when remanded there requires to be faster access to MAT. Of the four people not in treatment in community addiction services, they all waited more than two weeks from referral to starting treatment. In this time potential for drug harms increased as reported drug use increased. The wait to start MAT also impacted on motivation to change and was viewed by some participants to be a missed window of opportunity. The prison and NHS healthcare service need to consider how they proactively identify and engage with people who use substances to start treatment.

Prison officers and other prisoners were identified as a good source of information on services available in prison and consideration should be given to approaches that capitalise on this.

For people who had previous prison experience, it was acknowledged that waiting times to access appropriate MAT has improved but there were still improvements to be made.

## Choice

Participants felt informed about prescribing options in terms of medication available. There was less agreement with this sample around involvement in decision making around dosing. The importance of being able to access information in an accessible format was highlighted. For participants who continued their treatment from the community there was missed opportunities to review dose and engage in the process of MAT in a prison setting.

For individuals not on treatment in the community better access and information on what is available to them is required.

Having adequate support is imperative to make informed choices and increase satisfaction with treatment services in prison. This sample suggests a varying degree of knowledge on what is available to make an informed choice.

## Support

Extra support is required for people when waiting to start treatment and during the titration phase.

Access to support for mental health concerns needs to be addressed as participants expressed limited opportunities to speak to someone. Service development should also be clear on proactive engagement of individuals who may be reluctant to ask for help. Time and encouragement from staff to engage with treatment services were valued attributes.

This study provides evidence that drop out from treatment in a prison environment is less likely than a community setting. There is a unique opportunity in prison to engage people and provide a quality of care which provides stability beyond prison.

The global pandemic has limited the range of interventions available and increased time spent confined to cells.

The intermediary role of prison officers was viewed as key to linking with other services. This should be acknowledged and developed. People felt safe to engage with services on offer although the process of referral and the delay in responding results in the provision of appropriate help, by the right people, at the right time not occurring.

Continuation of support on release from prison requires to be strengthened.

Potential time delay in administering Naloxone was also highlighted as an area for improvement.

In line with the community survey, across the themes of access, choice and support, practice which is identified as disrupting delivery of MAT needs to be eliminated if the MAT standards are to mark a watershed moment in reducing drug related harms and drug related deaths in Scotland.



**Medication Assisted Treatment – Study of  
Current Practice in 6 Health Board Areas  
Across Scotland**

**\*Remember that participant should be currently in receipt of MAT  
\*Peer prompts in Blue**

Initials of Interviewer(s) - Staff/Peer Researcher \_\_\_\_\_

Date of Interview: \_\_\_\_\_

**Survey**

\*Peer prompt \*

Thank you for agreeing to take part today.

Hi, my name is.....and I am a peer researcher with SDF and I am going to carry out this questionnaire with you.

Remember we will not identify you in any way, everything you tell us is confidential unless we are concerned that you may harm others or yourself. If we have any concerns, we would discuss that with you first, so please don't worry.

You are not obliged to answer every question. Please feel free to ask me to repeat a question or to explain it if you don't understand what I mean.

You can withdraw from this study at any time.

Any questions?

Good to go?

**1. Demographic Information**

\* Peer Prompt\*

I am just going to ask you a wee bit about yourself, how you identify and where you live.

**1.1 How would you describe your gender?                      Male/ Female/ Other**

**1.2 What age are you?**

**1.3 Ethnicity**

**White**

- White – British
- White – English
- White – Irish
- White – Scottish
- White – Welsh
- White – European – non UK
- White – Other Background (Please Specify)

**Black or Black British, Black English, Black Scottish or Black Welsh**

- Black or Black British - Caribbean
- Black or Black British – African
- Black or Black British – Other Background (Please Specify)

**Asian or Asian British, Asian English, Asian Scottish or Asian Welsh**

- Asian or British Asian - Indian
- Asian or British Asian - Pakistani
- Asian or British Asian - Bangladeshi
- Asian or British Asian - Other Background (Please Specify)

**Mixed**

- Mixed – White & Black Caribbean
- Mixed – White & Black African
- Mixed – White & Asian
- Mixed – White and Chinese
- Mixed - Other Background (Please Specify)

**Chinese or British Chinese, Chinese English, Chinese Scottish, Chinese Welsh**

Chinese or British Chinese

Chinese - Other Background (Please Specify)

**Other**

Other Ethnic Group (Please Specify)

**1.4 Where are you living at the moment?**

Own tenancy	
Supported accommodation	
Temporary homeless accommodation	
Family home	

