MEDICATION ASSISTED TREATMENT: EVALUATION OF CURRENT PRACTICE IN 8 HEALTH BOARD AREAS ACROSS SCOTLAND

EXECUTIVE SUMMARY

SCOTTISH DRUGS FORUM

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BACKGROUND

Scotland has the highest drug-related death rate in Europe, with 1,051 deaths in 2022, 82% of which involved opiates/opioids. The Scottish Government's MAT standards, introduced in May 2021, aim to provide consistent, effective treatment across the country. A baseline evaluation by the Scottish Drugs Forum (SDF) highlighted the need for equitable access, choice, and support in MAT implementation and this evaluation sought to expand on this by capturing individual experiences during the implementation of the MAT standards using observation-based methodologies.

METHODS & AIMS

The evaluation sought to understand experiences of MAT across eight health boards: Greater Glasgow and Clyde, Lothian, Grampian, Tayside, Lanarkshire, Ayrshire and Arran, Borders, and Highland. Over a six-month period, participants were in contact with the research team to share their experiences, with appointment observations and two qualitative interviews carried out during this time. Participants from HMP Castle Huntly also discussed their experiences in MAT in focus groups.

The evaluation aimed to ascertain:

- Which MAT standards are currently being implemented and where are the gaps?
- Facilitators and barriers to accessing MAT according to participant experiences.
- Individual experiences and needs of people starting MAT, people who started MAT within the last year, people who have been offered/are seeking MAT and those who are not currently in treatment/have not been offered MAT.

DEMOGRAPHICS

The study included 65 participants from across the eight health boards, with 41 (63%) males, 23 (35%) females, and one non-binary participant, all aged 18-65+. Four people were seeking MAT, 19 had been prescribed in the last three months, 29 in the last 3-12 months and 13 had been in MAT for over twelve months. Two focus groups were held at HMP Castle Huntly with a total of six male participants, four of whom were prescribed Buvidal, one prescribed Espranor and one prescribed Methadone.

FINDINGS

ACCESS

- **Stigma:** Participants reported experiencing stigma when accessing MAT. 10 people referred to negative feelings triggered by service buildings and eight felt dismissed/judged by their GPs. Seven felt pharmacies were stigmatising due to things like being made to queue separately and consume their methadone publicly.
- **Waiting times:** Six participants accessed or restarted MAT during the evaluation. Two experienced same-day access and prescribing through drop-in clinics. Four had delays of up to several months for an appointment and two had further delays in getting a prescription due to other substances, mainly cocaine, being present in their drug screening tests.

- **Contact:** Communication with the MAT service was important for people, with many preferring direct contact through phone calls/texts with workers. Barriers including reliance on reception lines for contact and issues with letters, such as tone perceived to be threatening and late delivery of letters. 10 people had missed appointments, with eight of these followed up by contact from their worker. The majority wanted more frequent contact from services.
- **Travel:** 15 people said travel to services was a barrier, due to cost and/or distance. Eight participants had to cover their travel costs themselves, but three received free bus passes via other benefits. 12 people in rural locations benefited from alternative locations/options for their appointments, such as satellite clinics or home visits.

CHOICE

- **Initial medication choice:** Methadone was offered to all six people who accessed/re-accessed MAT, and four started on it as it was their only option and/or they felt it was the easiest/quickest option. Two people were also offered Espranor but received little explanation about starting dose and potential effects of this medication. One person started Buvidal after having all options discussed with them and found this process easy and empowering.
- **Changing medication:** Four people changed their medication from Methadone to Buprenorphine during the evaluation but felt the process of this was lengthy and stressful. Two people were taken off their Buvidal prescriptions due to physical/mental health reactions and subsequently felt limited in alternative options for treatment, beyond a Methadone prescription.
- **Choice of dose:** Half the participants felt in control of their dose, with two also mentioning having formal six-monthly reviews. The other half of participants felt workers dictated whether their dose would be changed and four of these felt frustrated about not being able to reduce their dose.
- **Choice of keyworker:** Most people had a say in which gender of keyworker they wanted but choices could be more limited in rural areas. The relationship built with an allocated worker was more important to people than having a specific choice of who this was.
- **Other choices:** 20 participants wanted more choice in appointment frequency and preferred face-to-face meetings than phone calls. Some felt they needed more information about treatment options and local support activities beyond what was displayed in waiting rooms. 10 people were aware of the MAT standards, having heard about them from SDF living experience groups or other peer networks.

