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

SCOTTISH
DRUGS FORUM

AUGUST 2024

TABLE OF CONTENTS

Introduction
- Background
- Aims and Objectives 4

Design & Methods 5

Demographics 6

Findings - Access 7
- Stigma
- Waiting times
- Communication
- Travel

Findings - Choice 12
- Initial Medication Choice
- Changing Medication
- Choice of Medication Dose
- Choice of Keyworkers
- Other Choices

Findings - Support 16
- Importance of a Key Worker Relationship
- Positive Key Worker Relationship
- Negative Key Worker Relationship
- No Allocated Key Worker
- Change of Keyworker
- Support in Criminal Justice
- Support from Residential Settings
- Lived and Living Experience
- Recovery Community/ Third Sector
- Harm Reduction
- Mental Health
- Buvidal

Prison Focus Group Findings 26

Researcher Reflections 31

Discussion 32

Limitations 36

Conclusion 37

Considerations & Good Practice 38

References 42

ACKNOWLEDGEMENTS

This work would not have been possible without the enthusiasm and commitment of our peer researchers who were involved in all aspects of the evaluation. Special thanks to Garry, Fran, Robert, Craig, Alana, Gary, Chris, Denise, Jacqui, Gordon, Alex F, Alex S and Nicki. Thanks also to Louise Horn the lead researcher for SDF on this project.

Thank you to the Scottish Government who partly funded this work. Thanks also to the Alcohol and Drug Partnerships and services involved who helped to identify participants and raise awareness of the evaluation across eight health boards.

Finally, a huge thank you to all the participants who willingly gave their time and engaged so openly and honestly about both their treatment and life experiences across the six-month evaluation period.

GLOSSARY

This report refers to the national Medication Assisted Treatment (MAT) standards which are listed below. Further information and resources on the standards can be found at the SDF website: www.matstandards.co.uk.

Medication Assisted Treatment (MAT) Standards

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

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

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

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

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

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

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

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

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

MAT 10. All people receive trauma informed care.

INTRODUCTION

BACKGROUND

Scotland continues to have the highest drug-related death rate in Europe (Christie, 2023), with latest recorded figures showing 1,051 deaths in 2022, 82% with opiates/opioids implicated in them (NRS, 2023). Being in effective treatment is a protective factor against risk of drug-related harms. Therefore, provision of Medication Assisted Treatment (MAT), currently primarily consisting of opioid substitution treatment (OST), has been a particular focus for Scotland as part of the National Mission to Reduce Drug Deaths and Improve Lives (Scottish Government, 2022).

In May 2021 the Scottish Government, in collaboration with the Drug Deaths Task Force, published the MAT standards, with the aim to provide consistent access to effective treatment regardless of individual circumstance (Scottish Government, 2021). Implementation of the standards across Scotland has been ongoing since their publication and developments are still taking place in all localities.

Ahead of implementation of the standards, Scottish Drugs Forum (SDF) conducted a baseline evaluation on MAT, looking at current practice across six health boards (SDF, 2021). The findings from this suggested implementation efforts should focus on improving access, choice and support related to MAT. Specifically, this included ensuring equitable access to various treatment options and fostering therapeutic relationships throughout the entire care system.

This subsequent evaluation sought to expand on the baseline by capturing experiences and individual journeys across an extended period of time throughout the ongoing implementation of the standards around Scotland. The observation-based methodology was chosen so as to gain unique insight into how people feel and what they go through whilst accessing or trying to access MAT.

AIMS & OBJECTIVES

The evaluation aimed to gain an understanding of individual experiences of accessing MAT through following individual journeys of people currently accessing or seeking MAT over a six-month period across eight health boards: Greater Glasgow and Clyde, Lothian, Grampian, Tayside, Lanarkshire, Ayrshire and Arran, Borders, and Highland.

In doing this, we were seeking to ascertain the following objectives:

- 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 accessing or seeking MAT.

Alongside this, participants from HMP Castle Huntly were invited to focus groups to discuss their experiences of being in MAT.

DESIGN & METHODS

Participants were recruited from eight health board areas across Scotland and the evaluation was approved by NHS Clinical Governance teams in each.

A sample of 65 participants (5-10 per health board) were enrolled in the evaluation, with an additional 6 participants involved from HMP Castle Huntly. The sample aimed to capture participants of different genders as well as age ranges.

Inclusion criteria was to recruit a variety of participants across the health board areas who were:
- seeking MAT
- in MAT or re-accessed MAT in past 3 months
- in MAT or re-accessed MAT in past 3-12 months
- in MAT longer term, meaning over 12 months.

Exclusion criteria was for anyone under 18 years of age or anyone who was no longer in MAT at the point of starting the evaluation.

Thirteen SDF peer research volunteers completed training relevant to the evaluation and were involved in all aspects of planning and delivery of the work. Eleven of these had their own lived/living experience of accessing MAT, with four being in MAT throughout the time of the evaluation. A core of eight volunteers carried out the interviews and attended various observational aspects of the evaluation.

The evaluation adopted a qualitative and observational approach where participants were enrolled in the evaluation for six months, and were in regular contact with the SDF research team about their treatment, where possible with SDF researchers observing their day to day appointments during participants' six month engagement period. These appointments were with NHS, pharmacy and dispensing services and/or with commissioned third sector support services.

They also completed semi structured interviews after three months and six months of involvement. These focused on experiences accessing MAT, support offered from services and choices and communication.

All participants received £50 PayPoint vouchers for each month’s engagement and a further £20 voucher for each interview completed as honorariums for their time and participation.

Of the 65 people initially recruited to the six-month observational element of the evaluation, 52 completed their three month interview, 50 remained engaged for all six months and 42 completed the final six month interview. Throughout the evaluation, 41 observations were completed across the eight health boards. Five participants chose to withdraw from the evaluation due to ongoing mental or physical health issues. Four others were unable to continue because they received custodial sentences. The remaining fourteen dropped out at different stages, including just prior to their six month interview, with no explanation given.

All participants were told of their right to drop out or stop being involved whenever they requested this as part of enrollment in the evaluation. It was also discussed that if the lead researcher could not get in contact with them over a certain period, this would count as them dropping out. It was explained verbally and in writing that all data gathered up until the point of no contact/ drop out would be included unless the participant asked for this to be removed. No participants asked for this, therefore all data gathered has been incorporated as part of the analysis and report writing process.

Two focus groups were conducted at HMP Castle Huntly with each group having had three participants in attendance. Discussion took place on topics including, but not limited to, accessing/continuing MAT in a custodial setting, support while in custody and comparisons with community support. The research team discussed participant incentives with the relevant staff at the establishment. While monetary or voucher incentives were not allowed, the researcher offered refreshments during the group sessions as a token of appreciation.

DEMOGRAPHICS

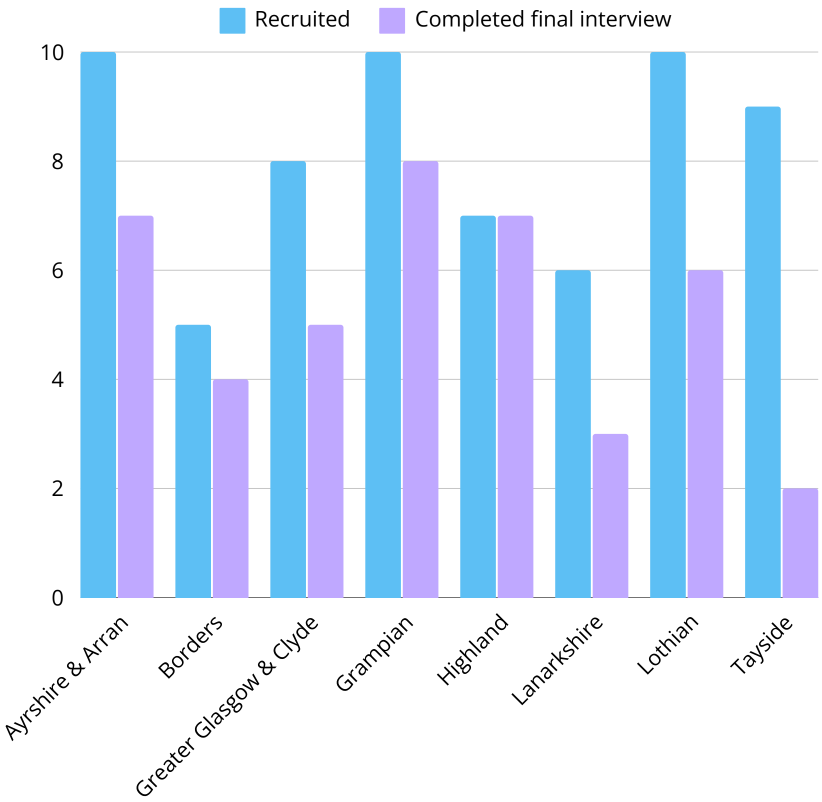
Of the 65 people recruited to the observational element of the evaluation, 41 (63%) were male, 23 (35%) were female and 1 was nonbinary. Although participants were not asked about having children, four females mentioned having regular contact with theirs. They had family or other support which provided them with flexibility to engage in treatment. Seven other females reported having children with whom they had no contact.

The age ranges of the participants were:
- 18-24 = 2
- 25-34 = 13
- 35-44 = 20
- 45-54 = 23
- 55-64 = 6
- 65+ = 1

When they entered the evaluation:
- 4 people were seeking MAT
- 19 had been prescribed MAT in the last three months
- 29 had been prescribed MAT in the last 3-12 months
- 13 had been prescribed MAT for more than 12 months.

The focus groups consisted of six male participants, all aged 35-55, and four of whom were serving life sentences. Four were currently prescribed Buvidal, one prescribed Espranor and one prescribed methadone.

The two groups took place in HMP Castle Huntly where participants were currently serving. Participants referred to experiences of being in MAT across a variety of prison estates.



