EXPERIENCES OF MEDICATION ASSISTED TREATMENT

Learning & considerations for practice

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SCOTTISH DRUGS FORUM

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- Research team: Louise Horn, Peers: Alana J, Alex F, Alex S, Craig A, David C, Denise M, Fran K, Gary F, Garry T, Gordon C, Jacqui M, Nicki M and Robert W.

- Participants who participated in the research

- Staff who supported recruitment

- Scottish government who provided partial funding towards the work

DESIGN & SAMPLE

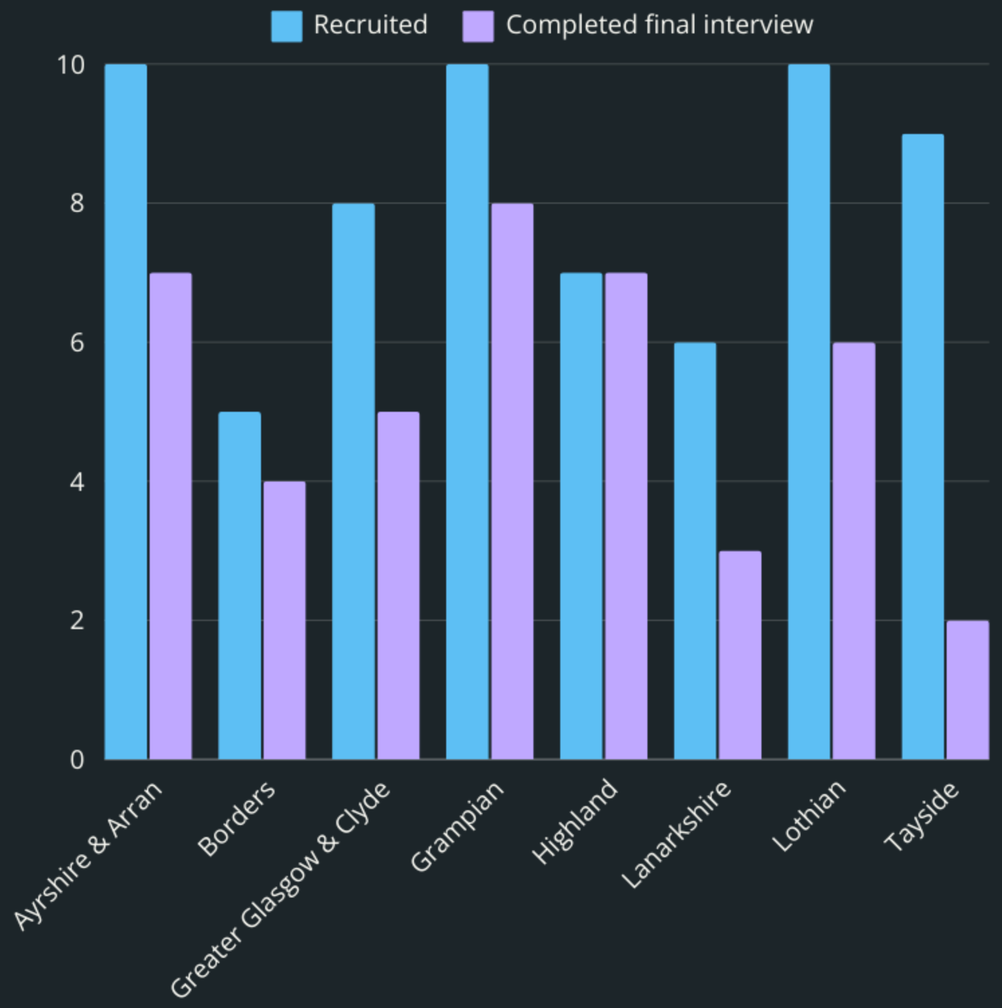
Participants were recruited from eight health board areas across Scotland.

Qualitative approach - observations (41) over 6 month period, 3 then 6 month interviews (52 and 42 respectively) and focus groups in HMP Castle Huntly.

65 participants enrolled in the observational study overall (41 male, 23 female, 1 non binary, 19-65).
6 participants engaged in focus groups (all males, 35-55, 4 of those serving life sentences).

Inclusion criteria was to recruit a variety of participants across the health board areas who were:

- seeking MAT = 4
- prescribed/ re-accessed in past 3 months = 19
- prescribed/ re-accessed in past 3-12 months = 29
- accessing MAT for over 12 months = 13



ACCESS

Stigma

Waiting times

Communication

Travel

REDUCING STIGMA

- Stigmatising behaviour, attitudes and language observed and reported
- Across multiple settings and practices and exacerbates negative feelings about MAT and themselves
- Must be addressed and challenged at all levels to reach a truly trauma-informed approach
- Service/manager leads must encourage culture change
- Training and resources should be utilised - e.g. Trauma-Informed Toolkit, Roadmap, SDF glossary

"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."