Other -

*Prompts Single or shared room? With friends in their house?*

**1.5 How many people live with you or do you live alone?**

0	
1	
2	
3	
4	
5	
>5	
<10	

**1.6 Children under 18 living with you? Yes/ No**

**1.7 What is the first half of your postcode?**

**1.8 What are you currently prescribed for your opiate use?**

## 2 Experience of Methadone/ Buprenorphine (including Espranor/ Buvidal)

2.1 How many times have you started on medication for your opiate use?

\* Peer note - other terms that might be used\*

OST - opioid substitution therapy

ORT - opioid replacement therapy

MAT - medication assisted treatment

Methadone (generic drug)

Dolophine/ Methadose /Physeptone (brand name for methadone)

Street terms for methadone - e.g. green, juice

Buprenorphine (generic drug)

Subutex (brand name for Buprenorphine most commonly tablet)

Suboxone (brand name for Buprenorphine and Naloxone medication, most commonly tablet)

Espranor (wafer tablets, contain Buprenorphine)

Buvidal (brand name , injectable Buprenorphine)

Street terms for buprenorphine -e.g. Sobos, Stops, Sub (s), Subbies,

(tick box)

1  2  3  4  5  5-10  >10

2.2 What's the longest time you've consistently spent on medication (methadone/buprenorphine)? (years/ months)

\* Peer note\*

Be clear that participant understands we are referring to medication for opiate/heroin use.

Years      Months

--	--

2.3 How long have you been on your current script? (years/ months)

Years      Months

--	--

2.4 What were you're dispensing arrangements before the COVID 19 lockdown?

\*peer note\*

By dispensing, we mean simply, how often did you go to your chemist to collect your medication before the COVID 19 lockdown?

Daily supervised dispensing	
Weekly take home doses	

Other (please state below)

*Prompts: How often would you pick up your medication from the pharmacy?*

2.5 What are your dispensing arrangements during lock down?

\*Peer note\*

By dispensing arrangements we mean how often did you go to your chemist during COVID 19 lockdown?

Daily supervised dispensing	
Weekly take home doses	

Other (please state below)

*Prompts: How often would you pick up your medication from the pharmacy?*

2.6 What are your dispensing arrangements currently?

\*Peer note\*

By dispensing, we mean what are your current arrangements. Check if dispensing arrangements have changed every time restriction levels have changed?

Daily supervised dispensing	
Weekly take home doses	

Other (please state below)

*Prompts: How often would you pick up your medication from the pharmacy?*



2.7 What would you like your dispensing arrangements to be?

*Prompts: How often would you pick up your medication from the pharmacy?*

### 3 Access to treatment

*\*Peer note\**

Thinking to when you started your current script?

3.1 For your current script - how long did it take you from the first time you contacted the service to getting your medication? (days/ weeks/ months?)

Months	Weeks	Days

3.2 What were things like for you while you were waiting to start your medication?\*

*Prompt – your mood? Your mental health and wellbeing? Your drug use? Your view on the service? How did you manage during this time? Did you have or try to access other support? Did the service give you harm reduction advice/ Naloxone? \* Don't assume that the wait was a negative experience*

3.3 Do you think the process of getting on methadone/buprenorphine could be improved?

Yes  No

If yes please describe how

*Prompt – in what ways do you think it could be improved? Number of days you have to wait before getting your methadone/ buprenorphine? What about the process? Were there criteria you had to meet? steps in the process?*

## 4 Choice of treatment

Thinking back to when you went on methadone/buprenorphine this time.

*\*Peer note\**

Thinking to when you started your current script?

4.1 Were prescribing options discussed with you? (e.g. choice of methadone or buprenorphine?)

Yes  No  Not sure

If yes, do you feel you had enough information to make an informed decision?

Yes  No  Not sure

4.2 Were dispensing arrangements discussed with you?

*\*Peer prompt\**

Did you get a choice of chemist? Did you get a say in how often you would go to the chemist?

Yes  No  Not sure

If so, what level of flexibility was offered?

*Prompts: were you offered a choice of daily, or other dispensing?*

4.3 Was dose discussed with you?

Yes  No  Not sure

If yes, do you feel that the dose you started on was a shared decision?

Yes  No  Not sure

*Prompts: do you feel this was the right dose for you? Was there any condition/ restriction placed on how much you would be prescribed? If so, were you explained why you would be prescribed a certain amount?*

## 5 Retention/coping with crisis

*\*Peer note\**

Referring to current script

5.1 Have you had times on your methadone/buprenorphine that you felt in need of extra support?

Yes  No  Not sure

If yes, how did the service respond

*Prompts: did the level of contact with your worker change? Did your worker review your MAT dose? etc Did you feel able to talk about this with your worker? What would have helped, e.g. advocacy or other types of outside support, directed/ referred to specialist for particular problem?*

5.2 Have you had times when you have been as risk of dropping out of the service?

Yes  No

If yes, why was this? and how did the service respond?