Participants recruited & who completed 6-month interview by health board

FINDINGS - ACCESS

STIGMA

Pharmacies were seen as a source of stigma by seven participants and described as negative experiences, or even a barrier to accessing treatment. Three of these participants, who were prescribed methadone, described being brought their medication in plastic cups for them to consume in the main area of the pharmacy. This was largely felt to be a violation of privacy, with participants feeling the private medication rooms should be utilised for them to avoid public consumption which caused severe embarrassment. Other issues raised by these participants relating to pharmacies included being told to wait in a separate queue or waiting longer whilst others were served before them, as experienced by four participants.

Ten participants mentioned that they found the statutory drug and alcohol service buildings stigmatising. They were said to heighten feelings of low self-esteem and low confidence, making people uncomfortable when attending. For example, during one observation, the participant stated they hated the building as it was “horrible and dingy” and made them feel like people in treatment did not deserve to be seen in nice environments.

“When you walk in, as soon as you walk in, when I have to go in, I get told to wait at the left and I can feel me getting the looks, folk start their whispers and that. I have experienced that for 20 years.”

Participants also described experiencing stigma from GPs, with one commenting: “GPs don't want to work with addicts, they want specialists to do it”. Eight participants described feeling judged and that their concerns were dismissed when accessing GPs for support, causing them to not want GPs involved in their treatment at all. These feelings became more prominent when people were discussing physical pain or their mental health needs as felt they were being accused of seeking more medication: “it's the stigma, because I’m an addict, I must be a drug seeker”. These participants mentioned they felt their GP’s did not want to offer them support once they were accessing statutory addiction services. Five also mentioned they could not get referred beyond their GP for mental health support due to already being involved with drug and alcohol services. One participant stated there were “knock on effects that come with being in treatment”, one of which was the general attitude of their GP changing towards them once they were in MAT.

“Even if we go to the doctors, and you say can we see a psychiatrist, they will not let us see a psychiatrist because we are under [service name].”

“So like the GPs attitude changes to all the other medication you’re on, I was stopped, it was a lot of other things that it affected, that it still affects, a year down the line.”

Thirteen participants who had been accessing treatment and/or been known to services for a long time, highlighted feeling judged on past actions and behaviours. Several participants mentioned this led to them feeling disheartened in their recovery because the changes they had put in place were not being recognised. They felt this judgement was a barrier to further progression in treatment and felt they were not offered all support they should be.

*"I just can't see how [worker] is going to let that happen, I really can't, he is going to make it so f*****g difficult for me... now that I am clean, all they remember is all the ten years of b******t , they're no like 'oh this guy's actually turning his life around, we can really help him'."*

"She said to me, you actually don't look like you're on MAT, you know, you don't look like one of our normal clients."

During direct observations and reflective conversations/ interviews, participants and researchers picked up some more subtle/indirect instances of stigmatising behaviour in real time. Examples of these included passing comments made by staff in services, such as when a participant and researcher were in a service waiting room and overheard a reception worker say: "I can't tie a string to the reception pen because one of them will try and hang themselves no doubt."

WAITING TIMES

During the evaluation, six participants from city-based areas accessed MAT for the first time or re-started MAT. The waiting times for a first appointment and access to prescribed medication varied across these individuals. Two commented on the tangible changes in this process compared to previous times they had accessed MAT. This included same day prescribing and being able to access a "drop-in" style clinic, allowing them to choose when to present rather than having to call up and make a direct appointment, thus making access easier overall.

"I managed to go to a daily drop-in clinic and got started on a script of buprenorphine that very same day which was great."

"I was a bit nervous... like ten year ago I had been through this, and I tried to get access before and it was so much harder back then. This time it was, I couldn't believe how easy it was basically."

Four of these participants experienced longer waiting times, varying between a week to several months, for their initial appointment and prescription to start. This prompted frustration towards the service, related to a lack of accurate information around the wait times and participants' rights to access treatment quickly.

"At the beginning it was, it was just ridiculous, it was just wholeheartedly inaccessible to begin with... I was genuinely phoning up in tears begging for this help, for months."

Once an initial appointment was given and attended, participants were usually started on a prescription quickly, within a day or two. However, two participants were delayed in starting MAT because other substances, mainly cocaine, were shown as present in their drug screening tests. Although this reason was given for why their treatment was then delayed, staff did not offer support to reduce this use or provide harm reduction information to these individuals, which left them feeling helpless about how to move forwards.

One of the six participants waited six months to get an initial appointment and start their prescription. This was partly explained to the person as being due to a dispute over which recovery hub they should attend, which left them feeling no one was willing to take responsibility for them and their care. The participant described being left with no further support during this time and how they had felt like “giving up” whilst waiting. This participant started treatment two weeks into this six-month evaluation, but had already been waiting six months prior.

“Well in the beginning it was absolute hell, four appointments it took me to get them to start me on anything, because I had faint traces of cocaine showing up and if that shows up, they’re not giving you anything and I think that is terrible.”

“There was literally days when I was on the phone, crying and screaming down the phone, please help me. Being told so many times, like literally months I was getting told you’re third on waiting list, you’re fourth on waiting list, you’re now seventh on waiting list. I didn’t understand any of that, so I don’t know why it took so long.”

COMMUNICATION

All participants were asked about communication and contact with the service they attended, and twenty-nine felt the frequency of contact was largely dictated by their keyworker. Several people noted that having a direct mobile number for their keyworker increased interaction and direct communication and they found this to be the easiest way to change appointments or raise any concerns between appointments. Texts to check in and remind participants of appointments were appreciated and made people feel valued and cared for. Workers using apps such as WhatsApp so participants did not need to pay for messages was identified as beneficial by several. Where participants did not have a direct number for workers, often they needed to make contact via main reception lines which was typically seen as a difficult process.

“He is always on the end of the phone if I ever need him... I send him texts now and then and he messages me back, so aye it's been good that way.”

Communication/ reminders about appointments were preferred over the phone/by text, rather than by letters by almost all participants. One reason given for this was that sometimes letters with reminders arrived after appointments were due.

In discussions around communication, three participants highlighted the importance of using methods which suited their individual needs. For example, one participant who was deaf encountered an additional barrier to accessing treatment because the communication was not initially tailored to their needs of requiring text or direct face to face contact.

"Everything goes via main reception, and I have no direct contact details with my worker, so if there is an issue then I need to get my mum to call up and they need to then call my mum back to tell me because they do not do text messages. Thats a barrier for me because if it was to be an emergency, you know, that doesn't work."

"I always get the letter, I know exactly which comes from her because of the colour of the letter through the envelope window, I'll know to open and see what date it is".

Another participant raised that due to changing their mobile phone often and having limited credit, text or phone call communication was challenging and letter contact was the most consistent way to reach them. This participant expressed their dislike of opening mail, and in response, the service then sent letters in coloured envelopes, making them easily identifiable to be opened so the participant was able to get to appointments.

Three other participants were able to request letter communication from their MAT service to be sent to their chemists so these participants knew they would receive any messages from their worker at their daily/weekly chemist pickups.

Five participants stated they felt it was down to them to initiate communication with the service to check appointments and have contact with workers.

"The first I've heard from them was today, and that's because I initiated it, I got my chemist to phone them for my prescription, and then I phoned them, so they had to be in touch with me".

Ten participants mentioned missing appointments, with six saying a phone call or text was received from their keyworker to check in and re-schedule quickly after this. Two participants stated they received home visits from their keyworkers following missing appointments if the worker could not get an answer on the phone, which they felt was the appropriate response. Two participants raised that their missed appointments were not followed up on via phone call but letters were sent out with a further appointment.

"I have missed appointments in the past and then [worker] has called me straight away or next again day because she will check in and basically do a welfare check just to see if I'm alright."

During the evaluation, three participants received letters or texts from their service or keyworker detailing appointment times and including a warning line stating if they did not attend then their prescription could be at risk. Participants raised that this left them feeling threatened and unwilling to engage in support rather than encouraging them to engage further.

> *“Some of the letters, it’ll say, if you don’t attend, you can lose your methadone, they say they will never do it if you speak to them, and I said I am not happy that you're sending this to me because I am engaging every single time... She went oh they're just generic letters.”*

It was noted that it could be difficult for participants to initiate contact or reach out to services for support for different reasons. Phone lines ringing without the option to leave a voicemail or needing to call services via a switchboard, were some of the barriers participants raised in trying to get through to services. Limited phone operating hours for services was also noted to be an issue, with some participants raising that they knew they could only access the services via phone at restricted times.

> *“You couldn't phone the normal number on the thing, it would only be open for four hours in total in the day, if you didn't hit the two hours in the morning or two hours in the afternoon, then that was it.”*

TRAVEL

Travelling to clinics or service locations was highlighted as a barrier for fifteen participants, due to travel distance and cost. Eight participants stated that no support was provided for using public transport by their service, so they had to organise to cover the costs of attending appointments or getting to pharmacies themselves: “it costs me a fiver to get here, a return today, so if you’re doing that maybe two days a week, that's a tenner”.

> *“If you were given the, the bus money to get up to appointments at [service name], that would be helpful, that would help you engage.”*

Three participants mentioned they had a bus pass via their Adult Disability Payment benefit, and this helped them access their treatment. One participant stated that the lack of support with travel passes was a reason they did not travel to the clinic for face-to-face appointments and instead had phone support.

In urban areas, walking, buses or sometimes taxis were used by participants to access services for treatment and there was limited evidence of home visits being offered or used as an alternative option. The length of time spent waiting on and travelling via public transport was also mentioned by four participants as an issue to accessing services, including pharmacies, and could mean participants skipped prescription pickups if they did not have the money for travel costs.

> *“I have found myself missing days, like maybe nearer the end of the fortnight and stuff like if I have run out of money... I just find it really difficult with the travel aspect, it's costing me £15 a week...I got a travel warrant on the first day and then they told me they were cutting down on travel warrants, so that was it”.*

In rural locations travel distances were often further to clinics/service buildings and public transport options limited and more expensive. However, twelve participants reported services and workers offering alternative locations and appointment options to ensure access to treatment continued. Some of the options observed were home visits, satellite clinics in local GP's, online meetings via 'Near Me' or walk and talk appointments at a location of the participants' choosing.