"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."

"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."

SUPPORTING ACCESS

- Practicalities of access must be considered on an individual basis, accounting for needs and preferences
- Waiting times are still variable - prioritising widening of drop-in clinics across days and localities
- Participants liked to be contacted in different ways and method/tone impacted how they felt about engaging
- Travel to services can represent multiple barriers for people
- Positive examples of outreach and options can be built on - e.g. home visits, alternative buildings
- Meeting people where they are - psychologically and physically - is key

"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."

"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."

"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".

"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."

"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."

GOOD PRACTICE SPOTLIGHT - “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.

CHOICE

Initial medication

Choice of dose

Choice of keyworker

Changing medication

MAT STANDARDS INFORMATION

- Only 10 participants aware of the MAT standards when they started the evaluation
- People must be informed about these initially and throughout their treatment journey
- Important part of applying a human rights based approach - central to Charter of Rights for People Affected by Substance Use
- Information/ resources must be accessible and consistent
- Use every opportunity to promote the standards - e.g. display in waiting rooms, hand out physical copies

"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".

"I wasn't aware as a drug user I had rights in treatment."

TREATMENT DISCUSSIONS

- Space must be given for collaborative discussions where people can ask questions and digest information
- Methadone was most commonly offered and seen as “easiest” to access in community and prison settings
- Clinical decisions/ reasoning must be explained and staff supported to do so
- Being fully informed and involved in decisions is empowering and fundamental to the MAT standards
- Proactively provide information about other support that can be offered

“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.”

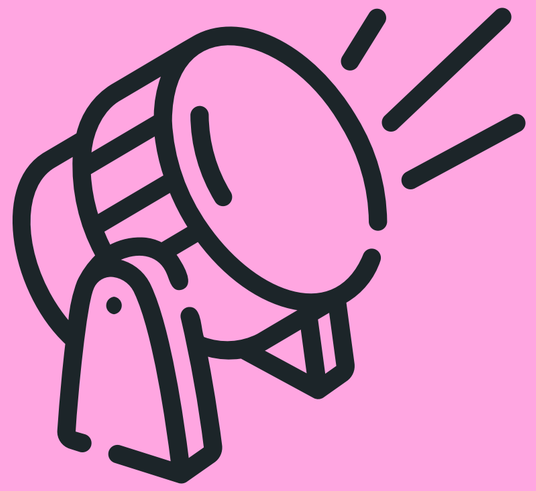
M2: “You get forced on methadone, so you do, forced on it, and it wasn’t getting moved.”

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.“

“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.”

*“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.”*

GOOD PRACTICE SPOTLIGHT - “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.

SUPPORT

- Residential settings
- Criminal justice
- Keyworker relationships
- Peers & community
- Harm reduction
- Buvidal
- Mental health

THERAPEUTIC RELATIONSHIPS

- Relationships with keyworkers most important part of treatment
- Staff must be given the time to build positive relationships from initial engagement
- Alleviate anxiety with choices and initial contact
- Manage duty cover and change of workers properly
- Imperative to trauma-informed care - staff need development time
- Power of compassion and small acts should not be underestimated

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

*"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."*

"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

"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".

"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" .

GOOD PRACTICE SPOTLIGHT - “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.

CONSISTENCY IN PROVISION

- Support offered alongside medication must be provided consistently
- Limitations in harm reduction, especially for other substances, observed in evaluation
- Ensure all substance use is discussed openly and explanations given when it affects MAT
- Mental health support is a priority - must be addressed in appointments as well as by specialists
- Third sector/recovery communities can provide support in line with MAT standards - e.g. advocacy and peer support

*"..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."*

"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" .

"[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".

"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."

BUVIDAL

- Has the potential to be “game changing” for people, often due to more flexibility
- People must be offered all the same choices and supports as other forms of MAT
- Contact can be limited beyond monthly injections
- Concerns about correct administration in prison settings
- Frequency of contact and additional psychosocial support must be patient-led

“..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.”

“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.”

“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 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.”

GOOD PRACTICE SPOTLIGHT - “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.

FINAL THOUGHTS & REFLECTIONS

- Observational component gave unique understanding of logistics, experiences and feelings of people in MAT in real time
- Researchers experienced the environments, journeys and interactions with people and impact these had
- The findings were enriched by peer researchers' approach and relationships they build with participants
- Lead researcher became an outlet for talking about treatment and other important things
- People felt heard and eager to share their experiences
- Consistency in implementation of the standards must remain a priority
- Primary aim of treatment should be empowering people in treatment
- Positive and consistent therapeutic relationships are key to engaging and retaining people in treatment

THANK YOU

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