SUPPORT

- **Keyworker relationships:** All participants felt the relationship with their keyworker was an important factor to engage/keep them in treatment. 12 people had positive relationships with their keyworker; they described being in regular contact and feeling heard and respected. 16 participants had limited contact with their assigned worker and 12 felt unsupported/uncared for by theirs. Some participants found the relationship they built with the lead researcher to be more valuable than the one with their allocated keyworker.
- **No allocated keyworker:** 10 participants had no allocated keyworker and relied on duty workers instead. They reported feeling isolated, left behind and unable to make progress in their MAT due to this.
- **Change of keyworker:** Four participants experienced a change in keyworker and this could be difficult when they had to repeat personal information/stories. One person described a positive handover between their old and new keyworkers. Two felt changing to a new worker was beneficial for them as they built a more positive relationship with them than they had previously.

- **Criminal justice:** Three participants were remanded in custody for some of their time in the evaluation and all continued to receive their MAT here. They did not receive any other support/appointments when in custody or any through/aftercare when released. Three others were mandated to attend Drug Treatment Testing Orders (DTTO) and two felt the support provided in this was much better and more thorough than from the statutory MAT service.
- **Residential rehabilitation:** Three participants attended residential rehab during the evaluation and all said they received positive, structured support here. They were able to develop tools and coping skills but felt more preparation before going and aftercare when leaving would have been beneficial.
- **Lived & living experience:** Four participants explained the valuable role peers had in recovery, third sector and residential rehab services. Thirteen people discussed ways people with lived/living experience could feature in statutory services, such as supporting people in their appointments.
- **Recovery communities/third sector:** 14 participants felt these services filled gaps of statutory support, including via provision of psychosocial interventions and harm reduction. Eight people felt they had stronger relationships in these contexts, often due to extra time they could spend with workers/peers.
- **Harm reduction:** Harm reduction provision was generally limited. Three people reported accessing injecting equipment provision (IEP) where they also received blood testing and injection advice. Four people felt more support was needed for other substances they were using, such as cocaine, as this could be a barrier to receiving/changing MAT. Two people were signposted to third sector support for this use but otherwise no harm reduction was offered in these cases.
- **Mental health:** Four people were seen by mental health professionals but most participants felt they needed much more support with their mental health. Six people were on waiting lists for psychiatry appointments, often for several months. 14 people said they did not receive any mental health support, even psychosocial interventions, or discuss this with their keyworker.
- **Buvidal:** 20 participants accessed or were already accessing Buvidal and this could be seen as "game-changing" for people's recovery. Eight people felt they received positive support alongside their Buvidal, usually due to positive keyworker relationships. Eight others felt the support provided with Buvidal was limited/non-existent and three said support was less compared to that received with Methadone and Subutex. Short 'injection only' appointments where no other help/discussion was offered were mentioned by fourteen people.

PRISON FOCUS GROUPS

- **Access:** The four participants serving life sentences felt they were treated more poorly and under more scrutiny than others. Participants felt the fear of being moved to closed conditions was a barrier to asking for more support. Methadone was seen as the easiest medication to access and the most consistent in terms of dispensing.
- **Choice:** Most participants felt methadone was the most stigmatised form of MAT. Buvidal was usually a preferred option but could take longer to get prescribed. Some challenges with Buvidal were also explained, such as injections being administered late. These delays could lead to withdrawals, including when on home leave which left people at risk of relapse.
- **Support:** Participants felt they were often stigmatised and seen to be "drug-seeking" by healthcare professionals and could experience punitive practices, such as withholding of MAT/other medication. There was a lack of wraparound support experienced, with it being common not to have an allocated worker or any help beyond medication offered. Care plans were limited and usually led by staff but participants felt more involvement in these could help their progress in MAT. Non-clinical and third sector staff were viewed more positively than others. Overall, support provided could be inconsistent between and even within establishments, but mental health was one area seen to be especially lacking.