> ***"It varies, so sometimes it's in the hospital at [location], sometimes its nearer where I live, so yeah, sometimes in the GP surgery round the corner... it's great and to have someone close to your house and be rural, is very good."***

Five participants mentioned they had home visits from workers alongside appointments at clinics which took away some travel concerns. Having this level of flexibility offered participants choice with what worked best for them and increased their engagement due to their travel needs being met.

FINDINGS - CHOICE

INITIAL MEDICATION CHOICE

Six participants accessed or re-accessed MAT during the time of the evaluation. Methadone was offered to all of these individuals and it was always discussed that this could be started the same or next day by the service provider. One participant stated that getting onto treatment quickly was important to them because they were "slowly killing" themselves but they would rather have waited a bit longer and got the treatment they wanted to avoid "the crap and stigma associated with methadone".

Three participants, all of them accessing treatment for the first time, were initially only offered methadone, despite two requesting a Subutex prescription. Two of these people were not given reasons or explanations as to why they received a limited choice, however another was told Subutex was not available to them due to it being "expensive medication".

> ***"I phoned up and I got a prescription next day, so second day so it was pretty good but all I got offered was methadone."***

> ***"Despite asking for Subutex, I was told categorically no, you know, methadone is, its methadone or methadone, and it wasn't until I actually started taking the methadone, I was told that eventually further down the line if I chose to, I could move over to a Subutex injection."***

The three participants who were initially prescribed methadone stated they felt they needed to accept this treatment because of how unwell they had been at the time of presentation, with one participant raising they did not want to have to continue to use "other substances against my will". Another participant stated they agreed to methadone despite not wanting it because their initial appointment was with the service manager, and they assumed "[their] advice would be correct" due to their position within the service.

One participant who was re-accessing treatment after several years away from services wanted to re-access methadone because they had past knowledge and experience of this, so it felt like the best choice for them. This participant was also offered Subutex and Buvidal.

For participants in general, methadone was the treatment they felt they knew most about, despite those accessing it not being given information leaflets or offered discussions about it.

Buprenorphine was offered as a choice to two participants, as well as methadone, in the form of the Espranor wafer or tablet. In both circumstances there was little explanation given around starting dose, how this treatment worked in the body or wider effects of this treatment. This led one of the participants to refuse it due to their previous experience of taking Subutex when in custody.

> ***"I'd had my mind set on methadone, because I'm of the age that that was the treatment that was available when I first started."***

One participant was able to access Buvidal on the day they presented to the service during the evaluation. They found the process extremely easy and stated they "felt empowered" and "in control of treatment" due to being able to choose their medication. This participant felt informed of all available options and was able to ask questions to understand the effects this medication could have. Relevant leaflets were also made available to help further inform their choice and they expressed "it's much better being able to make an informed decision yourself".

> ***"I had loads of questions, because I had never been on it before, you know, and every question I asked was answered, and if she didn't know the answer herself, she went and saw her boss and asked her boss. I had tonnes of questions you know, about the process, the dose, is it sore, all this stuff."***

CHANGING MEDICATION

Four participants changed their medication during the evaluation, either due to a reaction to a certain medication or because they wanted to move onto a buprenorphine form of MAT as part of their plans. These participants asked their workers about doing this but described the process of changing as lengthy and often requiring them to "jump through hoops" of drug testing and waiting for appointments with prescribers. This added extra stress and pressure to their experience of treatment.

> ***"It's not been plain sailing, I've had to jump over every, every hurdle... I had to fight to prove that I wanted to go on Espranor... I eventually got it, but I had to jump through every single hoop possible, I had to constantly give clean samples."***

Two participants, after discussions with their workers, were removed from their Buvidal treatment during the evaluation, due to concerns about it having a negative impact on their mental health and one also having a physical reaction. Both were offered methadone as an alternative which was not something they wanted, and this raised conversation with the researchers about other things that could be offered to people accessing treatment. For some people services seemed focussed on MAT and wider treatment options were not discussed, nor was MAT contextualised within wider options. For example, detox/rehabilitation were not frequently discussed with participants but was something five felt would have been a useful option. One participant believed they were not offered detox or rehabilitation due to issues around funding.

> ***"I was begging them for rehab, no, no, no, nothing, you can't do it as there's not enough funding... I would of loved to have been offered a detox over the past 6 months, see if I could of went in, in hospital or something, and got myself detoxed, that would have been brilliant."***

CHOICE OF DOSE

Experiences of reviewing and/or changing dose varied, however most participants stated they were asked about dose informally within their appointments or during phone call check-ins. Half the participants felt in control of their medication dose, whilst the other half felt workers dictated whether their dosage was increased or decreased.

Two participants stated they had a formal review of their MAT every six months, involving an addictions GP alongside their keyworker to discuss next steps. In one observation it was noted the GP and keyworker discussed other areas such as sleep and mental health when discussing the participant decreasing on medication. The participant acknowledged that although having the GP present for review felt like a "formality", it did add to a positive, supportive discussion and dose reduction. The GP and worker agreed to a "2mg decrease every 4 weeks" and wrote this into a care plan to be reviewed further.

> ***"She kept saying that you can't, you can't, no you can't start reducing, you're emotionally unstable... I'll never go away from that."***

For four participants, although the worker discussed reducing their dose, little action was taken, and they had to wait for months for the decrease to happen. Eventually, this caused two participants who were prescribed methadone to reduce their dose at home and then update the workers on this later: "I would bring myself down then I would just turn up and say, oh I've brought myself down another 8ml or whatever". These participants felt getting a reduction in their dose was harder than getting an increase. From one observation, one participant's worker suggested they buy a bottle of Calpol and "use the syringe from this to withdraw the desired amount" for their own reduction on methadone instead of the dose decreasing via the pharmacy. The participant stated they were shocked this was suggested and did not feel this was a safe way of going about reduction.

> ***"No, that was me, reducing was all my idea, and then talking and communicating with [workers name]".***

> ***"I wanted to start reducing, they told me I needed to see a doctor...so from the day I asked to start reducing, I had to wait nine months, but I didn't have to wait any time to get put up, you know what I mean? So, I eventually just thought f**k this, and started detoxing myself."***

Four participants mentioned that they valued their workers' opinion on dosing and would take their feedback into consideration when deciding about decreasing or increasing. One of these participants stated "you need to meet in the middle" and have that discussion with workers to really work out what is the best decision. Two participants felt their keyworker knew their life and situation well and this gave them confidence in trusting their worker about dose and what might be the right decision for them. One participant stated they wanted to reduce medication quickly but had a recent family death and their worker discussed "staying where you are now to stabilise yourself". Ultimately, they mutually agreed it would be best to review this again at a later date.

CHOICE OF KEYWORKER

> ***"I requested for a female worker to start... since I requested that I have always been provided with female workers"***

All participants said workers were usually allocated to them when they started treatment or when their worker changed due to absence or leaving the service. However, most participants reported being given a choice of whether they would like a male or female worker.

It was noted by six participants from rural areas that their choice of worker was more limited due to lower staffing levels and smaller services. For a few this meant they had no choice of their worker's gender, as they were simply allocated to one of a few within the service.

However, the keyworker relationship that was built with a worker once allocated, was seen as more important to participants than being able to choose a specific worker. One participant who changed workers expressed that he "couldn't believe he had no hope six weeks ago for the future" and since meeting his new worker and having a couple of appointments with them felt "excitement for the future and confident about things moving forwards".

OTHER CHOICES

Twenty participants mentioned they would like more choice in appointment frequency and to be seen more face to face rather than having appointments over the phone.

Having access to more information was mentioned by most participants, such as about treatment options or the supports/activities going on in the local area. People felt more active discussion and promotion of these things, beyond simply posters in waiting rooms, would be of benefit, with one person stating "they're only giving drugs, they're not giving recovery". These wider activities and engagement with other services were perceived as broadening treatment and associated with wider progress.

> ***"I would say there needs to be more communication, more phone calls, more appointments, regular appointments even if its once a fortnight, or once a month, you're no even getting that".***

Ten participants stated they had knowledge of the MAT Standards before enrolling in the evaluation, mainly though speaking to peers and attending recovery community events and engagement groups. Most participants were not informed of the MAT Standards by their worker or the service they attended so not sure what they should expect or be entitled to in terms of their treatment. This contributed to a sense of being or remaining disempowered, with one participant stating "I wasn't aware as a drug user I had rights in treatment".

"That's something they really need to do, you should walk into the room and there should be on the wall 'Medical Assisted Treatment'... this is what your rights are in here, 1, 2, 3, 4, 5, it's no done, they don't mention it, it's never spoken about".

FINDINGS - SUPPORT

WORKER RELATIONSHIPS

The participants' relationship, or lack thereof, with their keyworker impacted feelings of support and progress in their treatment in a significant way. This relationship was seen to be an important aspect of treatment for all individuals.

"Key worker came across as essential to the whole experience of someone accessing and being supported in treatment. You could hear and feel how participants felt about workers based on their tone of voice, facial expressions, and general body language." - SDF Peer Researcher

POSITIVE RELATIONSHIPS

Twelve participants described the relationship with their allocated worker as positive and this was attributed to having frequent contact with them and feeling respected and heard within their treatment. Having regular appointments with time for discussion, meant participants could build a relationship and trust with the worker, allowing them to feel comfortable in being open and honest. Being listened to without judgement was valued as it gave space to discuss a variety of issues in life that people often felt they could not share elsewhere.

"I feel now, because I had that breakdown, I can just go and say whatever I want now, without feeling the need to watch what I'm saying, but what I will say was, she gave me a helping hand with that, I was able to say to [workers name] this, that and the next thing".

Participants also mentioned workers proactively responding to their needs, which increased feelings of positivity around the relationship and enhanced participants' engagement with treatment as they could see tangible benefits of support: "they have always been there for me when I needed them". Having discussion around care plans, future goals and further support options gave participants confidence in their treatment and more purpose to engagement rather than being seen as medication only.

"Being able to be open and honest and yeah, I tell him like I am no doing great, and stuff and he'll be like right, do you want to make an appointment, come in and have a talk... it's not just being intrusive, you know, he's like, I'm your nurse, it's not just your medication and he, I'm also here to be your nurse, your psychiatric nurse."