*Prompts: did the level of contact with your worker change? Did your worker review your OST dose? etc Did you feel able to talk about this with your worker? What would have helped, e.g. advocacy or other types of outside support, directed/ referred to specialist for particular problem?*

## 6 Staff attitudes/feeling safe in the service

6.1 Do you feel safe to engage with the addiction service?

Yes  No  Not sure

If no, can you give us more detail on the reasons why you do not feel safe?

*Prompts: staff, service access, waiting room, stigma, communication?*

If yes, can you give us more detail on what the addiction service does to make you feel safe and supported?

*Prompts: staff, communication, service access, waiting room etc...*

Peer Researcher should explain that we are going to ask about their prescriber, their support worker and their pharmacist in turn. Please provide brief explanation of the different roles when asking the first question

*\*Peer note\**

Clarify that you mean the person who writes prescription i.e. psychiatrist, doctor, nurse prescriber

6.2 Do you feel supported by your prescriber?

Yes  No  Not sure

If no, can you give us more detail on the reasons why you don't feel supported by your prescriber?

*Prompts: staff, relationship with staff, communication with staff, communication with service*

If yes, can you give us more detail on what the prescriber does to make you feel supported?

6.3 Do you feel supported by your support worker in addiction service if you have one?

Yes  No  Not sure

If no, can you give us more detail on the reasons why you do not feel safe or supported?

*Prompts: staff, staff understanding, relationship with staff, communication with staff, communication with service*

If yes, can you give us more detail on what your support worker does to make you feel safe and supported?

6.4 Do you feel supported by your pharmacist?

\*Peer note\*

Clarify that we mean the pharmacist in the chemist or other pharmacy staff

Yes

No

Not sure

If no, can you give us more detail on the reasons why you do not feel safe or supported?

*Prompts: staff, staff understanding, relationship with staff, communication with staff, communication with service*

If yes, can you give us more detail on what the pharmacy or your pharmacist does to make you feel safe and supported?

6.5 What more could be done to make you feel safe and supported when engaging with addiction services?

*Prompts: prescriber, support worker, pharmacist, advocacy, peer support/mentor*

6.6 Is there anything else you would like to tell us in relation to your MAT? (medication for opiate use)

Additional Information Box

**That's the last question. Thank you very much for taking part in the survey!**

## Appendix 4: MAT Participants Information Sheet



### **Medication Assisted Treatment - Current Practice in 6 Health Board Areas Across Scotland**

#### **Participant Information Sheet**

Below is the participant information sheet for the Medication Assisted Treatment study of Current Practice in 6 Health Board Areas Across Scotland. You have been asked to take part in this.

Everything you say as part of this study will remain confidential.

The anonymous information you give about your experience of Medication Assisted Treatment will be used to define current practice and produce information that will inform the delivery of best care regarding medication assisted treatment. You can be assured that you will not be identified in any correspondence.

By agreeing to take part in this study you are agreeing that you fully understand what you are being asked to take part in, that you are fit and able to take part in a survey and that you give your full consent for your anonymous information to be used to support the study. Please speak with the peer researcher and ask any questions about this process that you may have.

#### **What is this study about?**

Scottish Drugs Forum (SDF) want to find out more about your experience of receiving Medication Assisted Treatment (MAT). We want to find out what is working well and what is not, to find out if MAT is causing problems, and find if there are ways to fix problems or to stop them happening.

New standards of what to expect from MAT have been agreed by services and people with lived experience as part of the Drug Death Task Force to improve health outcomes for people who use drugs. Consultation on the implementation of the standards is under way. Your views, as part of this study, will provide information to support the delivery of these standards.

Volunteers who have a history of substance use will be conducting this study, these volunteers are the peer research team. SDF will be supporting the peer research team to run the study.

SDF will report back to Drug Death Task Force and to people who commission, deliver and work in services.

#### **What do I have to do to take part?**

After you have received this information sheet, we will ask if you want to take part in the study. We will call you, so it won't use up your phone credit. We will then go over the information again so you can ask questions about taking part. After this we will ask if you want to continue. If yes, we will continue with the survey. You do not have to take part in the study if you don't want to.

During the phone call, the peer researcher will ask you a few questions, and the SDF team member will also be on the call to listen to your answers and answer any questions. The chat should take no more than 45 minutes.