RESEARCHER REFLECTIONS

The observational component of this evaluation provided a unique understanding of the logistics, experiences and feelings encountered by participants whilst in MAT. Accompanying individuals to their appointments enabled the research team to directly observe and experience some of the challenges faced in accessing MAT. This included long journeys to clinic buildings and encounters with service spaces that were often unwelcoming. The team also gained direct insight into how people responded and felt about aspects of their treatment, such as the immediate impact of either positive or negative interactions with keyworkers.

The peer researchers own experiences brought insight and emotional connection to the stories they heard. Some found it challenging to hear about the more negative experiences but also acknowledged how inspiring it was to hear about positive progress. The strength of the peer research approach was evident in the relationship between peers and participants, often resulting in authentic and engaging conversations, enriching the findings.

CONCLUSION

The combination of observations, qualitative interviews and focus groups used in this evaluation provided unique insights into the variability of individual experiences of MAT treatment across Scotland, within community and custody environments.

Overall, whilst there were good examples of choice and access to MAT observed, there was a clear need for greater consistency across and within local areas. This is crucial to ensure that all individuals have positive treatment experiences no matter where they are in Scotland. More widely promoting the MAT standards and what they mean in practice to people in treatment is an essential starting point for all areas to ensure the delivery of equitable treatment and support.

The primary aim of all treatment should be the empowerment of people in treatment, achieved by successful implementation of all ten MAT standards . Positive and consistent support alongside MAT emerged as the most important factor in engaging and retaining people in treatment, a known preventative factor in drug related deaths. To effectively address Scotland's ongoing drug death crisis, all staff in treatment services must focus on fostering therapeutic alliances with individuals in MAT, ensuring this remains a priority in both daily practice and ongoing implementation.

CONSIDERATIONS & GOOD PRACTICE

The findings from this evaluation suggest some considerations for practice are required to continue to implement the national MAT standards in a therapeutic and supportive way. Good practice examples from participants in the evaluation are used to illustrate these considerations.

ACCESS

REDUCING STIGMA

Stigma must be addressed and challenged at all levels, and in all aspects of MAT provision, for people to feel able and willing to access treatment. Services, including prisons, should work towards a culture change which accurately reflects a trauma-informed approach, such as by removing all examples of punitive practice in relation to someone's support. Resources such as the *Trauma-Informed Toolkit* (Scottish Government, 2021) and the *Roadmap For Creating Trauma-Informed and Responsive Change* (Scottish Government, NHS & COSLA, 2023) can be accessed and used as starting points for making necessary developments to practice.

Service environments should be adjusted to be as welcoming as possible within resource limits but lasting cultural change ultimately relies on staff. Therefore, all staff should undergo stigma training and have access to available resources to challenge stigma, examples include SDF's *Moving Beyond 'People First' Language: a glossary of contested terms in substance use* (SDF, 2020).

Service leaders should foster environments where workers can comfortably address stigma and challenge any discriminatory practice among colleagues in a constructive way. People in MAT and MAT providers should be clear that being in effective and person-centred MAT is not a lesser option or merely a step toward abstinence; that is not its primary goal. The primary aim of all treatment should be the empowerment of people in treatment so as they can make decisions and act, with support if necessary, to make the changes in their life which they prioritise.

SUPPORTING ACCESS

Practicalities of accessing treatment vary between individuals. Adjustments should be made to make access easy for all, regardless of circumstances and preferences.

Preferred methods of communication for each person accessing MAT should be discussed to ensure people are connected services in an appropriate way for them. Different methods offered should include, but may not be limited to, reminder texts or letters and regular phone check-ins.