Having the same worker over a length of time increased feelings of being supported and allowed for the relationships to strengthen: "[workers name] has been brilliant from the start, that's like the last three years, she is always ahead of appointments, and she always checks in".

Throughout the evaluation, some participants felt their worker went beyond the remit of their role to support them, and this had an often significantly positive impact on individuals. One participant stated they felt "that wee bit of care, that wee bit of security" in appointments with their worker that they did not experience from anyone else in their life.

"She is someone that you feel you can be really honest with and be truthful. The amount of times I have had to ask for extra support with food and bus passes... it's a shame on her, she shouldn't have to do that, she's got enough of her own duties" .

Other examples included keyworkers picking up food parcels and dropping them off at people's homes, because they were struggling to walk and lived a distance from the nearest food bank. In rural areas it was demonstrated that some keyworkers offered their clients support to attend referral appointments elsewhere such as at a hospital, to ensure their clients could access the support without the barrier of travel and distance. Three participants had frequent home visits, with one of these participants also benefitting from getting a lift from his keyworker to attend a mental health support group in a neighbouring area. These instances highlight the social isolation people were often facing and therefore further demonstrate the importance of the worker relationship.

NEGATIVE RELATIONSHIPS

For most participants, although they had an allocated worker within the service, they did not view this relationship positively. Sixteen participants reported having limited contact with the service and/or their worker, creating a disconnect and leaving them feeling they had no relationship or a poor one. In one participant's appointment, the researcher observed the relationship appeared to be "fraught with tension". One participant discussed that "there was a time, there was a point where I was quite keen" but had recently felt alone in their treatment and that their worker "in reality doesn't care". These feelings were further compounded when at one drug testing appointment, this participant was met in the carpark of the service by their worker to complete an oral swab there and then, leaving them feeling "humiliated". A lack of contact left another participant feeling "quite resentful if I'm honest" towards their keyworker.

Overall, twelve participants stated they felt uncared for and unsupported by their worker due to little support or sense of purpose within their treatment. Shorter, less frequent appointments also left some participants feeling rushed and unable to speak about important things for them and ultimately provided less opportunity to develop the relationship.

"I'm no really interested in the workers, just let them do their own thing, because they've no really done nothing for me anyway, so I'm no, it's no really as if I've got a connection with them".

Ten participants described feeling unheard within their treatment, further compounding the idea that they were not cared about. One participant described feeling dismissed because their worker had “no patience”. These participants found it challenging to engage with treatment because they were not able to raise their needs or felt like if they did, they would not be heard or taken seriously.

> *“Totally wrong worker... he just wasn’t interested. Every time I wanted to get put down, he would say right, so you want to go up then, and I was like do you not hear me?”*

When discussing their involvement in the evaluation, some participants mentioned they had found the relationship they built with the lead researcher to be more valuable than the one with their keyworker. They felt the researcher was filling the gap they had for having someone to speak to openly as they did not have an assigned keyworker.

> *“I felt that you’re the only person that was giving a f**k about me to be honest, it was, I didn’t even get that from addictions, that somebody even phoned up saying how are you, how you doing, what’s going on, nothing like that, not a thing.”*

> *“Therapeutic to vent, you’re lovely, I feel like you care, and you actually care about your job, and you want to make it better for people, but like if [worker] had like 10% of how you are, it would have been a lot different, a lot different like.”*

These participants mentioned things like the research team being “easy to talk to” and it was a unique experience for some to feel someone was interested in them and their life/situation, as they would normally expect people to “give up on them”. This further demonstrates that participants were often limited in terms of a supportive social network and therefore positive worker relationships could be crucial.

NO ALLOCATED WORKER

Ten participants stated they had no allocated keyworker during the evaluation. These participants described feeling lost in treatment and as if they “fell through the cracks” of the system. Being given duty workers or having no allocated worker increased the difficultly for participants to contact a nominated person in an emergency or if they felt they needed more support, enhancing feelings of isolation and that there was a lack of overall care for them.

> *“She’s saying that she couldn’t really do anything because she is only a duty worker, she doesn’t know my background or whatever, doesn’t know nothing about me”.*

> *“I feel like, I'm just you know, a number now, you know, I don’t feel a personal relationship with anyone. You know, there's no anyone that I could maybe lift the phone and speak to like if I needed to”.*

Duty workers were often used in service settings to ensure cover for any gaps but several participants reported only ever seeing duty workers throughout their time in treatment. This impacted on their engagement and progress because they were continually unable to discuss their treatment in detail or make any changes. One of these participants experienced having to take a drug screening test with a duty worker they had not met before, with a discussion on their options being had while they were still in the toilet cubicle. On another occasion, this person walked out of the service as a different duty worker they did not know started to have a very personal conversation with them in the service waiting room. This person had an extremely difficult relationship with the service due to incidents like these.

CHANGE OF KEY WORKER

Four participants had a change in their keyworker during the evaluation and discussed how difficult this was, especially when they had a positive relationship with the previous worker. Participants acknowledged that workers leaving services could not be avoided, but felt there were ways this process could be improved. One participant described wanting to be more informed about their worker changing so they could be "more at ease" instead of turning up to find they have a new worker unexpectedly. Due to having no notice of a change in worker, one participant stated their "anxiety was really high" during appointments which left them feeling overwhelmed.

> ***"It's like you build up trust with one person, and then before you know it, you're getting chased to the next person and then you've got to start from the beginning".***

The biggest barrier identified when getting a change of worker was the need for participants to repeat stories and their life history to someone new. For one participant, having a joint handover with workers helped the transition of changing and allowed them to feel supported during this period. This was observed during a handover meeting whereby this individual's body language changed through the duration of the appointment, eventually becoming "relaxed and laid back". Having their previous worker present in the meeting allowed the participant to feel comfortable in speaking up and contributing to the ongoing conversation. After this appointment, the participant described their experience as positive and stated they "felt lighter" having had the added support of previous worker there.

For two participants that did not have a positive relationship with their worker, changing to a new one was beneficial. One discussed that they felt this gave them the chance to build a relationship with someone who provided more options for support and gave the opportunity to access a new treatment pathway.

> ***"It makes all the difference having that right, that right worker in the right place at the right time...I can't speak high enough of the guy, makes a big difference".***

CRIMINAL JUSTICE

Three participants were remanded in custody for a period during their time in the evaluation. All three described this as a negative experience due to lack of support offered in this environment, with one commenting "it's shocking right, but us folk that are in custody, it's just normal to us". All three participants continued their MAT while in custody, including one on Buvidal who had their injection administered on the same day that it would have been due in the community which they stated they were “surprised” by as they had expected to not receive it.

However, mental health support and getting appointments related to MAT did not happen for any of these participants, with one commenting that they felt people in custody were just “left to rot” and that there was no recovery support beyond medication provided.

“None of that is taken into consideration, your mental health doesn’t exist in there, you don’t exist in there”.

Throughcare and support after release was highlighted as a further gap by all three of the participants. They reported being left with no onward referrals or follow up appointments with addiction services on their release. One participant described this as “you’re flung out that day and that’s you left to your own devices”. Two had to call their worker and/or service provider to get a follow up appointment in the community and waited a couple of weeks for their next appointment. However, their prescriptions were maintained in this time. The third participant stated they texted their worker on release and were given an appointment the following week at the local service clinic.

Three participants were mandated to attend a Drug Treatment Testing Order (DTTO) in the community during the evaluation and thus had their MAT taken over by criminal justice social work teams. This was seen as a positive experience by two of these individuals, who felt they got better support than from the statutory drug and alcohol service.

“There has been an improvement since I have been taken on by DTTO, but I think that is due to staffing more than anything, they seem to have staff available and because they’re based at court and they’ve got social workers there, they’ve got good ties with the likes of housing and things like that”.

One stated they felt this was due to support being regular and structured with set appointments as part of the DTTO which made engagement pathways clear. One participant also noted they were offered more frequent and longer appointments when on this order. The workers also had contacts with other organisations such as housing associations and group work programmes, which were mentioned as contributing to people feeling better supported in this context.

RESIDENTIAL SETTINGS

Three participants attended residential rehabilitation during the evaluation, all of whom were referred by their keyworker as part of an overall care plan, with the eventual goal to be discharged from MAT. All three spoke highly of their experience within these residential settings and discussed that the nature and structure of support allowed for reduction and stopping of MAT that they felt would not have been possible within the community.

> ***“I went in there to do a specific thing, get off my last bit of medication and it done the job for me, what I couldn't do for myself out on the street, for years and years I couldn’t get off it, went into treatment centre and it worked for me and I got off my prescription”.***

Residential rehabilitation provision was described as a mixture of one-to-one professional support, group activities and direct links to local recovery communities, which allowed participants to develop a range of tools and coping skills. Participants also discussed getting reviewed regularly to discuss progress and future needs.

> ***“I had a six-week review and a twelve-week review and that, and that's when you get the chance to discuss how I’m moving forwards with the next six weeks of treatment... I started realising that I wasn't just addicted to drugs, I was addicted to everything, you know what I mean?”***

> ***“well if somebody coming out of residential treatment, there needs to be a lot more support in place for you when you come out...what really happened to me was a massive lack of support , when I came out and I felt like when I came out I just came out to nothing, and I was totally lost”.***

Two participants felt they could have received more support with preparation before going into rehab and then after they had left, in terms of an aftercare plan. For example, one participant discussed feeling anxious as they had no idea what to expect and no check-ins from their worker before attending - “haven't heard from drugs team, so have given up on them”. Equally, it was identified that it would be useful to have appointments in the community set up before leaving the facility to ensure continued care and that other supports would be in place.

LIVED AND LIVING EXPERIENCE

Participants said they would like to see more representation of lived and living experience in services. Four participants raised that lived & living experience plays a vital role in the recovery community and is seen more in these third sector contexts, through groups and voluntary opportunities. Rehabs were another area where lived and living experience was seen and peers had roles within the service, which one participant said helped them see “it could be done”. However, this did not feel as prominent within statutory treatment services.