If you like, we can send you the questions before the phone call, just ask the peer researcher. It's fine

If you want to take a break or stop during the call, please just let the peer researcher know.

### **What will you ask me about?**

We will ask you things like:

- Past and current experience of being prescribed either methadone or another opioid substitute.
- Access to treatment.
- Choice of treatment.
- Staff attitudes.
- Feeling safe in your service.

### **Will things I say be confidential?**

We guarantee that the answers you give will be kept confidential. We won't use your name and won't give anybody information they could use to identify you. Your anonymity is guaranteed. Answers will be grouped together to give overall responses; for example, 79% of people stated We may use

quotes of what you said, but all quotes will be anonymous.

If you tell us that you or somebody else is at risk of being harmed, or that you are going to harm yourself, we will tell someone else to help. We will tell you before we do this.

The information you give will be stored anonymously in a MAT database and may be shared for the purpose of ongoing evaluation of MAT.

### **Informed Consent**

We will ask you to give us verbal consent when the phone conversation starts. That means you are happy to take part in our survey. You can change your mind at any point during the survey. If you do change your mind, we will not use any of the interview.

When agreeing to take part in the survey, you are also allowing us to use your anonymous information to speak to health services or other people to inform the delivery of MAT. You are also giving permission for us to store your anonymous information in the MAT database with the potential for it to be used for other studies into M

# Medication Assisted Treatment – Study of Current Practice in 6 Health Board Areas across Scotland

## What to do if..... Protocol





## Appendix 6: Prison questionnaire

### Questionnaire Themes and questions

#### **Section 1: Demographics – tell us a bit about you?**

What age are you?

How would you describe your ethnicity?

How would you describe your gender? Male/other? Which local authority area you are from?

Is that the area where you hope to return to? What are you currently prescribed for MAT?

#### **Section 2: Experience of treatment**

How many times have you started a treatment plan or medication for your drug use? What is the longest time you have consistently spent on medication?

Were you in treatment immediately before entering prison?

- If yes, was this continued? Did your medication change when you entered prison?

-If no, had you tried to access treatment before entering prison? How long have you been on your current prescription?

What are your dispensing arrangements in prison? How does this work for you? What would you like your dispensing arrangements to be?

#### **Section 3: Access to treatment**

Did the prison service contact you with an offer of help to access the service or did you self-refer?

For your current prescription, how long did it take from you first making contact to get help before you started your medication?

What were things like for you before you accessed help?

What were things like for you when waiting to start your treatment plan?

What was the most important thing that helped you decide to take the offer of support at this time? Do you feel the process of accessing a treatment plan could be improved in any way?

Do you feel able to get help, support, and information that you need to keep safe and well?

What has been the most useful piece of harm reduction support/information you have received in prison?

## **Section 4: Choice of treatment**

Did you have an idea of what you wanted when you first accessed services in prison?

- Yes, no, not sure -can you explain your answer? Were prescribing options discussed with you?

Do you feel you had enough information to make an informed decision? Were dispensing arrangements discussed with you?

Was dose discussed with you?

To what extent do you feel the dose you started on was a shared decision?

If you are prescribed Buvidal, what are the pros/cons it has brought to your daily routine?

What will happen to your treatment plan when you leave prison? Has this been discussed with you?

## **Section 5: Retention/coping with crisis?**

Have you had times on your medication that you felt in need of extra support? (what kind of support?)

Have you had times when you have been at risk of dropping out of the service?

- If yes, why was this and how did the service respond? Are you aware of support offered inprison?

## **Section 6: Staff attitudes/feeling safe in service?**

Do you feel safe to engage with addiction service in prison?

Can you give some more detail on why you feel this way?

Do you feel supported by your prescriber? Yes/no/notsure.

Can you give more detail on why you feel this way?

Do you feel supported by addiction staff in prison? Yes/no/not sure.

Can you give some more detail on why you think this?

Is there anything else that you would like to tell us in relation to you MAT?

**Thank you for taking part in the survey.**



## Scottish Drugs Forum

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91 Mitchell Street, Glasgow, G1 3LN

t: 0141 221 1175

f: 0141 248 6414

e: [enquiries@sdf.org.uk](mailto:enquiries@sdf.org.uk)

[www.sdf.org.uk](http://www.sdf.org.uk)

- [@SDFnews](https://twitter.com/SDFnews)
- [facebook.com/scottishdrugsforum](https://facebook.com/scottishdrugsforum)
- [youtube.com/user/scottishdrugsforum](https://youtube.com/user/scottishdrugsforum)
- [instagram.com/scottishdrugsforum](https://instagram.com/scottishdrugsforum)

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