GOOD PRACTICE 1 - "SIMON"

- **Accessing services for several months and always seen at same building due to quicker travel time from his home.**
- **Designated worker who is aware of the importance of Simon's communication preferences because he is deaf and this has been a barrier to treatment in the past.**
- **Appointments are always discussed in advance, and are face-to-face to allow Simon to lip read.**
- **Text communication/ reminders always used between appointments.**
- **Worker ensures Simon's bus pass remains valid so he can attend appointments at the clinic and elsewhere as required.**

More effective and continuous communication between appointments will improve engagement and outcomes for those accessing support. Services should discuss suitable access to service buildings and where possible, offer solutions such as travel passes. More outreach options, such as home visits and satellite clinics, should be made available. Areas should also consider development or expansion of drop-in clinics across as many localities and days as possible, to help with same-day prescribing.

CHOICE

MAT STANDARDS INFORMATION

People accessing MAT must be informed about the MAT standards and their rights within these. Services should communicate information about the standards when people first engage with treatment and as soon as possible for those already engaging. Awareness of the standards should be revisited regularly at routine appointments and reviews.

Any information and resources provided must be accessible and consistent with national requirements. SDF's MAT website (www.matstandards.co.uk) can be utilised to access resources for staff to develop their own knowledge and to share with people in treatment. Copies of the MAT standards should be displayed in waiting rooms and clinic spaces with physical copies offered. Other opportunities for sharing and promotion should be encouraged in accessible formats for this population.

GOOD PRACTICE 2 - "ALAN"

- **Called the service to self-refer for treatment and offered to attend that day to start a prescription.**
- **On the phone before attending, treatment options given: methadone, Subutex and Buvidal.**
- **Saw worker he already knew and options for his treatment were re-discussed, with adequate time for asking questions.**
- **Information leaflets on all treatment options available in the waiting room and a specific leaflet on Buvidal handed to Alan.**
- **Dose and titration explained fully.**
- **Experience left Alan feeling well informed, empowered and confident he had made the correct choice.**

TREATMENT DISCUSSIONS

For people to understand choices in their treatment and reach decisions, space must be given for collaborative discussions. This will allow for questions to be asked, information to be digested and properly understood.

When initiating MAT and at reviews thereafter, people should be provided with as many medication options as possible. Accessible, thorough information should be provided about their choices, such as up-to-date leaflets.

Where choices may be limited for clinical reasons at any time, staff must be willing to explain this fully to the person affected. Staff should be able and encouraged to seek support from colleagues, such as prescribers, in order to do this confidently.

People should be proactively provided with information about other support they could access as part of their recovery. For example, within the community or in the form of rehabilitation, as appropriate.

SUPPORT

THERAPEUTIC RELATIONSHIPS

People accessing treatment must be given the opportunity to develop supportive and positive relationships with their workers. This means all those accessing MAT should ideally be allocated and introduced to a keyworker from when they first engage.

Where possible, people should have the option of which gender of worker they would prefer. Contact prior to first appointment meeting face-to-face for the first time such as by a phonecall can also help alleviate any anxiety for people newly in treatment and can help build a positive relationship from the start

Although it is hard to eliminate all need for duty workers, people should only be assigned to one for short periods of time. When a new keyworker needs to be allocated, the handover period should involve discussions with the previous worker where possible. This will help prepare people for the transition and avoid repetition of stories and information. Equally absences of main key worker and temporary cover arrangements should be fully communicated to people in treatment. taff should be given space and time to build and develop meaningful relationships.

GOOD PRACTICE 3 - "DONNA"

- **Worker seen at drop-in clinic for starting MAT was then Donna's allocated keyworker moving forwards.**
- **Eliminated some anxiety for her as knew who she would be seeing at next appointments.**
- **During titration, Donna was offered and attended weekly appointments with the worker, allowing their relationship to develop and other areas of support to be discussed such as housing and mental health.**
- **Keyworker remained the same, with Donna engaging every four weeks.**
- **Successfully engaging in treatment for over six months, largely attributed to this positive relationship.**

Appointments must be long enough to discuss individual preferences and choices. Trauma-informed practice should be applied to support individuals in feeling valued and cared for. It is imperative staff are afforded the time to attend training and have access to resources and support to be able to offer trauma-informed care. Staff should not underestimate the power of genuine warmth and compassion or the small acts of help such as food parcels can make on people in treatment and how they feel towards the relationship as a result.