Thirteen participants voiced a range of views of how lived and living experience could be promoted and integrated within statutory services. For example, having peers present in the waiting areas, attending initial appointments or supporting people to attend community groups. Four participants mentioned that they wished they had had the opportunity to have a peer mentor or to speak with someone with lived experience from the services to help them realise their goals and feel better understood.

Six participants discussed having the opportunity to be involved in services in some capacity would allow them to “give something back”, as well as help motivate them in their own recovery goals.

“So in a perfect world, I think it should be somebody like [workers name] and somebody with lived experience, sitting in the appointment if you’re comfortable”.

“I would have loved to have had a peer mentor kind of thing, do you know what I mean, just someone to talk to. That guy [name], I knew him from my past, it was good to see him working here and you know, knowing there was oppertunities”.

RECOVERY COMMUNITY/ THIRD SECTOR

For fourteen participants, recovery community groups and third sector services provided valuable support and were said to fill gaps of statutory services. Participants were sometimes informed or referred into these services by their statutory keyworker, but most stated they found out about these support options from their peers or leaflets. Six participants stated they would rather get support from these services over the statutory service because they felt they could access better options such as harm reduction, psychosocial support and advocacy, things that in some cases had only ever been offered in these contexts.

“[Third sector service] covers it all, it does, they’re so lucky, I’d advise anyone to try [third sector service] because you get it all on a weekly basis, there is advocacy, there are people to help with your benefits, there is Citizens Advice there as well, there is specific people for specific things”.

It was noted by eight participants that engagement and relationships with third sector organisations were stronger because of the extra time allocated to appointments. As a result, participants could see more visible outcomes from this working relationship. Three participants mentioned that the recovery community and groups they joined provided them with an alternative type of support and structure.

“At [statutory service] it's just more of a clinical feel, I am not going to say cool..but I guess not as warm or friendly, you know, helpful even, as [third sector service].”

*“I wouldn't be f*****g anywhere without [workers name], and that’s not me just bigging her up because she is my worker here, but I think, I wouldn’t even be on a script if it wasn’t for her.”*

HARM REDUCTION

Harm reduction support and examples of provision varied throughout participant’s experiences. Blood Borne Virus (BBV) and Dry Blood Spot Testing (DBST) were rarely mentioned apart from some participants thinking they had been offered tests in the past, most often when in custody. However, these were not offered routinely by services/keyworkers.

“They offer me the usual, say to you inject safely kind of advice that needle exchanges have always offered, but that’s it, there’s not really much they offer me”.

Three participants accessed injecting equipment provision (IEP) within their service whilst in the evaluation and were offered blood testing and injection advice.

One participant raised that their worker provided updated information about current drug batch alerts in the local area and risks associated with this. They found this particularly useful for keeping safe as there was no drug testing within services.

Four participants felt that more support was needed for addressing the use of other substances while they were accessing MAT. Cocaine, benzodiazepines and alcohol were some that people felt they did not get enough support with due to the focus being on opiate treatment. One participant was told “alcohol use can be addressed later”, despite them being turned away by their worker from a previous appointment for being under the influence of alcohol.

For one participant, cocaine was showing in drug tests when attending the service. They were subsequently asked by a worker to “flush out their system over the weekend” before their next appointment so as to get a clear test, but they were given no detail on what this meant. This also became a barrier for increasing their dose due to opiates and cocaine showing in their system. The participant was told “not to ask for it if I’ve got cocaine in my system, I won’t get another rise” but was never offered any advice or support to reduce their illicit use.

“The other problem is benzos, everyone, everyone's got a benzo problem of some sort and there's no sort of, there's no sort of help in coming off that”.

Two participants stated they were signposted by workers to third sector services to support with cocaine use but participants felt they should be able to access this as part of their MAT treatment from the statutory drug and alcohol service.

MENTAL HEALTH

Mental health was raised regularly throughout the evaluation by participants as an area where more support was largely wanted. Participants were aware of psychiatry referrals and forms of mental health counselling such as Cognitive Behavioural Therapy (CBT) but only four were seen by professionals for this support during the evaluation.

Six participants mentioned being on waiting lists for psychiatry for several months with little communication as to how long this may be. Three participants had been listed to access but, again, were waiting on initial appointments with little updates. One participant said they found waiting 18 months with nothing being done “hard to believe”.

> ***“I feel really deflated, it’s a let down, do you know what I mean, because it’s the main, that’s one of the main bits that makes everybody relapse or have an overdose... because the mental health in this country has went to pot”.***

> ***“its like you’re on a waiting list and the waiting list is, it gets longer every time, and then it’s meant to be three months waiting list, but then I’ve waited umpteen years and still no got seen with anybody”.***

Two participants mentioned that in rural areas psychiatry appointments were only available via videocall, rather than face to face due to the worker being based in the main city centre. One participant commented that they felt uncomfortable discussing mental health issues over a videocall due to fears of being overheard within their home and the support feeling less personal this way but that was the only option given.

Fourteen participants mentioned they did not receive any support with mental health from drug and alcohol services or their worker. Several participants raised that mental health was never mentioned in appointments or phone calls, but instead “you just get the generalised ‘how are you doing’ question”. One participant stated they felt a barrier to accessing further mental health from their worker was due to them continuing to use cannabis, “well it’s really difficult to get a real judgement on your mental health if you’re smoking every day”. This participant mentioned feeling judged about their choice to use cannabis, but also stated that cannabis was a way to cope with intrusive thoughts when no other mental health support was being offered. In this sense, their use of cannabis was an indicator of the state of their mental health.

> ***“There probably could have been a little bit more involvement or just enquiries about mental health because I would of touched on it at some point, but they’re probably overwhelmed with numbers post Covid, so we are at the bottom of the pile.”***

There was some evidence of psychosocial interventions support being offered to a small number of participants alongside their MAT. One participant discussed their keyworker also being a Community Psychiatric Nurse (CPN) and that they took time to offer coping skills techniques for anxiety within their appointment. This eased some stress when this person was waiting for psychiatry support and expressed they were able to put things into practice they “never had before”.

Three other participants were put on a waiting list for group work sessions “to improve coping with emotional reactions”, such as Survive and Thrive. However, one had not been offered this type of support until they had been in MAT for ten months and all had been waiting several months to access it.

BUVIDAL

Twenty participants accessed or were already accessing Buvidal during the evaluation. As a treatment option, it was seen by some as “game changing” to their recovery progress and a much-preferred option compared to methadone. Participants felt being able to get an injection once a month helped them pursue other things in life and gave them freedom from attending a community pharmacy daily or weekly.

> ***“I think this is what I’m telling you, I’m no joking, that this Buvidal injection has literally saved my life, I wouldn’t have been, like I don’t know where I would have been if I was still on methadone.”***

Overall, however, experiences of support from services/keyworkers when on Buvidal were split. Eight participants felt they had a positive support experience alongside this medication, but another eight stated support was limited or non-existent on Buvidal. Four participants were unsure how they felt about the support offered with Buvidal and three others felt there was less support given compared to methadone or Subutex, and that this was not explained prior to treatment commencing.

> ***“The support is different. When you’re on Espranor, you’re getting your drug worker, when you’re on Buvidal, it’s a nurse with the injection, that’s it”.***

> ***“I probably would have expected a little bit more from them, to be honest, the contact has been, it has been really, really poor since I went onto the Buvidal. I did used to have regular contact from my drugs worker and it's just, just kinda stopped.”***

Fourteen participants described Buvidal appointments to be short, simply involving administration of their injection, with one explaining they “leave the taxi running outside” whilst they got their injection because the appointment was done so quickly. Injection appointments were sometimes offered at Buvidal clinics, with a ‘one in one out system’ that left several participants feeling like a number in a process rather an individual accessing support.

Four people said their injection would be administered by different nurses each month so they would attend clinics not knowing who they would be seeing that day, meaning there was no consistency in support. These participants stated they were unsure if they had an allocated keyworker anymore due to being in Buvidal treatment and having had no contact with anyone beyond the injections. One participant said they felt their drug and alcohol service has “removed the need for workers and some nurses” since Buvidal was introduced as a treatment. For those that felt the support around Buvidal injection was poor, often they were not given the option of further appointments to discuss support such as mental health.

> ***“They need to look into the mental health aspect of it, because you’re just kind of left, and oh you’re on the Buvidal jag now, that’s you kind of cured, and that’s no true.”***

> ***“I feel as if when you go in, it’s a matter of get your injection and out the door, you know? It’s a rushed job, its hiya then bye. You’re in and out in three minutes. I don’t see any compassion there or time to ask you anything about you.”***

For those that felt supported whilst on Buvidal, this was related to the positive relationship they had with their keyworkers and being provided with extra appointments beyond the monthly injection to offer support: “she will make a 45-minute appointment after my 2-minute Buvidal injection”.

Overall, most participants accessing Buvidal stated they wanted more chance to review their doses and discuss reduction plans for when they would eventually come off treatment as this did not happen often: “there has never been talk of how long I’ve got to be on Buvidal for, or anything like that”.

PRISON FOCUS GROUP FINDINGS

Participants in the prison focus groups shared experiences of the open estate and their experiences of other estates. They spoke both of their own direct experiences but also shared examples of their peers in prison. Whilst there were some issues which related to the open estate, the majority of themes applied to their experience across a variety of estates. The majority of the sample were currently accessing Buvidal (n=4), one was currently on methadone and another was on Espranor; all had experience of methadone at some point in their treatment journey.

ACCESS

Four out of the six prison residents were serving life sentences. These individuals typically reflected poorer experiences of getting treatment and support that was compliant with MAT standards. They felt they were treated differently and were more scrutinised than others due to the nature of their index offence, despite often having a long history of stability in treatment.

> ***“I haven’t failed a drug test since 2016...And yet the, it’s still holding up my progression, it’s still, I’m still getting slow played.....and I don’t understand why, the only thing I can point to is that I’m a lifer, you know, and they’re, they’re very wary.”***

> ***“No, I’d never go and say I’ve got a drug problem. I’ll deal with it myself...because the minute you go and ask them for help, everything’s..you’re getting f***ed..”***

Examples included lack of choice, challenges and delays when making changes to MAT, lack of access to detox options and limited progression in treatment. People in the open estate highlighted a constant concern about the risk of being moved to closed conditions, this was a barrier to asking for support about substance use, including when people were experiencing a high trigger period or had relapsed.

Participants highlighted issues with access to medication, especially when it came to alternative medications to methadone. Methadone appeared to have smoother access and continuity such as consistent dispensing. For two participants, one currently on it, and the other who had previously been on it, this stability within their treatment had made it an acceptable treatment, the other four participants however felt it was not their preferred choice. Some went further, feeling it was used as an instrument of control within prison.

> *"It's not too bad, I mean with the methadone you get, you get that at the same time every morning,..they've been doing it for years and it's really uncomplicated, it's just 55ml, 60ml whatever it is, pour a cup, you take it and you're away."*

> *"I was on methadone for 1 year, then I went onto the Espranor, you know what I mean, but that was the management that put me on that, that's all me, I'm going to do this, you know what I mean, but I had to fight f***ing hard, I had to dig my heels in for 2 year, you know what I mean, I shouldn't, I shouldn't need to do that, you know what I mean."*

> *M2: "You get forced on methadone, so you do, forced on it, and it wasn't getting moved."*
>
> *M3: "It's no an isolated incident, I've known many guys that have felt under pressure to go onto methadone for the sake of their progression.“*

Continuity with collecting prescriptions in community pharmacies was highlighted by a couple of participants, they described issues either getting a community pharmacy that would accept their prescription or having a problem with some kind of error on their prescription.

CHOICE

Overall, the majority of the sample suggested a greater stigma towards methadone generally, with reasons ranging from how it was administered, the lack of progression should they wish to either reduce or change medication and on occasion the historic context of its use in the community or prison estates. An example given of this was a time when they had felt people were given methadone without evidence of any drug history. Two participants shared the view that it was easier to increase methadone doses than it was to reduce.

In contrast, Buvidal was often described as a more preferred option, although participants spoke of long waiting times to access it and some suggested they felt clinicians had less experience or knowledge of Buvidal. Experiences of Buvidal were generally positive when provided as intended, however some participants had experienced challenges around delays, consistency and continuity to their injections. Examples included being given their injection late or not receiving their injection prior to home release which could result in withdrawal symptoms.

> *"..see that Buvidal, see for me personally, see if you get it properly and it's dispensed properly and all that, it's, it's been brilliant for me... I've had 15 jags, I've only had like 7 times properly."*

The impact of delays were discussed, with examples given of challenges of being in the community/public place when experiencing withdrawal, how it could impact on family time during their home leave and the risk of relapse as a result.

> ***" I'm out to play with my grandkids, right, and I'm going, what happens if I can't be bothered, because I feel withdrawal, and I can't be bothered playing with my grandkids or I feel a wee bit sick or anything, they're going to go, how does grandad no want to play with me, what's wrong with him, my daughter or whatever, and I don't want to say oh I'm withdrawing, do you know what I mean, and if you're no strong minded, it could lead to other things, well do you know what, I'm going get myself drugs to keep myself alright, just to get back in prison, and you come back, get a drug test, and you've failed it and you're sent back again, and it's going to cost me years.."***

SUPPORT

> ***" ..That's a big point, they automatically assume that we are, we are lying, that we're, we're, it's drug seeking behaviours.."***

Stigma was discussed both in terms of people's offending history and subsequent risk but also in terms of their history of substance use. Participants felt there was often a judgement by healthcare professionals towards prison residents when seeking general healthcare where they were perceived to be "drug-seeking" or on occasion, avoiding attending work.

There were various examples shared of punitive practices surrounding MAT dispensing or accessing healthcare such as the withholding of MAT and pain medications, people being incorrectly marked down as refusing their MAT and not receiving MAT before a court appearance.

> ***"I'm out of the hospital with one of my testicles swelled up to like the size of a tangerine, it was so painful, it's the most painful thing I've ever experienced, and when the doctors saw it, they got us out to the hospital right away...when I come back they put me on a painkiller or something, I don't know, but they put me on a strong painkiller and when I got back to [prison], they were like that, you're no getting them and that was that, you're no getting them.."***

There was a general sense among participants of being hesitant to challenge aspects of treatment and support or indeed to make complaints. This was often due to fears of being subject to punitive practices as a result and in some cases the fear of being downgraded to closed conditions as discussed earlier. Several shared direct experiences or witnessing others' experience of this where it had then taken several years to get back to the same point. This concern resulted in some being fearful to speak up about their treatment which did not meet the MAT standards whilst in the open estate, when they had "done everything to get here".

> *“If you, if you start questioning the, the system, and how they do things, then, then you’re put down as a problem prisoner, you know, you’re basically, you’re a problem prisoner. “*

> *M1: “That’s why people don’t complain a lot.”*
> *M3: “Aye and nobody puts, nobody writes, CP’s [complaints procedure]”*
> *M1: “You’re scared in case you get downgraded.”*

Issues surrounding confidentiality were discussed by four out of six participants. This tended to relate to data sharing between healthcare and prison staff and lack of privacy from prison staff when being dispensed their MAT. Again the fear of consequences of complaining often meant people felt they could not challenge their right to confidentiality.

> *M1: “There’s no confidentiality at all.”*
> *M2: “There’s no confidentiality at all, a prison officer shouldn’t know what I’m on.”*

Support needs discussed by participants highlighted core themes of lack of psycho-social support around MAT, the importance of getting help when you need it and the importance of a positive worker relationship. The need to address specific mental health issues among prison residents was also highlighted, including anxiety management and coping skills in preparation for community release.

There were examples of people on all forms of MAT who experienced limited wrap around support. For some, this meant the only support in their treatment was medication. For those participants, they suggested they did have named workers they could access but it felt that the responsibility was on them to ask and support was not proactively offered by workers. This could create a loop with people not tending to ask for the support they needed because they felt they would not get it based on their past experiences.

> *“M1: Jag and go, that’s it.*
> *M2: Aye.*
> *M1: Methadone, nothing, there’s your meth, bang, away.*
> *M2: Aye, bye.”*

> *“..they don’t come chasing you, but if you need it, it is there, aye.”*

Some participants shared how a poor experience with a clinician could make a dramatic impact in terms of people engaging with other wider healthcare and supports within prison. Conversely, a good experience had the potential to make a significant impact on an individuals’ progress and general satisfaction with treatment and support which in turn fostered self efficacy. Participants gave several positive examples of relationships with non clinical staff, which included regular contact, the ability to be able to talk when they needed support or advocating on their behalf around receiving or making changes to their MAT. Two people discussed the limited powers of individual staff “without the institution behind them”.

> *“..see the boy I was telling you about, that she tried to get him downgraded...she certainly held a grudge against him, because he did nothing, he’d nothing but trouble out of that medical centre after that and it wasn’t his fault..”*

> *“You can come any time and talk to them, they’ll speak to you, that’s what’s good about them..”*

> *“I pop down to see my addiction worker if I’m stressed out about things”*

Experience of having or being involved with care plans was mixed there was a general theme that plans where they did exist, tended to be led by staff and there were limited opportunities for people on MAT to give meaningful input to, for example when reducing or changing MAT.

> ***"I know my file follows me, I know when you go in that bus, you're medical file goes with you, I know you're f***ing prison file goes with you, so why is that care package no going with you.."***

Overall, people seemed unclear on what best practice should be surrounding care plans but some expressed an interest in having a clear plan they were fully involved in. One person highlighted the need for care plans and a support package to follow you much in the same way as your prison file does. There were several examples of people feeling they had regressed in their MAT treatment and general progress due to a lack of continuity of their MAT and wider support package when transferring prison estates.

The majority of participants discussed the limited support around mental health with more formal or higher tier support being more difficult to access or having longer waiting times. Some felt they could ask for support through their non clinical addictions staff. The most common supports that would be desired were things like having someone to talk to immediately if in crisis and support around anxiety management.

> ***"..there should always be somebody there, if somebody has got mental health issues, there should always be somebody there to speak to them... but it's no, guys are getting left for f***ing months and months at a time, guys are slitting their f***ing wrists."***

> ***"you can get told, oh we're busy the now, give us, they need to see you next week, but you're looking for support there and then, you're no looking for support next week, you need it there and then.."***

> ***"it should be a case of, if you're wanting to come off drugs, and wanting help there, that help should be there, shouldn't be fucking 6, 7, 8 month down the line, when, you know, oh f**k, that notions passed, f**k it, I'll just, you know what I mean, it should be when you want it, because that's the best time to get somebody.."***

The importance of timely support when you need it was outlined by most participants. Time pressures on staff was alluded to by participants, where it may not be possible to reach workers during a crisis. There was a general sense it was easier to access support more quickly from non clinical than clinical staff. Inconsistencies between establishments were also discussed by a couple of participants in terms of the support they were able to access. For example, there were examples of individuals accessing external support such as counselling or community drug services which was not a universal experience.

Where people did have community supports such as third sector drug services, this support was talked about positively and others felt it should be routinely offered as part of home leave.

Mutual aid and peer networks were highlighted as potential supports to access by several participants. These were generally spoken about favorably or neutrally with one participant identifying potential issues of peer support where people were still dealing with their own issues and could be triggered. One spoke of the benefits of having something like a prisoners forum to be able to share experiences of treatment and support to help improve things.

> ***"it would be useful if we had like a, like a forum that we could all talk about our experiences, with prescriptions and all that, to try and get things moved, try and get things changed.."***

RESEARCHER REFLECTIONS

The observational component of this evaluation provided a unique understanding of the logistics, experiences and feelings encountered by participants whilst in MAT. Reflections from the lead researcher and peer research volunteers have been included in the analysis of the findings.

Accompanying participants to appointments reinforced travel-related challenges reported by participants, including long distances to clinic buildings, associated costs of transport, and the anxieties about being late or missing appointments. Similarly, waiting in pharmacies for prescriptions with participants demonstrated the daily process some go through to receive their treatment. For example, being overlooked in queues and needing to take medication in a public setting. This drew attention to them, making them feel that people were aware why they were there, and reinforcing feelings of shame. Attending service buildings showed the type of environments people faced and brought to life the sometimes bleak descriptions given by participants. For example, some reception areas and waiting rooms felt more clinical and cold, compared to others that had more open space and provided comfortable seating. The differences in how this made you feel whilst waiting was stark.