CONSISTENCY IN PROVISION

Support offered alongside medication, in line with the MAT standards, must be provided consistently. This includes provision of harm reduction, mental health and psychosocial support and applies to custody and community settings.

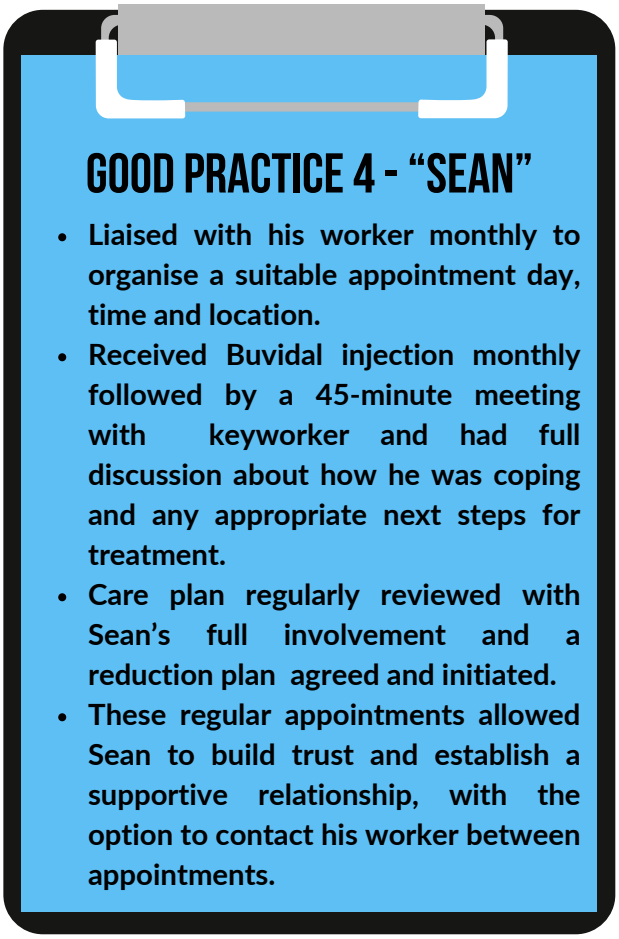
Staff should ensure all substance use is discussed openly, including cocaine, benzodiazepines and alcohol, and should give this adequate attention and support. Resources such as the Cocaine Toolkit (MAT SPMG, 2022) should be used to enhance staff skills and confidence in providing advice and interventions. Staff should circulate accurate and up-to-date alerts/information they receive with people in MAT, and use these opportunities to discuss risks and harm reduction further. In cases where substance use affects MAT, this must be explained fully, specific harm reduction provided, and a plan for how best to proceed agreed between the worker and the individual.

Mental health should be prioritised to ensure people are referred appropriately and referrals followed up to give an accurate idea of waiting times. Staff should offer alternative options to support with mental health related issues, such as one-to-one sessions and coping strategies, in line with low threshold interventions. Time within appointments must be made to explore mental health and offer support even when people are waiting for more specialist interventions.

BUVIDAL

Those accessing Buvidal should be offered all the same choices and supports as those on other forms of MAT. This includes being allocated a keyworker, with whom they can develop a supportive relationship with. They should be given the option to have the level of contact needed or desired, rather than only when attending for monthly injections. Full discussions around care plans and treatment goals should be had during appointments, in the same way they should for all forms of MAT.

A clear benefit of Buvidal for some is that it allows flexibility to attend the service less frequently; for example monthly contact with a service, often for a short appointment for their injection. Therefore, frequency of contact and additional psychosocial support should be patient-led, with appropriate options for more contact/help offered at regular intervals, should someone's preferences or circumstances change.



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