Being present when appointments were cancelled or moved locations meant observing the impact, noticeable through their body language and feeling the frustration alongside participants. Witnessing the process of re-booking or leaving details to be called back clearly left people feeling deflated, especially when people had been nervously anticipating the appointment. Equally, when appointments were positive, participants spoke optimistically during debriefs; the immediate benefit of the interaction through someone's body language and general presentation was apparent.

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.

PEER RESEARCHER REFLECTIONS

"Direct observations allowed for great insight into how people access services and what support is offered and how".

"When you speak with participants on the phone or face to face for interview, you get a lot of information. They want to chat and tell their story and want to share the good and the bad with the aim of helping others in the future and that was so good to hear".

Most participants made contact with the lead researcher more frequently than the agreed check-ins, sometimes daily or weekly. They would send texts, leave voicemails/voice notes, and call to provide updates about their appointments and support. Sometimes participants would discuss other issues going on in their life, such as other health appointments, daily activities and their mental health. Participants wanted an outlet to talk about what was happening for them and felt comfortable sharing with someone whom they had not known for a long time.

People seemed eager to share their experiences and seek support or advice, even from someone who was not directly providing help. This was likely due to the research involving a process of active listening, curiosity and genuine interest about their experiences, making participants feel heard. This approach appeared to provide a level of emotional containment. Additionally, the length of the evaluation and freedom of the contact with the same lead researcher possibly contributed to the development of a therapeutic alliance, not always afforded within statutory settings.

DISCUSSION

ACCESS

Ease of access to MAT is fundamental to successful implementation of the standards. The findings outline that there are multiple factors which can affect how straightforward access is, both in terms of the practicalities of access, and, how the service and staff make people feel.

Stigmatising behaviour, practice and language were directly observed by researchers and reported by participants in interviews and focus groups. Stigma is recognised as a significant barrier to engagement in treatment, as highlighted in extensive literature and a recent national campaign (Scottish Government, 2021). Experiences within this sample included, but were not limited to, discriminatory comments by staff or differential treatment such as creation of separate pharmacy queues. Stigmatising staff behaviour and attitudes do not reflect a trauma-informed approach to treatment as outlined in MAT standard 10 and as is broadly accepted as how services should be designed (National Trauma Transformation Programme, 2023).

It was clear that stigma exacerbated negative feelings participants had towards engagement in MAT and themselves in general. For some, attending physically uninviting buildings reinforced feelings of unworthiness and reduced their willingness to attend. Additionally, some participants felt stigmatised in pharmacies and by GPs, again having an impact on their own confidence and overall recovery experience. This is supported by other literature, which highlights the link between public stigma and increased self-shame or self-stigma (Matthews, S et al., 2017). MAT standard 7 states that individuals should have the option to have their GP involved in their treatment due to the "possibility of wider health needs being met" (Scottish Government, 2021). Whilst there were a few positive examples of involvement of GPs, for example in care plans and general support, people reported often feeling dismissed or judged by GPs. Ultimately, this led to people preferring not to have GPs involved in their MAT treatment. The substance use treatment guidelines, often referred to as the 'Orange Book' suggest partnership working between services such as primary care and treatment services is an important component of effective treatment (Department of Health, 2017). The decision whether to have a GP involved in MAT treatment should be based around the health needs and wishes of the individual rather than being led by poor historic experience and fear of stigma.

Waiting times for treatment varied for those who were starting MAT during the evaluation and therefore impacted the ease of access. Notably, some participants were able to access drop-ins which supported facilitation of same-day access and/or rapid re-starting of medication, meeting MAT standard 1. However, others had significant difficulties in getting an initial appointment and prompt access to MAT, with one person waiting six months to be seen and commence a prescription. Implementation of MAT standard 1, which is fundamental to accessing treatment, remains inconsistent across and even within local areas. This is echoed in the recent benchmarking report on implementation by Public Health Scotland which shows no areas have "sustained implementation and monitoring" for MAT standard 1 (PHS, 2024) . Ways to ensure same-day access is made universal and consistent, such as widening provision of local drop-ins, should be prioritised by all service providers in Scotland.

The findings demonstrated the importance of good communication in helping people access MAT and retaining them in treatment. Experiences in this evaluation showed that receiving person centred communication and the overall tone of communication impacted greatly on motivation to engage and feelings towards the service. Those participants who received check-in and reminder texts from workers reported feeling valued and looked after. In comparison, receiving generic letters with punitive tones or having direct communication with workers they perceived as judgemental or dismissive left others feeling fearful and reluctant to engage, It was clear from observing individual journeys that every instance of contact with a service matters; this was essential in establishing the psychological safety needed to engage which is a key part of trauma informed practice.

Personalised communication was crucial for retention in MAT; for example those contacted in their less preferred ways (such as by letter), had poorer engagement and were at higher risk of dropping out. Encouragingly and aligning with MAT standard 3, participants who reported missing appointments generally felt that they were proactively contacted for follow-up, either through assertive outreach/home visits or texts and calls. However, there was little evidence of assertive outreach taking place for those who were trying to access/re-access MAT, with a sense the individual seeking treatment often had to be proactive about gaining access. There were a few examples of people leaving custody or residential treatment with limited follow up despite this being a known high risk period (Scottish Government, 2021).

Travel to services was another key factor affecting access to MAT, with cost implications, travel time and challenges with public transport being potential barriers; this was especially prominent for those travelling longer distances. Some people in rural locations were given a choice of where their appointments took place, which helped make access easier. This demonstrates a further example where logistics of treatment being tailored to individual needs enabled access and made the overall experience of treatment more positive. In the NHS Recovery Plan, effective outreach is outlined as a priority to support people "where they are" for alcohol and drug treatment (Scottish Government, 2021), a concept which underpins the standards overall. Flexibility with appointment location would be useful to extend to urban services in addition to rural locations, as evidence of this was limited with participants in city environments.. The consistent provision of travel passes could also benefit people in accessing treatment services as well as wider recovery networks. Ensuring services are "geographically and financially accessible" is a key element of the 'Right to the highest attainable standard of physical and mental health' outlined in the Charter of Rights for People Affected by Substance Use (National Collaborative, 2023).

CHOICE

The findings highlighted that there are several aspects of treatment where people should be offered choices more consistently. For many participants, they were not informed about what choices they had. Significantly, many were not aware of what the MAT standards were and what rights they had within their treatment. Better informing people accessing treatment of the MAT standards has been previously recommended in SDF's baseline evaluation. (SDF, 2021). A Human Rights Based Approach is central to the forthcoming Charter of Rights for People Affected by Substance Use which aims to support people to "enjoy their rights" (National Collaborative, 2023; p3). For this to be realised, an important first step is to ensure people are aware of their rights by being consistently informed of the MAT standards at every opportunity in their treatment journey. Building better awareness of the standards is an essential part of supporting individuals to make informed choices and be empowered in their treatment overall.

The information given to participants about their choices for treatment varied significantly. For example, some had leaflets provided or had brief discussions with a keyworker. As outlined in MAT standard 2, people accessing treatment must get appropriate time and resources to explore all options and consider how different treatments might affect them to make a fully informed choice. From discussions with participants, it was clear that myth busting on treatment was needed to ensure people had the facts about each medication including the current evidence. People's views were often heavily influenced by perceptions of newer versus older medications, stigma towards specific medications, experiences of their peers or previous negative experiences of treatment. The power of example is a key motivator in engaging people in treatment so it it essential that lived experience is framed within information which also takes account of the individuality of how people respond to different treatments. Consistent and accurate information about treatment options is essential; services require up-to-date resources and training on how to communicate and share this information with all people, so that people are better equipped to make an informed decision on their treatment.

There were inconsistencies in which options of medication people were routinely offered, especially at the start of treatment or where medication was being offered on the same day; methadone was the most commonly offered treatment in both community and custody settings. Participants in prison said Buvidal could be a good option for them but there was a long process required to access it and it was not always administered properly, with many having experienced delays and disruptions especially around release.

In contrast, methadone was viewed as more reliable and easy in terms of dispensing yet carried a much greater stigma for those in prison generally making it a less preferred option. Participants did make changes to their medication or dose during their involvement with the evaluation but usually had to undergo a lengthy process to do so. The ease of making a change could depend on other factors, such as the relationship with their keyworker and their current illicit substance use. It is necessary for services and clinicians to account for safety when decisions are being made about people's MAT, which may mean someone cannot commence certain medications or doses at a specific time (Department of Health, 2017). However, in line with MAT standard 2, discussions about any limitations on choice and why these exist must be had with people accessing treatment and steps taken to support them to be ready for the changes they want in the future. When participants were offered choices and had opportunities for comprehensive discussions, they described feelings of empowerment and control in treatment, even when they selected the option recommended by the service.

The findings demonstrate that increasing information for people in treatment should go beyond medication choice and the MAT standards. Participants expressed a desire to receive information about various other aspects of their treatment and support; this included changes to workers, appointment reminders, and opportunities like recovery groups and residential rehabilitation. When participants were adequately informed about their treatment and available options, they reported feeling more cared for and expressed optimism about their future - both during and after treatment. This highlights the significant impact of information on treatment satisfaction and its role in offering choice and control; an idea echoed in other work by SDF (SDF, 2019) and a key part of trauma informed practice (Scottish Government, 2021).

SUPPORT

This evaluation explored many aspects of support people in MAT were given and offered, as well as identifying where gaps within the MAT standards were. Although there was evidence of support being offered relating to multiple standards for some individuals, this was not consistent across or even within areas and services.

Whether or not participants had a consistent keyworker with whom they had a positive relationship was a crucial element of support that influenced their emotional state and motivation for treatment. Building therapeutic relationships and having a consistent worker are key features of successful trauma-informed treatment (Scottish Government, 2022). Keyworker relationship and continuity of worker impacted many aspects of support, such as contact frequency and trust in the service. Participants indicated that the relationship with their keyworkers determined whether they felt valued and cared for, and ultimately whether they were deserving of good support. People also discussed the impact of keyworkers going "above and beyond", such as by collecting food parcels for them, could have. Staff should not underestimate the power of even small acts of help in building relationships and demonstrating compassion. A positive relationship also affected how likely they were to access other types of support, including psychosocial interventions. These findings made clear that having a strong relationship with one's keyworker was the most important aspect of an individual's treatment; it was the key factor in retaining them in treatment, a requirement of MAT standard 5 and a known protective factor for preventing drug related deaths (SDF, 2019).

The experiences of participants in this sample showed that there can be a 'worker lottery' within areas, with stark differences between individuals, sometimes even within the same services. Poor relationships caused some people to feel negatively towards their support. Participants shared feeling "worthless", "lost" and "neglected", reflecting the significance that their relationships with workers had on their self esteem and wellbeing. There were a small number of incidences experienced by participants, related to how or where they were screened for illicit drug use, which impacted on their views towards treatment services and the staff. One example was an individual tested in a carpark, and another around staff having personal discussions about their care in a public arena such as the waiting room.

The theme of continuity of worker was also pertinent to this, due to the sensitive nature of testing. Participants shared being subject to such monitoring from duty staff (with whom they had little relationship with), could make the process feel much more difficult. These examples are in contradiction to a trauma-informed approach and the participants reported losing trust in treatment with some discussing thoughts of leaving treatment. As outlined earlier, retention in treatment is a key factor in preventing drug related deaths as well as reducing a variety of other drug harms. The nature of the relationship someone had with their keyworker influenced the likelihood of having a care plan and whether they had ample opportunity for therapeutic discussions. Care plans are a crucial element of healthcare support (Nursing and Midwifery Council, 2024: NICE, 2017) and are recommended throughout the MAT standards as a cornerstone of treatment recording and reviews (Scottish Government, 2021). Some of those with a consistent keyworker relationship discussed feeling involved and in control of their care plan. Comparatively, those with negative relationships felt uninvolved and unheard. Those with duty worker only contact reported difficulties making any changes to treatment or being involved in their care plans and often felt no one was taking responsibility for their care.

Participants without a keyworker or where they had a negative relationship with their allocated worker often made more frequent contact with the lead researcher for this project. The relationship built with the researcher appeared to provide the support they were seeking, but at times not receiving, in treatment. These individuals typically expressed that having this consistent contact with someone who took an interest in them made a positive difference to their journey and general wellbeing. It was even referenced as being the only thing keeping them engaged in MAT in a few cases. This makes clear that having at least one positive relationship is an essential feature of MAT provision. The impact of consistency, warmth and care from one’s workers should not be underestimated and staff need to be afforded the time needed to foster these relationships.

Provision of evidence-based harm reduction should be a key aspect of support offered at the point of MAT delivery, as outlined in MAT standard 4. Only a few participants discussed accessing injecting equipment provider (IEP) services and were able to get blood testing and equipment through them. However, harm reduction was not discussed routinely with all participants in MAT services; there were a few incidences of unclear, and at times, potentially unsafe advice given to individuals. Gaps in harm reduction were most evident for participants who continued to use other substances alongside their MAT. Some participants were not offered support for other substances they were using, yet also could not increase their MAT dose. This left them feeling stuck in treatment with often high levels of illicit use continuing without tangible support or advice to progress to where they wished to. Low threshold prescribing aims to reduce harm to individuals and promote overall better health outcomes without the need for abstinence from other substances (SDF, 2019). Equally the ‘Orange Guidelines’ offer a comprehensive list of interventions which should be offered where illicit substance use on top of prescribed medication is observed, including more frequent contact, medical review and ensuring access to harm reduction advice and equipment (Department of Health, 2017). There remains a gap for harm reduction in support for people who continue to use substances whilst on MAT, placing individuals at a high risk of drug-related harm.

Mental health was a priority for most participants and it was clear for many that far more support was needed. Evidence of MAT standard 9 implementation, which focuses on mental health, was limited. Participants experienced barriers to specialist support such as lengthy waiting lists and exclusionary criteria related to substance use. These findings are reflective of well-documented issues with people who use substances struggling to access mental health support (SDF, 2021; Scottish Government, 2022). MAT standard 9 recommends staff should routinely inquire about mental health and offer in-house supports where possible (Scottish Government, 2021), yet many people in this sample said their keyworker never discussed mental health with them. It continues to be pertinent for services to work together more effectively around co-existing mental health and substance use issues.

This should include improving referral processes and removing requirements for abstinence to access specialist support to avoid people falling through the gaps. Equally, as outlined in MAT standard 6, psychosocial interventions do not need to be provided by specialist mental health staff with all staff working across MAT services having "a role in delivering psychologically informed care" (Scottish Government, 2021). For many in this sample, any mental health intervention would have been beneficial and wider access to psychosocial interventions would have provided a much needed first line response.

The findings highlighted some examples of keyworkers promoting low-threshold interventions during community appointments, which met requirements of MAT standard 6. These included techniques such as breathing exercises, mindfulness, and coping skills for issues like anxiety. Several participants also shared their experiences of support from third sector organisations, which were generally highly valued. Third sector services could often offer more varied supports over a range of issues, including harm reduction, housing and benefits, than seemed to be accessible from statutory MAT services. They were also key to people feeling connected to recovery communities as often had lived/living experience staff or peers involved. Similar positive support was experienced by those who spent time in residential rehabilitation during the evaluation. Referrals to advocacy and other agencies were far less common from statutory services, perhaps undermining MAT standard 8 which covers provision of these. Notably, due to the negative experiences some went through, the lead researcher signposted some participants to advocacy, as it was needed but not proactively promoted by MAT services.

Access to basic mental health support was said to be completely lacking in the prison establishment, as was wraparound support such as general healthcare or practical support unless people felt able to proactively ask for it. The Public Health Scotland benchmarking report acknowledges that implementation and reporting of the MAT standards is at an earlier stage in custody settings than in the community (PHS, 2024); this was supported in a recent Scottish Government report on the support needs of Scotland's prison population. (2022). The focus group participants discussed a culture of fear surrounding much of MAT provision. They shared concerns that honesty about their substance use, raising complaints around their treatment or even asking for additional support would lead to negative consequences like being moved to closed conditions or having medications withheld. Furthermore, provision of medication could be delayed or affected when people were on day release, for example, which placed people at risk of issues such as relapse. It is key these issues are addressed within prisons and there are concentrated efforts made to boost implementation of the standards overall.

Experiences of the medication Buvidal varied, with more difficult experiences being related to the support package people were offered alongside it. It was acknowledged by several people that it could be a very positive option, for reasons such as not being tied to services or community pharmacies. Indeed, some viewed Buvidal as a "transformative" forward step in their recovery and therefore felt extra support alongside it was not needed. In comparison, others felt they were "left to it" on Buvidal. Many discussed receiving only short appointments often with different workers simply to get their injection, meaning they had little opportunity to discuss other supports and their general progress. Most participants in this sample felt they needed more support on Buvidal than was being offered, especially where mental health was concerned.

These experiences of Buvidal reflect current feedback from people in treatment who attend SDF's living experience engagement groups, currently running across Scotland. People who attend the groups have shared that they feel support is limited beyond their monthly injection. Some state that the reduced contact with pharmacies as well as lack of contact with their worker has led to them becoming more isolated. This has resulted in people dropping out of treatment and re-lapsing or in other cases is linked with the increased use of other substances, notably cocaine, on top of their medication (SDF, 2024). This suggests that the more distant and relaxed treatment regime associated with Buvidal is welcome by some people in MAT and perhaps service providers, but others need more frequent contact than is generally offered and want wider supports beyond medication.

There are clearly individual preferences and needs within those who currently access Buvidal which must be understood and catered for in a person-centred way, as with any form of MAT. As Buvidal provision continues to gain momentum across Scotland (PHS, 2024), and due to its significant potential to be "life changing" as identified by some in this sample, it is important issues with provision are explored further and addressed. For example, combining Buvidal clinics with keyworker appointments and consistently offering all wraparound support interventions as offered for other forms of MAT. More information about those who use other substances on top of their Buvidal and the impact this has on them would help understand potential risks and harm reduction needs. Further examination of staff knowledge and approaches to provision could also be beneficial to improving the consistency of support offered.

LIMITATIONS

Recruitment in some areas relied on staff engaging with people they supported, which resulted in a few key individuals doing most of this. This was anticipated and every effort made to promote the evaluation across a range of sites and peer networks to reduce bias in the sample as far as possible. The sample overall could likely have been more representative of people in treatment at a national level. However, the design of this evaluation intended to provide more in-depth insights of individual experiences of MAT, as was achieved.

The age distribution of the sample had fewer participants from the youngest and oldest groups. This could be considered a limitation, as it may result in less representation of themes specifically impacting these age groups. The sample also contained a relatively low number of women who disclosed direct caregiving responsibilities for children. It was also expected that more gender differences in experiences would have been observed. However, the demographic split of the sample is largely reflective of those with an opioid dependence and accessing treatment in Scotland (PHS, 2023; PHS, 2024).

Some participant dropout was anticipated due to the length of engagement required and did indeed occur. The most common reason for dropout was contact not being maintained, despite repeated efforts by the lead researcher. Nevertheless, the majority of the sample completed the full six month observational period (n=50) and a final interview (n=42), thus garnering a significant level of data.

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.

GOOD PRACTICE 4 - “SEAN”

- **Liaised with his worker monthly to organise a suitable appointment day, time and location.**
- **Received Buvidal injection monthly followed by a 45-minute meeting with keyworker and had full discussion about how he was coping and any appropriate next steps for treatment.**
- **Care plan regularly reviewed with Sean’s full involvement and a reduction plan agreed and initiated.**
- **These regular appointments allowed Sean to build trust and establish a supportive relationship, with the option to contact his worker between appointments.**

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August 2024

Scottish Drugs Forum (SDF) is a company limited by guarantee, registration no. 106295 with charitable status and is also a registered Scottish charity registered SC 008075